



Final Report: Southern Africa Nutrition Initiative

Period: March 17th 2016 to March 31st 2021

Countries: Malawi, Mozambique, Zambia

Project No. #D-002000 PO 7062252

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| Project Information | |
|----------------------------|--|
| Project Name | Southern Africa Nutrition Initiative (SANI) |
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| Total Project Budget | <p>Contribution Agreement (CA) signed March 17th 2016: Total project budget: \$24,652,087 CAD GAC contribution: \$21,117,438 CAD Match: \$1,599,649 CAD in cash and \$1,935,000 CAD in kind</p> <p>CA Amendment #2: Signed July 16th 2020 increased the GAC contribution by \$1,100,000 CAD to \$22,217,438 CAD, and reduced the match in-kind contribution to \$1,770,048 CAD.</p> <p>CA Amendment #4: Signed March 29th 2021, increased the GAC contribution by \$3,900,000 CAD to \$26,117,438 CAD, bringing the total project budget to: \$29,487,135 CAD</p> |
| Project Start and End Date | <p>Project start date: March 17th 2016, with 4 years and three months implementation to June 31st, 2020</p> <p>CA Amendment #1: Signed July 10th 2019, extended project duration to December 31st 2020.</p> <p>CA Amendment #2: Signed July 16th, 2020, extended project duration to March 30th 2021.</p> <p>CA Amendment #3: Approved by GAC via email on March 9th 2021 extended project duration to April 30th 2021.</p> <p>CA Amendment #4: Signed March 29th 2021, extended project duration to June 30th 2022.</p> |

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Acronyms

| | |
|--------|---|
| AEHO | Area Environment Health Officers |
| AEDO | Agriculture Extension Development Officer |
| AEO | Agriculture Extension Officer |
| ACLAN | Area Community Leaders Action for Nutrition |
| ADC | Area Development Committee |
| ANC | Antenatal Care |
| ANCC | Area Nutrition Coordinating Committee |
| APES | Agente Polivalente Elemental |
| CBGMP | Community Based Growth Monitoring Promotion |
| CDA | Community Development Assistant |
| CLAN | Community Leaders Action for Nutrition |
| CLTSH | Community-led Total Sanitation and Hygiene |
| CLTS | Community-Led Total Sanitation |
| CMAM | Community-based Management of Acute Malnutrition |
| CSC | Community Score Card |
| CSO | Civil Society Organizations |
| CSONA | Civil Society Organization Nutrition Alliance |
| CGP | Care Group Promoters |
| CHW | Community Health Worker |
| CUSO | Canadian University Service Overseas |
| DEC | District Executive Committee |
| DHMT | District Health Management Team |
| DHO | District Health Office |
| DHS | Demographic Health Survey |
| DNHA | Department of Nutrition and HIV/AIDS |
| CLAN | Community Leaders Action for Nutrition |
| COMACO | Community Markets for Conservation |
| COWLHA | Coalition for Women Living with HIV/AIDS |
| CSONA | Civil Society Organization Nutrition Alliance |
| DNCC | District Nutrition Coordinating Committee |
| DOPE | Development Organisation for People's Empowerment |
| EIA | Environmental Impact Assessment |
| F2F. | Father-to-Father |
| FAW | Fall Army Worm |
| FFS | Farmer Field School |
| FGD | Focus group discussion |
| FHF | Feed Her Future |
| FIES | Food Insecurity Experience Scale |
| GAC | Global Affairs Canada |
| GBV | Gender Based Violence |
| GE | Gender Equality |
| GMP | Growth Monitoring and Promotion |
| GMV | Growth monitoring volunteers |
| HH | Household |
| HCW | Health Care Worker |
| HOPEM | Men for Change Network Mozambique |
| HMIS | Health Management Information System |
| HSA | Health Surveillance Assistant |
| ICT | Information Communication Technology |
| IDWS | Improved Drinking Water Sources |
| IEC | Information, Education and Communication |
| IMAM | Integrated Management of Acute Malnutrition |
| IPV | Intimate Partner Violence |
| IYCF | Infant and young child feeding |
| LF | Lead Farmers |
| LM | Logic Model |

| | |
|--------|---|
| MAD | Minimum Acceptable Diet |
| M2M | Mother-to-Mother |
| MAG | Male Action Group |
| MDD | Minimum Dietary Diversity |
| MGCDSW | Ministry of Gender, Children, Disability and Social Welfare |
| MIS | Management Information System |
| MIYCN | Maternal, Infant and Young Child Nutrition |
| MMF | Minimum Meal Frequency |
| MoA | Ministry of Agriculture |
| MoH | Ministry of Health |
| MUAC | Mid-Upper Arm Circumference |
| NCC | Nutrition Coordinating Committee |
| NFNC | National Food and Nutrition Commission |
| NHC | Nutrition Health Committee |
| NNP | National Nutrition Programme |
| NSG | Nutrition Support Group |
| NFNC | National Food and Nutrition Commission |
| ORS | Oral Rehydration Salts |
| OTP | Outpatient Therapeutic Programme |
| PACHI | Parent and Child Health Initiative |
| PAWOC | Passion for Women and Children - Malawi |
| PE | Public Engagement |
| PET | Performance Education Theatre |
| PLW | Person Living with HIV |
| PMF | Performance Management Framework |
| PVCW | Program for Vulnerable Children and Women |
| PNC | Post-natal Care |
| RBM | Results-Based Management |
| PNCC | Provincial Nutrition Coordinating Committee |
| RHC | Regional Health Coordinators |
| RUTF | Ready-to-Use Therapeutic Food |
| RUSF | Ready-to-Use Supplementary Food |
| ODF | Open Defecation Free |
| SAA | Social Analysis and Action |
| SAG | Sanitation Action Group |
| SAM | Severe Acute Malnutrition |
| SANI | Southern African Nutrition Initiative |
| SUN | Scaling Up Nutrition |
| TA | Traditional Authority |
| ToT | Trainer of Trainers |
| VSLA | Village Savings and Loans Association |
| WASH | Water, Sanitation and Hygiene |
| WDD | Women's Dietary Diversity |
| WMC | Water Management Committee |
| WNCC | Ward Nutrition Coordinating Committee |
| WPC | Water Point Committee |
| WPMC | Water Point Management Committee |
| WRA | Women of Reproductive Age |
| VNCC | Village Nutrition Coordinating Committee |
| VHC | Village Health Committee |
| VH | Village Headman |

Executive Summary

The Southern Africa Nutrition Initiative (SANI) is a \$29,487,135 CAD project to address undernutrition in women of reproductive age (15-49) and children under 5 years in Malawi, Mozambique and Zambia. A partnership between CARE, Cuso International, Interagency Coalition on AIDS and Development (ICAD) and McGill University and the Governments and communities of implementing countries, SANI aimed to improve the nutritional status of women of reproductive age (15-49 years) and children under-5 years old. SANI was designed to align with national health and nutrition strategic priorities of Malawi, Mozambique and Zambia, and has been implemented in close collaboration with the Ministries responsible for Health, Agriculture, and Gender in each country, as well as national and district-level nutrition coordination committees (NCC and DNCC). Between June 2016 and March 2021, SANI contributed directly to the improved health of 234,000 women, children and men directly and over 498,000 individuals indirectly.

This final report covers the implementation period of the original SANI contribution agreement and project implementation plan finalized in February 2017. All activities and outputs under this initial contribution agreement were completed by March 30th, 2021, and progress towards outcomes was measured in endline studies completed between January 2020 (Malawi) and November 2020 (Zambia and Mozambique). As described in the Project Information table on pg 2., SANI was granted two costed extensions (in July 2020 and March 2021) to respond to the COVID-19 pandemic. All reporting for COVID-19 response activities, as well as financial reporting and disposal of assets, will be conducted separately in a subsequent report following the end of project activities in June 2022.

Key project achievements:

Outcome 1100 aimed to improve nutrition practices and services for women of reproductive age, boys, and girls under 5 by strengthening the delivery of community-based nutrition services at the intersection between community health and the health system. Growth Monitoring and Promotion (GMP) and Community Management of Acute Malnutrition (CMAM) programs built this link, working on the continuum of prevention of malnutrition and early detection and treatment of moderate and severe acute malnutrition. Training and support on Maternal, Infant, and Young Child Nutrition (MIYCN), CMAM, and GMP was provided to health service workers and community health workers, and Care groups were established to support families to learn about and apply gender-sensitive MIYCN practices. Interactive teaching was also done at scale through participatory education theatre and cooking demonstrations using local nutritious foods. Social Analysis and Action (SAA) dialogues encouraged families involved in the program to identify, discuss, and challenge traditional social norms and practices that affect women's health, nutrition, and empowerment.

Endline data revealed the following increases in nutrition-specific indicators from baseline:

- All three countries had considerable increases in rates of exclusive breastfeeding of children up to 5 months, increasing by 15-percentage points in Zambia (from 70% to 85%), 25-percentage points in Malawi (from 61% to 86%) and 17-percentage points in Mozambique (from 65% to 82%)
- Minimum Acceptable Diet (MAD) for children 6 to 23 months increased by 24-percentage points for boys and girls in Malawi (from 7% to 31%) and in Zambia by 7-percentage points for boys (from 24% to 31%) and by 13-percentage points for girls (from 17% to 30%)
- Knowledge of men and women on MIYCN practices improved by 6-percentage points for men (from 79% to 85%) and 4 percentage points for women in Malawi (from 90% to 94%), by 12-percentage points among women (from 59% to 71%) in Mozambique, and by 11-percentage points for women (from 81% to 92%) and 14-percentage points for men (from 72% to 86%) in Zambia.

Outcome 1200 addressed the determinants of under-nutrition with activities that influenced long-term improvements in the overall health of the population. SANI worked with communities to improve access to and availability of food by establishing climate-sensitive homestead gardens that meet the minimal acceptable dietary needs of women and boys and girls under five. Water, sanitation, and hygiene (WASH) was improved by the construction and rehabilitation of water points, the engagement of communities in Community-led Total Sanitation (CLTS) processes and water management committees (WMC). SANI made progress towards the following indicators for this outcome:

- Minimum dietary diversity (MDD) increased among women and children in Malawi and Zambia, with a 20-percentage point increase in dietary diversity among women in Zambia (from 57% to 77%) and a 50-percentage point increase in Malawi (from 18% to 68%).
- The number of men and women using improved drinking water sources increased by 3-percentage points in Zambia (from 29% to 32%), by 8-percentage points in Malawi (from 77% to 85%), and by 7-percentage points in Mozambique (from 66% to 73%).
- Improvement in water treatment practices in all three countries. In Malawi, there was a 6-percentage point increase (from 25% to 31%), a 46-percentage point increase in Zambia (24% to 70%), and a 16-percentage point increase in Mozambique (from 8% to 24%).
- Prevalence of diarrhea decreased in all three countries, by 19-percentage points in Malawi (from 54% to 35%), 4-percentage points in Zambia (from 24% to 20%), and 7-percentage points in Mozambique (from 19% to 12%).
- Moderate and Severe Food Insecurity decreased in Malawi by 18-percentage points (from 72% to 54%), and by 9-percentage points in Mozambique (from 54% to 45%).
- Women's Dietary Diversity (WDD) improved by 50-percentage points in Malawi (from 18% to 68%), by 20-percentage points in Zambia (from 57% to 77%) and by 1-percentage point in Mozambique (from 21% to 22%).

Outcome 1300 took a multi-sectoral approach to ending malnutrition in Malawi, Mozambique and Zambia at multiple levels of government administration, strengthening Nutrition Coordinating Committees to plan, implement and monitor multi-sectoral nutrition programs. In Malawi, SANI focused on strengthening the capacity of already functioning District and Area Coordinating Committees to provide supported supervision and outreach, project management and monitoring. In Mozambique and Zambia SANI strengthened the Provincial Coordinating Committees and established district coordination committees. Communities were engaged in Community Scorecard processes to facilitate citizen participation in the planning, delivery, and evaluation of nutrition services at the community level. SANI contributed to the following key results under this outcome:

- Increase in female leadership in nutrition governance, with at least 30% of DNCC members and leaders who are women in all three countries.
- 100% of targeted districts across all 3 countries developed gender-sensitive multi-sectoral nutrition action plans.
- Responsiveness of health service providers for gender-sensitive MIYCN and global acute malnutrition improved by 25% in Malawi, 8% in Mozambique and 7% in Zambia.

Under outcome 1400, SANI engaged the Canadian public through a public education campaign, Feed Her Future (FHF). The aim of this campaign was to engage Canadian men and women in understanding the complex relationship between gender equality and nutritional status, as well as highlight Canada's leadership in fighting malnutrition among women and girls through SANI. The campaign launched in June 2018 and ran until August 2020. CARE and partners developed material for a variety of fora and media, including the FHF webpage, conferences and workshops, videos, infographics, and social media. These materials were based on research findings, both pre-existing and conducted as part of SANI, and stories and testimonials from people reached by the project.

- A total of 112 campaign information products were developed, as well as 21 campaign videos featuring project participants and staff, 1 bilingual website and 4 social media channels.
- 27 Canadian public outreach activities were conducted, engaging with 381 Canadians at farmers markets and with 404 Canadians during street outreach, and an additional 19 presentations about SANI were delivered at separate workshops and conferences in Canada.
- Reached 2,578,243 social media impressions, 55,414 social media engagements, and saw 4,833 unique visitors to the SANI website.

Access to nutritious food is constrained by a complex intersection of poverty, gender, and community dynamics, and SANI was designed with a range of gender-specific and gender-sensitive interventions to address gender inequality. This included the promotion of male engagement and participation in MIYCN in Care groups, M2M and F2F groups, opening space to reflect and examine not only men's

knowledge and participation but also women's autonomy, and the nutrition and health benefits of equitable decision making and sharing the work burden within the household. To shift social norms, SANI also implemented Social Analysis and Action (SAA), a gender-specific approach for working with communities through recurring dialogue to examine, reflect and address how social and gender norms perpetuate health challenges, malnutrition and gender inequality. SANI also aimed to strengthen female participation and create spaces for women to express their rights within nutrition governance structures by promoting women's leadership in nutrition governance committees and participation in CSC processes.

The impact of the gender equality interventions of SANI was noted through improved attitudes of women and men toward gender issues that influence nutrition practices for women of reproductive age (WRA) and boys and girls under 5. The project, in collaboration with local partners, addressed cultural norms that negatively influence family nutrition, and more men were seen to be accompanying wives and children to health facilities. In addition, SANI addressed myths surrounding nutrition through home visits and support groups and influenced men's roles in nutrition and health within the household. By project endline, women are equipped with agricultural knowledge, have better access to more land for growing crops, to agricultural inputs like vegetable seeds and seasonal crops.

Volunteer sending

Cuso and CARE successfully deployed 35 volunteers over the course of the project, all of whom contributed their skills and time to achieving over \$1.7 million in in-kind contribution to the project. An end of project survey of 12 CARE country office staff who directly worked with the volunteers or helped manage the partnership administratively found that 100% of staff valued the partnership and would recommend having volunteers on future projects, and 93% of staff felt the volunteers helped to reduce their workload. While the COVID-19 pandemic brought the final cohort of volunteers home several months earlier than planned, the volunteers continued their assignments from home in Canada and completed their scope of work in support of SANI remotely.

Twinning

As part of SANI, the Interagency Coalition on AIDS and Development (ICAD) implemented a twinning project with organizations in Canada, Malawi and Zambia to build the capacity of community-based organizations to address intersections between HIV and nutrition and improve information, education and services for women living with HIV and children living with and/or affected by HIV. Throughout the project, seven participating organizations in Canada, Malawi, and Zambia strengthened their capacity to deliver gender-equitable nutrition programs for women living with HIV, and generated important lessons learned on building nutrition programming that is responsive to the needs of people living with HIV in Malawi, Zambia, and Canada.

Overall, the SANI project directly reached a total of 233,990 people, including 125,557 women and girls and 108,433 men and boys, as well as indirectly reached 498,245 people, including 288,775 women and girls, and 209,470 men and boys.

While SANI's theory of change and implementation strategy remained consistent through project implementation, several shifts in operating context forced SANI to adjust operational timelines and strategies. Major events included elections in Malawi and Mozambique, gassing attacks in Zambia, cyclones Idai and Kenneth in Mozambique infestation of the fall army worm, and recurrent cyclical flooding and droughts. The COVID-19 outbreak at the beginning of 2020 arrived just as the project entered a final phase, with operations having wrapped up in Malawi, and most activities coming to a finish in Mozambique and Zambia. At the same time, the social and economic pressures of the COVID pandemic pushed communities to new heights of vulnerability, threatening to reverse the progress of the SANI project. Activities were quickly adjusted, and an emergency response program rapidly launched with funding from a costed extension from GAC.

While the original activities and outputs planned under the initial program implementation plan for SANI have come to an end, CARE will continue to implement COVID-19 response activities in communities reached by SANI in Malawi, Mozambique, and Zambia through the end of June 2022 with a costed extension from GAC. This response is intended to support communities preserve the nutrition and livelihood related gains achieved during the SANI project through the COVID-19 pandemic.

1: Project Description and Context

1.1: Project Description

SANI was designed to bring together UNICEF Conceptual Framework on Nutrition (1990), which looks at direct and indirect causes of under-nutrition and the Lancet Series on Maternal and Child Nutrition Framework for Action (2013). The Framework addresses under-nutrition interventions under four pillars: Nutrition Specific, Nutrition Sensitive, Governance, and Accountability and Women's Empowerment. The SANI project also includes the SUN Movement¹ approach of the first 1000 most critical days from conception to a child's 2nd birthday but is expanded to include children up to the age of five.

Many nutrition initiatives focus primarily on nutrition for childhood development and often neglect health and nutrition needs specific to women and girls. CARE places women at the centre of the Southern African Nutrition Initiative, focusing on women's health and development outside of their roles as mothers. CARE achieved this in SANI by implementing both gender-specific and gender-sensitive nutrition interventions.

The ultimate outcome of the SANI project is to contribute to the reduction of maternal and child mortality in targeted regions. The intermediate outcomes are:

1. Improved nutrition practices and services of women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia;
2. Improved nutrition sensitive practices for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia;
3. Strengthened governance and accountability of gender-equitable nutrition policies and programs for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia; and
4. Increased active engagement of Canadian women and men, including youth and aboriginal peoples, in support of women's and girl's development initiatives.

1.2: Context

1.2.1: Malawi

In Malawi, SANI was implemented in the most remote areas of **Dowa** and **Ntchisi** Districts, in Central Malawi, covering 4 Traditional Authorities (TA) (sub-Districts), specifically in Dzoole TA and Kayembe TA in Dowa District and in Kalumo TA and Kasakula TA in Ntchisi District. Malawi is a low-income country, ranking 174 out of 189 countries on the Human Development Index in 2019. Poverty levels are high, with over 70.3% of the population living below the income poverty line and 29% of people considered vulnerable to multidimensional poverty on the Multidimensional Poverty Index (MPI), which highlights overlapping deprivations for health, education, and standard of living (HDR, 2019).



Malnutrition is endemic in the country and the single biggest contributor to child mortality. Children and women in particular suffer from malnutrition as a result of an unbalanced diet and lack of food diversity for optimal complimentary feeding. Other factors contributing to malnutrition include low levels of education, lack of understanding of the nutritional needs of young children, women's workload, and food and nutrition security related shocks.² The baseline survey highlighted that gender inequalities compound nutritional issues in Dowa and Ntchisi including physical and psychological abuse, various forms of GBV, disparities in intra-household food distribution in times of scarcity, women, girls and young children eating leftovers or foregoing meals altogether, and few female district-level staff, frontline workers, and various community volunteers active in community structures.

¹ <http://scalingupnutrition.org/about-sun/the-history-of-the-sun-movement/>

² USAID, Nutrition profile updated February 2018.

The baseline survey assessed knowledge, practices, and coverage of key nutrition and health messages. Results showed that several maternal practices needed to be addressed including premature introduction of food to children below 6 months of age, failure to practice exclusive breastfeeding; traditionally feeding children water with herbs “*dawale*”; feeding infants watery porridge; inadequate frequency of feeding; lack of food diversity characterized by low provision of foods from animal sources, vegetables, fruit, legumes, nuts and fats; poor access to safe water; inadequate sanitation practices; and frequent child and maternal illnesses.

CARE designed the SANI project to promote positive social behaviour change to improve the nutrition situation and community members took the lead in identifying the most vulnerable households to benefit from the project. The program approach was based on the Diffusion Model, which holds that community behavior is changed step by step: training early adopters first then approaching the next group prepared to change. Resistant community members would gradually be conditioned to change due to the changes in their environment. This model assumes that health behavior can be enhanced in communities by creating model families that others will admire and emulate.

In Malawi there is an active network of civil society organizations advocating for the prioritization of nutrition in Malawian policy and budgeting, regrouped under the CSONA umbrella. SANI’s advocacy nutrition work under Intermediate outcome 1300 focused on supporting the policy advocacy work of this grassroots network. In Year 3, following the tripartite elections and mass demonstrations that followed, CSONA advocacy was affected due to the uncertainty surrounding whether or not the government in office would remain. During this period, campaign activities influenced attendance of some of the project activities including routine Care Group, Farmer Club, Community Gender Dialogue Sessions, and Village Savings and Loan meetings as some participants were prioritised political meetings and/or were running for public offices. Mass protests of the election results across the country affected SANI communities and caused CARE head office in Lilongwe and the SANI field office in Mponela to close temporarily. This resulted in delays in cancellation or rescheduling of planned SANI activities such as Village Nutrition Coordinating Committee (VNCC), Growth Monitoring Volunteers (GMV) refresher trainings.

COVID-19 began to spread rapidly in Malawi at the time when SANI was closing out in the implementing areas and led CARE Malawi to pivot rapidly to respond. The President declared a state of disaster on March 20, 2020 and instituted preventative restrictions such as limited numbers of public gatherings and 6-month school closure across the country. The numbers of cases and deaths rose steadily across the country. As of October 29, 2020, confirmed cases in Ntchisi and Dowa were 4 and 95, respectively, with total deaths, 0 and 3, and 3 and 81 recoveries, according to Public Health Institute of Malawi COVID-19 updates. Unlike other Sub-Saharan African Countries, there was no lockdown in Malawi, but the imposed restrictions resulted in an increased number of GBV, early pregnancy, and child marriage cases. In 2021-2022, the costed extension phase of SANI aims to address and orient local community structures and members about COVID-19 and GBV issues in collaboration with the MGCDSW.

1.2.2: Mozambique

In Mozambique, SANI was implemented in the Province of Inhambane in the Districts of **Funhalouro** and **Homoine**. Poverty in Funhalouro is reported in the latest national demographic data as 69-85%, 49.5% of the total population being female-headed households. The districts are particularly vulnerable to drought and have low agricultural productivity. Homoine has a reported poverty rate of 51-58% and has the highest number of female-headed households in the province (54.5%).



Of the three SANI countries, Mozambique’s enabling environment has been affected the most with several socio-political, environmental, and health shocks throughout the lifecycle of the project which negatively impacted the livelihoods and nutritional status of SANI targeted families and the implementation of project activities.

When SANI began implementing in 2016, one-third of Mozambique’s population was chronically food-insecure, and half a million children aged 6-23 months were undernourished and malnutrition in children under 5 was alarmingly high at 43%. One of the underlying causes was recurrent climatic shocks – drought, floods and cyclones – that compromised income from farming and further contributed to food

insecurity., injured, killed, and displaced individuals and families, and damaged households and other infrastructure. In Year 2, (2017/2018) the arrival and infestation of the Fall Army Worm (FAW) reduced agricultural production (maize and other cereals, which are staple crops) further exacerbating the food insecurity crisis. In 2018, following Cyclone Idai, the agricultural harvest failed and Funhalouro district was classified as “Phase 3 Crisis” in the Acute Food Insecurity scale.³ This situation continued during the 2019/2020 agricultural season but with Cyclone Eloise and the floods that followed, general soil moisture situation improved, and it is expected that this year’s harvest will be better.

The 6th general presidential and provincial elections diverted some attention within government institutions and communities. Some SANI activities and meetings were cancelled due to conflicting priorities within the community or as precautionary measure to avoid being seen as taking part in partisan of party-political activities specifically community dialogues and CSC activities.

The spread of COVID-19 represented an unprecedented shock for Mozambique that has caused wide-ranging health, welfare, nutrition, food security and socio-economic consequences, especially due to the loss of livelihoods and income streams. Key drivers of food insecurity include drought and the consequences of the restrictions imposed due to COVID-19, which have resulted in a significant decline in daily wage opportunities and income of small traders⁴. Additionally, the gendered impact of the pandemic has threatened to undo the positive nutritional and social impacts of SANI. Migrant workers, mostly men returned home unemployed, women’s workloads increased which meant less time to commit to SANI activities, and school closures resulted in early pregnancies, child marriage, initiation into the informal market, increased cases of GBV for women and girls, and exposure to drugs and alcohol. A second wave of COVID took place between January-April 2021, with numerous infections and an increase in hospitalizations and deaths due to COVID-19. The situation remains challenging well into 2021, with frequent spikes in cases and low rates of testing and vaccination.

1.2.3: Zambia

The SANI project was implemented in Muchinga province, Zambia, in **Mpika, Shiwag’andu and Kanchibiya** Districts, across a total of 10 wards. Zambia is among the countries with the highest levels of under-nutrition in the world with an estimated 40% of the population without enough nutritious food to eat. Approximately 60% of Zambia’s population lives in rural areas where poverty levels are estimated to be as high as 75%. This factor makes most rural households highly dependent on agriculture, natural forest, and woodlands for their livelihoods. The problem of poor nutrition is compounded by other nutrition sensitivity issues such as food insecurity, inadequate access to clean and safe water, poor sanitation and gender-related barriers to food and incomes.



Malnutrition is a major burden on the Zambian health care system. It is currently one of the major contributors to child mortality and women and children suffer from malnutrition due to an unbalanced diet and lack of food diversity for optimal complimentary feeding. In addition, low levels of education, lack of understanding of the nutritional needs of young children and women’s workload, negatively affect food and nutrition security. Other compounding factors include issues of gender inequality and harmful social cultural norms, which contribute to poor gender-sensitive nutrition practices and to poor agricultural practices. This is accompanied by lack of extension services and no or inadequate input support to the farmers which further exacerbate the food insecurity situation. Other nutrition sensitive issues such as inadequate access to clean and safe drinking water, poor sanitation and gender-related barriers also contribute to poor nutrition in Zambia.

Prior to the start of project implementation, consultations with Government stakeholders were conducted in 2016 to establish the relevance of the SANI project to the context of undernutrition, especially for women and children under five. It was confirmed from these meetings, that the districts of Mpika, Kanchibiya, and Shiwang’andu in Muchinga province would be prioritized for SANI support as many vulnerable households were concentrated in these areas, also affected by poor road networks, a lack of other NGOs, and limited internet connectivity and infrastructure.

³Integrated Food Insecurity Phase Classification <http://www.ipcinfo.org/>

⁴ <https://reliefweb.int/report/mozambique/mozambique-ipc-acute-food-insecurity-and-acute-malnutrition-analysis-october-2020>

The project operated in an environment where key factors such as weather, outbreaks of diseases, socio-political issues, and project perception by community members impacted the success of planned activities. From Year 1 to 3, no major incidences affected activity implementation. In Year 4 (January – March 2020) the first challenging event that hindered project implementation was a safety and security issue reported as *gassing* - events of gassing by criminal gangs with an unknown chemical that made people dizzy or unconscious in some cases; that was followed by mob justice of suspects and in some cases resulting into mob killings. The *gassing* and mob justice incidents instilled fear in people and threatened the safety and security of communities and project staff. As a result, productivity of most entities, at the farm or factory, and safe program implementation was negatively affected. In order to ensure staff safety, CARE Zambia restricted staff movements and suspended field activities in the communities.

On the socio-political front, the situation remained relatively stable throughout the project implementation period. The voter registration process was smooth with no major incidences in November - December 2020. The devaluation of the local currency continues to negatively impact livelihoods of vulnerable communities.

Throughout the lifecycle of the project, the country has experienced uneven rain patterns impacting agricultural activities. Severe drought affected the 2018-2019 rain season, creating uneven patterns of crop production nationally, worsening food security in 2019 and early 2020, particularly in Southern, Western provinces and parts of Central province. In the 2019/2020 rain season, Muchinga province experienced floods between February and March 2020, washing away key crops. In addition, numerous houses and pit latrines collapsed posing a high risk of water borne diseases like cholera and dysentery in some parts of Kanchibiya and Shiwang'andu districts. Activity implementation was delayed during this period, especially in project areas such as Kabinga and Mbatu in Kanchibiya district as well as Chibamba in Shiwang'andu district.

In Zambia, the first confirmed COVID-19 case was reported in March 2020 and since then, cases have continued to be reported in different parts of the country including Muchinga province, where the SANI project is being implemented. CARE implemented preventive measures to safeguard staff and their families and the community. As a result, all CARE offices were closed and field activities were suspended for nearly two months and as a result, there were some delays with some project activities such as community dialogues and Ward Nutrition Coordinating Committee (WNCC) meetings. In addition, travel and movement restrictions negatively affected livelihoods for vulnerable populations, especially female-headed households. Cases of GBV were reported to be on the rise from the time “stay home stay safe” measures were instituted. The situation remains complex in 2021, with frequent resurgence in cases forcing periodic lockdowns.

2: Operations

2.1: Implementation

2.1.1: Outputs and Activities

For a complete summary of all outputs and activities completed by the SANI project, including comments on variances against targets see **Annex 3.2**.

2.2: Management Issues and Adjustments

2.2.1: Management issues and adjustments

CARE implemented the SANI project in close partnership with the governments of Malawi, Mozambique, and Zambia, as well as project partners CUSO, ICAD, and McGill. All consortium and project partners had clearly defined roles and worked collaboratively throughout the program, jointly planning, sharing knowledge, and working together to ensure project results were achieved. Shifts in approaches, staffing, and activities were discussed, shared, and implemented accordingly. Developing and updating the LM, PMF, and Risk Register was done whenever possible in a participatory fashion with government and project partners, and this has been an integral part of the project planning from the PIP process through to endline evaluation. All stakeholders, including project participants, were involved throughout the project life cycle.

Overall, the project has had stable management across the five years of implementation. Transitions in program management staff within CARE Canada and CARE country offices included rigorous documentation and effective knowledge management. Close oversight by senior management and senior technical staff helped to bridge transition periods, ensuring continuity and knowledge retention throughout the five years of implementation. Using Results Based Management (RBM) methodology for SANI ensured reliable program management and monitoring and evaluation throughout the project.

Over the life of the project, all operational context changes that resulted in programmatic shifts for SANI were discussed and approved by Global Affairs Canada (GAC) as they arose. Key operational changes included:

- A no-cost extension from March 2020 to September 2020 to allow the continuation and further development of MIYCN, CSC, and CLTS activities at community level in Mozambique and Zambia, enabling sufficient follow-up and monitoring to elicit and observe longer-term changes in habits.
- Partnerships were reviewed periodically, and the scope of work of partners adjusted to best meet the operational requirements of the project. These are discussed further in section 3.2.4.
- In March 2020 all SANI activities were adjusted to accommodate the shift in operational context caused by the outbreak of COVID-19 – this required pausing activity implementation to accommodate stay-at-home orders, as well as modification of standard operating procedures. In some cases this required reducing non-essential travel to communities, conducting more meetings by phone or virtually. A costed extension was approved by GAC to enable an initial response to COVID-19, focused on equipping health facilities, households and communities to protect themselves from the epidemic. This costed extension also re-established operations in Malawi for COVID-19 response.
- The adjustment of endline study methodology to accommodate the limitations and restrictions on household-level data collection brought on by the COVID-19 pandemic in 2020/2021.
- On February 1st, 2021, the operational and fiscal management of CARE Zambia was transitioned from CARE Canada to CARE USA. This had no significant operational implications on the SANI project, but the reporting and accountability lines for senior leadership of the CO were shifted from CARE Canada's former International Operations unit to the CARE USA International Operations and Programs Unit, under the CARE USA board of directors.

Despite these readjustments and short periods of delay, SANI was able to complete all major project activities, and achieve or make considerable progress towards the project's ultimate and intermediate outcome targets.

2.2.2: Adjustments made to the Logic Model, Risk Registry, or Performance Measurement Framework

Since the project implementation plan, the following changes have been made to the Logic Model and the Performance Measurement Framework:

- The Performance Measurement Framework that accompanied the Project Implementation Plan was reviewed in February 2017 as part of the PIP review process, at which point some modifications were made, primarily among outcome indicators and targets.
- As Baseline data became available, it was included in the PMF for all ultimate and intermediate outcomes, as well as immediate outcomes.
- In year 4, the indicator for Intermediate Outcome 1400 was changed. The original indicator was: "% of Canadians reached who report increase in knowledge of women and girls development and nutrition issues." As this was an indicator selected prior to the development of the campaign. As Feed Her Future was developed, the scope of the campaign changed and expanded throughout the three years and as a result, the campaign ultimately chose (instead of a survey) to deliver numerous digital engagement metrics toward this specific performance indicator, instead of single one-time survey.

The original Risk Register defined in the PIP remained relevant throughout the project period. In year 5 of the project (2020/2021) the project's risk register was updated to prevent and mitigate risks associated with the COVID-19 pandemic. A summary of these changes can be found in Annex 2.3.

2.2.3: Cross-cutting themes

2.2.3.1: Gender equality

The baseline gender qualitative study conducted by SANI in July 2017 revealed that access to nutritious food is constrained by poverty, gender, and community dynamics. Gender divisions of labor constrain women's ability to participate outside of the household. Across the SANI countries, a woman's role centers around care work: taking care of the children, the sick and the elderly, ensuring domestic chores and feeding the family; leaving women with very little opportunity to participate in other social activities, enjoy leisure/rest time and take part in community level decision-making. Men, on the other hand, are engaged in farming, pursuing income generating activities and have greater ability to take part in training opportunities as well as decision-making spaces.

Nutrition is mainly a woman's responsibility given her role in cooking. Access to nutritious food, however, is further constrained by women having limited time to either cultivate their own land to produce enough food for the household or engage in income generating activities that would enable them to purchase food. There are strong community pressures surrounding men's involvement in nutrition and care work at household level. As final decision makers/influencers on what is produced, cooked/consumed/who eats what and how much, what production is kept for household consumption and what is sold, this has a significant affect on the nutritional status of women and children, particularly while women are pregnant and/or lactating. Men who strive to do their part may face ridicule and ostracization. As a result, men are often not actively involved in the well-being and welfare of their partner and children may not be aware of the nutritional needs of family members. The study findings served as a basis for the development and implementation of interventions to address the identified gender inequalities that exist in the communities which aggravate undernutrition.

To address women's work burden, in and outside the home, low levels of access and control to reproductive and productive resources as well as meaningful participation at community level, SANI implemented gender-specific and gender-sensitive interventions to address gender inequality. The project integrated gender equality components and the promotion of male engagement and participation in MIYCN Care groups, M2M and F2F groups, opening space to reflect and examine not only men's knowledge and participation but also women's autonomy and the nutrition and health benefits of equitable decision making and sharing the work burden within the household. SANI also worked to improve quality of nutrition related health services in CMAM/IMAM as well as the provision of women-centred services.

SANI also implemented Social Analysis and Action (SAA), a gender-specific approach for working with communities through recurring dialogue to examine, reflect and address how social and gender norms perpetuate health challenges, malnutrition and gender inequality. The CLTS and nutrition sensitive agriculture components were designed to reduce women and girl's workloads, train women on water systems maintenance and repair, support their participation in water committees as well as increase household dietary diversity. These components were impactful in 1) decreasing the gap in meaningful participation of women in the governance of community WASH systems; 2) decreasing the gap in women's access to and control over agricultural resources and benefits (with a focus on those necessary to produce nutritious food), and 3) increasing the community's ability to list women's rights, identify social norms and gender stereotypes that pose a barrier to equality in nutrition.

Finally, the project worked on facilitating an enabling environment for improved nutrition outcomes and greater gender equality for SANI beneficiaries. This included building the capacity of the Nutrition Coordinating Communities (NCC) at provincial, district and/or Ward levels to fully address and integrate gender equality into all aspects of national nutrition programming. The Community Scorecard (CSC) component also included gender equality criteria. The goal being to support a majority of government stakeholders to take concrete actions to address gender inequalities in health service delivery, including through the pro-active discussion of gender issues in multi-stakeholder fora

Similar to other activities related to transforming gender norms, there were some anticipated risks. These include gender-based violence for "empowered" women and/or backlash for male participation.

CARE continues to be guided by the CARE International 'Do No Harm' strategy and throughout implementation, has worked with communities on how to mitigate these risks. Although there are some observed changes on gender equality, there is still significant work to be done to realize the goal of gender equality, especially considering the effect of COVID-19. The pandemic has had disproportionate effects on women, men, boys, and girls. There is evidence of increased GBV and IPV cases, increased stigma and discrimination, reduced household income due to restriction in movement and closures.

Results obtained

Intermediate Outcome 1100: Improved nutrition practices for women of reproductive age and boys and girls under 5

In Zambia, under Output 1111, 16 HCWs (10w, 6m) and 239 (124w, 115m) CHWs/WNCCs and HCWs were oriented on integrating a gender perspective into their routine service delivery. In Malawi, MIYCN education training materials included images of men involved in activities that are traditionally assigned to women (e.g.: men feeding children, husband carrying/accompanying wife to an antenatal appointment and helping with household chores like fetching water and women and men receiving nutrition health education together from a CHW) to prompt discussion and reflection on gender roles. One image also showed a man taking a large portion of the household food as a demonstration of unequal intra-household food distribution. The purpose of this image was to ignite conversations around how this affect the nutritional status of women, particularly those who are pregnant or lactating, and children.

Under 1112, 1113, and 1114, male engagement activities focused on encouraging men to actively support their spouses in childcare and sharing responsibilities for work within the household. The formation of Male Action Groups (MAGs) in Zambia promoted the involvement of male caregivers/fathers in the growth monitoring of children, cooking demonstrations, and domestic chores. Through community dialogues and community meetings, MAGs actively emphasized the need for more women to participate in farmer groups to learn about livestock technologies for improved agricultural practices. The balance, however, was to ensure that male power and privilege was not reinforced through these practices, such as men skipping the queue or men being paid to attend these sessions. In Zambia, drama groups were also used for social mobilization in annual Child Week activities. Overall, a total of 5,462 (4,324w, 1138m) people were sensitized on nutrition messages and gender equality.

"The Male Action Group (MAG) has really brought a lot of good things in our community. At first it was not easy for me to start taking part in HH chores as I was so shy, but I now cook, wash plates and involve my wife in decision making." – Male Champion of Kanchibita District, Zambia

In all three SANI countries, nutrition practices among women and men improved and CHWs noted more confidence in administering care and sharing nutrition-sensitive messaging. In Zambia, the project saw an increase in the number of female CHWs delivering and teaching key MIYCN lessons and access to resources such as bicycles for household counselling improved HH reach and eased movement throughout the community for female CHWs. In Malawi, gender dialogues influenced a change in gender roles and increased male participation in nutrition activities among some community members in Dowa and Ntchisi districts. Rolling profiles highlighted that more men and boys became more involved in household chores and GMP.

The impact of gender equality interventions was noted through improved attitudes of women and men toward gender issues that influence nutrition practices for women of reproductive age (WRA) and boys and girls under 5. In Mozambique, food security of male-headed households improved by 6 percentage points (15.6% baseline, 21.7% endline). In female-headed households, food security improved by 15.4 percentage points (11.9% baseline, 27.3% endline). The project, in collaboration with local partners, addressed cultural norms that negatively influence family nutrition and more men were seen to be accompanying wives and children to health facilities. In addition, SANI addressed myths surrounding nutrition through home visits and support groups and influenced men's roles in nutrition and health within the household.

"The gender component has also helped to change some of our beliefs like on death cleansing (i.e., if the husband dies, the brother must marry the widow). In addition, that if a pregnant woman eats, say eggs, she will have a baby without hair. These cultural beliefs have ended with the things we

learnt from CARE. Even the things we mentioned about death cleansing have ended because they were wrong cultural practices, which we used to follow. Now we do follow nutritional practices and try to eat same foods. We do not discriminate on foodstuffs to say this is only for men or only for women.”
– Man of Kayembe TA, Malawi

Intermediate Outcome 1200: Improved maternal, infant, and young child nutrition and gender sensitive practices for women of reproductive age and boys and girls under 5

In all three countries it was found at baseline that female participation in leadership positions and decision making at household level was low. It was also found that women had high workloads for household and productive work, yet low levels of access and control to reproductive and productive resources. Under this outcome, gender integration contributed significantly towards improvement in diet diversity as this ignited good nutrition sensitive practices. There was a 3-percentage point increase in respondents who consumed food produced within the household (95% baseline, 98% endline) in Zambia, and a 4-percentage point increase in both Malawi (89% baseline, 93% endline) and Mozambique (95% baseline, 99% endline).

Outputs 1212, 1213 and 1214 strongly promoted the involvement and meaningful participation of women in the formation of WMCs and CLTS to challenge gender roles and strengthen women’s agency. Promoting women’s participation in the management of water points was critical because of the challenges women face while fetching water when a borehole breaks down. In Malawi, the project involved the Area Development Committees (ADCs), which are normally comprised of the Village Development Committee members. Among these members, 50% of them were women. By the end of the project, in Zambia, 47 WMCs were formed with a membership of 306 (132w, 174m) of which 43% were women and held positions of secretariat, vice chairperson, or chairperson. Compared to other structures like the DNCCs and WNCCs, where women’s representation is 36% and 32% respectively, this shows a significant improvement for women’s participation and inclusion in community structures in Zambia. Of female respondents who reported the existence of the community water supply in their area, 80% indicated that *“women voice their opinions about community water supply in public.”* Further, 78% of the female respondents who reported the presence of the community water supply in their area said, *“women make decisions about the community water supply.”* While in Mozambique by Year 3, more women than men were trained to become community leaders on CLTS (180w, 170m). Following the training, leaders developed community action plans to improve sanitation with local WASH officers, which other community members attended and shared ideas and experiences in latrine construction. For example, community members shared and learned tactics to prevent latrines from collapsing.

In Zambia, under output 1221 and 1222, more men than women are represented in farmer’s groups. In Malawi, 46 men and 43 women were elected as leads and trained in nutrition and gender sensitive climate resilient agriculture. To assist women with their roles as lead farmers, the SANI team procured gender-sensitive work aids such as bicycles which are easy to mount and gumboots that are lighter and easier to walk in to help facilitate mobility and protection. In Mozambique, the project established a total of 66 farmer groups with more women than men involved (1,602w, 358m). After the training on climate smart agriculture and small-scale animal management, which included modules on the importance of female participation in leadership, individual groups developed their own leadership structure. Since 70% of members were women, several occupied leadership positions, acquired management and governance skills, and knowledge of good farming practices to consume and/or sell their own produce to improve their family’s diet diversity. In Year 3, the SANI team monitored efficiency of leadership in one FFS group with 21 members (19w, 2m) in Homoine where it was found that there was shared decision-making and values among men and women.

“I have noticed a change in my husband, he helps in the preparation of food, particularly when I am walking to and from the market. He did not do this before. There would be a shame associated with him going to go fetch water and community members seeing a man do this. There is pressure from the other men, they can often laugh or make jokes. Although slowly, attitudes are changing.” - Woman of Funlahouro District, Mozambique

Changes in perception of gender attitudes and social norms varied among SANI countries. At baseline in Zambia, 94% of women and 86% of men agreed with the statement, *“Men should go with their wives for ante-natal check-ups to provide support for their wives.”* At endline, 92% of women and 95% of men agreed with the statement. Amongst men, this is a significant 9 percentage point increase.

This can be explained by the number of women and men who attended SANI activities such as GMP activities, WNCC meeting, and CMAM and participation in established groups. For example, in Zambia, partnerships with the Chikanjebela Women's Club and Program for Vulnerable Children and Women (PVCW) succeeded in disseminating key gender messages and expanded reach of the project target. Chikanjebela Women's Club took part in WNCC at ward level and PVCW trained Male Gender Champions.

In Malawi, women and men's attitudes saw an improvement, especially toward gender issues that influence nutrition practices for Women of Reproductive Age (WRA) and boys and girls under 5. Results of the HH endline study showed that attitudes of men and women toward gender issues that influence nutrition practices improved by 8 percentage points against the project target of 5 percentage points (42% baseline, 50% endline). The project through volunteers (Care Group Promoters, Lead Farmers, PET groups and Village Agents) in Dowa and Ntchisi districts conducted 1,868 gender dialogues during project life span reaching out to 51,040 (18,854 men and 32,186 women) to challenge social and gender norms negatively impacting on nutrition of women and boys and girls under five. Further, women's role in decision-making, including budgeting, showed positive changes over time and marital relations and open communication between husbands and wives improved from baseline. Although an increasing number of women participated in local community structures because of the project, leadership positions were reserved for men and on occasion some women could not contribute openly.

"In the past, we used to say, "gender... gender...", without really understanding what it means. Now we have come to understand that gender equality means this one can do that, and that one can also do this." - Community leader, Kalumo, Malawi

The nutrition sensitive component of the SANI project has complemented the gender equality strategy successfully in all SANI countries. Women are equipped with the knowledge and have better access to more land for growing crops. Access to agricultural inputs like vegetable seeds and seasonal crops has been economically empowering for women and encouraged joint decision making in the household in SANI countries. In some cases, one household member attended demonstration plot training sessions and would revert the information to husband/wife. This sparked interest and partners began managing their own homestead gardens in Zambia. In fact, at endline, 75% of women owned land, which they used to establish homestead gardens, compared to 57% of women at baseline. Women's access to land for agricultural inputs increased by 31 percentage points in Mozambique (61% baseline, 92% endline) but decreased by 8 percentage points in Malawi (89% baseline, 81% endline). Further, more community members consumed food they produced (95% baseline, 98% endline) in both Zambia and Mozambique where the results were the same. While in Malawi there was a 4-percentage point increase (89% baseline, 93% endline).

"I joined the vegetable group because I didn't want to be left behind in learning new ideas of growing vegetables. We consumed most of the vegetables and managed to reserve some to sell and this helped us to have income to buy other essentials like sugar, cooking oil and soap. Most of our income comes from farming, specifically the growing of maize, cassava, and millet." – Woman of Kanchibiya District, Zambia

The rigidity of gender bias in the household directly impacts women and children's nutrition status, specifically with food allocation. Changes were especially significant in instances where both wife and husband participated.

"The value of what we have, both in finances and materials, is low and we still find ourselves in need at times. The benefit of this training is that now at least we can sit together and prioritize what needs to be done and purchased. Now in my household, certain foods or quantities aren't reserved for any specific member. When I'm serving the family, I do so as equally as I can and in a way I think is best." - Woman of Funlahouro District, Mozambique

In Malawi, there was a 3% increase in VSLA membership for women (9% baseline, 12% endline). Women also felt that increased economic empowerment enhanced their ability to participate in decision making on nutrition and health within their households. Women's economic empowerment, however, has been shown to potentially lead to intimate partner violence. To mitigate this risk, gender dialogue sessions in VSLA groups provided an opportunity to discuss women's financial autonomy and issues of joint money management

Despite several positive strides made through the project, towards gender and nutrition-sensitive practices, these results were not generalizable across the board. Men remain the primary decision-making member in the household in all SANI countries, especially on financial decisions and resource allocation. This calls for more efforts to continue engaging all stakeholders using the “do no harm” principles through recurrent dialogues and this is an opportunity for the second phase of SANI to re-strategize on how best to address some of these negative socio-cultural and gender norms.

“My husband was also a member of the VSLA, and we all had access to the account but when it comes time to deciding what to buy it is largely my husband who makes the decisions with some input from me.” – Woman of Kanchibiya District, Zambia

In Mozambique, FFS were economically empowering for women and triggered gender equality dialogues among community members.

“After the trainings we were able to sit down as a couple and talk about where and how we would spend our family income. The FFS group was an opportunity to gain knowledge on how to simply live well, whether it be production techniques or good relations at home.” – Woman, Mozambique

The combination of approaches implemented by the project enabled participants to discuss how best to address gender inequalities by empowering women and men through community led ideas and interventions. Community dialogues in Zambia (SAA and the use of Outcome Mapping as a monitoring methodology), were affected by implementation delays - SAA should have been rolled out in the early stages of project implementation to make a more meaningful impact. The delay impacted the level of uptake of promoted gender-sensitive nutrition, health practices, and behaviors and resulted in limited information being collected to track gender changes.

In Zambia, under output 1232, 27 people (9w, 18m) were trained through SAA (government partners and project staff) in November 2019, and trained facilitators conducted 30 community gender dialogues in their respective communities from January 2020. However, due to COVID-19 prevention measures and gassing incidences, SAA dialogues did not continue after March 2020. Therefore, the team was not able to observe any concrete changes at the community level as it would require a significant amount of time to see behaviour change at the household level.

In Mozambique, SAA dialogues discussed gender norms and behaviors related to intra-household distribution of food, resources and assets. A shift was observed; previously, some men perceived that gender equality was a topic *“only discussed by women”* and household chores and childcare were solely reserved as women’s responsibilities. Women’s attitudes towards gender norms improved significantly with a 45-percentage point increase among women who believe that women and men should have equal amount of chores (28% baseline, 73% endline). Further, there was a significant increase in the number of women and men who agreed that women are the main decision makers over the use of men’s money (37% baseline, 46% endline). Toward the end of the project, SAA dialogues were suspended due to COVID-19, but SANI Mozambique continued introducing gender equality content (i.e., GBV prevention) in their COVID-19 response reaching 5,398 people (1,620 m, 3,778 f) in 58 community meetings.

Intermediate Outcome 1300: Strengthened governance and accountability of gender-equitable nutrition policies and programs for women of reproductive age and boys and girls under 5

Gaps on governance issues still exist across all structures at district (DNCC and DDCC) and community levels (WNCCs, lead farmers, and farmer interest groups) because of power dynamics in most of these community structures, which remain biased towards men. SANI, therefore, tried to strengthen female participation and create spaces for women to express their rights. In Zambia, under output 1311, two trainings (Gender Equality and Planning and Governance) were conducted in November 2019 for selected DNCC and WNCC representatives to improve DNCCs and WNCCs functionality, supervise members on how to train community structures like CHWs, WPMC, CLTS champions and MAGs, and strengthen gender mainstreaming across nutrition programming. Good progress was observed in the area of women’s representation during the last two quarterly DNCC and WNCC meetings in Zambia with 36% men and 32% women representatives compared to 30% men and 25% women representatives in Year 3. In Mozambique women’s representation in leadership roles was equally challenging but improved over time with less than 15% (3 women, 22

men) of members being female in Year 3 meetings held under output 1311. However, in Year 4, 4 DNCC/CDCN meetings took place (2 per district) with 46 women and 58 men participating in meetings, which accounted for 44% female representation. In Malawi, training on gender equality and gender-sensitive nutrition was conducted in DNCC and other community structures like ADCs. Community dialogues on equal representation and increased female participation resulted in a woman being appointed in the role of ADC chairperson, a position that has been dominated by men since inception of the platform. The representative of a Chief added that, "People are now empowered, and women are able to speak out their voice and hold leadership positions."

Women's participation in the CSC process allowed women to voice issues affecting their nutrition and health, which were subsequently addressed by the local health system. CSC and gender dialogues increased the voice of communities in demanding accountability from community and nutrition service providers/leadership as well as by holding each other accountable in terms of responsiveness. For example, in Mozambique, CSC reinforced the need for health personnel in Funhalouro and according to CARE Mozambique, the local government intends to continue this process, or parts of it, to identify community service needs. Additionally, CSC helped to address stigma and fear among women and girls about reporting cases of GBV.

In Zambia, under output 1321, five CSC interface meetings were held to assess progress towards accountability and transparency among Service Users (Community members) and Service Providers (Health Care Workers). The assessment showed that male involvement in health-related activities was scored very low. The project worked with the local health system to involve MAGs to support men's support and engagement. It was further observed that women's participation in CSC in Malawi, led to issues of maternal child health being addressed including provision of beds in the maternity wing, construction of a placenta pit, safeguarding of therapeutic and supplementary foods under CMAM, provision of ambulance to service among the list maternity referral cases for further medical attention.

"Culture hindered women from taking up leading positions in the past, but now people are aware of the importance of including women in leadership positions." - Woman, Dowa District

2.2.3.2: Governance and Human Rights

CARE's nutrition programming takes a rights-based approach to nutrition for women, and boys and girls under 5, anchored around Human rights principles which include universality and inalienability; indivisibility; interdependence and interrelatedness; non-discrimination and equality; participation and inclusion; accountability and the rule of law. The project used the following human rights instruments: the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW); the global targets set out in the Sustainable Development Goals (SDGs); the Convention on the Rights of the Child (CRC); the International Covenant on Economic, Social and Cultural Rights (CESCR); and the Maputo Protocol under The African Charter on Human and Peoples' Rights.

In recognition of human rights, the project ensured country teams and partners were trained in Prevention of Sexual Harassment, Exploitation and Abuse (PSHEA) to create awareness and equip team members with skills on how to prevent and manage instances of SHEA during project implementation. The project maintained a zero tolerance for all forms of SHEA, whether perpetrated against a project participants, staff, or volunteers, and remained committed to ensure that prevention, response, and assistance was available for all project stakeholders.

As the dominant language used to refer to gender equality and nutrition focuses on a woman's nutritional status as a means for healthy children, CARE incorporated a rights lens within its gender transformative approach. Although women's adequate nutrition is an important health link for the well-being of their children, women often remain instrumentalized, rather than recognizing their own right to a healthy life. As outlined in the gender equality section, SANI countries saw positive outcomes for gender equality and nutrition because of the gender transformative approach. For example, in Zambia, local structures (DNCC/WNCC) worked collaboratively to plan and implement activities, in partnership with CHWs and farmer interest groups. Currently, DNCC chairperson positions in all three districts are held by women.

Participation and inclusion

Each of the project teams in Malawi, Mozambique and Zambia undertook an exercise of identifying the participating households by using a needs-based approach, which focused on female headed households, most at risk populations (e.g. affected by or infected with HIV) and married adolescent girls. These populations are often at risk of undernutrition.

Each of the project teams in Malawi, Mozambique, and Zambia engaged with government and community counterparts in project design, implementation, and monitoring at Regional, Provincial and District and Ward/Locality levels to ensure accountability, sustainability, and transparency. Local community and government structures were trained on leadership skills and how to ensure interventions are sustained. For instance, ensuring maintenance of boreholes and conducting GMP services is embedded in the community to ensure they are sustained post project. Further, WASH committees were formed at Provincial, District, and Ward levels and encouraged women and men to take a lead role in WASH governance.

Transparency and accountability

CARE collaborated with the Civil Society Organization Nutrition Alliance (CSONA) in Malawi. Founded in 2013, CSONA is a coalition of 106 local and international Non-Governmental Organizations (NGOs) and local CSOs working to ensure sustained improvements in nutrition in Malawi and provide support to government's effort in scaling-up nutrition. CSONA has four priority objectives, which are influencing national budgets and policies; district coordination; nutrition sensitive social protection; and communication. Canadian technical volunteers whose skills are in organization development and nutrition policy were placed with CSONA for more than 10 months.

The Community Score Card (CSC) methodology was one of the accountability tools that SANI used to influence quality, efficiency, and accountability with which services are provided at the local level. The project trained government staff as CSC facilitators to enhance skills and support CSC activities to the wider community. CSC experienced some challenges including limited funding to implement CSC action plans.

Apart from the CSC, processes, CARE engaged with government departmental heads and community leaders (e.g. traditional and church leaders) through close-out meetings and sense-making sessions. Partners provided feedback on how the project worked to uphold transparency and accountability.

2.2.3.3: Environment

Environmental Context:

Environmental conditions such as erratic rains, dry spells, and flooding affected SANI countries' food security. Both El Nino and La Nina weather systems have drastically impacted rain patterns, temperatures, and access to food and water in Southern Sub-Saharan African countries, particularly Mozambique and Malawi. For example, prolonged dry spells and Fall Army Worm infestation in Malawi delayed the start of the agricultural production season and significantly reduced crop yields in 2017/2018. Notably, maize yields were as low as 10% of usual harvest in 2018. Ultra poor households were not able to diversify diets and essential food commodities rose in price. For smallholder farmers, the disruption to the input supply chain and access to market have significantly affected the planting and harvesting seasons, in many cases for staple food such as maize, vegetable and rice.

Similarly, in Mozambique, the drought affected SANI agricultural outcomes and poor households had challenges producing food for consumption. Despite these shocks, the project shared positive practices which resulted in communities no longer burning grass, for example, to open fields and after weeding as farmers realized that mulch helps to conserve moisture in soil, suppresses weeds, and adds a layer of protection for plants against harsh weather conditions. This technique helped to prevent uncontrolled burning of forests and contributed to the conservation of wild fruit and game animals, which are main sources of food.

"To make it more interesting they should distribute food as well, because they only talk about a good diet, but we can't afford some of the things they tell us ... because of the drought, there's nothing, it's all dry now." – Mozambique (Member, Focus Group Discussion 3)

In Y5, the project responded to the impact of the drought in SANI implementing areas by supporting districts in constructing livestock waterers in Chiane, Massalane, and Mutsitsi communities in Funhalouro and Chimbofo, Catine and Mubecua communities in Homoine. The project will work with

the MoARD in SANI Phase 2 to validate and distribute seed kits to HHs and provide extension services to small-scale farmers. Seed kits will include seeds that produce food with high nutritional value and capacity to withstand the changes in the climate, and vulnerable households will be provided with food baskets to bridge the lean season before planting.

Environmental considerations in SANI implementation:

SANI was implemented with careful consideration of the impact on the environment and sustainability of its programming. The project made positive interventions by constructing water points to improve water supply, and engaging communities through a range of means to improve access to clean drinking water and water and sanitation conditions and behaviours, including a particular focus on reducing rates of open defecation.

Comprehensive environmental impact assessments were conducted to evaluate the potential for adverse environmental effects of all planned construction projects, as well as assess risks and develop strategies to mitigate them. The environmental assessments were conducted in collaboration with national and district-level government representatives, including technical water resource engineering staff. These assessments were used to inform the development and implementation of construction plans for the construction or rehabilitation of all water structures. Throughout construction, all water and sanitation construction works were supervised by CARE or partner water and sanitation officers with engineering expertise.

In conjunction with the construction and rehabilitation of water infrastructure, communities and local government were engaged in water management committees, designed to monitor and maintain water point access. Water management committees were provided with training in water point governance, water point maintenance, and were connected to district level water resource management authorities. Following the completion of construction, all water points were handed over to community water management committees.

All water points constructed by the SANI project were certified as operational by government authorities. All certifications are available in **Annex 10**.

3: Outcomes

3.1: Highlights and Key Achievements

3.1.1: Malawi Project Outcomes

The project registered the following key achievements in its four-year period of implementation in Malaw, as measured in the baseline and endline household surveys in 2017 and 2020:

- **Stunting and wasting** in children under-five largely remained consistent from baseline to endline. While a small decrease was observed in stunting and wasting recorded at endline, the sample size was not sufficiently large to assess change in these indicators.
- **Minimum Acceptable Diet (MAD)** for children 6 to 23 months increased 343%, (7% at baseline and; 31% at endline)
- **Exclusive breastfeeding (EBF)** increased by 20% (68% at baseline and 82% at endline)
- **Minimum Diet Diversity (MDD)** of women increased by 55% (18% at baseline and 28% at endline)
- **Minimum Diet Diversity (MDD)** of children between 6-23 months increased by 184% (13% at baseline and 37% at endline)
- Improved drinking water sources (IDWS) (piped on premises or other improved drinking water sources) **increased by 17%** (77% at baseline and 90% at endline)

Baseline and Endline methodology:

In order to measure progress towards outcome indicators and project performance, the project implemented mixed methodologies including qualitative and quantitative methods. In Malawi, CARE conducted an assessment at baseline in January and July 2017 for quantitative and qualitative studies respectively, and an endline quantitative and qualitative study in March 2020.

Data collection and analysis for the Endline Survey (Quantitative and Qualitative) was completed in February and March 2020, just before COVID-19 impacted Country Office operations in Malawi. Dr. William Ksapila carried out the study in Dowa and Ntchisi Districts, with a team of 23 enumerators for

field work and interviews. In total 770 beneficiary households were surveyed, in addition to interviewing key individuals and groups at community level.

The household surveys took anthropometric measurements from 626 children 6-59 months and mid-upper arm circumference from women of reproductive age (WRA) whether pregnant, lactating or neither. The survey methodology for selecting household participants, was coverage-based with similar scope as baseline and did not specifically target SANI participants. Exposure questions were included in the survey to understand how the population engaged with different project activities within SANI. The evaluation also included a gender qualitative study. Methodology for this study included focus groups with women using photovoice (two focus groups with 6 people each), focus group discussions with men (2 focus groups of 6 people each) and interviews with 10 community and religious leaders. Ethics approval was granted.

The numbers reported in the tables below refer to Baseline and Endline averages of the full coverage sample, including both project participants and non-participants living in villages where project interventions took place. Note that Baseline values have changed slightly from baseline report to ensure the same rigorous cleaning and calculation methods were used with both samples.

Ultimate Outcome - Contribute to the reduction of maternal and child mortality in Malawi, Mozambique and Zambia

| Indicators | Baseline data | Endline data | Project target | Cumulative To Date (#/%) |
|---|---|---|---|---|
| Wasting: % of boy and girl children 6 up to 59 months with weight-for-length < - 2 sd | girls: 2% (n=6/d=292) boys: 4% (n=10/d=252) | girls: 2% (n=6/d=302) boys: 4% (n=12/d=299) | 5% decrease girls: 2.9% boys: 3.8% | *Difference not statistically significant |
| Stunting: % of boy and girl children 6 up to 59 months with height-for-age < - 2 sd | girls: 34% (n=100/d=295) boys: 42% (n=109/d=259) | girls: 35% (n=106/d=302) boys: 46% (n=138/d=300) | 5% decrease girls: 32% boys: 41% | *Difference not statistically significant |
| % of women with MUAC <23 cm | women: 2% (n=12/d=595) | Women: 10% (n=65/d=651) | 5% decrease 1.9% | Target not met |

Wasting & Stunting

The difference observed for measures of stunting and wasting between baseline and endline was not statistically significant, but the measures obtained by the baseline and endline studies align with trends observed at the national level.

Wasting or acute malnutrition reflects the current nutritional deficit. It is usually a result of recent food shortages, poor nutritional and diet practices and current illnesses that result in rapid loss of weight and body tissues. At the national level in Malawi, wasting has remained at around 5% from 5.4% in 1992 to 5% in 2004, a period of 12 years, and only declined to 4% in 2010 and 3% in 2015/2016 due to multiple nutrition interventions implemented by the government and partners. Stunting, also known as chronic malnutrition is a result of impaired growth & development that children experience from poor nutrition, repeated infection, & inadequate psychosocial stimulation (WHO), and it is a measure that is challenging to make progress towards over the course of one generation. While SANI saw some evidence of a positive change in nutrition practices, such as MAD and exclusive breastfeeding, as well as a reduction in diarrhea and access to drinking water as reported under Outcomes 1100 and 1200, the sample design was not able to capture significant change at the higher level outcomes. The household survey was designed to measure changes of 15% in magnitude for indicators such as exclusive breastfeeding, but this sample size is not sufficient to assess smaller changes in indicators such as stunting and wasting.

Women's MUAC

Despite project interventions, wasting among women (as measured by Measurement of Upper Arm Circumference of below 23cm) deteriorated at endline to 7% from 2% at baseline. Dr. Marco Pomati of Cardiff University conducted additional analysis on this indicator and offered a range of possible reasons why, contrary to our expectations, the overall MUAC distribution might have changed. First, the percentage of underweight mothers at baseline was extremely low for Malawi. According to the

Demographic and Health Survey (DHS) estimates, the percentage of underweight mothers has been decreasing to 7% nationally, but not a single region in 2015/16 had underweight rates (measured using heights and weights) as low as 2%. While the distribution of baseline MUAC measurements shown shows no strong evidence of clear measurement error, we cannot completely rule out that possibility.

Changing nutritional status of women has been particularly challenging due to gender related aspects. When food is in short supply, mothers will often give priority to children to eat first, leaving them vulnerable to malnutrition, a possible hypothesis for persistent undernourished in women even when there is an improvement in children's nutritional status. Additionally, the length of the reproductive stage of life (early and late pregnancies), as well as short intervals between pregnancies contribute to a permanent state of depletion that is particularly hard to change.

The changes to the MUAC also show an increase in the number of women who measure as 'properly nourished' as the number of 'overweight' and 'obese' declines from baseline to endline. The double burden of malnutrition is characterized by the coexistence of undernutrition along with overweight and obesity, or diet-related noncommunicable diseases, within individuals, households and populations, and across the life course (WHO). The high-level rates of overweight and obesity, while likely indicative of shifts in food consumption beyond the SANI project, will be important to monitor and to take into account for future nutrition programming in Malawi.

Intermediate outcome 1100: Improved nutrition practices and services of women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia

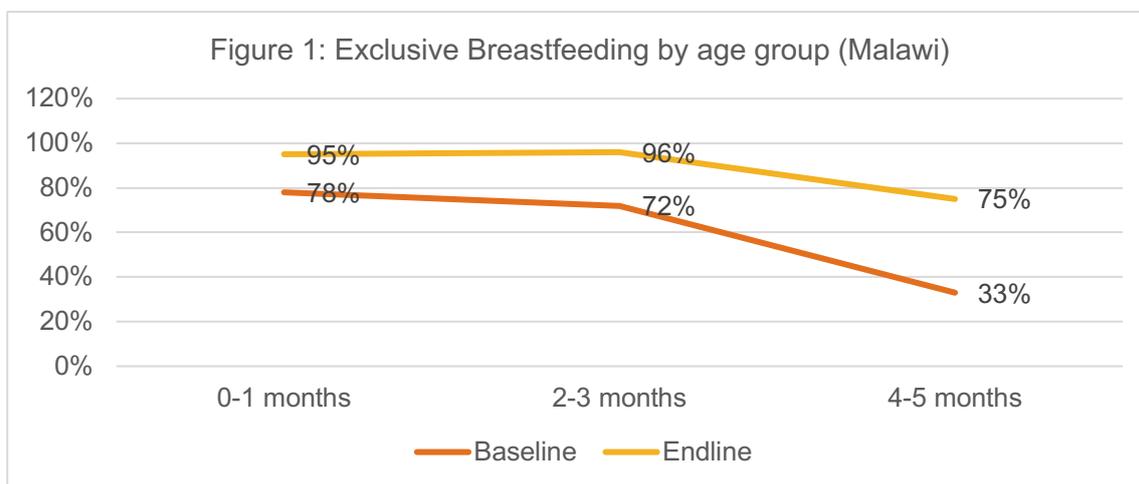
| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|--|---|---|--|---|
| % of children 6-23 months with MAD by meeting MMF and MDD in the previous 24 hours | girls: 5% (n=10/d=190) boys: 7% (n=13/d=181) | girls: 31% (n=68/d=218) boys: 31% (n=61/d=197) | 8 percentage point increase girls: 15% boys: 15% | girls: 31% (207% of project target) boys: 31% (207% of project target) |
| % of children 0-5 months who are exclusively breastfed | 61% (n=88/d=144) | 86% (n=136/158) | Children: 75% | 86% (115% of project target) |

Minimum Acceptable Diet, Minimum Meal Frequency, and Minimum Dietary Diversity

Child feeding practices have improved in the course of the project, measured by Minimum Acceptable Diet (MAD), a measurement that includes both minimum meal frequency (MMF) and minimum dietary diversity (MDD). Among girls, this indicator increased by 25 percentage points, and among boys it increased by 24 percentage points.

Exclusive Breastfeeding in Malawi

There were notable increases in breastfeeding knowledge and behaviours observed in Malawi. At endline there was a 25-percentage point increase in children 0-5 months who are exclusively breastfed, from 61% at baseline to 86% at endline. The chart below shows that not only a larger number of children (17-percentage point increase) are not exposed to other liquids during their first month of life, but also more children (44-percentage point increase) are exclusively breastfed for up to 5 months.



Source: Baseline and endline household surveys, February 2017 and February 2020

The use of Participatory Education Theater (PET) groups to mobilize communities for gender sensitive nutrition and health messages contributed to behavior change and adoption of promoted child feeding practices. Normalizing men's participation in nutrition and care work increased men's participation in project activities, actively contributing to their improved understanding of the importance of nutrition on children and women. Because men are most often final decision makers in male headed households, this is an important shift.

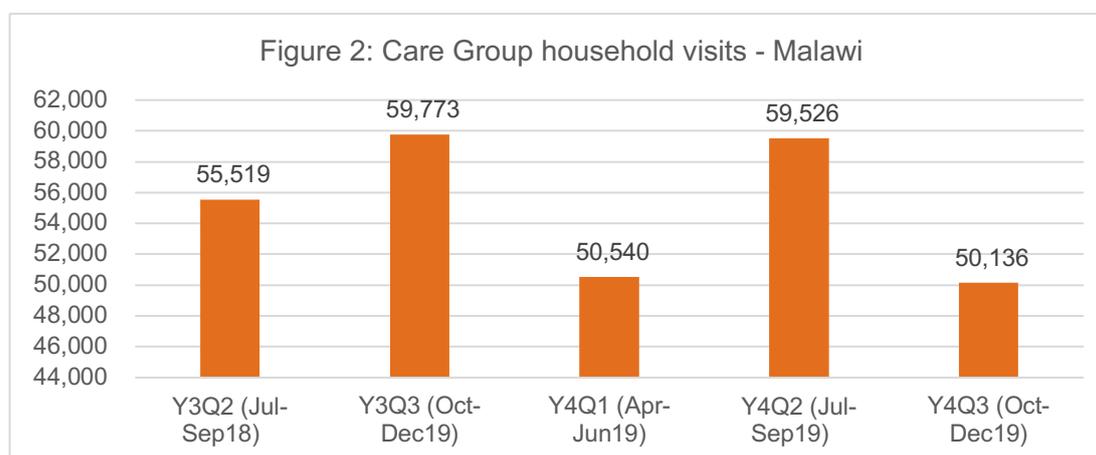
Immediate Outcome 1110 Increased knowledge of gender-sensitive MIYCN and caregiving practices for women of reproductive age and boys and girls under 5

| Indicators | Baseline | Endline | Project target | Cumulative to Date (#/%) |
|---|---|---|------------------------|---|
| % change in knowledge of men and women of MIYCN practices | men: 79% (n=416/d=526) women:90% (n=637/d=708) | men: 85% (n=325/d=382) women:94% (n=724/d=770) | men: 87% women: 99% | Men: 85% (98% of project target) Women: 94% (95% of project target) |

Change in MIYCN in Malawi

Endline results show that CARE Malawi improved the knowledge of men and women in MIYCN practices, particularly the age at which to start complementary feeding, by 6-percentage points for men and 4 percentage points for women, though slightly under the project target. As knowledge of when to correctly start complementary feeding was already very common at baseline, it was difficult to achieve the target for this indicator. However, as seen on the section above, change in practice of exclusive breastfeeding until 6 months has improved beyond was expected, which is a firm indication of starting complementary feeding at the correct age.

There were some challenges encountered during the roll out of Care Groups that are worth being noted as lesson learned for future projects. Due to high number of Care Group participants (77,535) against the numbers of promoters (226) and Nutrition Coordinating Committee members (422) to supervise and monitor the activities within Care Groups, it was challenging to effectively monitor performance, quality, and supervise Care Groups. The chart below shows the number of household visits carried out by Care Promoters in each district in the final year of the project. The reach of Care Group visits was extremely large in Malawi, with on average over 50,000 household visits conducted each quarter. This could have resulted in efforts of the relatively small group of promoters being spread too thin.



Source: project monitoring data, Malawi, Y3 and Y4

The project design also did not include community level structures such as Area Community Leaders Action for Nutrition (ACLAN) and Community Leaders Action for Nutrition (CLAN) at the very beginning of the project. Though they were included later in the project, this was seen as a missed opportunity. These structures are instrumental in the reinforcement of practices and behaviors and could have been an important actor to monitor and improve the quality of MIYCN household visits.

During the project life span, SANI rolled out 6 nutrition and health education modules (*The Scaling Up Nutrition (SUN) 1000 Special Days Key Messages; Maternal Nutrition; Optimal Breast Feeding; Complementary Feeding; Food Preparation (Cooking Demonstration); Hygiene and Sanitation*) to 77,535 households to increase their knowledge on maternal, infant young child nutrition. The Care Group approach in Malawi uses a cascade model of training, which included topics on gender equality. DNHA trains the DNCCs, DNCCs train ANCCs and ANCCs train VNCCs and VNCCs facilitate formation of Care Groups and identification and training of Care Group Promoters (CGP) who train household cluster leaders. The household cluster leaders educate individual households during biweekly visits to their homes. The system is effective in that volunteers are living within the villages and communities as such they are trusted, and it is easier for them to deliver the key nutrition and health messages regularly. From the Rolling Profile longitudinal analysis, it showed that this approach positively impacted gender roles in Dowa and Ntchisi as more men and boys began to take on household and reproductive chores (cooking, fetching water, washing dishes, and taking care of children), which are traditionally reserved as women's responsibilities.

The qualitative study reported important findings in nutrition learnings and gender dynamics. Communities surveyed felt that Care Groups have succeeded in disseminating lifesaving information to the targeted communities. The knowledge and skills acquired have resulted in a high uptake of simple positive behaviours by caregivers of children under five years of age that has in turn led to reductions in undernutrition. The messages were delivered in households, where in some cases men and women were available. Overall, more women than men are knowledgeable about nutrition, since they participate in more activities where issues of nutrition and health are discussed such as Care Group, growth monitoring, health campaigns, and antenatal clinics whereas men tend to stay away from such activities due to social stereotypes whereby these activities are considered "for women". Having said that, the increase in men's knowledge, although modest, is still significant. Longitudinal analysis from the Rolling profiles also show that there has been improvement in gender roles in the areas of intervention due to SANI's interventions; couples who received the information together are more likely to support each other in practicing the behaviors learnt. In most cases the man would take lead in buying nutritious foods once they understood the importance of maternal and child nutrition.

Immediate Outcome 1120 : Improved skills of Health Care Workers and Community Health Workers to deliver quality MIYCN counselling and treatment for acute malnutrition

| Indicators | Baseline | Endline | Project target | Cumulative to Date (#/%) |
|---|---------------------------|---------------------------|----------------|------------------------------|
| % of women, boys and girls u5 completing CMAM treatment | 93.4% (Jan-Mar 2016 HMIS) | 96.8% (Jan-Mar 2020 HMIS) | >85% | 97% (114% of project target) |

| | | | | |
|---|-----------------------------|--|--------------|------------------------------|
| % of women, boys and girls U5 recovered from acute malnutrition | 91.1% (Jan-March 2016 HMIS) | 93.9% (Jan-Mar 2020 HMIS) | >75% | 94% (125% of project target) |
| % change in satisfaction of services | NA | 24% increase 67 score at cycle 2 (Oct 2019) 54 score at cycle 1 (Feb 2019) | 10% increase | 24% (240% of project target) |

CMAM Treatment & Recovery from Acute Malnutrition

The Malawi government through the Ministry of Health in 2006 adopted Community Management of Acute Malnutrition (CMAM) to ensure maximum coverage, timeliness, access and provision of care in managing severe acute malnutrition (SAM) and Moderate acute malnutrition (MAM).⁵ To support government efforts to reduce acute malnutrition through CMAM program, in May 2018 SANI supported the training of health workers in 6 health facilities in Dowa in the new CMAM guidelines, the 4 facilities in Ntchisi were trained with support from WFP. The project added gender equality topics in the training for the participants to reflect on and understand the role of gender inequality and its impact on nutrition. SANI also supported routine follow up supportive supervisory and monitoring visits to 10 health facilities in the project implementation area in both Dowa and Ntchisi, distributed 31 mother and Child digital sorter scales and 84 height/length boards to aid case identification and monitor child growth during monthly growth monitoring exercise. These interventions were carried out in close collaboration with the government to ensure the effective roll-out of CMAM in Dowa and Ntchisi.

Analysis of the data from Health Management Information system (HMIS) to track the changes that occurred after SANI interventions show a 4-percentage point increase in women, boys and girls under five completing CMAM treatment, from 93% at baseline to 97% at endline. There was also a 3-percentage point increase in the percentage of women, boys and girls under fives recovering from acute malnutrition in the Dowa and Ntchisi districts, from 91% at baseline to 94% during endline.

Change in Satisfaction of Services

The Community Scorecard (CSC) program is seen by CARE Malawi as having improved health service delivery through enhanced communication between service users and providers. Overall, comparing original scores to current scores, analysis of Community scorecard results show increase in satisfaction of service from service users by 24%. CSC sessions revealed that the distribution of supplementary and therapeutic foods to malnourished children under the CMAM program in most health centres were being sold by health personnel instead of being distributed. This malpractice compromised the recovery of acutely malnourished children. During follow up on the second round of CSC, improvement was reported and no supplementary or therapeutic foods were found on the market; these were effectively reaching malnourished children thus resulting in many children recovering from their condition. Project staff observed an increase in male participation in GMP in both districts. This is in part because there has been a campaign by health workers encouraging men to attend, which has been complemented by SANI gender messages promoting male involvement in nutrition practices.

Intermediate Outcome 1200: Improved maternal, infant and young child nutrition and gender sensitive practices for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia

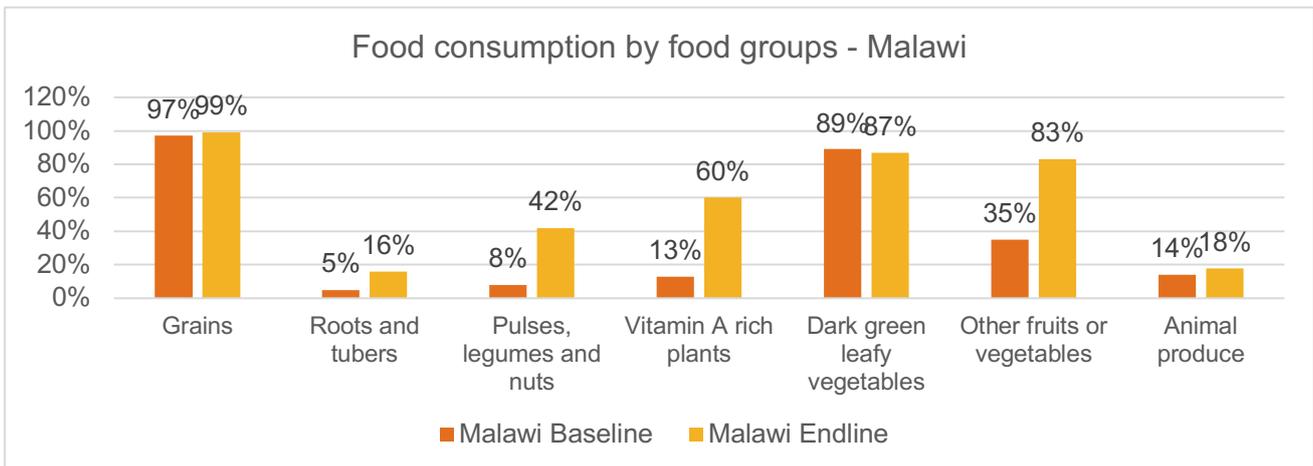
| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|--|--|--|---|--|
| % of women and children (boys and girls) 6 – 23 months who meet minimum diet diversity | Women: 18% (n=127/d=708) girls: 9% (n=19/d=215) | Women: 68% (n=524/d=770) girls: 43% (n=106/d=247) | Women: 30% (12 percentage point increase) Girls: 20% | Women: 68% (226% of project target) Girls: 43% (215% of project target) |

⁵ CMAM guidelines (July 26 2013)

| | | | | |
|--|--------------------------|---------------------------|---|---------------------------------------|
| | boys: 9% (n=19/d=209) | boys: 38% (n=83/d=219) | (8 percentage point increase) Boys: 21% (8 percentage point increase) | Boys: 38% (181% of project target) |
| % of men and women using improved drinking water sources (piped on premises or other improved drinking water sources) | 77% (n=545/d=707) | 92% (n=708/770) | 85% | 92% (108% of project target) |

Minimum Dietary Diversity

There was a significant increase in dietary diversity among women, girls, and boys seen from baseline to endline, with a 50-percentage point increase of dietary diversity among women, a 34-percentage point increase among girls, and a 29-percentage point increase among boys. Nutrition education and counselling in Care Groups, PET performance, cooking demonstrations, promoting production of diverse crops in homestead gardens, gender dialogues and income generating activities such as Village Savings and Loan Associations (VSLA) were effective in contributing towards this significant improvement in diet diversity. The table below shows that food consumption of all food groups except dark leafy vegetables increased from baseline to endline in Malawi, reflecting a trend towards improved dietary diversity.



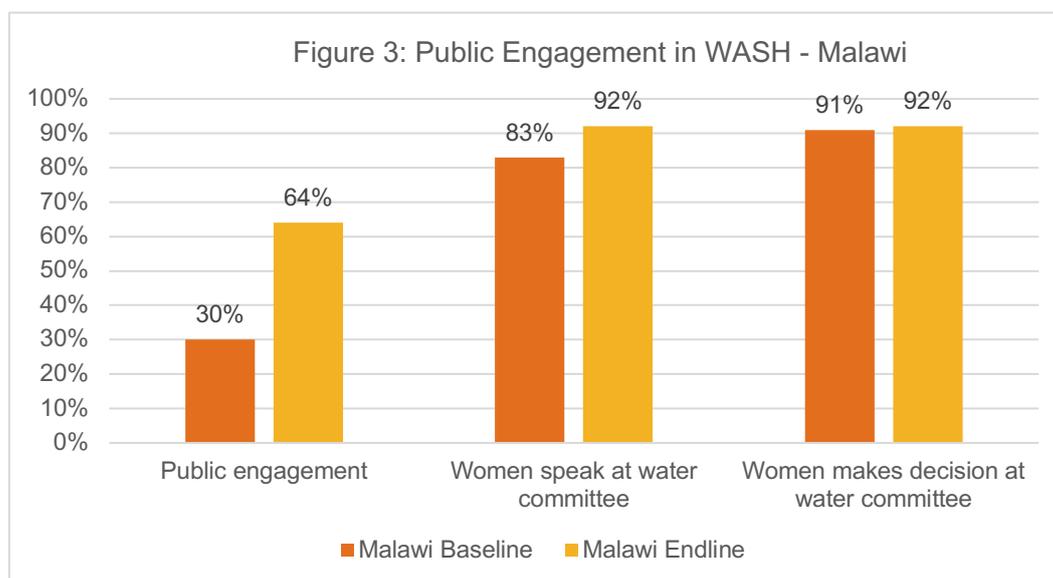
Source: Baseline and endline household surveys, February 2017 and February 2020

However, in the endline survey participants reported challenges they are still facing regarding nutrition, noting that although households are aware and making efforts to have a balanced diet, sometimes they struggle with accessing enough nutritious foods. It was also noted by a few participants that some households still struggle to be food secure and thus are not able to consume all six food groups daily, though their knowledge has improved, and they are aware of the importance of a balanced and diversified diet.

Improved Drinking Water

Self-reports by women and analysis of WASH data from the endline evaluation show that SANI has contributed to improved access to safe drinking water in Dowa and Ntchisi by 15%, from 77% at baseline to 92% at endline. Unsafe non-potable water is the major cause of diarrhea that leads to underweight and wasting in children under five years of age. SANI's core work on WASH focused on increasing access to safe water by sensitizing communities to use improved sources. A total of 1,856 water points were mapped and assessed in the districts by the project in collaboration with government line department staff. Although no boreholes were built by SANI in Malawi, training in water management and borehole repair by SANI has resulted in an increase in access to clean water, as shown in the endline results. SANI also worked with established water management committees and aimed to support an increase in men and women's participation in these committees, as community members. Though this indicator was particularly low at baseline, there were observed improvements in community participation among both men (from 6% at baseline to 11% at endline) and women (from 3% at baseline to 5% at endline). While some improvement in women's participation

(from 83% to 92%) and leadership (91% to 92%) in WASH committees was observed, as reflect in the chart below, in future, particular emphasis should be placed on enhancing women’s inclusion in WMCs, as rates of women’s participation did not increase to the same degree as men’s participation. Additional advocacy is required for the government, District Water Development Office and Water Management Committees (WMC) at community level to continue to construct boreholes and renovate the broken ones in a large majority of communities in the district.



Source: Baseline and endline household surveys, February 2017 and February 2020

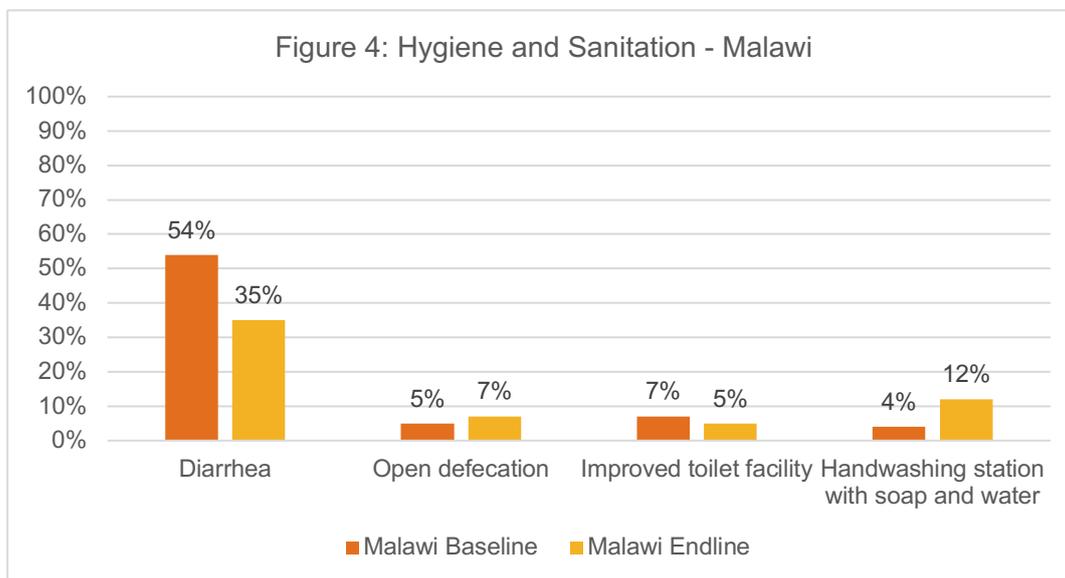
Immediate Outcome 1210 Increased access of women of reproductive age and boys and girls U5 to hygiene and sanitation facilities and safe drinking water for domestic and productive use

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|---|---|---|--|---|
| # and % of communities declared ODF | 75% (3 TAs certified) | 100% (4 TAs all certified) | 80% of communities | 100% (125% of project target) |
| % of boys and girls under five with diarrhoea | girls: 54% (n=198/d=366) boys: 54% (n=185/d=342) | girls: 34% (n=130/d=383) boys: 36% (n=139/d=387) | 9 percentage point decrease girls: 45% boys: 45% | Girls: 20 percentage point decrease (222% of project target) Boys: 18 percentage point decrease (200% of project target) |
| % of women with access to safe drinking water | 31% (n=219/d=708) | 41% (n=318/d=770) | 10% increase 34% | 41% (121% of project target) |

ODF Communities

At baseline three of the four Traditional Authorities (TA) were already declared Open Defecation Free (ODF). These included Traditional Authorities Kayembe, Dzoole in Dowa and Kasakula in Ntchisi. In Year 2 of SANI, the project was involved in the assessment of Traditional Authority Kalumo following various interventions implemented by other stakeholders. In Year 3, the project was involved in the commemoration of attainment of ODF status not only of the remaining Traditional Authority in Ntchisi (Kalumo) and also celebrated the same status for the Dowa and Ntchisi Districts. The Ministry of Health accorded a Certificate of Honor for the two district councils for attaining ODF status. In Year 4, the project focus was to maintain the ODF status the traditional authorities acquired.

Community roll-out of hygiene and sanitation modules through Care Groups and training of Village Health Committees who later sensitized communities on maintaining the ODF status also played an important role in maintaining good practices of hygiene and sanitation amongst the communities. Open defecation was not a common practice at the beginning of the project, and remained so at endline. Although there was no improvement in the number of households with a handwashing station since baseline (35%), more stations had both water and soap (12% at endline, up from 4% at baseline).



Source: Baseline and endline household surveys, February 2017 and February 2020

Children Under 5 with Diarrhea

The endline results show impressive reduction in incidences of diarrhea, where 35% of the children 0-59 months suffered from diarrhea in the past two weeks prior to the survey, down from 54% at baseline. There were no significant differences in child diarrhea between Ntchisi (32.9%) and Dowa (35.6%). The evaluation also found no sex differences in diarrhea between girls (33.7%) and boys (36.4%) under five years of age. The reductions registered are due to improvements in WASH behaviors and management of the disease across communities

Women with Access to Safe Drinking Water

Since women are the primary users of water points from their gendered role of fetching water, SANI strongly promoted women's involvement in the mapping process to identify which water points were too far, functional, non-functional, and/or needed maintenance. CARE Malawi worked with Area Development Committees (ADCs), which have 50% female representation, to continually assess Water Point Committees activities and progress towards gender equality within SANI communities. The project also educated communities through Care Group platform and in water committees on how to treat water from unimproved sources using purifiers like water guard and chlorine, and traditional methods that involve boiling and filtering. Proper water treatment – boiling, using chlorine and tablets - has improved from 27% at baseline to 75% at the end of the project (a 48-percentage point increase).

Despite the improvements in sanitary and hygiene practices, the project faced some challenges in promoting WASH behaviours. Many people believe in washing hands when they think they are dirty only, this perception is however fading due to sensitization meetings. Many people in the communities do not use soap when washing their hands. This is because the use of soap following use of the toilet is not prioritised over soap for bathing due to financial constraints of the household. Promotion of income generation activities and VSLA coupled with intensive sensitization through local leaders and structures should be a priority in WASH activities.

Immediate Outcome 1220 Increased ability of women and men to produce, store, preserve and process high nutrient food for women of reproductive age and boys and girls U5

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|--|---------------|--------------------------|----------------|--|
| # of HHs with improved homestead gardens | N/A | 4105 HH (1,768m, 2,337f) | 3500 HH | 4105 (1,768m, 2337 f) (117% of project target) |

The project worked with 1,768 male and 2,337 female farmers in farmer clubs, all of whom adopted improved homestead gardens. SANI adopted the Farmer Field School (FFS) model in Malawi and used demonstration plots to promote climate resilient agriculture practices. The farmer club members learned climate resilient technologies promoted in the demonstration where numerous early maturity and drought resistance crops were promoted. The project also promoted bio-fortified orange maize and orange fresh potatoes to supplement Vitamin A in people's diets. In addition, the project promoted homestead gardens for the production of different varieties of vegetables and legumes for easy accessibility throughout the year and carried out a post-harvest loss crop management training to the FFS.



A SANI participant harvesting mustard from a homestead garden, during the project evaluation in January 2020. (photo credit: DNCC member)

Homestead gardens were also promoted amongst Care Group participants through a joint effort among promoters, lead farmers, cluster leaders, VNCCs and project staff. Though these gardens were not counted in Outcome 1220 because monitoring was limited due to the sheer number, the highest number of homestead gardens recorded in the project was between January to March 2019, where 21,615 gardens were observed among Care Group participants. According to rolling profiles analysis, involvement of men in caring for the homestead gardens increased; their involvement in Care Groups improved their knowledge on nutrition and diet diversity while gender dialogues made them realize the importance of working together as a team with their partner to better the family's food production and diet.

Rolling profile participants noted the skills and knowledge gains they had received in agriculture production mainly through their adoption of modern farming technologies and practices to improve food production for household consumption. Women and men worked together to establish backyard gardens, which helped participants to increase yields and diversify crops. Newly adopted practices included pit planting, planting improved crop varieties, manure making, crop diversification, mulching, planting two rows of soybeans, etc. The use of compost manure is another area that has improved as people have information on the benefits and the costs are low compared to chemical fertilizer which is expensive. All participants noted that the adoption of modern farming techniques has led to an increase in yields.

A challenge for this immediate outcome was the limited number of lead farmers (90 in total), trained to support the 3,500 farmer club members. It was difficult for these farmers to provide the same level of service to each of these farmers. In future, the project would increase the number of lead farmers trained, to ensure they are able to provide more direct support to a larger number of households. Additionally, some rolling profile participants noted that erratic rainfall, prolonged dry spells, water scarcity, and pest infestation including Fall Army Worms (FAW) posed a threat and hampered crop production and maintenance of homestead gardens in implementation areas.

Immediate Outcome 1230 Improved attitudes of women and men toward gender issues that influence nutrition practices for WRA and boys and girls under 5

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|----------------------------------|---------------|------------------------------|--------------------------------|------------------------------|
| % of VSLA members who are female | N/A | 78% 18,267(4047m, 14220f) | >70% of VSLA members are women | 78% (111% of project target) |

| | | | | |
|--|----------------------|----------------------|-----------------------------|------------------------------|
| % change in attitudes of men and women toward gender issues that influence nutrition practices | 42% (n=269/d=628) | 50% (n=311/d=626) | 10% increase Malawi: 46% | 50% (109% of project target) |
|--|----------------------|----------------------|-----------------------------|------------------------------|

VSLA Members who are Female

Analysis of the household data from the evaluation showed that the membership of women increased by 34 percentage points, from 12% at baseline to 46% at end of the project. Men's participation in VSLA increased by 15-percentage points, from 3% at baseline to 18% at endline. The groups received training on savings and investment to ensure they succeed in their operations. The training on savings and loans imparted the necessary experience and opened opportunities for financial growth. For example, one third (37%) of the women interviewed in the endline study reporting having access to credit services from financial service providers such as VSLAs, commercial banks as well as agricultural associations and cooperatives, including Savings and Credit Cooperatives (SACCO) and Community Savings and Investment Promotion (COMSIP), representing a 17-percentage point increase from baseline, as summarized in Table below:

Table 1: Percentage point change in access to financial services (m/f)

| Indicator | Baseline | Endline | Percentage point Change |
|---------------------------------------|----------|---------|-------------------------|
| % of women using financial services | 12% | 46% | 33% |
| % of men using financial services | 3% | 18% | 15% |
| Women's access to credit services (%) | 20% | 37% | 17% |

Between 2016-2020, CARE Malawi supported the formation and capacity building of 846 VSLA groups, with 18,267 (4,047m,14,220w) members. The project provided training to 61 village agents on VSLA methodology and Selection, Planning and Management (SPM) of Income Generating Activities (IGAs) using a cascade model to reach all VSLA members. Reports from community volunteers during quarterly review meeting indicated that VSLA members reinvested the money from VSL in agricultural production mainly to buy farm inputs, livestock, starting small scale business like selling of farm produce, flitters as part of boosting their income at household level and supporting their children with school fees.

In the endline study, it was observed that there has been good contribution of VSLA towards better nutrition, as members often use part of the money to buy food for the families. Gender dialogue sessions in VSLA groups provided an opportunity for couples to discuss issue around money management, decision making and how it relates to nutrition.

"This project has helped us women to know the benefit of being in the village savings and loans groups, this group has made us to have food diverse since we are able to start rearing livestock and this is because of the village bank, which started through the project of CARE".

Woman, Kayembe

All rolling profile participants noted the immense impact of VSLAs in their communities, not only for improved financial literacy but also to the potential for loans and the increased discussions this has encouraged amongst household members. Often, VSLA meetings occur during the day, when men are potentially unavailable. As such, it is common for more women to be involved than men, even though savings may come from both parties which fosters more discussions between the partners regarding financial management. Participants noted that involvement in VSLAs has greatly increased joint financial decision making in their households. "They [husband and wife] both belong to VSLA groups and when time comes for sharing, they bring the money together and make plans on how to make use of the money for the benefit of the household. They discuss and agree on what to do including purchase of assets. They always agree on what they want to buy as a household," (Woman, Dowa District). Another participant noted that the training they had received, regarding VSL and small-scale business management and loans, has contributed to both the husband and wife getting involved in other income generating activities. "Levels of income have increased for the past six months since both husband and wife participate in VSL. I am involved in tomato buying and selling while [my] husband does the frying and selling of potato chips. The profits are mixed and then [we] save."

Another participant also noted that their household had been encouraged to participate in other income generating activities in the community which has caused their household income to increase. Many participants noted that the savings and income they have been able to generate from VSL and IGAs, in addition to the access to loans, have enabled them to buy farm inputs (such as fertilizers, seed and even livestock like pigs and goats), kitchen utensils and additional foodstuffs, all contributing to better nutrition and nutritious practices.

Change in Attitudes of Men & Women

According to the results of household endline study, attitudes of men and women toward gender issues that influence nutrition practices has improved by 8-percentage points (42% at baseline to 50% at endline). According to the endline qualitative study, women’s role in decision-making, including budgeting, shows indications of change over time since baseline. Respondents noted these changes in relation to the SANI project. This also seems to have resulted in improved marital relations and open communication between the husbands and wives. Participants in qualitative endline study, particularly in TA Kayembe Dowa district, have noted an increase in women’s leadership resulting from the project.

“People are now empowered and women are able to speak out their voice and hold leadership positions. A good example is at ADC where a woman now holds the chairperson position which has been dominated by men for a long time, all because of SANI interventions especially gender dialogue sessions which has enabled men to realize that women too need to be given space to lead.”

Chief from TA Kayembe

Intermediate Outcome 1300: Strengthened governance and accountability of gender-equitable nutrition policies and programs for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|--|----------------------|---|--------------------------|--|
| % of DNCC members and DNCC leaders who are female | NA | female members: 30% (128/422) female leaders: 37% (66/178) | 30% of members / leaders | Members: 30% (100% of project target) Leaders: 37% (123% of project target) |
| % of District Nutrition Coordinating Committees with good governance practices in place that feed into national policy | NA | 100% | 80% of DNCCs | 100% (125% of project target) |

Female DNCC Members/Leaders

A challenge within DNCC structures was low female representation. Even though these positions are government appointed, CARE Malawi continued to advocate for increased diverse female representation on these committees, especially in leadership roles. The project had limited influence on membership of DNCCs as membership and leadership positions are based on who is in the position within government departments, and CSOs working in the district who are supposed to be a member or in a leadership position. Though this figure had little variance from baseline, by the end of the project DNCCs were composed of 30% female members and 37% of DNCC leaders were female.

DNCC Governance

The project supported and coordinated regular meetings for the DNCCs, ANCCs, and VNCCs in Dowa and Ntchisi Districts. In addition to supporting and attending the periodic meetings for these structures, the project supported annual joint planning meetings and monitoring visits for the two DNCCs. The joint planning meetings helped the stakeholders in the district to share resources and conduct joint implementation of activities. For example, during training of promoters in different modules and distribution of inputs attracted the participation of government and other stakeholders as they became aware of the consolidated District plan. The project participation in and support to Dowa and Ntchisi DNCCs improved the performance of the structures to be able to coordinate

nutrition interventions and enhanced collaboration among stakeholders. By the end of the project, all DNCCs reported having good governance practices in place that feed into national policy.

Towards the end of the project SANI began working with Area Community Leaders Action for Nutrition (ACLAN) and Community Leaders Action for Nutrition (CLAN), an important link to nutrition governance at the local level. Optimally, engagement with these community level structures would have happened earlier in the project, but these structures were only created after the project had been established, and insufficient budget remained to support them comprehensively. Maintaining a strong relationship with DNCC, ANCCs, VNCCs, as well as ACLAN and CLAN were crucial to the sustainability of project activities, as these committees are important for nutrition monitoring, coordination, and programming in both districts.

Immediate Outcome 1310 Improved ability of regional, national, district governments and stakeholders to plan and scale up gender-sensitive evidenced-based maternal, infant and young child nutrition

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|---|---------------|--|------------------------------|-------------------------------|
| % of districts with gender-sensitive multi-sectoral joint action plans | N/A | 100% | 80% of districts and regions | 100% (125% of project target) |
| # of gender-sensitive nutrition policies and programs drafted for WRA, PLW and boys and girls U5 with project support | N/A | 3 policies implemented in both districts | 2/district | 3 (150% of project target) |

Districts with Gender Sensitive Multi-Sectoral Joint Action Plans

By the end of the project, all project districts had developed annual joint-action plans. The annual plans consolidate all nutrition efforts from all stakeholders in the district and are developed, coordinated, and supervised by the DNCC. CARE Malawi staff noted early in the project that MIYCN training materials for inter-sectoral MICYN committee meetings were gender-blind, focusing solely on nutrition and not on how gender inequality directly affects nutrition outcomes. In Year 3, the project worked closely with members at the village level to ensure gender was integrated into training materials and that the approach of delivery included messaging on women’s empowerment and men’s engagement.

The project participation in and support to Dowa and Ntchisi DNCCs improved the performance of the structures to be able to coordinate nutrition interventions and enhanced collaboration among stakeholders with Area Community Leaders Action for Nutrition (ACLAN) and Community Leaders Action for Nutrition (CLAN). ACLAN and CLAN structures are key in reinforcing behaviours in the communities being the custodians of culture and beliefs, and they will remain important partners in future nutrition advocacy and programming.

Gender-sensitive Nutrition Policies and Programs Drafted

By the end of the project, 3 primary policies were drafted and launched, in collaboration with policy and project partner the Civil Society Organisation Nutrition Alliance (CSONA). CSONA, with funding from the SANI project, conducted numerous lobbying meetings with relevant ministries such as the Department of nutrition and HIV/AIDS and Ministry of Finance as well as held consultative meetings with other networks such as the Civil Society Agriculture Network and Malawi Equity Justice Network. CSONA’s work, with the support of SANI, has led to approval of the Food and Nutrition Bill by the cabinet, to parliament for discussion and passage in February 2020. The lobbying also led to launch of Malawi food composition table, which provides a basis for improving minimum acceptable dietary intake among Malawian population. Thirdly, The Malawi multi-sectoral nutrition policy was launched successfully and disseminated in all the 28 districts of the country.

Immediate Outcome 1320 Improved responsiveness of health service providers for gender-sensitive MIYCN and global acute malnutrition

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|-----------------|---------------|-------------------------------------|----------------|------------------------------|
| % change in CSC | NA | 25% increase 73 score at round 2 | 10% increase | 25% (250% of project target) |

| | | | | |
|--|--|-----------------------------------|--|--|
| | | (Oct 2019) | | |
| | | 58 score at round 1 (Feb 2019) | | |

During the 4-year project period, 2 rounds of community scorecard were conducted in 10 health facilities. Implementation of CSC in the health facilities resulted in number of issues raised by service users being addressed by service providers from both the health facility and District Health Management Team (DHMT). The percentage change of responsiveness of health service providers for gender-sensitive MIYCN and global acute malnutrition has improved to 25% at endline surpassing the project target of 10%. CSC improved health service delivery and mobilized a number of other community initiatives with government support. The issues addressed through the CSC action plans included:

- Availability of hygiene and sanitation facilities and access to portable water both at facility and the villages resulting in the rehabilitation of toilets and borehole at the guardian shelter at Ntchisi district hospital
- Male participation in sexual and reproductive health and nutrition issues resulting in more men accompanying their wives to antenatal clinics, accessing family planning services and accessing diversified food items for the home.
- Referral transportation issues, with guardians of patients charged for fuel by ambulance drivers in Dowa health facilities when a patient has been referred to a referral hospital. The DHMT identified one issue being fuel allocation and addressed it by increasing the fuel allocations for Chisepo, Mbingwa, Kayembe, Chizolowondo and Dzoole health facilities in Dowa. This resulted in the guardians no longer being charged.
- Performance of Health Center Management Committee (HCMC): The selling of drugs and food supplements by health personnel at Mbingwa health facility in Dowa, this malpractice stopped through the measures that were put in place during the interface meeting by involving communities structures such as the Health Centre Management Team (HCMT) to track health facility supplies.

As a result of CARE's CSC implementation and these District Interface Meetings, major challenges to health services were addressed, including:

- A pharmacy being constructed to secure drugs at Dzoole Health Facility
- Treatment and level of respect shown by health care workers to patients
- Bed bug treatment at Mponela Health Facility
- Improving food rationing happening at Mponela Health Facility
- Commitment to building a new placenta pit at Chisepo Health Facility
- Improving the performance of the health facility management committees at all health facilities

The participation of women in the processes of scorecard was emphasized from the beginning, ensuring women were present at the scoring and had space to voice and be heard on the issues affecting their nutrition and health including provision of beds in the maternity wing, construction of a placenta pit, safeguarding of therapeutic and supplementary foods under CMAM, provision of ambulance to service among the list maternity referral cases for further medical attention. A challenge faced in implementation of community scorecard was that it was introduced late in the project implementation, as such follow up on the outstanding action plans for second round was not possible with the project closure.

3.1.2: Mozambique Project Outcomes

Highlights:

The project registered the following key achievements in Mozambique:

- **Improvement in meal frequency** by 68%, from 22% at baseline to 37% at endline. Despite the improvement in the frequency, there were no significant improvements in regard to the dietary diversity. Minimum Dietary Diversity (MDD) was estimated as 10% at baseline and at 9% in the endline evaluation.
- **Exclusive breastfeeding (EBF)** increased by 26%, from 65% at baseline to 82% at endline.

- **Timely complementary feeding of children 6-9 months** increased by 51%, from 53% at baseline to 80% at endline.
- **Food security improved by 53 percent**, from 15% at baseline to 23% at endline - despite the fact that the endline happened during lean season and the baseline during main harvest.
- **Diarrhea prevalence decreased by 11% in Funhalouro and 7% in Homoine**, while treatment seeking reached 100% at endline, from 82% in Funhalouro and 86% in Homoine.
- **Use of improved drinking water sources (IDWS)** (piped on premises or other improved drinking water sources) remained consistent from baseline (66%) to endline (66%)
- **100% of DNCCs achieved a high rating on the governance scale**, exceeding the project target by 125%.

Baseline and Endline methodology:

After the COVID-19 pandemic restrictions began in May 2020, the endline study assessment in Mozambique was delayed and modified to ensure adherence to COVID-19 prevention protocols. Instead, an endline household survey with a modified scope was carried out by Apolowil Consultores LDA in October 2020. This modified methodology limited the collection of anthropometric data, reduced the sample size to 150 HH, removed many of the original questions, targeted households with children from 6 to 23 months of age (at baseline the target was children between 0 and 59 months), and changed the interview guides and tools. While the endline sample has similar socio-economic characteristics as baseline, it is not representative of the whole population as it targets project participants only. Participants were chosen using the monitoring registry of household visits and peer groups.

A sufficient sample was maintained to enable calculation of WDD, MDD and MAD using same methodology as baseline. The proposed new calculation for exclusive breastfeeding (using recall for children 6-23 months instead of 0-6 months) reached similar results as the original one at baseline and allows for baseline- endline comparability. The same calculation methodology was maintained for all other indicators.

A qualitative endline study was also conducted in Mozambique in order to generate in-depth data in understanding any changes in knowledge, attitudes and practices around nutrition, feeding practices, gender equality and women's empowerment. This data helped to determine whether gender dynamics in the project area have changed in a way which sustainably improves nutritional outcomes for women of reproductive age (WRA) and children under 5. The original qualitative methods used at baseline (including Photovoice and focus groups with wives, focus groups with mother-in-laws, and focus groups with husbands) were changed to Key Informant Interviews in order to minimize COVID-19 transmission. Oral consent was obtained from participants for the endline as it was deemed safer than written consent.

Given the differences in methodology and scope between the baseline and endline, indicators relying entirely on anthropomorphic data were not calculated. In addition, delays in endline data collection may have influenced the results due to a seasonality effect - the baseline was conducted in the middle of the main harvest (May) and the endline at the beginning of the lean season (October). In this period, food unavailability was not only related to seasonality for SANI beneficiaries who depend on agriculture, but also to the impact of the curfew set in place for COVID-19. This forced the repatriation of most male heads of households, unprepared to return home without income, and the high cost of living in the country caused by the impact of terrorist attacks, extreme weather events (Idai & Kenneth) and the devaluation of the Mozambican currency has had implications on the prices of essential good, especially for food. This means that the real impact of the project on food security as of May 2020 has not been captured, as many research questions asks about recent experience.

In lieu of measuring the original indicators (stunting, wasting, MUAC), SANI in Mozambique drew upon other sources of data and other means to measure change towards achieving the ultimate and intermediate outcomes, including the Johns Hopkins University research conducted in 2018 on nutrition specific indicators.

Ultimate Outcome - Contribute to the reduction of maternal and child mortality in Malawi, Mozambique and Zambia

| Indicators | Baseline data | Endline data | Project target | Cumulative To Date (#/%) |
|------------|---------------|--------------|----------------|--------------------------|
|------------|---------------|--------------|----------------|--------------------------|

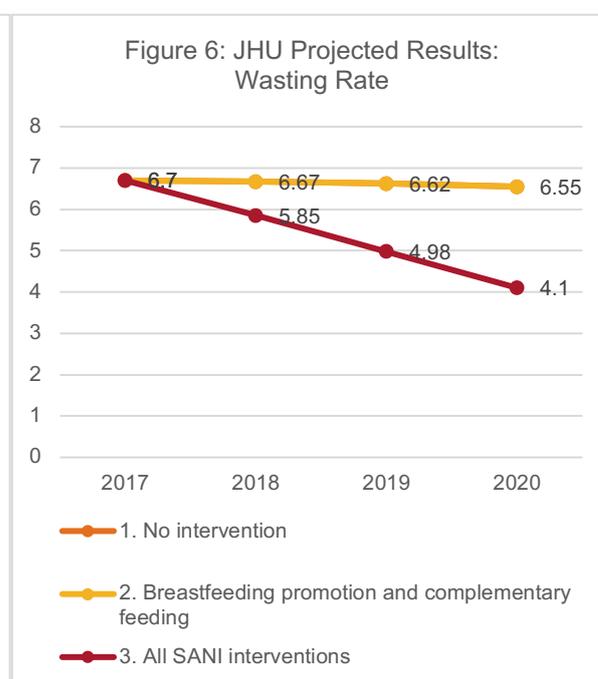
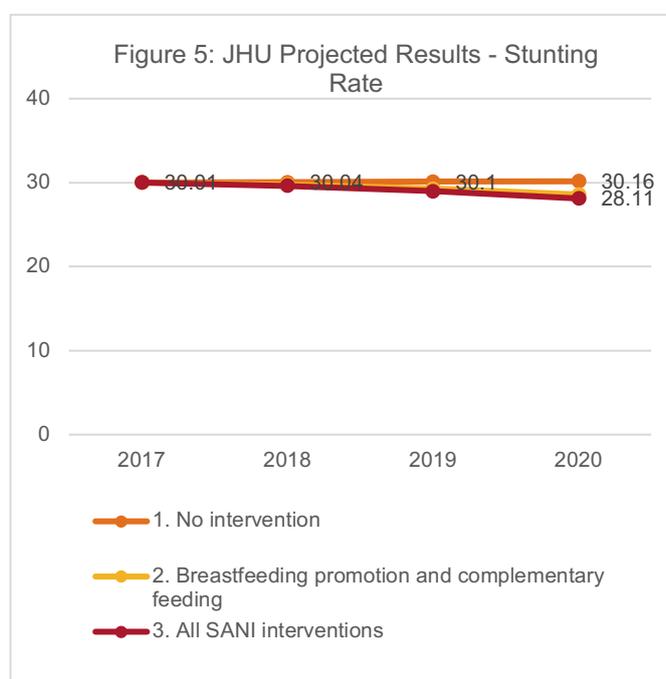
| | | | | |
|---|---|-----|---------------------------|-----|
| Wasting: % of boy and girl children 6 up to 59 months with weight-for-length < - 2 sd | Girls: 7% (34/513) Boys: 7% (32/475) | N/A | Girls: 6.7% Boys: 6.7% | N/A |
| Stunting: % of boy and girl children 6 up to 59 months with height-for-age < - 2 sd | Girls: 34% (100/295) Boys: 42% (109/259) | N/A | Girls: 25% Boys: 32% | N/A |
| % of women with MUAC <23 cm | women: 2% (26/1262) | N/A | 1.9% | N/A |

Stunting and wasting

Due to COVID-19, SANI Mozambique scaled back its quantitative endline survey and did not collect anthropometric data at endline, and therefore did not measure progress against the stunting and wasting indicators under the SANI ultimate outcome.

At project midline in 2018, JHU conducted a study to project potential progress against stunting and wasting given a range of different interventions, including those covered by the SANI project. Overall, the study found that ultimate outcome indicators in the 3-years of intervention would likely only show a small and potentially statistically insignificant change, as these standardized nutritional measures for boys and girls under-5 are not usually sensitive to change in short periods of time.

The study found that without intervention, the stunting rates in the program area would be expected to stay more or less the same at 30% by project completion. Complimentary feeding and breastfeeding promotion would be expected to decrease stunting rates slightly to 29% and with all SANI interventions to 28% (adding improved sanitation). Given that the SANI project covered between 40 – 60% of the total population, based on this simulation, changes in stunting rates are expected to have been small in Mozambique. In terms of rates of wasting, breastfeeding promotion and complementary feedings would be expected to remain relatively the same, but with all SANI interventions wasting would drop to 4%, from 6% at the outset of the project.



Source: Simulation using Lives Saved Tool (LiST)

Women's MUAC

Similarly, due to restrictions on anthropometric data collection, women's MUAC measurements were not collected at endline, limiting the ability of the project to measure progress towards this indicator.

Intermediate outcome 1100: Improved nutrition practices and services of women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|--|--|---------------------------------------|-------------------------|---|
| % of children 6-23 months with MAD by meeting MMF and MDD in the previous 24 hours | Girls: 3% (10/362) Boys: 1% (4/311) | Girls: 3% (2/75) Boys: 1.5% (1/65) | Girls: 12% Boys: 10% | Girls: 3% - 25% of target Boys: 1.5% - 15% of target |
| % of children 0-5 months who are exclusively breastfed | 65% | 82% | 72% | 82% - 114% of project target |

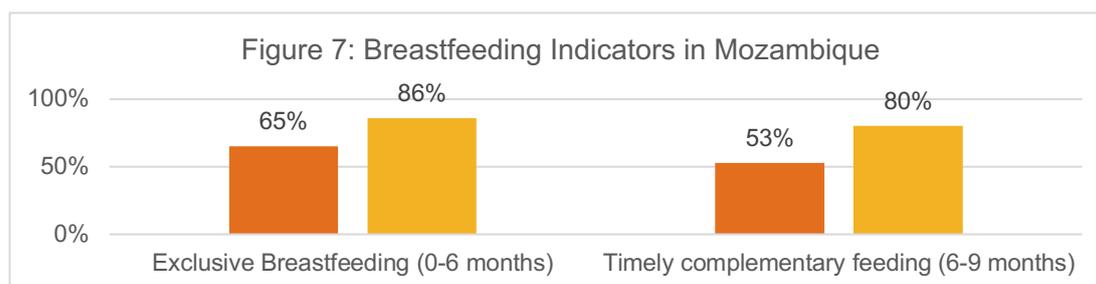
Minimum adequate diet, minimum meal frequency, and minimum dietary diversity

By the end of the project, the percentage of children 6-23 months with Minimum Accepted Diet (MAD) remained the same as the baseline: girls 3% to 3%, and boys 1% to 1.5%. However, there is evidence that this situation is related to the context in which the endline evaluation took place, because the results indicate relative improvement in Minimum Meal Frequency (MMF) per day which increased from 22% to 37% at endline, while Minimum Dietary Diversity (MDD) remained very low due to unavailability of diverse food. This could be explained by the seasonality effect described above, as the endline was collected during the lean season when households rely more heavily on staple crops, and dietary diversity is a more significant challenge.

To improve nutrition practices and services for women of reproductive age and children under five, SANI ensured maternal nutrition counseling for mothers and caregivers through training and supervision of trained community health volunteers to conduct activities that encouraged the desired healthy behaviors among communities and created an enabling environment for the use of nutrition services. The project adapted all nutrition education materials to promote men's involvement in the well-being of the family unit and recruited male volunteers to be trained on MIYCN and gender. Male volunteers played an important role as agents of change by engaging more men to participate in nutrition education activities under this outcome. Cooking and feeding demonstrations using locally available food were also implemented to improve nutrition education. However, as previously mentioned, many factors contributed to the unavailability of food, contributing to poor diversification, including drought, and rising food prices.

Exclusive breastfeeding

An area of significant improvement is in the percentage of exclusively breastfed children 0-6 months, with 82% exclusively breastfed at endline compared to 65% at baseline (an increase of 17pp). At baseline, the Mozambique DHS (2011) showed that only 27% of children received exclusive breastfeeding at the age of 4 months. These figures are in line with the results from the baseline evaluation where breastfeeding practices generally decreased when the child reached 4 to 5 months of age (84% at 1 month of age to 30% at 5 months of age). Similarly, the endline survey saw an increase in timely complementary feeding, with 80% of households introducing new foods when children reach between 6 and 9 months old, compared to 53% at baseline (an increase of 27pp).



Source: Baseline and endline household surveys, May 2017 and October 2020

Immediate Outcome 1110 Increased knowledge of gender-sensitive MIYCN and caregiving practices for women of reproductive age and boys and girls under 5

| Indicators | Baseline | Endline | Project target | Cumulative to Date (#/%) |
|---|---|----------------------------------|------------------------|--|
| % change in knowledge of men and women of MIYCN practices | Men: 53% (111/210) Women: 59% (745/1262) | Men: N/A Women: 71% (102/143) | Men: 58% Women: 65% | Men: N/A Women: 71% (109% of project target.) |

Knowledge of MIYCN practices among women and men

At endline, there was a 12-percentage point increase in knowledge of women on MIYCN practices, from 59% at baseline to 71% at endline. Note that the sample of men surveyed was insufficient to calculate change towards this indicator among men.

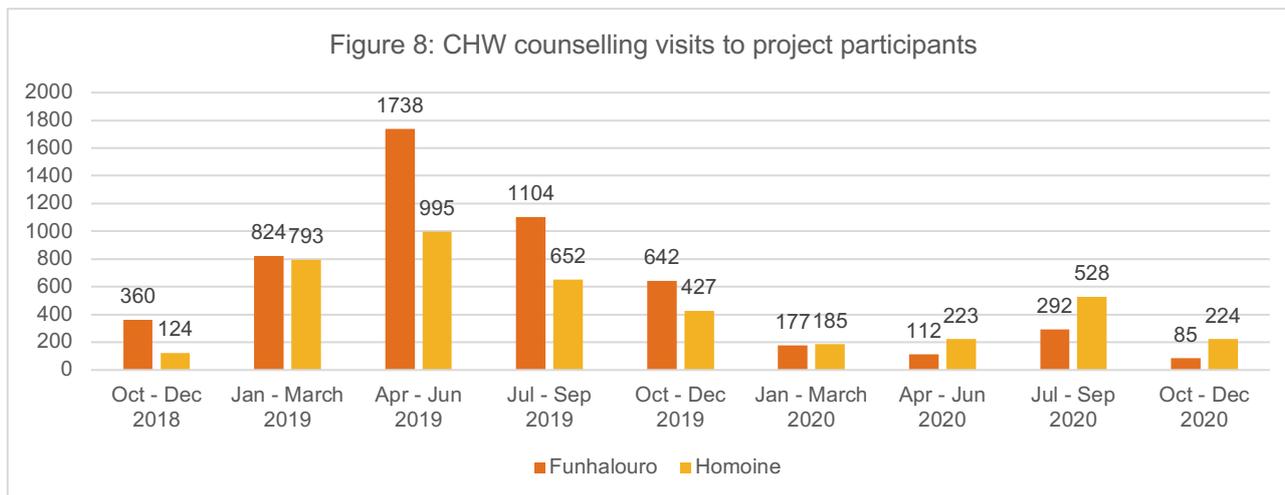
The key approach to achieve the immediate outcome 1110 was to build capacity of 346 (116m, 260f) Community Health Workers (CHWs) through training, supervision and ongoing mentoring on gender-sensitive maternal, infant and young child nutrition (MIYCN), Growth Monitoring and Promotion, cooking and feeding demonstrations and community awareness through peer groups. CARE Mozambique partnered with HOPEM (Men for Change Network) and rolled out HOPEM's 'Men in the Kitchen' intervention, which teaches men how to cook and encourages men to take on this role within the household. During demonstrations culinary preparation and presentations were done by a male volunteer/role model within the community as a strategy to normalize men's presence within the kitchen, defy gender norms and break down barriers that prevent men from assisting in domestic chores.

Community Health Workers are well-respected community members who live in the community where household counselling is delivered. They are responsible for conducting activities that encourage healthy behaviors and working with communities and health services to create an enabling environment and encourage the use of nutrition services. The CHWs have a unique opportunity when they visit households to interact with children and families in a way that may not be appropriate in a group setting. More importantly, CHW's customize the content of the visit according to the specific needs of the women they visit.

Topics for MIYCN household counselling during home visits were developed following the Mozambique National Strategy for behavior change to prevent malnutrition in women and children under five.. The topics included feeding during pregnancy and lactation – addressing myths and taboos, exclusive breastfeeding, complementary feeding, family planning, hygiene and sanitation, importance of diversified diets, antenatal care visits, importance of delivery in a health facility, role of the fathers during women's pregnancy and breastfeeding, and h care of children. Due to low literacy levels among community members, the project adapted MIYCN materials to include mainly images, which included pictures of men caring for children while engaging in household chores in order to challenge entrenched gender norms. A key message in all materials was the importance of male involvement in improving the nutritional status of women and children.

Since the beginning of the project, community health workers have visited a total of 2,991 women (1426 women from Funhalouro and 1565 from Homoine). A total of 40% of women started receiving visits while pregnant. The overall number of individual CHW visits to households in the project life is 9,940 with an average of 3 visits per beneficiary household. See below for the distribution of visits throughout the life of the project:

Figure 8: CHW counselling visits to project participants



Data source: project monitoring data

There was a notable decrease in visits in 2020, primarily to the COVID-19 pandemic when CHWs were restricted from travelling from house to house. Visits resumed to a rate more consistent with pre-COVID times in July to September 2020 between COVID waves, and then declined again as infection rates climbed in late 2020 and early 2021.

Findings from the mid-term evaluation conducted by Johns Hopkins University revealed that almost all (98%) counseling beneficiaries said that they can follow the CHW's nutrition advice using food they have in their house and most of them (89%) also could recall at least one food a pregnant woman should consume. A high proportion of beneficiaries (88%) correctly recalled when a person should wash his or her hands and 85% had correct knowledge about family planning methods.

It should be noted that the majority (73%) of Community Health Workers are illiterate. A similar proportion of literate and illiterate CHWs have correct knowledge about ANC services (30%), diarrhea (86%) and family planning benefits (75%). This is an interesting finding because it shows literacy does not have significant influence on the CHWs ability to provide effective counselling on MIYCN. These findings support existing evidence that suggests greater investment and scale up of the home visit program, and a higher volunteer-to- population ratio can improve maternal and newborn health. At the end of the project 64% of women had good knowledge of MIYCN practices, an increase of 5 percentage points comparing with the baseline (59%).

During the last year of the project, CARE trained CHWs to use the opportunity of making home visits to address COVID-19 prevention and gender-based violence as one of the negative effects of the pandemic, correct contradictory messages identified during the mid-term evaluation and updated counselling and MUAC screening protocols during the pandemic.

Immediate Outcome 1120 : Improved skills of Health Care Workers and Community Health Workers to deliver quality MIYCN counselling and treatment for acute malnutrition

| Indicators | Baseline | Endline | Project target | Cumulative to Date (#/%) |
|---|----------|--------------|----------------|-------------------------------|
| % of women, boys and girls u5 completing CMAM treatment | N/A | 92% (61/66) | >85% | 92% - 108% of project target. |
| % of women, boys and girls U5 recovered from acute malnutrition | N/A | 100% (66/66) | >75% | 100% - 115% of project target |
| % change in satisfaction of services | N/A | 1% increase | 10% increase | 1% (10% of project target) |

Completion of CMAM treatment & Recovery from malnutrition

In the last year of the project 92% (108% of project target) of women, boys, and girls under five completed Community Management of Acute Malnutrition (CMAM) treatment and 100% of them totally recovered.

CARE used a mix of training approaches to improve the skills of Health Care Workers (HCW) to be able to deliver quality maternal, infant, and young child nutrition counselling and treatment for acute malnutrition. CARE provided training to 33 (15m, 18w) Health Care Workers to be able to identify, provide education on, monitor and treat malnutrition in mothers, pregnant and breastfeeding women and infants and children under 5 years. Of the 33 HCW's trained 5 nutrition staff were trained and mentored on collection and analysis of sex disaggregated health information system.

In coordination with the provincial department of health, CARE also conducted on job trainings and continuous mentorship to HCWs through joint monitoring and supervision visits, between CARE staff and health department members. In addition, the health department at district and provincial levels were supported to deliver community campaigns to encourage optimal breastfeeding, Growth Monitoring and Promotion (GMP), and family planning. Cooking demonstrations were integrated to encourage the use of new and unfamiliar foods.

Time since last weighing was also used as an indicator to track growth monitoring behaviour of parents, following GMP activities. Between baseline and endline there was a notable increase in parents reporting recently weighing their child within the past month, and within the last 3 months – from 68% at baseline to 74% at endline. This indicates an increase in growth monitoring behaviour among families in both Funhalouro and Homoine districts.

Change in satisfaction with services

Community satisfaction with services provided at health facilities was assessed as part of the last round of Community Score Card (CSC) that took place in February 2020. Service users reported average satisfaction scores (2.5 on a 0 to 5 scale composed of 10 items) due to the low availability of human resources at Health Center, and also commented on services related to nutrition. Low ratings were given due to lack of availability of agricultural inputs from agriculture extension services, lack of access to socio-economic infrastructure and services, and low level of coverage for agricultural extension services. Only slight improvement (1%) was observed from Round 1 to Round 2 of CSC in the quality of services provided, suggesting more work is required to improve community satisfaction of health services. This low rate of improvement on the satisfaction indicator is not necessarily linked directly to CMAM. It is possible that the lack of improvement in satisfaction is due to factors beyond the control of the SANI project, including deficits in supplies, staffing, and resources at the health facility level.

Intermediate Outcome 1200: Improved maternal, infant and young child nutrition and gender sensitive practices for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|---|---|---|---|---|
| % of women and children (boys and girls) 6 – 23 months who meet minimum diet diversity | Women: 21% (260/1262) Girls: 13% (46/362) Boys: 8% (24/311) | Women: 22% (31/143) Girls: 8% (6/74) Boys: 11% (7/64) | Women: 30% (260/1262) Girls: 13% (46/362) Boys: 8% (24/311) | Women: 22% (31/143) = 73% of project target Girls: 8% (6/74) = 40% of project target Boys: 11% (7/64) = 73% of project target |
| % of men and women using improved drinking water sources (piped on premises or other improved drinking water sources) | 66% (834/1262) | 66% (88/131) | 73% | 66% (88/131) = 90% of project target |

Nutrition sensitive practices are determinants to achieve long-term improvements in the overall health of the population. SANI project worked with local government and communities to improve access to and availability of food, establishing homestead gardens that help to meet the minimal acceptable dietary needs of women, boys, and girls under five. The other necessary nutrition sensitive interventions focused on water, hygiene, and sanitation (WASH) to reduce incidences of diarrhea and water-borne illnesses. SANI also undertook the rehabilitation and construction of water points and

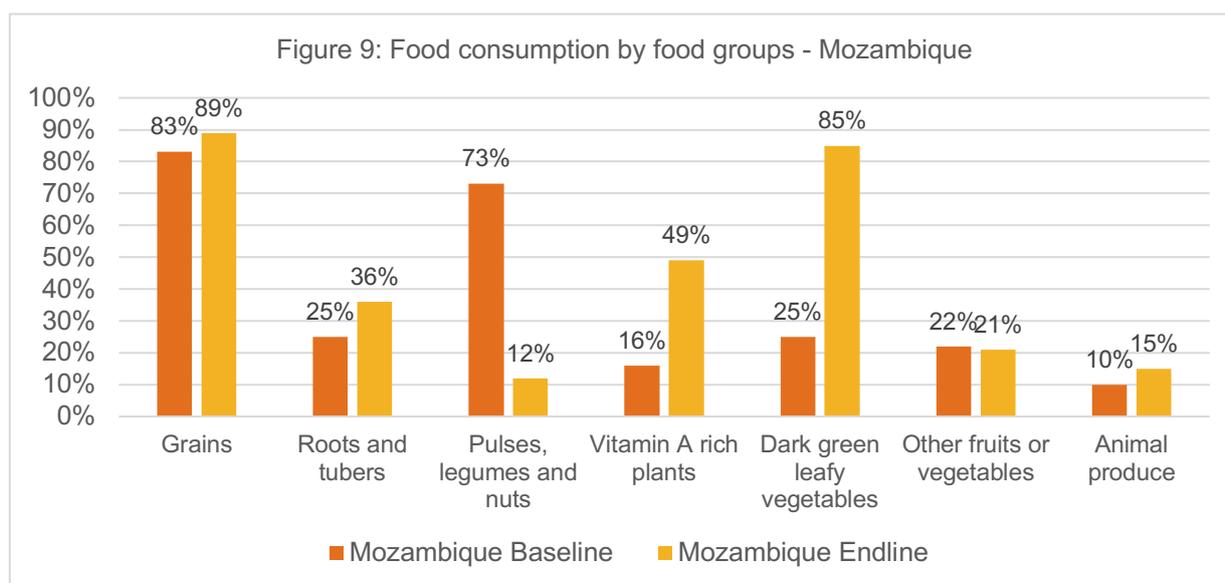
livestock waterers. Community dialogues were conducted using the Social Analysis and Action (SAA) model aiming to increase equitable decision making leading to improved nutrition outcomes.

Minimum Dietary Diversity:

As mentioned above in 1100, households' ability to diversify food tended to decrease with the impact of recurring droughts and the impact of COVID 19 on the country's economy. The project team suggests that community knowledge about diversification exists, but there were few options for this because of limited food availability. This was reflected in the endline survey, where effectively no change in minimum dietary diversity was registered between baseline and endline. Note that the small sample size at endline compromised the ability of the project to meaningfully measure progress towards this indicator - while slight changes in percentages along this indicator were registered, the sample size of the endline was too low to affirm there is an actual difference between baseline and endline.

This trend was reflected in the qualitative endline assessment findings - while there is general understanding of the importance of diversity in food, particularly during pregnancy and breastfeeding, there is a lack of diversity of food due to the unaffordability and unavailability of food. At endline it remained a challenge to access diverse food given the drought, and it is also difficult to ensure enough food to eat three times a day. Food security and malnutrition remain as issues.

There is however evidence that food consumption patterns changed during the project. At endline, households were less likely to be consuming pulses, legumes, and nuts and more likely to be consuming vitamin A rich plants, grains, roots and tubers, dark green leafy vegetables, and animal produce. This may have been influenced by seasonality, as the endline was completed in a different season to baseline.



Source: Baseline and endline household surveys, May 2017 and October 2020

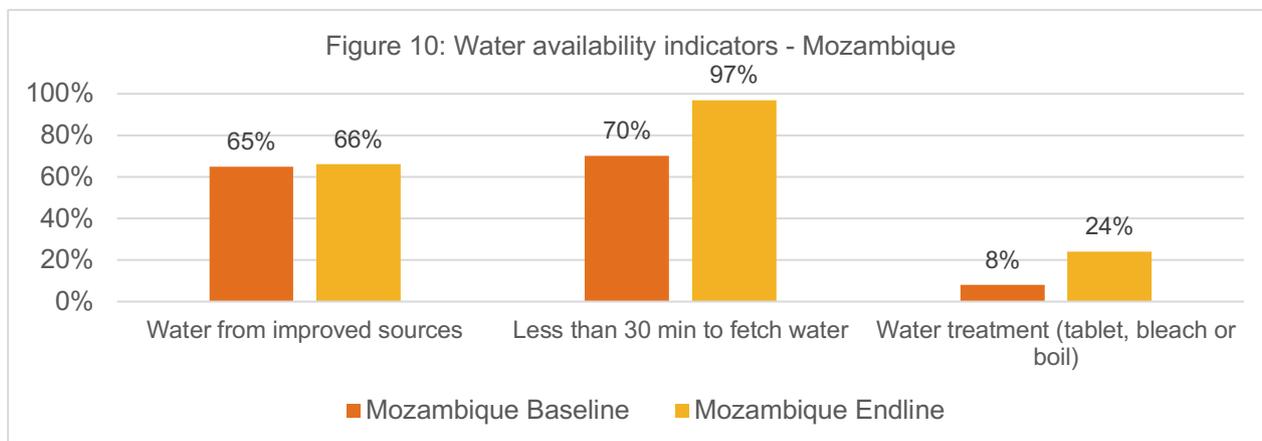
The issue of recurrent drought was persistent and posed a challenge for the project's primary strategy of distributing seeds as part of home gardening promotion. The project did not modify its strategy to adequately address the issue of lack of food, and in future, options like cash transfers or food distribution, income diversification, or drought-resistant agricultural technology should be adopted in addition to seed distribution. This has been considered for the COVID-19 response strategy for SANI in Mozambique as part of the costed extension period – the most vulnerable households will be provided with food baskets in addition to wider seed distribution.

Improved drinking water sources

The percentage of men and women using improved drinking water sources (piped on premises or other improved drinking water sources) remained consistent from baseline to endline. While the target (10% increase) was not met, it is possible that the endline sample size was insufficient to be representative of the SANI communities. Of 8 communities involved in the endline survey, only 3 benefited from the construction of water points (2 constructions and 1 rehabilitation) however, the project constructed or rehabilitated water sources in 24 communities, therefore, if the coverage in

terms of communities had been greater this information may have been better captured. It should be noted that the main criteria for the choice of communities by the consultants were related to the beneficiaries of maternal and child nutrition counseling.

There was important progress towards water availability indicators noted at endline, with a 37-percentage point increase in women reporting they require less than 30 minutes to fetch water, as well as a 16-percentage point increase in those treating water. Progress towards this indicator has disproportionately positive implications for women and girls, as they are more frequently responsible for fetching water.



Source: Baseline and endline household surveys, May 2017 and October 2020

Every waterpoint constructed or rehabilitated was done in collaboration with local WASH committees. Where these committees didn't exist (in the case of new water points) new ones were created. Following completion of construction, committees took on responsibility for water point maintenance and repair, and will continue this function beyond the end of the project. SANI focused on enhancing the representation and engagement of women in these committees and saw progress towards more gender inclusive and sustainable management of water points in Mozambique. The endline survey found an increase of 17-percentage points in women who make decisions at water committees (from 58% at baseline to 75% at endline), and a 12-percentage point increase in women who speak at water committees (from 70% at baseline to 82% at endline). Another interesting finding observed by the SANI Mozambique team is that the committees that had the highest levels of contribution and good maintenance were led by women - this inspires other women to experience leadership positions by showing that they also have the capacity to make informed and important decisions for the development of the community.

Immediate Outcome 1210 Increased access of women of reproductive age and boys and girls U5 to hygiene and sanitation facilities and safe drinking water for domestic and productive use

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|---|---|--|-------------------------|--|
| # and % of communities declared ODF | N/A | 9% | 80% of communities | 11% of project target |
| % of boys and girls under five with diarrhoea | Girls: 20% (129/640) Boys: 19% (116/622) | Girls: 15% (11/71) Boys: 10% (6/62) | Girls: 15% Boys: 14% | Girls: 15% - 100% of project target Boys: 14%- 180% of project target |
| % of women with access to safe drinking water | 8% (99/1262) | 25% | 9% | 25%- 278% of project target |

Community Led Total Sanitation:

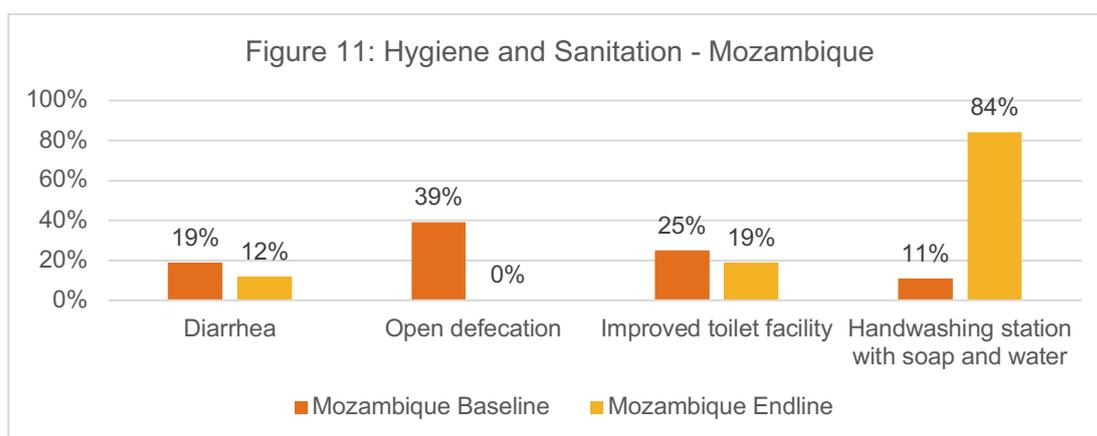
CARE Mozambique, through Community Led Total Sanitation (CLTS) programming, worked towards achieving the Open Defecation Free (ODF) target in at least 80% of communities targeted by the project. However, moving communities towards being certified as ODF requires significant time to achieve this level of community-wide behaviour change.

While the target for communities ODF was not achieved, it is evident that considerable progress was made towards achieving ODF status in many communities. The requirements for a community to be declared ODF is to have all community households with adequate latrines, requiring at least one latrine with a lid, handwashing system, and a roof/protection. Looking at the detailed ODF analysis per community, in some cases households had latrines but lacked a lid, handwashing station, or a roof, and therefore were not counted. In some instances, most households in a community were considered ODF, but a few households had not built latrines that meet all of the ODF criteria, meaning the community did not achieve ODF status. Money and lack of available labour were a common reason for not constructing or completing latrines, indicating the importance of resource limitations in preventing progress towards ODF status for low-income households. It is also possible sample size restrictions limited the generalizability of the endline study findings. The number of communities surveyed to measure progress towards this indicator was also quite small, and the project team was only able to collect data of ODF status in Funhalouro district. This was primarily due to the travel difficulties caused by COVID 19 and the impassibility of the roads due to torrential rains in the end of Y5.

Following CLTS training of community leaders, each community developed an action plan in collaboration with local WASH officers, which laid out activities to improve sanitation across communities, with the goal of eliminating open defecation. Although women and men actively participated in action plan implementation, SANI staff observed an increase women’s involvement in operation and pump maintenance, which challenges perceptions that these are men’s jurisdictions. The team also advocated for opportunities for women to lead water committees to break down barriers and transform exclusion standards. CARE believes that the CLTS approach will continue to support the community to achieve ODF status. Increasing the number of leaders engaged in monitoring CLTS at the end of year 4 was an important step towards ensuring this sustainability.

Boys and girls under five with diarrhea:

At endline, a reduction of diarrhea episodes was observed, reducing to 15% among girls (from 20% at baseline) and 9% among boys (from 19% at baseline). There was also a significant increase in handwashing stations with soap and water at the household level (from 11% at baseline to 84% at endline) and on reported levels of open defecation (from 39% at baseline to 0% at endline), as noted in the chart below. Given the timing of the endline survey in November 2020, it is probable that the handwashing awareness campaigns and soap distributions that took place as part of COVID-19 response activities had an influence on the increase in this indicator. Nonetheless, this is a notable improvement, indicating that sometimes change in knowledge is not enough to change behavior and access to key inputs can make the difference in achieving desirable practice. The chart below also indicated a slight decline (6pp) in use of improved toilet facilities from baseline to endline – this is likely due to some household latrines lacking certain features to be considered an “improved” latrine.



Source: Baseline and endline household surveys, May 2017 and October 2020

Women with access to safe drinking water

In the endline survey 25% of women reported access to safe drinking water, a 17-percentage point increase from baseline, indicating a significant increase in women who are treating water by boiling or using chlorine tablets. In Mozambique, the majority of teaching on water treatment was carried out by CLTS facilitators as part of the CLTS process. This was an effective mechanism for teaching,

as households were engaged in learning and applying these new behaviours by a trusted person in their community.

Immediate Outcome 1220 Increased ability of women and men to produce, store, preserve and process high nutrient food for women of reproductive age and boys and girls U5

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|--|---------------|--------------|----------------|-----------------------------|
| # of HHs with improved homestead gardens | NA | 846 | 1500 | 846 (56% of project target) |

The agriculture component of the SANI project involved promoting household consumption of foods produced in community and homestead gardens. This included educating communities about improved agricultural practices to enhance production, diversify their crops and reduce wasting of harvested food through organized farmer groups. However, the climatic conditions in the country, and in southern Mozambique in particular, have negatively impacted this activity, with reduced rainfall. Another major shock to Southern Africa has been the arrival and infestation of the Fall Army Worm (FAW). The FAW flourishes in areas that are impacted by drought like Funhalouro and part of Homoine districts, followed by rain, which is precisely what Mozambique has been experiencing.

SANI trained 48 community volunteers (25 female and 23 male) to provide guidance to 1724 community members (321m, 1403f) organized in 66 Farmer Field Schools (FFSs) on nutrition sensitive climate smart agricultural techniques, food processing and storage demonstrations, and small scale poultry and small livestock management. The farmers received drought tolerant and high nutritious seeds such as maize, sorghum, peanut and beans to increase productivity for the high lands and vegetable seeds for horticulture such as onion, cabbage, lettuce, tomato and carrot for low-lands or around rehabilitated or constructed water points. Rolling profile data highlighted that FFS trainings improved relationships between married couples by opening up dialogue about joint decision-making at home. Participants acknowledged these conversations were initially difficult to have due to deeply entrenched gender norms, however women now feel like their husbands listen to their input and household management has improved. With more income from food production, households were able to purchase food they did not produce, hygienic items, and other commodities.

With the need to accelerate and scale up the counseling in MIYCN through home visits and focus on the implementation of advocacy and governance activities towards close out, the project stopped creating new household gardens at the end of the 2019 planting season, focusing instead on supporting those who had already created gardens. By the end of the project 846 (56% of project target) HHs had created improved homestead gardens.

The final evaluation results show that overall food security increased in both districts (2% in Funhalouro and 17% in Homoine). While there was a small increase in moderate food insecurity in Homoine of 2%, Funhalouro on the other hand recorded a huge increase of 30%. Food security increased in male headed households by 6% at endline (16% to 22%) and by 15% in female headed households (12% to 27%) However, severe food insecurity increased in both districts, from 18% to 29% in male headed households and from 23% to 41% in female headed households. This figure is concerning and speaks to the compounded challenges faced by female headed households. This lesson has been integrated into SANI’s COVID-19 response strategy, in the extension period of SANI CARE Mozambique will work with community and government staff to select vulnerable households, including vulnerable female headed households, and will distribute food baskets to the most vulnerable households in addition to providing seed kits and extension support for climate smart agricultural production.

Immediate Outcome 1230 Improved attitudes of women and men toward gender issues that influence nutrition practices for WRA and boys and girls under 5

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|--|-------------------|------------------|----------------|--|
| % change in attitudes of men and women toward gender issues that | 70% (n=657/d=943) | 53% (n=69/d=131) | 77% | 53% (n=69/d=131) - 69% of project target |

| | | | | |
|-------------------------------|--|--|--|--|
| influence nutrition practices | | | | |
|-------------------------------|--|--|--|--|

The baseline study found several intra-household food distribution inequalities with men inadequately involved in nutrition programs, home management, or food hygiene practices. CARE conducted 192 community gender dialogues to address these issues.

Training was provided to the 2 District Nutrition Coordination Committees and 60 (27 Women and 33 men) community facilitators to cover 46 communities on the Social Analysis and Action (SAA) approach. SAA work with communities through recurring dialogue to address how social and gender norms perpetuate gender inequality and poor health outcomes in general and nutrition practices specifically. In this way, SAA seeks to enable communities to reflect on and identify linkages between social and gender norms and health and then determine how to address them.

From baseline to endline, there was a smaller percentage of women that answered she herself has the final decision about which foods to consume from the land at endline (53%) compared to 70% at baseline. When asked about attitudes towards gender roles (such as distribution of household chores, who should take care of children etc.), we saw a small improvement from 4% at baseline to 6% at endline. It is important to note the limitations of a quantitative indicator to measure what are often subtle changes in gender attitudes and behaviours. Nonetheless, there were a number of important positive changes in attitudes and behaviours highlighted in the qualitative evaluations in the following key areas:

Gender and Nutrition

At baseline, it was found that when women are pregnant, they cannot eat certain foods such as: xibotsa (a wild animal that is hunted), certain birds that are like pigeons (as it is believed this will lead to no breastmilk), and tortoise meat. It was also noted that children should not eat eggs or tortoise meat. It was also identified that the “good” parts of the chicken (e.g. head of chicken, neck, gizzards) is intended for the man as head of the household. Also, women were not supposed to eat the ox head. However, at endline, interviewees stated that some of these customs are changing with passing time and new information and teachings.

The qualitative endline study showed that it was clear that women from the SANI project understood exclusive breastfeeding and that this included giving nothing to the baby except breast milk for the first 6 months of a child’s life. Husbands identified that babies needed to be positioned properly to breastfeed, that a woman can leave breast milk at home in a bottle for the husband to give the baby if she is away, and that babies had to be fed multiple times a day

At endline, respondents identified that they had learned that a baby needs to eat often, that everyone should eat the same food (and that no food should be kept separate for the husband), that children should eat first, have their own side plate, and that children can eat eggs and high-quality meat. Community leaders in particular noted this change.

Intermediate Outcome 1300: Strengthened governance and accountability of gender-equitable nutrition policies and programs for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|--|---------------|---|--------------------------|--|
| % of DNCC members and DNCC leaders who are female | NA | female members: 30% (128/422) female leaders: 37% (66/178) | 30% of members / leaders | Members: 30% (100% of project target) Leaders: 37% (123% of project target) |
| % of District Nutrition Coordinating Committees with good governance practices in place that feed into national policy | NA | 100% | 80% of DNCCs | 100% (125% of project target) |

Female DNCC members & leaders

Although DNCC meetings are regularly held, working towards female representation and participation has been a challenge since most of the members are appointed at national level, and most of these positions are traditionally held by men. By the end of the project 38% of DNCC members and DNCC leaders were female, ensuring a minimum level of representation of women within these committees.

DNCC with good governance practices

CARE supported the revitalization of the Provincial Nutrition Coordinating Committee (PNCC called SETSAN in Mozambique) and the establishment of two District Nutrition Coordinating Committees. By the end of the program, the two (100%) DNCCs have good governance practices in place (125% of project target) that feed into national policy. These good governance practices were measured using a governance tool, including who was present (male/female), how frequently the meetings took place, if minutes were taken, and if action points were reviewed. CARE staff were present at each meeting to take notes and to observe the meetings. By the end of the project, all meetings were led following these good governance practices.

Immediate Outcome 1310 Improved ability of regional, national, district governments and stakeholders to plan and scale up gender-sensitive evidenced-based maternal, infant and young child nutrition

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|---|---------------|--------------|------------------------------|-------------------------------|
| % of districts with gender-sensitive multi-sectoral joint action plans | N/A | 100% | 80% of districts and regions | 100% (125% of project target) |
| # of gender-sensitive nutrition policies and programs drafted for WRA, PLW and boys and girls U5 with project support | N/A | 1 policy | 2 | 1 (50% of project target) |

Districts with gender-sensitive multi-sectoral joint action plans

After approval of terms of reference for the DNCCs, these platforms designed district action plans to prevent malnutrition and collaborated with CARE to identify communities for the implementation of SANI. The DNCCs added visibility to the multi-sectoral issue of undernutrition. The meetings held were used to discuss among others the following themes: nutritional and supplementation status of the community, immunization status, deworming, pre- and post-natal care, family planning, sanitation and gender-based violence.

The identified goals for the multi-sectoral plans of the DNCC are:

- 1- Strengthen activities with an impact on the nutritional status of adolescents
- 2- Strengthen interventions that impact the health and nutrition of women before/during pregnancy and lactation
- 3- Strengthen nutrition activities for children in the first years of life
- 4- Strengthen activities aimed at households to improve access to highly nutritious foods
- 5- Strengthen human resource capacity in the area of nutrition
- 6- Strengthen the Food and Nutritional Surveillance system.

These goals were agreed at PNCC level to be used for all Inhambane districts. Goals number 2, 3, 4 and 5 made good progress, as SANI was focused on them. The DNCCs plan to do an assessment in 2022 to see what targets have been achieved.

Considering that the establishment of DNCC as part of nutrition policy has not yet been implemented in other districts, CARE has been engaging with PNCC to use the experience of Homoine and Funhalouro districts and advocate for scaling up of inter-sectoral MIYCN committees in all districts of the province as a way to increase oversight of specific and sensitive nutrition programs in all districts of the province.

CARE also encouraged increased female leadership in civil society groups, however, achieving equal membership may take time as state representative positions are typically held by men. Nonetheless, in each district, the DNCC had a Women and Social Affairs Bureau (RAMAS) female representative from the District Health Service who raised awareness about gender-sensitive nutrition and gender equitable health practices. A RAMAS representative stated that she felt empowered, and her voice was heard within the platform. Further, through GE training, some men in DNCC committees have

become gender equality champions. A DNCC member in Funhalouro acknowledged the lack of female representation as an issue and has now become a strong gender advocate in the committee.

Gender-sensitive nutrition policies and programs

SANI began its implementation at a time when the National Multisectoral Action Plan for chronic malnutrition had not yet started in the provinces. Thus, SANI focused its efforts on advocacy for the implementation of this policy instead of engaging to influence new policies. During consultation, the project and districts stated they do not see the necessity of creating new policies, but instead the project has been working within the existing policies (influencing to make them more gender sensitive) and strengthening them.

Immediate Outcome 1320 Improved responsiveness of health service providers for gender-sensitive MIYCN and global acute malnutrition

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|-----------------|---------------|----------------------------------|----------------|-------------------------------------|
| % change in CSC | NA | 8% increase - (2.78-2.571)/2.571 | 10% increase | 8% increase – 80% of project target |

In Mozambique the CSC process was conducted in four health facilities and their catchment areas, two in Homoine district in Chinjinguir and Nhaulane communities and two in Funhalouro district in Mavume sede and Chiane communities. The main criteria to select the health facilities was highest cases of acute malnutrition and a high number of patients regularly using the health facility. These criteria were agreed with the district nutrition departments.

In the first round (Y3), inadequate infrastructure at health facilities, as well as limited availability of human resources, agricultural inputs, coverage of agriculture extension services in relation to nutrition, and low access to drinking water were the dominant problems raised in the communities. A second round of CSC was conducted at the same Health Facility catchment area during Y4. Overall, an 8% increase in satisfaction measures were reported from the beginning of the CSC process to the end. This was below target, but important changes were noted by the end of round II - in the Homoine district, access to health and nutrition information and quality of care had satisfactorily improved, but the availability of health infrastructure and availability of human resources at health facilities remained weak. In Funhalouro district, there was a greater availability of medicines, but the limited availability of health infrastructure continues.

Health workers satisfaction with services provided at health facilities was assessed as part of the last round of Community Score Card that took place in February 2020. Service providers reported moderate average satisfaction scores (2.8 on a 0 to 5 scale composed of 10 items) due to lack of access to socio-economic infrastructure and services, low availability of human resources at Health Center and low level of coverage on the extension services. However, improvement was observed from Round 1 to Round 2 of CSC in sanitation conditions, availability of medicine and practices around feeding habits.

In the communities involved in this process, there was also a satisfactory knowledge of the rights and duties of citizens. This knowledge of rights may be linked to low satisfaction with the health services provided, having increased satisfaction of services offered by 1% instead of the 10% set as a goal (as reported under outcome 1120). Throughout the CSC process, the confidence that the community showed in presenting its concerns to the government shows the self-confidence that the knowledge of its rights in relation to health services has brought.

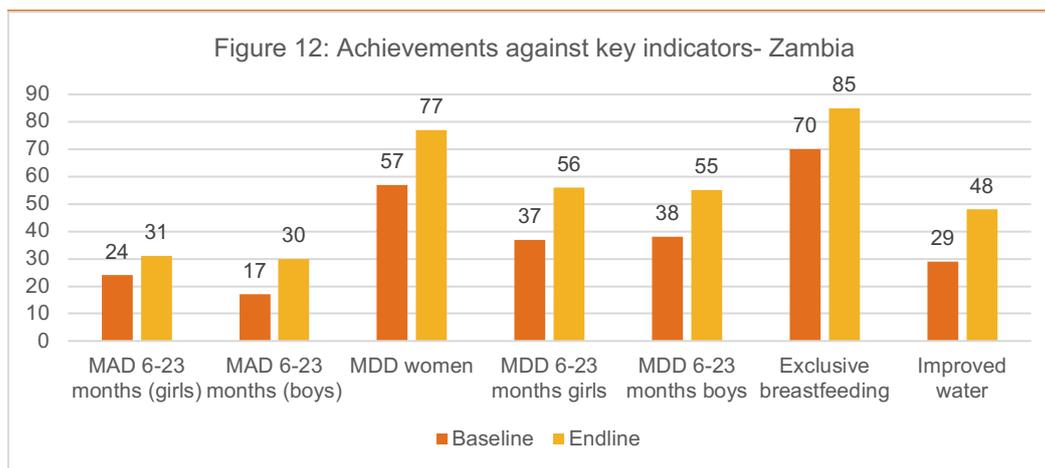
The lack of government actors' willingness to participate and follow-up on the CSC process was a challenge to the interventions' success. could be indicative of a lack of commitment on the part of decision makers to become continuously accountable for health service delivery and inclusive governance. Therefore, a reflection meeting with each government department was important to ensure continued and increased commitment from government actors, including an explanation of the process and its advantages to ensure the ownership within the government and local communities advisory councils (that feed planning in the districts) for future sustainability.

3.1.3: Zambia Project Outcomes

Highlights

In Zambia, the project has registered notable key successes;

- **Minimum Acceptable Diet (MAD)** for children 6 to 23 months increased, by 29% for boys (24% baseline; 31% endline) and by 76% for girls (17% baseline; 30% endline)
- **Exclusive breastfeeding (EBF)** increased by 21% (70% baseline; 85% endline)
- **Minimum Diet Diversity (MDD)** of women increased by 35% (57% baseline; 77% endline)
- **Minimum Diet Diversity (MDD)** of children 6 to 23 months increased by 45% for boys (38% baseline; 55% endline) and 51% for girls (37% baseline; 56% endline)
- There was a 66% increase in using **improved drinking water sources** (IDWS) (piped on premises or other improved drinking water sources) (29% baseline; 48% endline)



Source: Baseline and endline household surveys, February 2017 and July 2020

Endline methodology

Completed in September 2020, the endline survey was conducted by IMPACT Research, LTD. Due to the COVID-19 pandemic, the household survey was scaled down from the original pre-COVID 735 household target to 471 households. The reduced sample design, while providing less accurate results, is still representative of the project intervention areas, drawn from selected wards of Mpika, Kanchibiya and Shiwang'andu districts. Survey tools remained largely the same as baseline to ensure comparability. A few sections unrelated to key indicators were dropped to enable reduced interview time (eg. food storage and preservation) while other questions were added (eg. COVID-19 and exposure questions). Similarly, a qualitative approach involving in-depth interviews of 16 individuals to generate information to understand any changes in knowledge, attitudes, and practices around nutrition, feeding practices, gender equality and women's empowerment was conducted. This data was collected to help understand whether gender dynamics in the project area have changed in a way that will sustainably improve nutritional outcomes for WRA and children under-five.

The endline included questions on how COVID has affected households and communities (livelihoods, access to services, safety, etc) with the goal to better interpret the results and disentangle possible COVID effects from project results. The endline collected all PMF indicators except the following Ultimate Outcome Indicators:

- Wasting: % of boy and girl children 6 up to 59 months with weight-for-length < - 2 sd
- Stunting: % of boy and girl children 6 up to 59 months with height-for-age < - 2 sd
- % of women with MUAC <23 cm

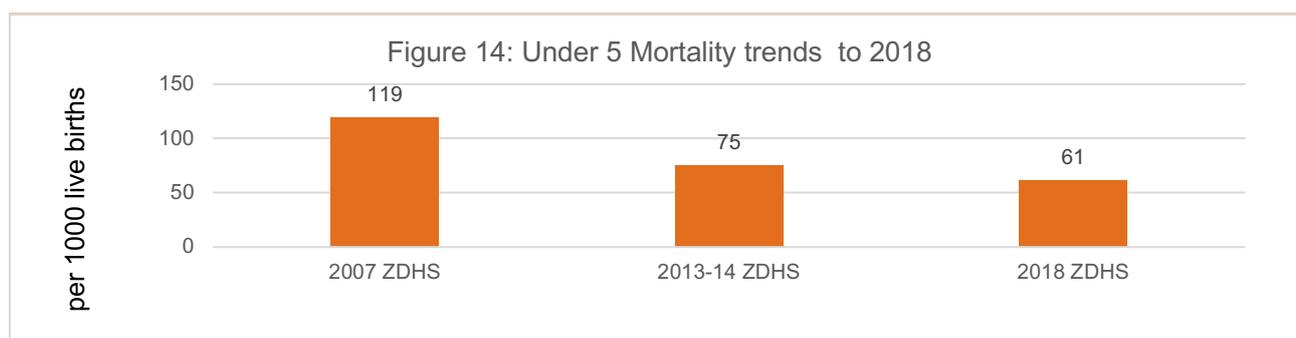
In the absence of anthropometric data collected at endline to measure progress towards these indicators, CARE used the ZDHS indicators measured in 2018. Data from Health Management Information System (HMIS) is not consistently being reported amongst the small number of health facilities in the project area, making it an unreliable source of data. Community perception of overall nutrition was reported using qualitative data.

Ultimate Outcome - Contribute to the reduction of maternal and child mortality in Malawi, Mozambique and Zambia

| Indicators | Baseline data | Endline data | Project target | Cumulative To Date (#/%) |
|---|---|--------------|--|--------------------------|
| Wasting: % of boy and girl children 6 up to 59 months with weight-for-length < - 2 sd | Zambia: girls:5%; boys:7% | N/A | 5% decrease | N/A |
| Stunting: % of boy and girl children 6 up to 59 months with height-for-age < - 2 sd | girls: 34% (n=100/d=295) boys: 42% (n=109/d=259) | N/A | 5% decrease girls: 32% boys: 41% | N/A |
| % of women with MUAC <23 cm | Zambia: girls:42%; boys:50% | N/A | 5% decrease | N/A |

Zambia has made good progress to reduce maternal and child mortality in the past 5-10 years, since the implementation of Scaling Up-Nutrition (SUN) approach and reproductive, maternal, newborn and child health (RMNCH) model that includes integrated service delivery for mothers and children.

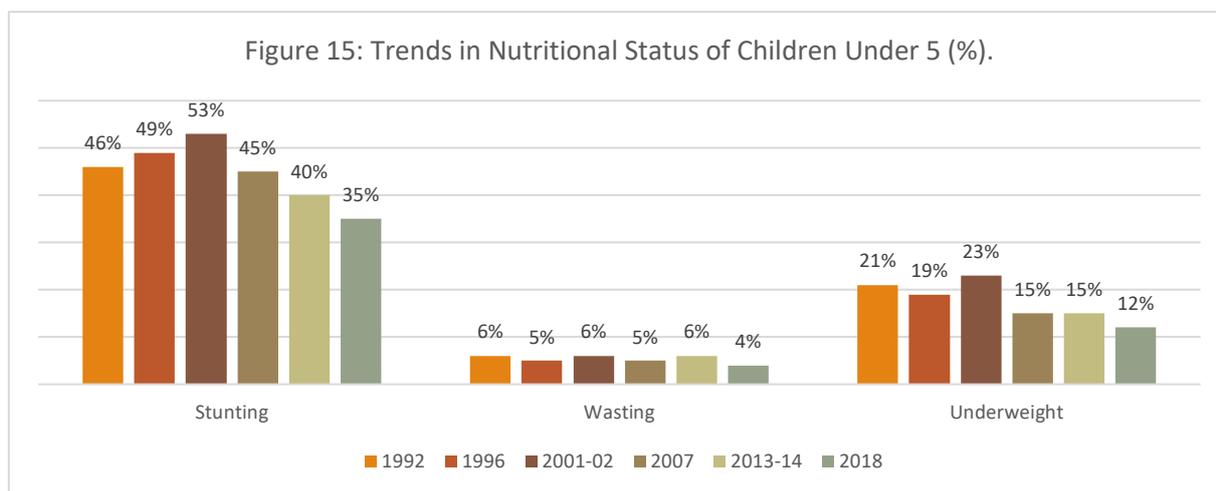
SANI aimed to reduce child and maternal mortality, measured using the indicators of stunting and wasting. While the COVID-19 pandemic restricted the ability to collect anthropometric data at endline to measure progress towards these original ultimate outcome indicators, data from 2018-ZDHS shows that the child mortality rate for Zambia has continued to decrease since 2007, with deaths per 1,000 live births in 2007 decreasing to 75 deaths per 1,000 live births in 2014, and continuing the downward trend to 61 deaths per 1,000 live births in 2018.



Data source: ZDHS-1992-2018

Nutrition status of under five-stunting, wasting and underweight

According to comparative anthropometric measurement data in the 2013-14 and 2018 ZDHS surveys all three nutritional status indices (stunting, wasting, and underweight) have improved in the last 5 years as shown in figure 3. ZDHS 2018 shows that stunting decreased from 40% to 35%, wasting decreased from 6% to 4%, and the proportion of underweight children decreased from 15% to 12% compared to ZDHS-2013/14. The proportion of overweight (weight-for-height above +2 SD) children remained relatively stable from 2013-14 to 2018 (6% and 5%, respectively). It is also worth noting that the stunting level in Muchinga province reported a reduction from 46% in 2013 to 32% in 2018, below the national average of 35% in 2018. SANI supported the multi-sectoral approach being implemented by the government, potentially a contributing factor to the above-mentioned changes in nutritional status.



Source: ZDHS-1992 and 2018

SANI in Zambia implemented an integrated package of interventions which included Nutrition specific (MIYCN, GMP CMAM, vitamin A supplementation, Antenatal care and postnatal care) and Nutrition sensitive interventions (WASH, agriculture, governance). The team also implemented a series of gender dialogues to respond to the findings of the project's gender analysis. To support the implementation of nutrition specific activities, CARE trained HCWs and CHWs in MIYCN, CHWs in GMP and in CMAM and to improve service delivery. Most of the GMP outreach areas were not functional at baseline, were strengthened and were still functional at endline. CARE also equipped GMP sites with anthropometric equipment which included salter scales, MUAC tapes, length and height boards, seca scales and weighing bags to improve service delivery. CHWs were provided with enablers (job aids) such as counselling cards, backpacks and bicycles to ease their work.

The Care group model was used as a dissemination model of MIYCN messages, and this increased knowledge levels among mothers/caretaker and fathers. CARE supported nutrition sensitive interventions which included WASH activities such as the construction and rehabilitation of boreholes that improved access to improved water sources, promoted agriculture-gardening and promotion of nutrient rich seasonal crops and keeping of small livestock (chickens and goats) at household level. This diversification in agriculture production resulted in improved dietary diversity at household level. CARE also supported interventions on governance using the Community Score card (CSC) to address issues of accountability and transparency. Furthermore, gender integration was at the centre of activity implementation through community dialogues on gender equality and Male Action Groups (MAGs).

Intermediate outcome 1100: Improved nutrition practices and services of women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia

| Indicators | Baseline data | Endline data | Project target | Cumulative To Date (#/%) |
|--|-------------------------------|---|--|---|
| % of children 6-23 months with MAD by meeting MMF and MDD in the previous 24 hours | Zambia: girls: 17%; boys: 20% | Girls: 30% (n=52/d=172) Boys: 31% (n=54/d=172) | Zambia: 6 percentage point increase girls: 23% boys: 30% | girls: 30% 130% of project target boys: 31% 103% of project target |
| % of children 0-5 months who are exclusively breastfed | Zambia: 70% | 85% (n=105/d=124) | Zambia: 77% | Zambia: 85% - 110% of project target |

Minimum Acceptable Diet

Endline results show CARE Zambia exceeded the targets for Intermediate Outcome 1100. The percentage of girls and boys with MAD at endline (30% and 31% respectively) is above the national average of 12% (ZDHS 2018). The combination of Care Group lessons on child feeding practices,

promotion of the six food groups, cooking demonstrations and homestead gardening have likely contributed to these findings. These improved practices on MIYCN, were also observed from quotes cited in the endline qualitative survey report:

“Previously, we would just leave home without preparing anything for the baby, we would tell ourselves that the baby will eat when we come back, but now we do make sure the baby eats before we leave and there should be something to eat over lunch as well. CARE has done a good job here, we really know a lot.”- Woman of Chisope Village

In addition, promotion of nutrition sensitive interventions such as homestead gardening, chicken and goats distributed to vulnerable households, improvements in crop productivity through training on climate smart agriculture and the provision of in-kind agricultural inputs contributed to this positive change. Furthermore, information dissemination and community engagement through community dialogues and the involvement of Male Action Groups (MAGs) who actively promoted participation of men, contributed to the improvement of male participation in childcare and ensuring children under five are given a priority in terms of feeding schedules. Through community dialogues and community meetings, MAGs emphasized the need for more women to participate in farmer groups to learn about livestock technologies to improve agricultural practices to sustainably improve uptake of diversified and nutritional diets at the HH level.

Breastfeeding and Complementary Feeding practices

Knowledge of the importance of exclusive breastfeeding for children under 6 months to reduce the risk of diarrhea and other diseases increased from baseline to endline in both districts from 72.3% to 82.3% for Mpika and 54.2% to 83.3% for Shiwang’andu respectively.

Exclusive breastfeeding practices (0-5 months) showed an increase of 13 percentage points and is above the national average of 70% (ZDHS-2018). Timely initiation of breastfeeding (0-23 months) for children also increased significantly by 11 percentage points from 81% at baseline to 92% at endline. Both districts showed comparable increases at endline from 83% to 91% in Mpika and from 76% to 92% in Shiwang’andu districts.

Changes in feeding practices among mothers, fathers and caretakers were noted by rolling profile participants that showed improved breastfeeding and complementary feeding practices and behaviours.

“I practiced exclusive breastfeeding for the first time on my youngest child and I can attest the advantages of [it]. My child’s growth was different from the older children as he never had numerous diseases and his weight was normal. There are a lot of things that I have learnt through SANI’s interventions that I’m practicing at home.” Woman of Chikakala Village

CHWs played an important role in promoting messages to households around exclusive breastfeeding and in the introduction of complementary feeding. Being from the communities themselves, their knowledge of the local community and ability to organize the mothers and fathers to attend Care group meetings was important in the success of nutritional messaging. CHWs delivered the key nutrition and health messages utilizing a visual job aid which gives CHWs guidance on what topic to cover and when. This offered the mothers, fathers and caretakers an opportunity to interact with fellow group members and share their experiences on various aspects of MIYCN. Through these interactions, project participants learned from each other and how deal to with certain challenges they faced with breastfeeding and complementary feeding practices. The guides were used during cooking and feeding demonstrations held at various GMP sites supported by the SANI project. The recipe books were used as reference points for cooking different types of recipes, according to the age of the child and placed an emphasis on utilizing locally available food for nutritious meals.

Immediate Outcome 1110 Increased knowledge of gender-sensitive MIYCN and caregiving practices for women of reproductive age and boys and girls under 5

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|---|--------------------------------------|--------------|-----------------------------------|---------------------------------|
| % change in knowledge of men and women of MIYCN practices | Zambia: men: 72% (n=411/d=573) | Zambia: | Zambia: men: 79% women: 88% | men: 86%-109% of project target |

| | | | | |
|--|-----------------------------|---|--|---------------------------------------|
| | women: 80% (n=588/d=735) | men: 86% (n=99/d=115) women: 92% (n=433/d=471) | | women: 92% -105% of project target |
|--|-----------------------------|---|--|---------------------------------------|

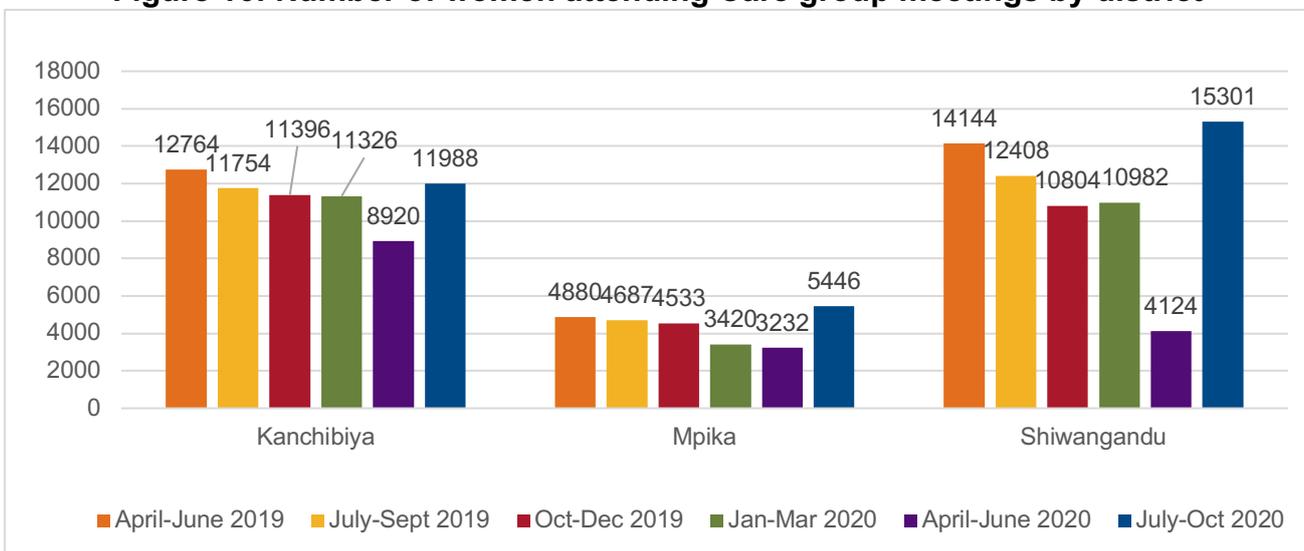
Change in knowledge of men and women of MIYCN practices

Endline analysis on change in knowledge of men and women of MIYCN practices show there was increased knowledge among men and women on when complementary feeding should be introduced. At endline 92% of women and 86% of men knew the appropriate time, compared to 81% and 72% respectively at baseline. At baseline there was limited access to MIYCN information and many myths and traditional gender norms that influenced nutritional practices, such as colostrum breastmilk being viewed as “dirty” and that men should be given the largest portions of meat instead of sharing as a family. The Care group model has played an important role in strengthening the adoption of improved nutrition behaviours. Key messages have also reached a wider population through the groups. Many community members have been exposed to ey MIYCN messages by either belonging to a Care group, or through interactions with members of the Care groups or other platforms such as water point management committees, Male Actions Groups and drama groups. Male engagement was an important focus, promoting male caregivers/fathers’ involvement in growth monitoring of children, cooking demonstrations, and domestic chores. Thus, CARE used drama and radio announcements to mobilize women and men to attend dialogues to discuss gender sensitive nutrition and address cultural norms that negatively influence family nutrition, including intra-household food distribution, unfair division of labour between men and women, and poor male involvement in nutrition and childcare.

Qualitative data from endline and rolling profiles reported most interviewees (male and female) were aware of the importance of breastfeeding exclusively until 6 months of age, when complementary feeding can be introduced. There is an understanding that exclusive breastfeeding includes not giving babies under 6 months anything else, including water, even if they are crying.

“The CARE program taught us that mothers should breastfeed for 6 months without giving the baby any solid foods, that first milk from the mother’s breast is very important because it has vitamins to protect the baby from diseases.” - Male respondent, Mbatii village

Figure 16: Number of women attending Care group meetings by district



Data source: project monitoring data

Figure 16 shows that the first round of the Care group model (April to September 2019) was well attended, namely in Kanchibiya and Shiwang’andu, and 97% of the planned meetings were conducted. Similarly, in the second round (October 2019 to March 2020) over 90% of expected meetings occurred with a significant number of participants. The number of meetings dropped by 69% in the last month of round 2 due to the pandemic. Additional factors impacted attendance during this period such as gassing attacks around the country, which spread fear and impacted livelihoods. National COVID-19 protocols were maintained, and prevention measures were thoroughly promoted. Round 3 was completed in October 2020. The MoH and NFNC have adopted the Care group model

as part of the implementation of the First 1000 Most Critical Days Program (MDCP) II in UNICEF supported districts, including in Mpika.

Job aids, cooking demonstration kits, counselling cards and incentives provided to CHWs (bicycles, t-shirts, backpacks) were noted by the project as contributing to the success of CHWs involved in the Care group model. In addition, the recruitment of CHWs from their respective communities ensured a deep contextual understanding of the social norms and behaviours. Review meetings between the MoH and CARE highlighted challenges including the lower participation rate of men in attending Care group meetings or refusing their partner attend, and poor response from Care group members to contribute foodstuff for cooking demonstrations.

Immediate Outcome 1120 : Improved skills of Health Care Workers and Community Health Workers to deliver quality MIYCN counselling and treatment for acute malnutrition

| Indicators | Baseline | Endline data | Project target | Cumulative to Date (#/%) |
|---|-----------------|--------------------------------------|------------------------------|--------------------------------------|
| % of women, boys and girls u5 completing CMAM treatment | NA | Zambia: 95% (175/183) | >85% | Zambia: 95% - 113% of project target |
| % of women, boys and girls U5 recovered from acute malnutrition | NA | Zambia: 75% (137/183) | >75% | Zambia: 75% - 100% of project target |
| % change in satisfaction of services | NA | Zambia: 26 percentage point increase | 10 percentage point increase | Zambia: 26% - 260% of project target |

Community Management of Acute Malnutrition and Recovery

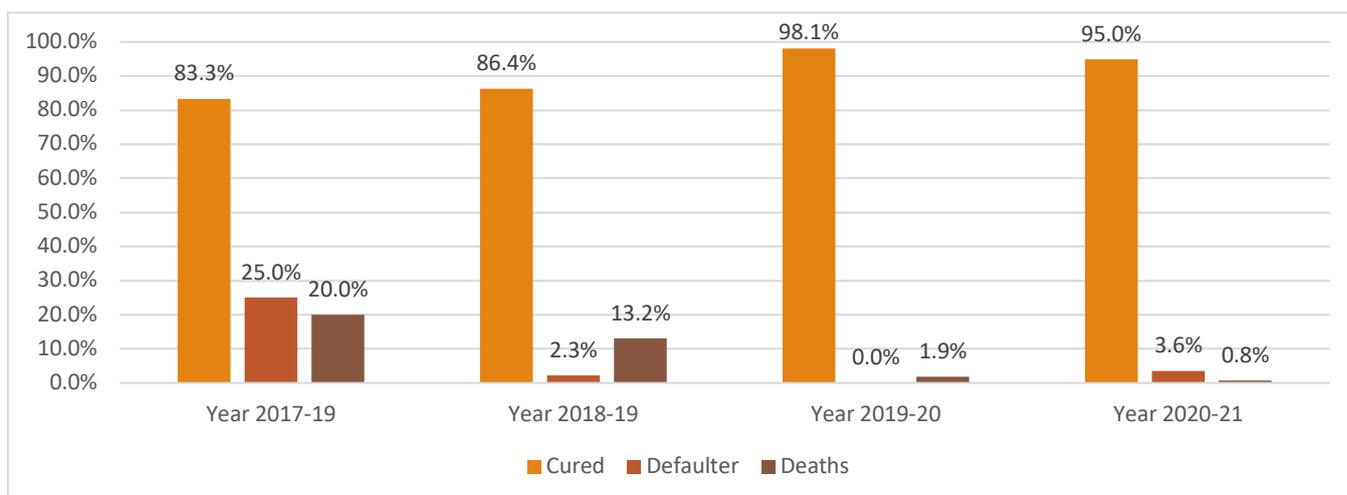
Endline results show CARE Zambia exceeded the targets for Immediate Outcome 1120. SANI supported government efforts to reduce acute malnutrition through the Community Management of Acute Malnutrition (CMAM) program, through the training of health workers and community health workers on the new CMAM guidelines and referral.

Prior to the SANI project, the CMAM program in the project area was weak, with gaps in monitoring skills among HCWs and CHWs and no official referral system between health facilities and communities. CARE Zambia worked with the MoH to strengthen the CMAM program through the training of HCWs and CHWs in CMAM monitoring and reporting mechanism. After initial training in 2018, HCWs and CHWs re-organized the way they were managing CMAM cases at the facility and community; CMAM registers, referral forms, reporting tools, referral system-from community to the facility and back to the community were put in place to improve overall functioning. CARE also engaged the MoH to facilitate documentation and reporting of malnutrition cases. Health Facilities are now using growth curve graphs to diagnose acute malnutrition. (by underweight). SANI supported and established CMAM registers at each facility by providing hard-cover books which was one of the gaps identified by facility staff. This led to more cases of malnutrition being identified among under-fives from GMP points and referred to the facility for management, and reporting from facilities improved from less than 10% to 69% by end of Year 5.

Some factors that continue to affect CMAM and which been highlighted in Zambia's policy brief, include irregular supplementary and ready to use therapeutic foods (RUTFs), staff attitudes, staff transfers and lack of full integration of the CMAM referral system into the MoH-HMIS.

Figure 12 shows that the recovery / cure rate improved over a period of time, 83% in Year 2, 86% in Year 3 and 98% in Year 4. However, there was a slight drop in Year 5 to 95% compared to 98% in Year 4. Some of the reasons for the drop could be related to a high defaulter rate recorded in Year 5 compared to the previous year It is worth noting that the death rate continued to drop from Year 2 to Year 5 as shown from 20% in Year 2 to 0.8% in Year 5.

Figure 17: Treatment Outcomes on malnutrition cases in under 5s-Year 2 to Year 5.



Data source: Baseline 2017 and Endline survey 2020

Satisfaction with services provided at Health Facility

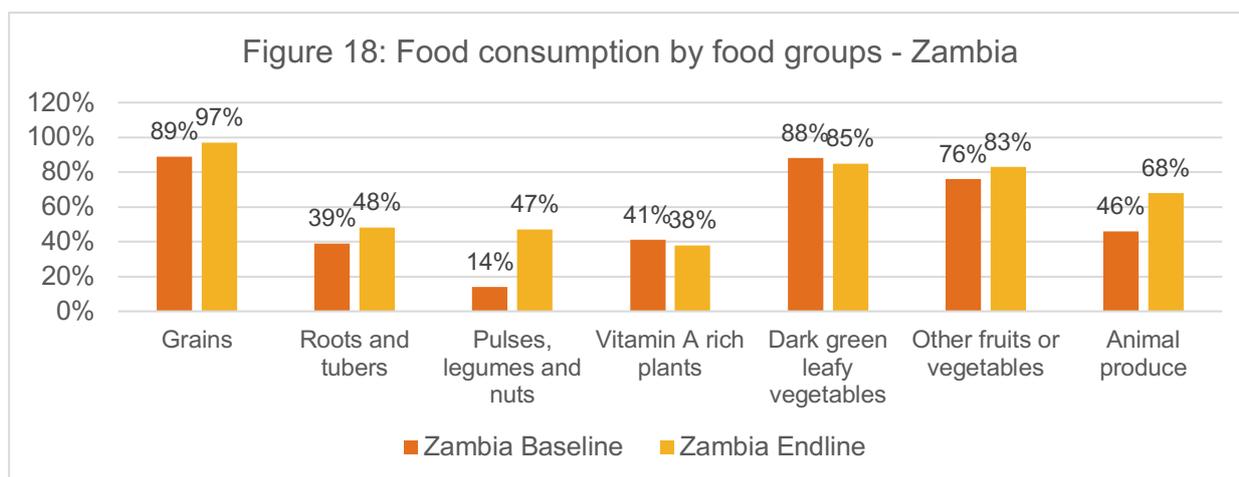
Community satisfaction with services provided at health facilities was assessed as part of the last round of the CSC that took place between August and November 2019. Service users reported average satisfaction scores (4.8 on a 0 to 10 scale composed of 10 items) due to a lack of availability of safe and clean water and the level of sanitation and hygiene at facilities. However, improvement was observed from Round 1 to Round 2 in the accessibility and utilization of health services for children under the age of five, attitude of service providers towards the community, and male involvement in supporting good health for women of reproductive age and children under the age of five. Some of the key reasons for this improvement were that the MoH district authority engaged the health care workers in these facilities and discussed how the concern of negative staff attitudes towards community could be addressed. After these discussions, some of the actions taken included displaying working hours at each facility and logging in and out by HCWs.

Intermediate Outcome 1200: Improved maternal, infant and young child nutrition and gender sensitive practices for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia

| Indicators | Baseline data | Endline data | Project target | Cumulative To Date (#/%) |
|---|---|--|------------------------------|---|
| % of women and children (boys and girls) 6 – 23 months who meet minimum diet diversity | Zambia: Women: 57%; Girls: 37%; Boys: 38% | Women: 77% consumed food from a minimum of four food groups (n=362/d=471) girls: 56% (n=96/d=172) boys: 55% (n=95/d=172) | 10 percentage point increase | Women: 77% (n=362/d=471) - 118% of project target girls: 56% (n=96/d=172) -136% of project target boys: 55% (=95/d=172)- 131% of project target |
| % of men and women using improved drinking water sources (piped on premises or other improved drinking water sources) | Zambia: 29% | 48% (n=225/ d=471) | 10 percentage point increase | Zambia: 48% (n=225/ d=471) - 150% of project target |

Minimum Diet Diversity

Endline results show CARE Zambia exceeded the targets for Intermediate Outcome 1200. The SANI project promoted dietary diversity by adopting the recommended consumption of different foods from the five food group staples, legumes, animal protein, fats, vegetables, and fruits. SANI interventions like dissemination of MIYCN messages on nutrition education and counselling through Care group meetings helped to promote consumption from at least all the five food groups. In addition, cooking demonstrations, promoting production of diverse crops, supporting households with small livestock like chickens and goats, gender dialogues contributed significantly towards improvement in diet diversity for women and boy and girl children under 5 through the promotion of nutrition and gender sensitive practices. SANI assessed the percentage of children 6-23 months who meet MAD by meeting MMF and MDD. The evaluation used the MDD for WRA (15-49 years) using the 24-hour recall preceding the KABP survey.



Source: Baseline and endline household surveys, February 2017 and July 2020

Participants interviewed through rolling profiles shared how nutritional outcomes in their family have improved due to an increase in access to a variety of vegetables, through homestead gardens, and the training sessions provided from Care group meetings. An increase in knowledge regarding crop diversification and the promotion of homestead gardens was also cited by participants to have helped with increased nutrition at household level. Notably, some participants commented that, although they had been unable to attend cooking demonstrations, the knowledge was being shared within the communities through informal networks and Care Groups/cluster leaders.

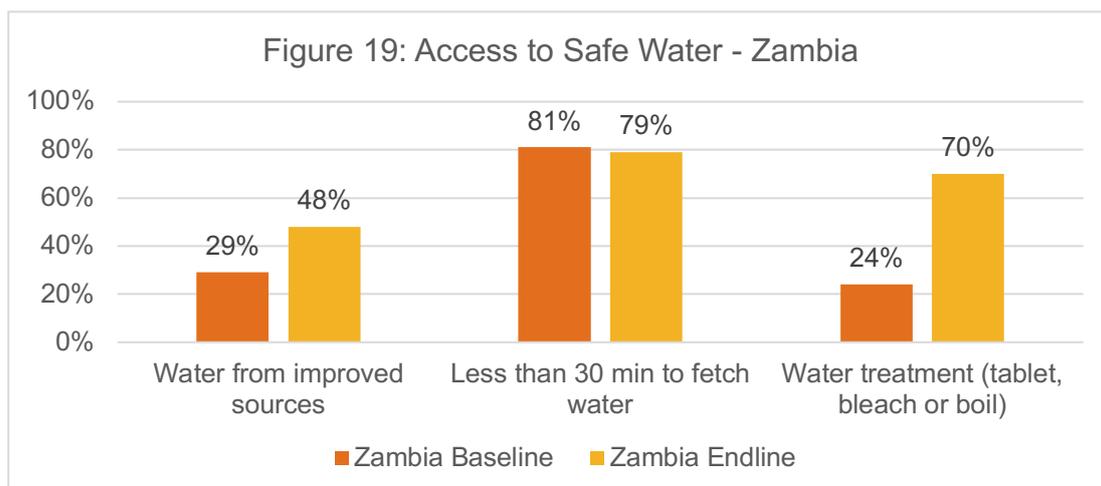
“I can now prepare nutritious porridge for my seven months baby by mixing pounded vegetables, kapenta and maize meal” I have now learnt small babies can also eat vegetables if poned and mixed, previously, I thought babies eat vegetables through breastmilk.” - Woman of Kawama village-Chalabesa

It is worth noting that 95% and 98% of the respondents at baseline and KABP survey respectively, indicated that they consumed the food that they produce.

Improved Drinking Water

Low access to clean water and poor sanitation practices in Zambia’s rural areas is a major contributing factor to poverty and increases the risk of spreading waterborne diseases, thereby compromising people’s health and wellbeing. Unsafe water is the major cause of diarrhoea that leads to underweight and wasting in children under five years of age. SANI’s core work on WASH focused on increasing access to safe water by sensitizing communities to use improved sources by constructing and rehabilitating 32 water points and also forming and strengthening water point management committees. These Water Point Management Committees (WPMC) have the mandate to ensure water points are maintained, and supply of safe water is sustained. SANI strongly promoted women from diverse backgrounds to be involved in mapping water points in villages as they are the primary users of water pumps but often not the primary decision-makers around their maintenance and location. This served an additional purpose to challenge gender norms and roles, while strengthening the agency of women to voice their needs and concerns about issues in accessing safe water, including raising awareness about GBV incidences when traveling to distant water points. The project

also educated communities through Care group meetings and through water committees on how to treat water from unimproved sources using purifiers like water guard and chlorine, and traditional methods that involve boiling and filtering.



Source: Baseline and endline household surveys, February 2017 and July 2020

The recruitment of a WASH expert from CUSO in year 3 accelerated advancement of WASH activities. Most of the rehabilitation works were initiated and completed resulting in an increase in the actual number of boreholes rehabilitated than what was targeted in the PMF. Support from the Local Authorities and the community who worked to rehabilitate some of the boreholes with minimal support from the project, reflected the strong community buy-in ensuring long term sustainability of WASH activities. Water point management committees (WPMC) were formed for the purpose of community management of water points and also as a means of dissemination of MICYN messaging. CARE Zambia advocated for women of diverse backgrounds to actively participate in water management committees specifically in key leadership and decision-making roles. At the end of the project women made up 43% of WPMC members with some holding leadership positions.

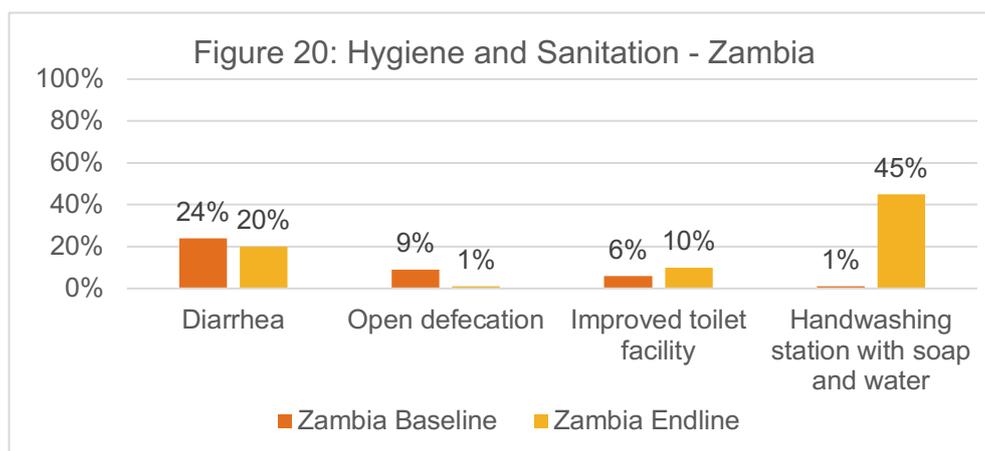
Immediate Outcome 1210 Increased access of women of reproductive age and boys and girls U5 to hygiene and sanitation facilities and safe drinking water for domestic and productive use

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|---|--|--|--|--|
| # and % of communities declared ODF | N/A | 4/46 – 9% | Zambia: 80% | Zambia: 9% -11% of project target |
| % of boys and girls under five with diarrhoea | Zambia: girls: 24% (n=90/d=379) boys: 24% (n=86/d=356) | Zambia: girls: 21% (n=48/d=234) boys: 20% (N=48/d=237) | Zambia: 6 percentage point decrease girls: 18% boys: 18% | Zambia: Girls: 3 percentage point decrease (50% of project target) Boys: 4 percentage point decrease (67% of project target) |
| % of women with access to safe drinking water | Zambia: 24% (n=179/d=735) | Zambia: 74% (n=348/d=471) | Zambia: 26% | Zambia: 74% - 285% of project target |

Open Defecation

SANI interventions promoted improved sanitation and good hygiene in the supported districts. Some of the interventions included capacity building of volunteers and traditional leaders in Community Led Total Sanitation (CLTS) where 272 CLTS champions were trained. Other activities included dissemination of messages on CLTS, triggering of CLTS activities such as construction of pit-latrines, tippy taps and improved waste disposal facilities in the community, and behaviour change communication including gender sensitive messages. CLTS is an approach for mobilizing communities to eliminate Open Defecation (OD). Communities are facilitated to conduct their own

appraisal and analysis of open defecation and take their own action to become Open Defecation Free (ODF).



Source: Baseline and endline household surveys, February 2017 and July 2020

While the target for communities ODF was not achieved, considerable progress was made towards achieving ODF status in 35% of communities. Open defecation has dropped considerably from 9% at baseline to only 1% at endline and the number of handwashing stations with soap and water increased significantly from baseline from 1% to 45%.

Boys and girls under five with diarrhoea

The project also educated communities through Care Group platform and in water committees on how to treat water from unimproved sources using purifiers like water guard and chlorine, and traditional methods that involve boiling and filtering. Proper water treatment – boiling, using chlorine and tablets - has improved from just 24% at baseline to 74% at the end of the project. The prevalence of diarrheal disease among children 0-24 months in the 2 weeks recall prior to the KABP survey was 20.4% compared to 24% at baseline. The project's contribution to improved water sources in the communities as a result of the construction and rehabilitation of boreholes coupled with improvement in proper hygiene practices is in line with the general decline of diarrhea cases in children 0-24 months at endline. Apart from having additional protected water points, HHs were also encouraged to treat their water to make it safe for drinking.

Safe Drinking Water

One of the determinants in reaching targets for boys' and girls' reduction in cases of diarrhoea is around the continued challenge of safe drinking water. Mpika reported 56% HHs with an improved source of drinking water compared to just 16% at baseline. There was an observed decline of HHs that reported an improved source of drinking water in Shiwang'andu from 42% at baseline compared to 36% during the KABP survey. One of the possible reasons for the decline in Shiwang'andu could be because he targeted strategy of the endline in which of the reduced endline sample size, more HHs were surveyed were rural than peri-urban at baseline, and peri-urban areas have a higher prevalence of safe drinking water. Women and girls are disproportionately affected by a lack of readily available drinking water, as water collection is predominately a domestic chore done by women.

Endline results showed important improvements in this area as households reported a decrease in the number of women primarily collecting water from 95% at baseline to 83% at endline and an increase in the number of boys (under 15) who primarily collected water for the household from 1.7% at baseline to 6.2% at endline. This result speaks to a change in gender norms and collection of water becoming more of a shared responsibility amongst household members.

Participants interviewed during rolling profiles reflected on the benefits of CLTS and how this has resulted in reduced cases of waterborne diseases.

"I used to see more than 50 cases of diarrhea in a month due to waterborne illness from drinking untreated water or cooking using unhygienic methods. There were so many cases that the hospital where they were sent would often be overwhelmed. Now, we only see about 10 cases or fewer a month which is manageable at the clinic." - Male WNCC member

“There is a decrease in dysentery cases. This could be because the sanitation and hygiene messages are being received and practiced and the community members are boiling drinking water and storing it safely.” - Male WNCC member.

Immediate Outcome 1220 Increased ability of women and men to produce, store, preserve and process high nutrient food for women of reproductive age and boys and girls U5

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|--|---------------|--------------|----------------|------------------------------|
| # of HHs with improved homestead gardens | NA | 3185 | 2500 HH | 3185- 125% of project target |

Household Gardens

SANI in collaboration with the Ministry of Agriculture set up demonstration plots in operational areas to form Farmer Field Schools (FFS) where technology transfer and knowledge sharing by project participants was conducted. At the end of the project, 91 demonstration plots were used in FFS for the purpose of practical learning and sharing ideas on climate smart agriculture (CSA). CARE worked with the MoA and trained 444 (257f & 187m) lead farmers who in turn trained group members and other project beneficiaries using the hands-on approach. Demonstration plots used a small portion of land where farmers learn and share good practices on agriculture-gardening, land preparation, planting and crop management as well as harvesting and climate-smart agriculture practices.

In the last two years, the number of households supported by CARE Zambia with improved household gardens increased from 1,110 in year 3 with an additional 1,323 gardens in year 4 and an additional 230 in year 5. This brings the cumulative figure to 3,185 HHs (including HHs that have gardens with support from ICAD supported Local NGOs) with improved homestead gardens (against the project target of 2,500).

The cumulative increase is linked to project support to lead farmers, through training and provision of inputs such as seeds, treadle pumps and technical support on climate smart agriculture. The households with improved gardens practiced climate smart agriculture including crop diversification and intercropping. The households grew at least three different crops (protein rich, dark green vegetables & energy giving vegetable) to ensure food diversity at household level.

Endline results reveal that the percentage of women that own the land on which they make their home garden increased from 57% at baseline survey to 75% at endline. The positive change could be attributed to sensitization activities on gender equality through the MAGs, community dialogues, farmer interest groups and the integration of gender equality components in all trainings conducted by the project. These activities contributed to an increased understanding among men on the role women play in household food security. With increased joint intra-household decision making and sensitization on gender roles, some men have become more involved in fetching water and collecting firewood, cooking, cleaning (sweeping, washing dishes), watering the garden, caring for children (including bathing, feeding), and taking children to the under 5 clinics. Access to new crops and vegetables has encouraged other improvements in the homestead such as eating food as a family and giving portions according to need (e.g., smaller portions for children, installation of pit latrines and water treatment water for safe drinking.

“Nutrition improvement has helped my family because it is now rare that my children get sick.” -Male Champion of Kanchibuya District, Zambia.

Immediate Outcome 1230 Improved attitudes of women and men toward gender issues that influence nutrition practices for WRA and boys and girls under 5

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|----------------------------------|---------------|--------------|----------------|--------------------------|
| % of VSLA members who are female | N/A | N/A | N/A | N/A |

| | | | | |
|--|-----------------------------|---|-----|--------------------|
| % change in attitudes of men and women toward gender issues that influence nutrition practices | Zambia: 33% n=147/d=451) | 42% (22% wife + 20% both husband and wife) ⁶ | 36% | 116% of the target |
|--|-----------------------------|---|-----|--------------------|

No assessment on VSLA was done because this activity was discontinued in Zambia due to a shift in focus on social analysis and action (SAA) in year 3 of the project.

Change in attitudes of men and women

SANI developed strategies on how to address gender attitudes that influence household nutrition practices using the SAA approach, working with communities through regularly recurring dialogues to address social culture norms that hinder positive behaviour changes in nutrition. Another strategy was the use of Male Action Groups (MAGs) to promote the engagement of men in issues related to gender equality and sensitization activities on gender equality through drama performances. SANI worked within the CARE gender framework to address these gender inequality issues.

The Endline KABP survey assessed respondents' (men and women's) attitudes on numerous gender related matters. Respondents were asked to indicate the extent to which they "agree", "partially agree" or "do not agree" with a list of statements regarding attitudes related to gender and social norms. Results revealed that 94% of men at endline agreed that men should go with their wives for ante-natal checkups compared to 86% at baseline. When asked whether it is a mother's responsibility only to feed and bath children 21% of women and 23% of men disagreed at endline compared to only 15% and 17% respectively at baseline.

While findings from the qualitative survey at endline and rolling profiles show increases in gender awareness, and improvement in attitudes close to nutrition practices (decision making on what to consume, helping pregnant women chores, men helping with childcare) this is not generalizable to other spheres (working outside the house, use of family planning, etc).

"These days things have changed. My husband supports me and in taking the child to under 5 appointments. [Husband] cooks and prepares the food for all to eat and we even laugh together now."- Woman, Chitumbi village

Intermediate Outcome 1300: Strengthened governance and accountability of gender-equitable nutrition policies and programs for women of reproductive age and boys and girls under 5 in Malawi, Mozambique, and Zambia

| Indicators | Baseline data | Endline data | Project target | Cumulative To Date (#/%) |
|--|---------------|-----------------|--------------------------|--------------------------------------|
| % of DNCC members and DNCC leaders who are female | N/A | (44/123) 36% | 30% of members / leaders | Zambia: 36% / 120% of project target |
| % of District Nutrition Coordinating Committees with good governance practices in place that feed into national policy | N/A | 100% | 80% of DNCCs | Zambia: 100%/ 125% of project target |

Female Representation in DNCCs

The District Nutrition Coordinating Committees (DNCC) and the Ward Nutrition Coordinating Committee (WNCC) were the functional units of coordination for nutrition activities at district and ward level. The Committees are comprised of government officials from departments that have a stake in nutrition at district and ward level drawn from various ministries. The assessment and findings from the governance scale tool used to describe the functionality of community structures showed that power dynamics in most of the community structures such as WNCCs, lead farmers, and other groups including DNCC at district level are still biased towards men. Female representation in the three

⁶ It should be noted that for the question "Who has the final decision about which foods you and your family consume from this land?", the consultant included a joint decision category, making results no longer comparable between baseline and endline. Therefore, the assumption is that the decision made by both wife and then joint wife and husband can be considered as a shift from only the men responsible in making decisions. Therefore, the achieved result was calculated as 42% (22% wife + 20% both husband and wife).

DNCCs was 36% (44 females out of a total of 123 members) as of March 2021. This increased from the initial 25% female representation in most of the government departments. At the end of March 2021, all the chairpersons in the three DNCCs were female. However, there are still gaps on governance issues across all structures at district (DNCC and DDCC) and community level (WNCCs, lead farmers and farmer interest groups) which are still male dominated. There is still a need to strengthen female participation and create spaces for women to express their rights and needs by strengthening the overall enabling environment.

DNCC Good Governance Practices

Prior to the start of the project, DNCCs did not exist in project districts. As a multisectoral committee formed in each district, DNCCs had the purpose to coordinate all partners involved in the implementation of nutrition interventions. At the start of the activity implementation, DNCCs in each district developed multisectoral plans that encompassed activities on WASH, health, agriculture, governance, gender equality and M&E from key ministries. CARE formed these DNCCs with guidance from the NFNC to drive and coordinate all nutrition related activities in the district using the multi-sectoral approach. The functionality of these DNCCs was monitored using the Governance scale tool which was administered at every meeting held. At endline all 3 districts-Mpika, Shiwang'andu and Kanchibiya had an integrated plan including both nutrition specific (nutrition and health) and nutrition sensitive (WASH, agriculture, gender equality and governance) interventions. Some of the key SANI achievements are a result of implementing multisectoral plans.

Immediate Outcome 1310 Improved ability of regional, national, district governments and stakeholders to plan and scale up gender-sensitive evidenced-based maternal, infant and young child nutrition

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|---|---------------|-----------------------|------------------|-------------------------------|
| % of districts with gender- sensitive multi-sectoral joint action plans | N/A | 3/3 Districts 100% | 80% of districts | 100% - 125% of project target |
| # of gender-sensitive nutrition policies and programs drafted for WRA, PLW and boys and girls U5 with project support | N/A | 1/2 | 2 | 1 - 50% of project target |

Districts with gender- sensitive multi-sectoral joint action plans

CARE facilitated the formation of Nutrition Coordinating Committees at district and ward levels and supported them to effectively coordinate all nutrition activities. CARE supported the DNCC to develop annual joint plans, hold quarterly meetings, field monitoring and reporting while the WNCCs were only supported to hold quarterly meetings, conduct field monitoring and reporting. The joint planning meetings helped the stakeholders in the districts to share resources and conduct joint implementation of activities. All three districts had joint annual work plans in place and the office of the DC coordinated its implementation. These annual district plans were reviewed annually and planning was done with the involvement of all key stakeholders.

The three DNCC gender-sensitive multi-sectoral joint action plans were completed in Year 4. The expectation is that these multi-sectoral plans will be used as a guide to key ministries such as, health, agriculture, local government, livestock and fisheries, community development and social welfare and other NGOs such as CARE to implement nutrition interventions. Implementation of these joint action plans has been slow due to limitations in funding amongst government partners. These multi-sectoral plans were reviewed during DNCC meetings and each department gave a report on how they were implementing the activities.

From the WNCC meeting minutes, it was observed the Gender Equality was a standing item on the agenda and, from the DNCC meetings, GE action points and plans to resolve GE issues were developed at the end of every meeting. DNCC and WNCC groups used monitoring tools like the Governance scale to monitor governance issues regarding gender representation, power sharing among men and women, and to determine whether women were given space to discuss during meetings. Good progress was observed in the area of women's representation during the last two

quarterly DNCC and WNCC meetings in Zambia with 36% men and 32% women representatives compared to 30% men and 25% women representative in Year 3.

Since the start of the DNCCs there has been improved coordination of activities amongst stakeholders. For instance, at the time of distributing COVID-19 supplies, CARE provided fuel to the Ministry of Health to distribute supplies in hard-to-reach health facilities with very rough terrain where Government vehicles could reach, while the CARE vehicle could not reach.

Gender-sensitive nutrition policies drafted

In the last year of the project, CARE Zambia drafted a policy brief on scaling up and leveraging the Care group model based on SANI's experience with Care groups in information dissemination on maternal, infant and young child nutrition. The Policy Brief was shared with Government partners during the dissemination meeting. The Provincial office under the Ministry Health is expected to see how the Care group model could be adopted for wider coverage. So far, UNICEF is in the process of adapting the Care group model approach therefore, there is a possibility of adapting some of the approaches used by CARE.

Immediate Outcome 1320 Improved responsiveness of health service providers for gender-sensitive MIYCN and global acute malnutrition

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|-------------------|----------------------|---|-----------------------|---|
| % change in CSC | NA | Zambia: 7% increase = (3.89-3.55)/3.55 | 10% increase | Zambia: 7% increase - 70% of project target |

Change in Community Score Card

In order to influence the efficiency and quality of essential services which impact nutrition outcomes, CARE Zambia worked with Government partners from key Ministries such as agriculture, livestock and fisheries, community development and social welfare and local authorities to implement CSC. CARE sought to address issues of lack of transparency, accountability and public and government partners' engagement that affect service delivery at all levels. CSC was implemented in the four-selected sites (Chikakala, Musonko, Mukungule and Mpepo) in Muchinga province. The SANI project adapted the CSC process with technical support from CARE Malawi involving a CSC team of experts as well as a team from CARE Canada. A core team of CSC facilitators drawn from government ministries were trained with technical support from the CSC consulting team from Malawi.

The CSC worked as a platform to inform the project to effectively adapt and deliver the desired project outcomes. Issues were identified around the essential health services, WASH, agriculture, gender equality by the community (service users) and service providers (government workers and Community health workers, lead farmers and WASH volunteers) and discussed in order to identify workable solutions and jointly devise strategies for implementation.

Community satisfaction with services provided at health facilities was assessed during the last round of the CSC interface meetings that took place between August and November 2019. From the assessment of selected indicators, service users reported moderate satisfaction scores (4.8 on a 0 to 10 scale composed of 10 items) on the following:

1. Staff attitudes among health workers towards patients in Mpepo, Mukungule and Chikakala improved after service users (community members) and service providers (health care workers) were engaged through CSC process.
2. Lack of infrastructure at Musonko community in Shiwang'andu - a GMP shelter is now functional and servicing more than 5,989 people especially under five children.
3. Inadequate availability of improved water sources. Five boreholes were not working for more than 3 years; 1-Musonko, 2-Chikakala, 1-Mpepo and 1-Mukungule. These boreholes were repaired after the community was engaged through CSC process. Currently these five boreholes are servicing 3,625 people who now have access to an improved water source. The community also formed a Water Point Management Committee (WPMC) that is overseeing the maintenance of these boreholes and they also manage user fees that community members contribute.

4. Distribution of fertilizer to farmers through the Farmer Input Support Program (FISP) improved in the 2020/2021 season after the CSC process in 2019 where farmers raised a complaint to the DC in Shiwang'andu and Mpika. The DC acted and this led to the improvement in the FISP distribution of fertilizers to farmers.
5. Participation of men in supporting their spouses in child-care such as accompanying their women to the ANC and GMP visits improved across the four sites where communities were engaged in the CSC process.

Intermediate Outcome 1400: Increased active engagement of Canadian women and men, including youth and aboriginal peoples, in support of women's and girl's development initiatives.

| Indicators | Baseline data | Endline data | Project target | Cumulative to Date (#/%) |
|--|---------------|--------------|---|--|
| # and type of resources on nutrition of WRA and boys and girls under 5 | N/A | N/A | 3 videos, 3 publications / reports, 1 website | 21 videos, 112 publications/reports, 1 bilingual website |
| # of presentations delivered at separate workshops and conferences in Canada | N/A | N/A | 16 presentations | 19 presentations |

Between 2018-2019, the SANI public engagement campaign was launched with the development of the *Feed Her Future* (FHF) brand, logo and creative concept and all the social media channels, public launch and public engagement strategy.

The primary purpose of engaging the Canadian public in CARE's Southern African Nutrition Initiative (SANI) was increased participation of Canadians (men, women and youth aged 15-30) in international development, particularly as it relates to maternal, newborn and child health (MNCH). Specific objectives of the SANI Public Engagement Plan set out in 2017 were:

- To ensure innovative nutrition and MNCH practices and knowledge are shared with Canadian colleagues and stakeholders;
- To generate interest and opportunities for engagement of the Canadian public in Canada's response to the needs of mothers, pregnant women and children under 5, globally;
- To demonstrate accountability and results for Canadian MNCH funding.

The original indicator for Outcome 1400 was: *% of Canadians reached who report increase in knowledge of women and girls development and nutrition issues*. As this was an indicator selected prior to the development of the campaign. As Feed Her Future was developed, the scope of the campaign changed and expanded throughout the three years and as a result, the campaign ultimately chose (instead of a survey) to deliver a host of digital engagement metrics toward this specific performance indicator, instead of single one-time survey, which CARE Canada has reported on for each semi-annual and annual report.

The digital engagement metrics, alongside all output-level indicators, have demonstrated the success of Feed Her Future, as CARE has over-achieved all indicators. These metrics are difficult to report against the specific indicator for Outcome 1400 but they do demonstrate the campaigns reach and ability to increase awareness amongst Canadians of women and girls' development and nutrition issues. Through many in-person events across Canada, FHF would engage Canadians in real-time and in-person quizzes on their knowledge of women and girls' development and nutrition issues in Mozambique, Zambia and Malawi. With FHF prizes at hand, it was always an engaging and fun way to speak with and engage men and women of all ages. Throughout the campaign, Feed Her Future **engaged with 2000 people coast-to-coast** through events, street campaigns and booths at markets, conferences and events.

Please see *Annex I – Communications* for the Communications Annex and the complete Feed Her Future Campaign Results Final Report which includes a full report on all Feed Her Future campaign successes, deliverables, metrics and resources created.

3.1.4: Outcomes of SANI Twinning Program:

The SANI Twinning Initiative involved the engagement of 10 partner organizations —three in Zambia, four in Malawi and three in Canada. These partners made up four sets of twinning partnerships working towards the implementation of local project seeking to improve nutrition amongst women of reproductive age living with HIV and children living with and affected by HIV. Following the selection process of these organizations, all organizations came together in Malawi in March 2018 for relationship building, capacity building and project planning. Project implementation began in July through September 2018. Projects involved activities such as trainings on HIV, nutrition, and gender, cooking demonstrations, training and provision of inputs for household gardens, linkages with health facilities, and procurement and distribution of chickens. Activities were in most cases implemented through existing community structures, such as Support Groups for people living with HIV, and these structures were engaged in the delivery of trainings and follow up support.

The project achievements stretch across outcomes 1100, 1200 and 1300, including such benefits as improved attitudes and knowledge about preparing local foods, improved access to nutritious foods through household gardens, chickens, and income generating activities, improved gender equality within households, improved adherence to antiretroviral treatment, and reduced HIV- related stigma in communities. Further, organizational benefits included those related to improved reputations and partnerships, increased capacity to deliver projects, and increased knowledge related to HIV, nutrition, gender equality and SRHR, and capacity to incorporate these in project delivery.

Intermediate outcome 1100: Improved nutrition practices and services of women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia

Partners jointly impacted nutrition practices within their communities through nutrition trainings, cooking demonstrations, support group follow-ups and household visits. Together, partners conducted over 80 trainings and cooking demonstrations, and 2,000 household visits. The trainings and cooking demonstrations provided community members with the knowledge and skills to prepare balanced meals, to preserve foods to retain their nutritional value, to plan meals, and budget for food.

A positive outcome that was repeatedly reported from the trainings and cooking demonstration was disbanding community assumptions that locally grown foods were not nutritious and promoting acceptance of locally grown foods. During ICAD monitoring visits Support Groups prepared a wide variety of dishes using locally grown foods and exhibited a great deal of pride in the showcase, as well as knowledge about the nutritional content of the dishes. While some were already eating certain local foods, others lacked knowledge about their nutritional value and are now making decisions based on the knowledge and information acquired.

Intermediate Outcome 1200: Improved maternal, infant and young child nutrition and gender sensitive practices for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia

Through cooking demonstrations and nutrition trainings, there were changes in attitudes and skills. However, as organizations and beneficiaries repeatedly noted, without sources of nutritious foods and/or income generation, the knowledge and skills gained about nutrition would have a limited impact on households. Therefore, all organizations incorporated some activities that generated food and/or income for participants, both as a means to enhance household nutrition and as a source of incentive for participation and community-buy in to the project. Without such buy-in, the nutrition specific information would not have had the same impact and uptake in communities.

1) Household gardens: Approximately 1,500 household gardens were established throughout the project. Seeds, soil, fertilizer, watering cans, and training on vegetable and herbal gardening were provided, as well as ongoing support and linkages with local support systems such as lead farmers and agricultural extension workers.

COWLHA and PVCW reported that demonstration gardens provided spaces for learning, community building, and sharing of new seeds for planting in household gardens. PAWOC reported that offering some choice to beneficiaries as to which seeds to plant was well received.

Access to water sources in the dry season and pests posed a challenge in the first planting season but organizations were able to adjust budgets to address these issues and avoid recurrence in the following planting season.

2) Chicken rearing: Through CWC, 112 project participants received four chickens each and 104 chickens remained with the Club for income generation and for distribution to other community members in need. The chickens have provided nutritional foods in the form of eggs, manure for the gardens, and a source of income for the Club and participants. Community members were empowered, and trust was built between stakeholders as the communities' priorities were being recognized. CWC learned from CARE Zambia and had an 85% survival rate of the chickens at the end of the project.

3) Village Savings and Loans Associations: Through NAPHAM, 10 VSLA groups received mentorship sessions, and 155 individuals (110 w, 45 m) took loans to invest in small business that have helped support school fees and improved diet. During the first cycle (ending December 2019) a total of MK 4, 034,980 (approximately CAD 7,700) was saved and loaned, benefitting 213 individuals (163 w, 50 m). In January 2020, two groups began buying shares for the second cycle, while the other groups began in April 2020.

4) Trainings about gender, HIV, human rights: Organizations delivered training on topics related to gender, HIV and human rights. These trainings complemented the nutrition-specific trainings and demonstrations.

Some of the reported nutrition-sensitive outcomes include:

- Interactions between stakeholders in VSLA groups and household garden support groups has helped shift community perception of people living with HIV and reduced HIV-related stigma.
- To address low participation of women, one organization held a women-only session to promote women in leadership roles and provide them with a more comfortable learning environment. PVCW reported improved confidence of women in mixed gender sessions, an increase in the acceptance of women in leadership and decision-making roles, for example as lead farmers, and individual shifts in behaviour among Male Champions towards their wives.
- Some women started small business ventures by producing herbal ointments or selling excess vegetable yields, leading to both increase household nutrition and women's economic empowerment.
- PVCW worked with "lead couples" to demonstrate shared decision making and improved power relations as a unit. CPIEM and CWC reported observations that men were willing to take part in improving the lives of WRA and children under five in their households; they participated in cooking demonstrations, took children to under 5 clinics, and accompanied their wives to the anti-natal clinic.
- Improved knowledge about HIV prevention and treatment has empowered women and men to seek and adhere to treatment. Project stakeholders reported an increase in follow up of care and improved HIV treatment adherence, which both support improved nutrition.
- Improved engagement from people living with HIV, for example 'Mentor Mothers,' who share their own experiences while supporting other women.
- Male Champion training has helped community members understand gender equality, openly challenge gender disparities, and support women in leadership positions. MCs encourage other men and boys to be more involved in work that is culturally labelled as feminine work, such as child minding, attending antenatal visits and engagement in PMTCT.

Intermediate Outcome 1300: Strengthened governance and accountability of gender-equitable nutrition policies and programs for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia

The seven participating organizations in Malawi and Zambia were strengthened in their capacity to deliver gender-equitable nutrition programs for women living with HIV. Progress under this outcome was tracked based on partner reports, comparison of baseline and endline capacity assessments, and end of project discussions (both one-on-one and as a full group of twinning partners). The key areas of capacity growth are summarized below.

Twining Partnerships

Twining partnerships brought many benefits to participating organizations. Malawian and Zambian partners have reported the following:

- New/different ways of implementing activities: PVCW learned about COWLHA and CEWAG's establishment of backyard gardens during their visit to Malawi. Similarly, COWLHA and CEWAG learned from PVCW about their use of health facilities in project implementation. In Zambia, organizations learned to plant near water sources and away from community livestock.
- Information and knowledge sharing: for example, ways to identify local trainers for lead farmers and support groups.
- Organizational support: for example, COWLHA supported CEWAG in the development of its Strategic Plan, which saved on costs to hire an outside consultant.
- Collaboration and capacity development in project management, report, and proposal writing
- Linkages with other sources of funding through Canadian partner contacts.
- Sharing of Canadian resources, such as those on U=U (undetectable viral load equals untransmittable infection) and information about outreach to faith leaders.

Canadian partners reported the following benefits:

- Program review and adaptation, for example for PLN the development of a community garden has not succeeded in the past but was very successful this year due to the focus on African, Caribbean and Black women.
- Beneficial in promoting internal staff teamwork.
- Heightened knowledge and understanding of the contexts in which clients lived prior to coming to Canada had strengthened case management and counselling work in Canada.

3.2: Project Performance

3.2.1: Relevance and importance

The SANI project aimed to support the implementation of government-led approaches and strategies, operate within existing health and community nutrition infrastructure, and take a women and community-centered programmatic approach to enhance nutrition knowledge, attitudes, practices and behaviour. SANI was designed and implemented in line with the Sustainable Development Goals (SDGs), in particular, Goals number 1 (no poverty), 3 (good health and well-being), 5 (gender equality) and 10 (reduced inequalities).

In Zambia, SANI built on the Scaling Up Nutrition program to address complementary nutrition-sensitive issues such as food insecurity, access to clean and safe water and sanitation and gender inequality, which are endemic to Muchinga province. SANI targeted important issues of governance and accountability that contribute to ineffectiveness of nutrition interventions by working with community, district, provincial, and ministerial level structures to improve advocacy capacity and sustainable practices in gender-sensitive nutrition and agriculture.

In Malawi, SANI responded to the challenge of malnutrition in the disproportionately affected districts of Dowa and Ntchisi – both of which had been prioritized by the Malawian government for enhanced investment in nutrition reduction. At a national level, the project contributed toward the attainment of national and global policies on nutrition over its 4-year life span, including the National Multi-Sector Nutrition Policy (NMNP) 2018-2022 and SUN Nutrition Education and Communication Strategy (NECS) of 2012-2017, the Malawi Development Strategy (MDHS) III and the Maternal Infant and Young Children Nutrition (MIYCN), Growth Monitoring and Promotion (GMP) and Community-Based Management of Acute Malnutrition (CMAM) protocols.

In Malawi, a member from the DHO office in Ntchisi said that “the SANI project came at the right time when people needed it most to address child malnourishment. Nutrition and health messages given have changed people’s behaviours and mind sets regarding the use of locally available food to prevent the problem. In the past, we thought nutritious foods are the ones purchased from the market and had no knowledge on how to prepare and utilize our own local foods well to make them nutritious and suitable for our children.”

In Mozambique SANI was designed to align with the strategies and policies of the Government to address malnutrition, including the Multi-sectoral Action Plan for the Reduction of Chronic Under nutrition (PAMRDC), the National Strategy for Food Security and Nutrition (ENSAN II), National Plan for Food Security and Nutrition (PASAN II), Food and Nutrition Strategy (ESAN II), Action Plan for Food and Nutrition Security (PASAN OF 2007), Technical Secretariat for Food and Nutrition Security (SETSAN), National Multi-sectoral and Multi-stakeholder Technical Working Group (GT-PAMRDC).

3.2.2: Appropriateness of design

SANI has aligned its project outcomes, outputs and activities with national nutrition priorities, programs, and community-based nutrition interventions in Mozambique, Malawi, and Zambia. As part of the project implementation planning, the design of the project was reviewed and refined through an inclusive and participatory process with government (including national, district, and local representatives), community, and local civil society representatives. PIP workshops were held in each country in May and June 2016, and brought together a wide range of stakeholders to jointly prioritize activities and approaches, as well as begin planning for implementation.

The project design was continually refined throughout the implementation of the project through annual workplan processes as well consultations, research, or analysis conducted to plan activities. These processes drew on monitoring data to make informed decisions, as well as specific assessments. For example, in 2017, SANI conducted a qualitative assessment of gender norms in all three countries to better understand the ways in which local social norms and customs influence nutrition behaviours and beliefs, ensuring that interventions are designed to be both culturally sensitive and gender transformative. In addition, as part of defining the MIYCN model in each country, an analysis was conducted in each setting to understand the ideal structure and approach for the care group model, drawing on local expertise and aligning with national and local values and plans for nutrition improvement. In Mozambique, when household visits started, it was brought to our attention that women only self-identified as pregnant late in their pregnancies. In response to this, CARE Mozambique worked with CHWs to prioritize the content of the 4 planned visits to ensure the information most relevant to their pregnancy would be passed to participant in the one or two visits they were getting prior to delivery. In Malawi, when the roll out of the Care Goup modules took longer than initially planned, we adjusted modules to reduce from two meetings a month to one meeting a month.

Throughout the project, designated space was offered to communities, government, and local civil society to provide feedback to project staff through regular coordination and collaboration meetings, as well as workshops held following data collection and analysis. These meetings integrated discussions on the relevance and appropriateness of the project design, allowing project staff to validate the continued appropriateness of project design with communities.

3.2.3: Sustainability

A defining feature of the SANI project is that the program incorporated sustainability strategies within its activities, partnerships, and implementation strategies. Key to this was ensuring that SANI interventions aligned with the national health and nutrition priorities of each country, as well as designing program approaches and models to be integrated within government and community systems and structures.

Some of the key strategic implementation approaches for SANI have included:

- Working in close collaboration with government staff for the design, planning, and implementation of project activities:
 - In Mozambique, the MIYCN model of home-visits from CHW was designed to integrate and bolster the government's CHW program, working with existing CHW volunteers and ensuring that any new volunteers trained, or any new training provided, were integrated into the national curriculum. This ensures that CHW are connected to ministry of health infrastructure, including critical health services and nutrition programming.
 - In Zambia, SANI collaborated with the Ministry of Agriculture to establish demonstration plots and train facilitators to engage Farmer Interest Groups and FFBS,

allowing close integration of this approach in the Ministry's offer of extension services. In addition, inclusion of community Artisan Area Pump Minders in the Water Point Management Committees (WPMC), has worked to ensure the functionality and sustainability of these committees. In addition, the MoH and NFNC have adopted and will continue the Care group model established by SANI as part of the implementation of the First 1000 Most Critical Days Program (MDCP) II in UNICEF supported districts, including in Mpika.

- In Malawi, collaboration with local CSOs took a movement building-approach to support longer term advocacy efforts. This put nutrition at the top of the development agenda, and ensured that advocacy efforts will not end when the project closes.
- Joint monitoring and mentoring visits were organized in collaboration with the government at the district and provincial level to learn from community based structures created and/or strengthened during the project's implementation.
 - In Mozambique, Community Health Committees were included to provide support and monitor CHWs. Although it was not initially planned, the training and monitoring of these committees brought a community dynamic that allowed a greater connection between Health Facilities (HF) and communities.
- Meetings with stakeholders (community and local government), to talk about the lessons learned during the project implementation including dissemination of results that came from the Endline studies. These exercises were particularly helpful for analysing progress towards goals, as well as identifying lessons learned and activities that could be continued through government channels.
 - Some community structures in Malawi requested that these meetings take place more regularly, particularly at mid-project. Additional meetings were therefore built into the workplan for the SANI II costed extension period.
- In the final year of implementation, handover to local government partners and community partners has been an area of focus for SANI, with a particular focus on nutrition and WASH infrastructure. In all instances, WASH committees consisting of men and women from the surrounding community were established and trained to ensure the preventative maintenance and repair of the WASH infrastructure. An important focus of these groups was revenue mobilization from the community to ensure funds are available for maintenance and repair. These groups were also linked to district-level authorities to support with on more substantial repairs.
 - In Mozambique, a sustainable value chain was developed for spare parts to maintain solar-powered pumps, including training local artisans on solar pump repair, and making connections between local vendors in Inhambane to suppliers in Maputo.

In Malawi, there is evidence of replication of positive behaviours in neighbouring villages not targeted by the project such as exclusive breast feeding, timely introduction of complementary feeding, crop and dietary diversity. This suggests that some communities have replicated SANI activities without project support.

SANI made an intentional effort to work in partnership and build capacity of nutrition district and area coordination structures throughout the project. It introduced them to the communities, provided them with educational materials and transport, and valued their contribution. This empowered district and area structures to provide oversight of the project to structures below them at village level. In Malawi, the project evaluation found strong evidence that most of the activities used to promote behaviour change by SANI will likely continue because of the knowledge and skills gained. The structures and volunteers are still present in the targeted districts and by virtue of their mandate they will continue with implementation of the SANI activities. Most importantly, all of them have already demonstrated the capacity and commitment to work with minimum supervision to eradicate child undernutrition.

Sustainability was part of the twinning program design via organizational capacity building and network strengthening managed by ICAD. Some of the measures that organizations undertook to promote sustainability include:

- CEWAG support groups established systems for collection of monthly fees from their members to contribute towards the purchase of herbicides and seeds once the project phases out.

- Engagement of district health and agriculture extension workers in monitoring and support Support groups encouraged to initiate some activities on their own, without organizational support, for example taking advantage of community gatherings to conduct awareness activities
- Engagement of local chiefs and other leaders, and raising awareness about HIV and nutrition amongst them, has been crucial to project success and will provide an ongoing source of support for communities
- Self-sustaining income generation activities such as VSLA groups will operate independently post-project. The extension of project activities allows for the further strengthening of these structures prior to the end of project.
- CWC is using a system of distributing eggs to other beneficiaries, as CPIEM is doing with vegetable seeds. This cascade system broadens the reach and sustainability of the project. CWC has offered to pass on some chickens to CPIEM caregiver groups to increase the potential for sustainability.
- COWLHA has imparted advocacy skills among the beneficiaries besides the PMTCT, herb and vegetable gardening skills. COWLHA has also encouraged people living with HIV to continue the advocacy work post-project.

3.2.4: Partnership

The SANI project was implemented in partnership with four Canadian implementing Partners. CARE, as lead Partner, held the principal agreement with GAC, and individual partnership agreements between CARE, Cuso International, the Interagency Coalition on AIDS and Development (ICAD) and McGill University.

- **CARE:** CARE Canada was the lead implementing organization for SANI, responsible for overall operational and financial management of the project, coordination of project partners, and the focal point for the project with external stakeholders. CARE country offices in Malawi, Mozambique and Zambia had the primary responsibility for implementation of the project in each country through their headquarters and field offices. CARE country offices liaised with relevant Government authorities and ensured project activities remained in line with government strategies and priorities, coordinated project activities with Provincial and District authorities, and supported them in the delivery of the interventions, as well as provided technical support and training to project partners and community groups.
- **ICAD:** The Interagency Coalition for AIDS and Development's (ICAD) twinning initiative with SANI worked to strengthen the capacity of civil society organizations in Canada, Malawi and Zambia to address the intersections between gender, nutrition, food security and HIV within a sexual and reproductive health and rights (SRHR) framework. The work of the twinning partners continued between 2016 and 2020 in Malawi and Zambia, and activities rapidly shifted to respond to the COVID-19 pandemic throughout 2021. The twinning project came to an end in March 2021.
- **McGill:** McGill University's Institute for Global Food Security guided the development of a monitoring plan, tools, and training for implementation of a monitoring system, provided data analysis for project learning and quality improvement, and led the development of operational research and support for knowledge management. The majority of McGill's engagement took place at project inception. Following the baseline and project inception, McGill's scope of work was adjusted to focus primarily on conducting intermittent research alongside project activities.
- **CUSO International:** CUSO International contribute to the SANI project through the recruitment, training and deployment of skilled volunteers for deployments of between six months and one year. Volunteer sending started in the second year of the project and continued through to the fifth year of the project, when the final cohort of volunteers were repatriated at the beginning of the COVID-19 pandemic.

SANI also worked in close collaboration with government ministries for the planning, design, and implementation of SANI. Primary government partners included:

- *Provincial Nutrition Coordinating Committees (PNCC) (Malawi, Mozambique and Zambia):* PNCCs ensured effective multi-sectoral coordination and linkages, provide leadership and established the strategic and programmatic framework used for planning, coordination and implementation of nutrition specific and nutrition sensitive interventions in SANI. They participated in activity launches, validation workshops, monitoring visits, project evaluation results-sharing workshops and dissemination.
- *District Nutrition Coordinating Committees (DNCC):* The DNCC led the nutrition activities within the district and developed the terms of reference, membership, frequency of meetings and the roles and responsibilities of implementing sectors. District NCCs were involved in planning and monitoring of the SANI project.
- *Ministry of Agriculture (MoAL (Malawi, Mozambique and Zambia):* SANI worked with the MoAL in SANI to build capacity of farmers in climate smart agriculture methods through the Farmer Interest Groups, Farmer Field Schools, and backyard gardens, integrating and aligning with district-level extension services.
- *Ministry of Health (MoH) (Malawi, Mozambique and Zambia):* SANI worked with the MoH to provide these services through training of community-based volunteers in GMP and MIYCN. The MOH approved all SANI health/nutrition promotion messaging, and contributed to the design of the MIYCN promotion model in each country. SANI also worked with the MoH to create or strengthen growth monitoring and promotion systems at the community level.
- *Ministry of Gender (Malawi, Mozambique and Zambia):* The project worked with the Ministry by including staff in training and supervising SAA community dialogues to transform negative socio-cultural norms and traditions.

Coordination, cooperation, and communication among all partners throughout the project remained strong, evidenced by joint planning, implementation, and supervision of some activities. Partners met at least on an annual basis throughout the project, with additional meetings held to coordinate joint activities as necessary.

3.2.5: Innovation

While SANI was primarily focused on scaling current best-practice approaches to improving nutrition, several innovative approaches were used to facilitate important processes and overcome challenges throughout program implementation:

- A digital information management system – DHIS 2 – was used for data collection, storage, and management, enabling advanced and rapid information flows on project indicators to program management. By experiencing the use of the platform project staff were better placed to access the government HMIS platform to extract relevant information and assess quality, as well as opportunities for improvement.
- Photovoice, a photography based tool , was used as a important source of information for program evaluation. This enabled a deeper and more nuanced insight into the lives and experiences of project participants, which prompted more in-depth discussions during the FGD.
- Due to low literacy levels in several project districts, SANI adopted new ways of making MIYCN materials accessible to project volunteers and households with low literacy. MIYCN materials were adapted to include mainly images, which also included men caring for children while engaging in household chores. This innovative approach sparked important discussions and lessons learned between participants and trainers on improving women and children’s nutritional statuses. Using a visual based learning approach facilitated the inclusion of CHWs in Mozambique who had low levels of literacy.
- The SANI Project used CSC and SAA methodologies to explore and challenge gender inequality and its effect on nutrition, health, and livelihoods in Malawi, Mozambique and Zambia. In the final year of the Project, due to the pandemic and preventative restrictions, dialogues were suspended or canceled. SANI teams innovatively integrated gender messages, initially planned for SAA, into COVID-19 response activities. For example, in an effort not to undo the nutritional achievements in the lifecycle of the project and reduce the effect of COVID-19 on SANI HHs, teams disseminated information and materials, through

radio announcements and brochures, to reinforce the importance of hygiene and sanitation and gender-sensitive nutrition.

- Engaging men in activities was a critical component of the gender equality strategy. One innovative approach was to establish 'lead couples.' Essentially, role models in home garden, farmer, and VSLA groups who influenced other couples to join and participate in agricultural and nutrition interventions in their respective communities. For example, in Mozambique, practical gender exercises were integrated into horticulture, agro processing, and nutrition training in which men were actively involved. Participants were trained to preserve food and seeds such as tomatoes, onions, beans, and cassava leaves and to make jam and porridge. The intention was to encourage more men to advocate for gender equality in food preparation and food preservation activities in the household and community.
- While women were the main target group of the SANI project, CARE included male volunteers to address behaviour change in implementing areas. The project saw more men participate in community dialogues on nutrition, health, gender, agriculture, and WASH because male volunteers approached parent-to-parent groups and other local structures to encourage men's involvement as agents of change.
- Within Water Management Committees and other groups, SANI included diverse age groups of women to better understand the varied experiences and concerns within communities, address gender-specific needs, eliminate risks, and encourage ownership by women. For example, women identified areas for CLTS Demonstration Centres and chose separate latrines for each gender, which were close to the community to eliminate the risk of GBV. In fact, at CLTS Demonstration Sites, women were trained to construct and repair latrines, which is a job commonly reserved for men.

3.2.6: Value-for-money

CARE used a range of means to ensure optimum value for money during the implementation of SANI, including the following:

- CARE maintains a procurement system which emphasizes value for money, using metrics to select vendors that include function, quality, timeliness, and price. Staffing structures were efficient, avoiding redundancy in staff positions while ensuring the project functions were adequately staffed with highly qualified and effective personnel.
- CARE and partners ensured a light but effective staffing structure, supplemented by the support of the volunteers provided through the volunteer sending component of the program. Operationally, the project leveraged where possible existing community structures to improve efficiency and sustainability. Where possible, SANI collaborated and complemented well with other ongoing projects in project districts, leveraging their activities and avoiding redundancy.
 - For example in Dowa district in Malawi, there were a number of organizations involved in the training of nutrition officers and government's frontline workers in the districts. In cases where trainings were completed by other organizations at the district level, CARE provided backstopping support and increased efforts to build the capacity of community volunteers and groups
 - In Mozambique, CARE worked with existing CHWs where possible, and provided supplementary training only.

Budget utilization rates were consistently on track throughout the project, reaching a 95% expenditure rate by the fifth year of the project. Over the 4 years of implementation, SANI spent \$112 CAD per direct participant over the five years of implementation, or \$43 CAD per participant considering both direct and indirect participants.⁷

3.2.7: Informed and timely action

The SANI project saw several important natural and socio-political events affect the lives of communities in SANI districts. Key events at the outset of the project included the severe El Nino drought in Zambia that took place prior to the project inception, as well as Cyclone Dineo in Mozambique. Conducting the baseline surveys in the relative aftermath of these events allowed the

⁷ This calculation was made using the budget and participant reach of the original contribution agreement, excluding COVID-19 response funds.

project implementation to be targeted to the specific needs of communities as they recovered from these major events.

Elections in Malawi in 2019, gassing attacks in Zambia in 2019, cyclones Idai and Kenneth in Mozambique in 2019, infestation of the fall army worm, and recurrent cyclical droughts have all forced SANI to make adjustments in implementation timelines, strategies, and approaches. In some cases, adjustments in operational strategy allowed the project to move forward as originally planned, and in other cases were beyond the scope of the project to respond.

The COVID-19 outbreak at the beginning of 2020 arrived just as the project entered a final phase, with operations having wrapped up in Malawi, and most activities coming to a finish in Mozambique and Zambia. At the same time, the social and economic pressures of the COVID pandemic pushed communities to new heights of vulnerability, threatening to reverse the progress of the SANI project. Activities were quickly adjusted, and an emergency response program rapidly launched with funding from a costed extension from GAC. This emergency response was based on a Rapid Gender Analysis conducted in May 2020, ensuring that the response was informed by the needs of people of all ages and genders in SANI communities, amid the highly dynamic context of the pandemic.

3.3: Lessons Learned and Next Steps

3.3.1: Successes

In addition to the results reported above, the following programmatic best practices have been identified through the endline evaluation as easy to adapt, effective, high impact, easy to sustain and cost effective:

Care group model: Implementation of the Care group model has shown to be one of the best practices for SANI, as it proved to be learner-centered, with a wide reach, and it is easy to sustain as less costly to implement as it leverages the existing MoH CHW system. In Zambia, the CHWs followed a MICYN schedule that contained 12 sessions for a period of 6 months. This model was able to reach 80% of women of reproductive age in the three districts and included men in discussions around gender norms. Women and men gained knowledge on good nutrition for women during pregnancy and lactation, breastfeeding and complementary feeding practices, and on WASH, including how to make drinking water safe, good sanitation and hygiene and how to keep the environment clean.

Community Scorecards: The CSC process is an effective tool for the engagement of stakeholders in planning, implementation, monitoring and promoted active participation and ownership. It helps in addressing the needs of the community without waiting for government support. In Musonko village in Zambia, through the CSC process, the community was able to solve a problem of lack of a structure at the health post. The community after CSC, organized themselves and with the coordination and support of national and provincial government, constructed a Primary Health Post (PHP). Construction works for this PHP were completed and it now reaching over 5,989 people. This is evidence that the CSC can help in solving some of the problems affecting both demand and supply of health service delivery.

Village Savings and Loan Associations: In Malawi, economic empowerment activities in the communities have allowed some households to become more food secure by providing financial support (through VSLAs) which allows for diverse crop production, the reinvestment of savings in the purchase of agricultural inputs and the purchase of food when the family is unable to produce enough. This increase in access to purchased food has greatly assisted some families with becoming more food secure and made them less reliant on producing everything themselves. By increasing women's financial literacy, networking, and agency, VSLAs have reduced social isolation and increased economic empowerment and participation in decision making on nutrition and health by women within households

Cooking Demonstrations and Participatory Education Theatre The use of cooking demonstrations as approach for sharing information on dietary diversity internalized cookery knowledge in the communities and at the same time incentivized households with malnourished children to adopt good nutritional behaviours by learning from fellow families without being stigmatized. In Malawi, the combination of participatory education theater and cooking

demonstrations were particularly helpful for ensuring community engagement, setting in place a strong foundation for community dialogues around social norms.

Leveraging community health workers for MIYCN education in a low literacy context. Lessons from JHU's research on engaging community health workers within SANI in Mozambique show that low literacy does not limit the ability to advise on maternal and child nutrition. This opens an opportunity to considerably expand the national network of community health extension workers in the prevention of malnutrition. The national health system has recognized the role of community volunteers trained by SANI and is currently integrating them into a new program called the Integrated Nutrition Program (PIN) that aims to supplement in micronutrients and nutritional screening at the community level.

The Feed Her Future campaign has demonstrated success by engaging Canadians in real-time and in-person, enabling the campaign to reach and increase awareness amongst Canadians of women and girls' development and nutrition issues in Mozambique, Zambia and Malawi.

3.3.2: Challenges

Limited improvement in women's nutrition outcomes: SANI saw notable improvements in women's dietary diversity but was not able to shift acute malnutrition rates among women at endline compared to baseline. Further investigation into this is warranted to better understand barriers to improving women's nutrition. A possible explanation is the need to strengthen the emphasis on the linkages of sexual reproductive health and nutrition in future programming. Early pregnancies and short birth spacing may be a key contributing factor to the slow progress on nutritional outcomes among pregnant and lactating women. In addition, transformation of gender norms around nutrition and food distribution needs to be integrated from the outset of all nutrition programming - in a situation of food shortages (as highlighted in all 3 countries) women will, and be expected to, share food with children.

Limited ability of ultra-poor households to diversify diets and increase household food security: In all three countries, household food insecurity was affected by erratic rains, prolonged dry spells and fall armyworms throughout the project period. The degree to which households were affected by these shocks varied considerably between districts, and between households with different vulnerability factors (eg. female headed households, poverty level, etc.). In general, ultra-poor households in disadvantaged districts were more likely to remain food insecure and did not experience the same degree of change of households with higher income and in less disadvantaged districts.

- This was particularly evident in the Funhalouro district in Mozambique, where the entire territory is semi-arid, with very sandy soils and no river access. There were recurrent droughts, meaning that distributing a diversity of seeds did not translate to improved food consumption or dietary diversity.
- In Malawi, agricultural in-kind distribution of seed and fruit trees inputs were meant to be used on demonstration plots and not on smallholder farmer's gardens. A large majority of ultra-poor households were unable to apply the knowledge and skills they acquired due to lack of the inputs used in the demonstration plots. As such, it was difficult for them to diversify diets as learned and maintain appropriate child feeding practices based on the six-food group guide that Malawi follows. In particular, female headed households were significantly more likely experience food insecurity and negative nutrition outcomes - this is a trend that continued throughout the project.

Limited implementation period for social norms & behaviour change: In all countries, the SAA interventions and Community scorecard were key interventions for changing social norms and improving nutrition outcomes. However these changes take time to accomplish and to measure.

- In Malawi, the final evaluation considered the four years that SANI has been in Ntchisi and Dowa a relatively short period of time to change people's long-standing behaviours, deeply entrenched gender norms, cultural beliefs and habits completely.

- In Mozambique, the CLTS model, while effective, requires more time to engage with communities to see lasting behaviour change, and potentially consider additional material support to households to help facilitate the construction or upgrade of toilets to reach ODF status.

Participation of men in Care Groups and project activities: A recurrent challenges of SANI was the engagement of men in activities and changing attitudes and behaviours of men towards activities typically done by women.

- In Zambia, men culturally considered Care Groups to be an affair for women since they are the ones who primarily cook and take care of young children at home. Out of the 184,165 people that cluster leaders reached, 32 percent were men. The project involved men by including them in village committees and groups so that they can also discuss messages that are promoted in the Care Groups and the role they can play as primary decision makers for their households. Other ways to address this problem in future are deliberate allocation of project tasks to men and boys, encouraging mothers to bring their husbands to nutritional activities, working with youth groups and supporting male champions of change.
- In Mozambique, emigration is one of the very common coping mechanisms in rural areas. A lot of men migrate to urban areas neighbouring countries, predominately South Africa for work. This reduces the number of men living in rural areas and increases the availability of women participating in project activities, posing a challenge to engage men in social norm and behaviour change activities.
- In Malawi, participation of men in gender dialogues was low despite efforts to mobilise them to participate. The low participation was due to stereotypes about nutrition activities being reserved for women. ACLAN and CLAN (local leaders) members are mostly men and reluctant to participate and engage in gender dialogues. Their response influenced community members participation, especially men. Future programming should ensure that ACLAN and CLAN members are engaged on the importance of gender equality in relation to nutrition.

Representation of women at senior leadership in nutrition governance and management:

- Leadership positions in local community structures and committees (e.g., chairperson, secretary, and treasurer) are traditionally reserved for men due to preexisting beliefs about gender norms and roles and low literacy levels of women as more boys attend school longer or rather than girls. To address this, future programming should take into account the necessity to build in life/leadership skills components that can build women's agency to take part in these spaces as well as targeting and working along traditional gatekeepers to create a safe and favourable environment supportive of women's leadership as part of key programming.

3.3.3: Recommendations

Policy Recommendations:

Continued advocacy for government support to nutrition monitoring & programming: District Councils should lobby for budgetary allocation in the District Implementation Plans (DIPs) from the government to support SANI project activities that require funding such as supervision, monitoring and evaluation as well as planning and review meetings. Experience has shown that such activities eventually stop after cessation of external support from humanitarian projects.

Leverage and scale up the Community Health Worker and Care Group models: CHWs have been a vital link between households and health services. National governments should ensure the continuation of household nutrition counselling and growth monitoring of children over the age of 6 months of age through increased budgetary allocation and mandate literacy as a non-criterion for CHW recruitment. The Care Group model has also proven an effective mechanism for reaching households with trusted and comprehensive nutrition advice at scale, in a cost-effective manner that integrates effectively with existing health system and community structures. Development partners should utilize and scale up these existing models for nutritional counselling, GMP and CMAM. Building on the findings of the JHU research in Mozambique, there is also a unique opportunity to leverage the CHW and/or Care group model to implement guidelines on monitoring MUAC of women. Maternal MUAC has been used in similar settings to screen women for malnutrition, and could be integrated in programs like SANI, building upon the existing expertise of CHW and Care groups.

National governments to prioritize investment and management of supply chains at sub-national level, to ensure consistent supply and availability of RUTF and RUSF for health facilities to treat severe acute and moderate malnutrition: to address all stages in the continuum of care it is vital for all health facilities to have an adequate supply of ready to use therapeutic food and supplements for treatment, CHWs might be hesitant to refer children to health facilities that don't have the required RUTF and supplies to treat them.

Leverage Community Scorecard for long-term inclusive governance & participatory monitoring: There is a need to advocate for the inclusion of CSC activities in the government processes, as well as provide support to communities to advocate for the inclusion of budget for actions agreed in district and national level budgeting processes. Scorecards can also be leveraged as participatory monitoring tools, alongside interface forums, as one way to measure the project goals and objectives together on a regular basis.

Recommendations for Development Partners:

Prioritize longer implementation period for social norms and behaviour change activities, as well as the use of gender synchronized approaches: Changing attitudes and behaviors regarding gender equality and nutrition takes time. Areas for focus may include women's and girls access and control over productive resources, mobility, autonomy in decision-making, including access to health care? and meaningful participation at community level, including decision-making spaces as well as continued support of men's involvement in household chores beyond specific circumstances (e.g. beyond "helping" only when the wife is sick, away, or pregnant and moving to shared responsibilities in the household). There is an opportunity for continued work in gender equality and nutrition to build on the work to date, with a particular focus on wider engagement of men, women, community leaders, and young people. Activities intended to make change in social norms, mindsets, and behaviours, including the Care group model, CSC, CLTS, and SAA should be started at the beginning of project implementation and carried on for multiple years, so that there is adequate time to transform social norms and change behaviours in a lasting way.

- **In Mozambique** there is the added dynamic of men being away from home, and it was a challenge to reach males when they are working in South Africa or other regions. It is recommended that for future projects, development partners reconsider strategies for male engagement to be more adaptive based on the mobility of males and also consider deeper engagement with local authorities who can facilitate men's inclusion once they return to the community to understand changes in their individual household and community.

Continued and more regular inclusion of local and traditional leadership: While special effort was made to involve local leaders throughout the project in a range of different means, this is something that could have been improved in the following ways:

- **In Zambia**, local leadership should be more closely involved in selection of volunteers to lead project components, this will help to select the most suitable people for volunteer roles.
- **In Malawi**, future nutrition programming should ensure inclusion of budget for involvement of local leadership structures in nutrition, especially ACLANs and CLANs who have emerged as primary drivers of change in behavior and practices surrounding nutrition.

Continued advocacy and designated measures for inclusion of women in nutrition governance: Future planning of CSC, SAA, and Care Group modules should incorporate reflective discussions on women's contributions and roles in local governance structures. SANI results have shown increased participation of women in community structures, however, further analysis is required on whether women's opinions and ideas were heard and if women felt empowered in the process. There is need for DNCC, WNCC, and other local structures to prioritize monitoring and evaluating participants experiences in meetings and community sessions as well as to revise the current practice of leadership roles being reserved for men.

3.3.4: Next steps

CARE and partners have shared project dissemination materials with key government offices, partners and donors through numerous platforms, including in-person and virtual results dissemination workshops and project close-out meetings with government officials and project

stakeholders. CARE will also share best practices and approaches with development partners in the nutrition sectors in Malawi, Mozambique, and Zambia.

Many of the lessons learned from the first five years of SANI have been incorporated into the design of the COVID-19 response and recovery programming planned as part of the SANI costed extension period. The implementation of the COVID-19 costed extension began in July 2020 and will continue through to the end of June 2022.

Project learnings are also being incorporated into different concept notes and proposals, with an emphasis on integrating SRHR and nutrition within the CARE federation.

3: Annexes

Annex 1: Communications Annex:

SANI Final Report

Project duration: March 17th 2016 – March 31st, 2021

Project Description: The Southern Africa Nutrition Initiative (SANI) is a \$29,487,135 CAD project to address undernutrition in women of reproductive age (15-49) and children under 5 years in Malawi, Mozambique and Zambia. A partnership between CARE, Cuso International, Interagency Coalition on AIDS and Development (ICAD) and McGill University and the Governments and communities of implementing countries, SANI aimed to improve the nutritional status of women of reproductive age (15-49 years) and children under-5 years old.

The ultimate outcome of the SANI project was to contribute to the reduction of maternal and child mortality in targeted regions through the following intermediate outcomes:

1. Improved nutrition practices and services of women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia;
2. Improved nutrition sensitive practices for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia;
3. Strengthened governance and accountability of gender-equitable nutrition policies and programs for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia; and
4. Increased active engagement of Canadian women and men, including youth and aboriginal peoples, in support of women's and girl's development initiatives.

Statement of Cumulative Results Achieved:

Overall, the SANI project directly reached a total of 233,990 people, including 125,557 women and girls and 108,433 men and boys, and indirectly reached 498,245 people, including 288,775 women and girls and 209,470 men and boys in Malawi, Mozambique, and Zambia.

Public Education Campaign Description:

Feed Her Future was a Canadian public engagement campaign dedicated to building awareness about the importance of giving women and girls' access to proper nutrition, through the lens and learning of CARE's Southern African Nutrition Initiative (SANI).

Empowering Women and Girls Includes Their Human Right to Food:

CARE Canada believes that empowering women and girls starts with the recognition of and respect for their rights, including their right to food. How people use, share, and grow their food affects their community's ability to grow and prosper. Our goal is to uncover the social and gender norms that are affecting women's access to nutrition so women and girls are empowered to create sustainable change for their future.

Women are primarily responsible for the care and nutrition of household members, but have very little control over income and possess limited authority to make decisions about their own and their children's healthcare, including what kind of food comes into the home and who in the family eats first. Malnourished women are more likely to die in childbirth or have low birthweight babies. Chronically malnourished children suffer life-long consequences in cognitive ability, school performance, and future earnings, limiting the development potential of nations.

Our Impact:

Working with local health authorities and communities in Malawi, Mozambique and Zambia, SANI delivers high quality, gender transformative programming that focuses on women and girls' right to food. We seek to reduce the inequalities between women and men, girls and boys through gender transformative programming, which includes:

- Political, economic, social analysis and formative research that digs deeply into the context and community-specific power relations, social norms and traditions which underlie gender inequalities and lead to poor nutrition.
- Maternal, infant and young child feeding programs that involve women, men, boys, girls and traditional leaders to tackle the key, harmful, gender norms affecting women's access to nutrition.
- Community dialogues and policy engagement at all levels, including promotion of women's participation in design and delivery of nutrition programming.
- Water points and agricultural programs that are designed and managed by women giving them choice in what land to use, which tools to use, and which foods to grow/store/sell.

Further information:

More information about the project and the campaign is available at: www.feedherfuture.ca

See also the campaign social media channels:

- Facebook: <https://www.facebook.com/FeedHerFuture/>
- Instagram: <https://www.instagram.com/feedherfuture/> (@feedherfuture)
- Twitter: <https://twitter.com/FeedHerFuture> (@FeedHerFuture)
- YouTube: <https://www.youtube.com/channel/UC8LAWvdJOvbUQoUjjWAvC6w>

Visibility and recognition:

The Government of Canada's contribution to the project was recognized with appropriate logo and verbiage on all communications materials developed.

The following table outlines all communications products created by or in in association with the SANI project:

| TITLE | DESCRIPTION | DATE | AUTHOR |
|--|---|------------|------------------------|
| Campaign Backgrounder | High-level overview of the Feed Her Future campaign. | June 2018 | CARE Canada & NATIONAL |
| Campaign FAQs | Answers to key questions about the campaign. | June 2018 | CARE Canada & NATIONAL |
| Campaign Key Messages | Key media messaging of the campaign. | June 2018 | CARE Canada & NATIONAL |
| Launch Press Release | Press release prepared and released on day of campaign launch. | June 2018 | CARE Canada & NATIONAL |
| Campaign banners for social media | Three branded banners of the Feed Her Future campaign, including logo and tagline. Intended for distribution and sharing across social media, especially at launch. | May 2018 | CARE Canada & NATIONAL |
| Why are we working in Malawi, Mozambique and Zambia? | Snapshot of the SANI Baseline survey findings across all countries. | April 2018 | CARE Canada |
| Nutrition in Malawi – Baseline data from 2017 | Snapshot of the SANI Baseline survey findings for Malawi. | April 2018 | CARE Canada |
| Nutrition in Mozambique – | Snapshot of the SANI Baseline survey findings for Mozambique. | April 2018 | CARE Canada |

| TITLE | DESCRIPTION | DATE | AUTHOR |
|---|---|----------------|-------------|
| Baseline data from 2017 | | | |
| Nutrition in Zambia – Baseline data from 2017 | Snapshot of the SANI Baseline survey findings for Zambia. | April 2018 | CARE Canada |
| Feed Her Future Campaign Overview | A “lunch and learn” presentation made shortly after campaign launch, to both CARE Canada staff and Cuso International staff. | June 2018 | CARE Canada |
| Voices from the Field: Exploring Gender Dynamics in Malawi | Feed Her Future campaign story, written by Ziana Ahmed, Cuso International Volunteer Monitoring and Evaluation Advisor, Malawi. | May 2018 | CARE Canada |
| Voices from the Field: Field Farmer Schools in Mozambique | Feed Her Future campaign story, written by Katie Kendall, Cuso International Volunteer, Mozambique. | June 2018 | CARE Canada |
| Voices from the Field: Women Transforming the Community | Feed Her Future campaign story, written by Celia Bartolomeu, SANI Gender Officer, CARE Mozambique. | August 2018 | CARE Canada |
| Voices from the Field: Promoting Safe Water & Hygiene in Malawi | Feed Her Future campaign story, written by Amanda Gawne, SANI Communications Advisor, CARE Malawi. | November 2018 | CARE Canada |
| Voices from the Field: Father-to-Father groups in Mozambique | Feed Her Future campaign story, written by Sabrina Neto, SANI Communications Officer, CARE Mozambique. | February 2019 | CARE Canada |
| Voices from the Field: Changing gender norms in Zambia | Feed Her Future campaign story, written by Tanja Kisslinger, Public Engagement Officer, CARE Canada. | February 2019 | CARE Canada |
| Voices from the Field: “Gender Boxing” in Mozambique, Oy yay! | Feed Her Future campaign story, written by Sabrina Neto, SANI Communications Officer, CARE Mozambique. | March 2019 | CARE Canada |
| Rolling Profile: Malawi, Gertrude Kaponda, Lead Farmer | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | August 2018 | CARE Canada |
| Rolling Profile: Mozambique, Cristofa Tizai, DNCC Member and Nutrition Technician | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | September 2018 | CARE Canada |
| Rolling Profile: Mozambique, Fatima Mazive, Water Committee Member | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | September 2018 | CARE Canada |
| Rolling Profile: Zambia, Titus Chitula, WNCC Member and District Nutritionist | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | September 2018 | CARE Canada |
| Rolling Profile: Malawi, Mary Mwase, Promoter | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | March 2019 | CARE Canada |
| Rolling Profile: Malawi, Eliza | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | March 2019 | CARE Canada |

| TITLE | DESCRIPTION | DATE | AUTHOR |
|---|--|-------------------|-------------|
| Watchi Brison, Cluster Leader | | | |
| Rolling Profile: Malawi, Cosmas Williams, Promoter | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | March 2019 | CARE Canada |
| Cuso International SANI volunteer self-made video | Laurent-Charles Tremblay Lévesque, a Cuso International volunteer in Malawi, shares his favorite day in the field working to improve water, hygiene and sanitation with SANI. | February 4, 2019 | CARE Canada |
| Cuso International SANI volunteer self-made video | Sabrina Neto, a Cuso International volunteer in Mozambique shares her best day working with SANI. | February 7, 2019 | CARE Canada |
| Cuso International SANI volunteer self-made video | Haile Hailmicheal, a Cuso International volunteer working as a WASH adviser in Zambia, tells us about the difference he witnessed in a community after their water pump was fixed. | February 8, 2019 | CARE Canada |
| Rose Sikawa shares her experience working on SANI in Malawi | Rose Sikawa, Gender Coordinator at CARE Malawi, inspires us by sharing the challenges she sees working to give women and girls the same access to opportunities as men and boys. As she tells us, she has hope for the future. | February 8, 2019 | CARE Canada |
| SANI's work with families and cooking demo's | SANI spotlight on how many families have been reached / how many cooking demo's conducted since 2016 in the project countries. | June 1, 2019 | CARE Canada |
| SANI's model of dispersing MIYCN information | SANI spotlight on how many community health workers have been trained and how their work will spread throughout communities. | August 2, 2019 | CARE Canada |
| SANI's 4 pillars | Spotlight on the 4 key interventions in SANI. | September 3, 2019 | CARE Canada |
| SANI's "Pass it On" model | SANI spotlight on the "Pass it On" model of the Livestock program to show chicken distribution to date. | September 6, 2019 | CARE Canada |
| SANI's cooking demo's | SANI spotlight on cooking demo's for World Food Day, and how they help to address malnutrition holistically. | October 16, 2019 | CARE Canada |
| SANI's partnerships | Spotlight on the wide network of SANI's Canadian, Malawian, Mozambican and Zambian partnerships for International Development Week 2020. | February 6, 2020 | CARE Canada |
| Feed Her Future Ambassador Guide | Mail-out guide for new Campaign Ambassadors to help them begin supporting the campaign. | June 5, 2019 | CARE Canada |
| Feed Her Future postcard | Printed and displayed/handed out at all public events. Two-sided snapshot of the campaign and SANI project. | April 1, 2019 | CARE Canada |
| Feed Her Future Social Media (Digital Engagement) Toolkit | Suite of online images and text to help engaged people readily share a social media post with FHF messaging. | December 2019 | CARE Canada |
| Feed Her Future Q2 Issue | Feed Her Future Q2 Newsletter – Spotlight on our new campaign video, "She is family"! | May 2019 | CARE Canada |
| Feed Her Future Special Edition Issue | Special Edition Newsletter – Spotlight on Women Deliver | June 2019 | CARE Canada |
| Feed Her Future Q3 Issue | Feed Her Future Q3 Newsletter - Spotlight on our new Social Media Toolkit | October 2019 | CARE Canada |
| Feed Her Future Q4 Issue | Feed Her Future Q4 Newsletter - Spotlight on our new SNAPSHOT of Project Progress! | January 2020 | CARE Canada |
| SANI Snapshot | Snapshot of SANI Project Progress: Improving the health of women and children in Malawi, Mozambique and Zambia | January 2020 | CARE Canada |

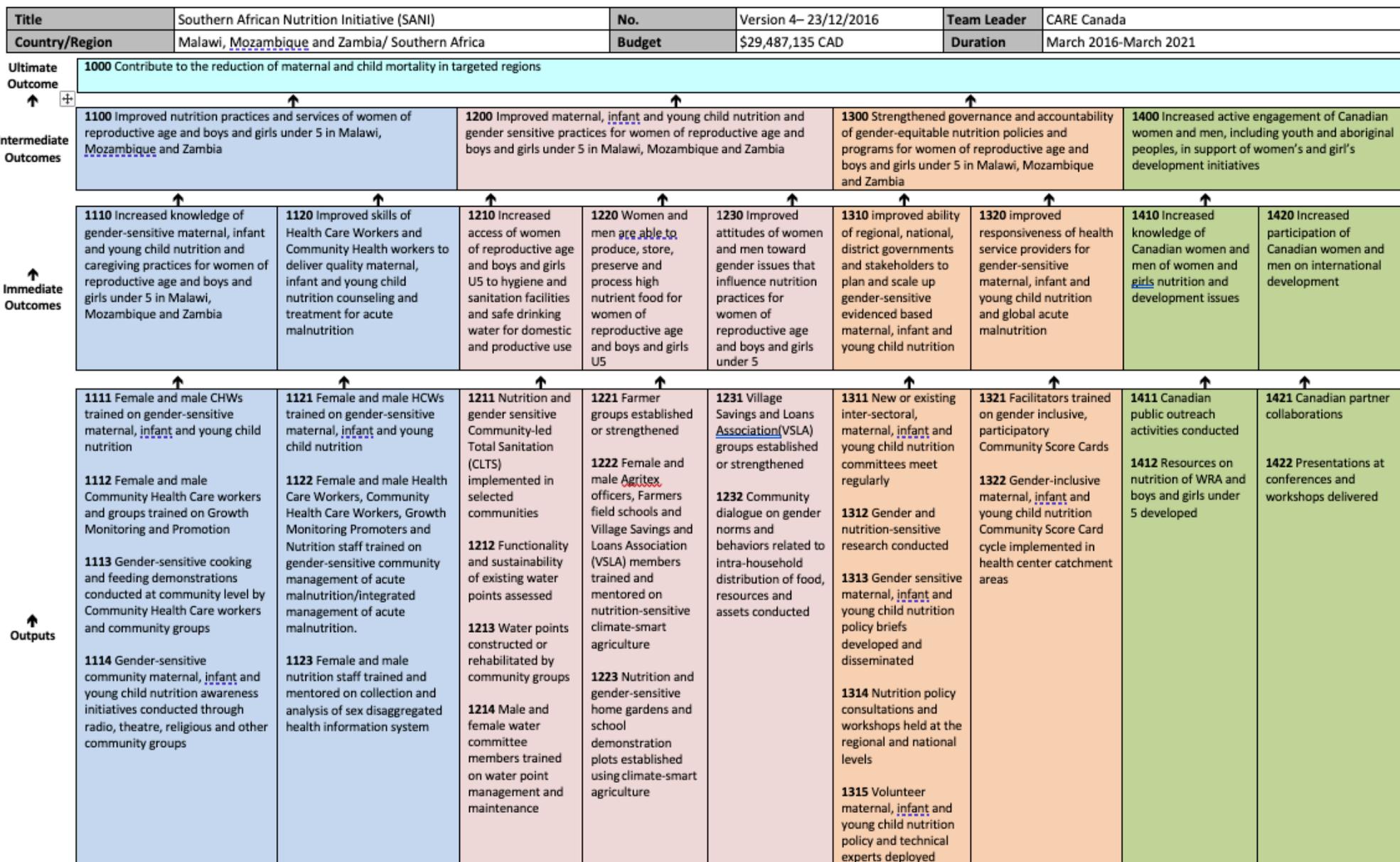
| TITLE | DESCRIPTION | DATE | AUTHOR |
|---|---|----------------|-------------|
| FHF perspective on UNICEF Report | Children are surviving, not thriving: Tackling child malnutrition requires a holistic approach that targets health care, water, sanitation, hygiene and gender equality | December 2019 | CARE Canada |
| Op-ed | Feminist evaluation of Canadian-funded international developments will improve outcomes and create lasting change | February 2020 | CARE Canada |
| ICAD blog on SANI project | SANI partners in Malawi work to tackle HIV-related stigma and discrimination | March 2020 | CARE Canada |
| FHF perspective on UNICEF Report | Children are surviving, not thriving: Tackling child malnutrition requires a holistic approach that targets health care, water, sanitation, hygiene and gender equality | December 2019 | CARE Canada |
| CARE Canada's Tanja Kisslinger | CARE Canada blog post featuring Q&A with Feed Her Future campaign lead, Tanja Kisslinger. | May 2019 | CARE Canada |
| Voices from the Field: Growing new ideas and practices in Zambia | Feed Her Future campaign story, written by Césarée Morier-Gxoyiya, Cuso International Volunteer, Zambia. | May 2019 | CARE Canada |
| Voices from the Field: "Twinning" for sustainability in Malawi | Feed Her Future campaign story, written by Chenai Kadungure, Cuso International Volunteer, Malawi. | May 2019 | CARE Canada |
| Voices from the Field: Getting to know Gezina in Malawi | Feed Her Future campaign story, written by Tanja Kisslinger, Public Engagement Officer, CARE Canada. | June 2019 | CARE Canada |
| Voices from the Field: Body Mapping as art therapy in Malawi | Feed Her Future campaign story, written by Chenai Kadungure, Cuso International Volunteer, Malawi. | August 2019 | CARE Canada |
| Voices from the Field: Celebrating World Water Week in Zambia | Feed Her Future campaign story, written by Tegan Holmes, Cuso International Volunteer, Zambia. | September 2019 | CARE Canada |
| Voices from the Field: SANI Agricultural Interest Group wins big | Feed Her Future campaign story, written by Jonathan Chewe (CARE Zambia) & Aston Chipanshi (Cuso International) | September 2019 | CARE Canada |
| Voices from the Field: Papaya trees are key to improved nutrition in Zambia | Feed Her Future campaign story, written by Florence Lushibashi, SANI District Coordinator, CARE Zambia | October 2019 | CARE Canada |
| Voices from the Field: Boosting small-scale farming success in Zambia | Feed Her Future campaign story, written by Césarée Morier-Gxoyiya, Cuso International Volunteer, Zambia | October 2019 | CARE Canada |
| Voices from the Field: How one family mobilized their community | Feed Her Future campaign story, written by Tegan Holmes, Cuso International Volunteer, Zambia | November 2019 | CARE Canada |
| Voices from the Field: Meet Margaret, a SANI Community Health Worker | Feed Her Future campaign story, written by Alice Tembo, SANI Development Officer, CARE Zambia | November 2019 | CARE Canada |
| Voices from the Field: Women and water point management in Zambia | Feed Her Future campaign story, written by Tegan Holmes, Cuso International Volunteer, Zambia | November 2019 | CARE Canada |

| TITLE | DESCRIPTION | DATE | AUTHOR |
|---|---|----------------|--|
| Voices from the Field: Climate-smart and leading the way in Zambia | Feed Her Future campaign story, written by Tegan Holmes, Cuso International Volunteer, Zambia | December 2019 | CARE Canada |
| Voices from the Field: The CARE Group Model is improving nutrition in Zambia | Feed Her Future campaign story, written by Easton Mhango (CARE Zambia) and Tegan Holmes (Cuso International) | January 2020 | CARE Canada |
| Voices from the Field: Why Felix Shares hygiene and nutrition knowledge in Zambia | Feed Her Future campaign story, written by Easton Mhango (CARE Zambia) and Tegan Holmes (Cuso International) | February 2020 | CARE Canada |
| Voices from the Field: Eusten says SANI-trained health workers key to reduced malnutrition | Feed Her Future campaign story, written by Easton Mhango (CARE Zambia) and Tegan Holmes (Cuso International) | March 2020 | CARE Canada |
| Rolling Profile: Zambia, Judith Ngosa (Beneficiary) | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | August 2019 | CARE Canada |
| Rolling Profile: Zambia, Joyce Malama (Beneficiary) | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | August 2019 | CARE Canada |
| Rolling Profile: Zambia, Titus Chitula (WNCC Member) | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | August 2019 | CARE Canada |
| Rolling Profile: Malawi, Avesi Julius (Beneficiary) | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | October 2019 | CARE Canada |
| Rolling Profile: Zambia, Beauty Mulenga | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | February 2020 | CARE Canada |
| Rolling Profile: Zambia, Peter Kateshi Chewe | Qualitative account of project impact in the community to date, by SANI field staff / beneficiary. | February 2020 | CARE Canada |
| "She is Family" | Official Feed Her Future campaign intro video. | April 29, 2019 | CARE Canada |
| "Elle est ta famille" | French captioned version of the above. | April 29, 2019 | CARE Canada |
| Feed Her Future cooking demo: Peanut butter, pumpkin & partnership to advance women's global health | Feed Her Future partnered with the Canadian Partnership for Women and Children's Health (CanWaCH) and broadcaster Kimothy Walker to show how Canadians are advancing the health, rights and well-being of women and girls around the world through nutrition. | May 24, 2019 | CARE Canada & CanWaCH & Kimothy Walker |
| Vancouver Speaks on Gender Equality | The #FeedHerFuture team hit the streets on Tuesday, June 4, 2019 to take Women Deliver outside the conference walls, and here's what they said... | June 6, 2019 | CARE Canada |
| Tribute on Father's Day | Fathers from the SANI project share their thoughts on family life. | June 17, 2019 | CARE Canada |

| TITLE | DESCRIPTION | DATE | AUTHOR |
|--|---|--------------------|--|
| Women's Health Rights in Development | On June 3, 2019, #FeedHerFuture invited three development leaders to share their stories of putting women at the centre of international development programming. We share the key takeaways from the session. | June 17, 2019 | CARE Canada |
| "She is... Like You" | Official FHF campaign video short. Theme: #FeedHerFuture is about more than #nutrition, it's about working toward a #genderequal world. Because, like you, she hopes for change. | July 19, 2019 | CARE Canada |
| "Elle est... Comme Toi" | French captioned version of the above. | July 19, 2019 | CARE Canada |
| "Her Right to Food" | Official FHF campaign video short. Theme: There is a relationship between #genderequality and #nutritionalstatus. Through SANI, we are reducing inequalities between women and men, girls and boys because #HerRightToFood matters. | July 19, 2019 | CARE Canada |
| Selfie-style, informal, social media video | Elina, Project Officer at The Coalition Of Women Living with HIV and Aids (COWLHA) in Malawi (a SANI partner), speaks about the benefits of Body Mapping for HIV+ women. | September 11, 2019 | CARE Canada |
| Tribute on World Water Week | Spotlight on SANI water activities for World Water Week social media | September 16, 2019 | CARE Canada |
| Spotlight on "tip tap" handwash station | Spotlight on SANI's "tip tap" handwash stations for World Water Week social media | September 16, 2019 | CARE Canada |
| Selfie-style, informal, social media video | Mackson Harawa, Executive Director of Passion for Women and Children (PAWOC) in Malawi – a local SANI partner – reflects on a "Body Mapping" session and what makes the technique so valuable and effective for the participants (i.e. women living with HIV/AIDS). | September 17, 2019 | CARE Canada |
| Feed Her Future Q1 Issue | Feed Her Future Q1 Newsletter – Spotlight on the impact of COVID-19 on SANI countries | May 2020 | CARE Canada |
| Feed Her Future Special Edition Issue | Special Edition Newsletter – FINAL ISSUE – Spotlight on #CelebratingSANI | July 2020 | CARE Canada |
| A Black Dog Enters the Home: Hunger and Malnutrition in Malawi | An academic article written by Dr. Anne Dressel and developed in collaboration with SANI staff in Malawi and Canada wa accepted for publication in <i>Medical Humanities</i> of BMJ. | March 2021 | Anne Dressel, CARE Malawi and CARE Canada staff. |
| Lessons Learned from the Twinning Initiative | A report outlining the lessons learned from ICAD's implementation of the twinning initiative under SANI | January 2021 | ICAD |
| HIV, Nutrition, Food Security and Gender | Exploring the Intersections of HIV, Nutrition, Food Security and Gender (English and French) | September 2020 | ICAD |
| A Black Dog Enters the Home: Hunger and Malnutrition in Malawi | An academic article written by Dr. Anne Dressel and developed in collaboration with SANI staff in Malawi and Canada wa accepted for publication in <i>Medical Humanities</i> of BMJ. | March 2021 | Anne Dressel, CARE Malawi and CARE Canada staff. |
| Lessons Learned from the Twinning Initiative | A report outlining the lessons learned from ICAD's implementation of the twinning initiative under SANI | January 2021 | ICAD |
| HIV, Nutrition, Food Security and Gender | Exploring the Intersections of HIV, Nutrition, Food Security and Gender (English and French) | September 2020 | ICAD |
| COVID-19 Update | COVID-19: 5 things we can do to help in developing countries | April 2020 | CARE Canada |
| Gender Equality and Nutrition | 7 things to know about the relationship of gender quality and nutrition in Southern Africa | April 2020 | CARE Canada |

| TITLE | DESCRIPTION | DATE | AUTHOR |
|---|---|----------------|----------------------|
| Pivoting for COVID-19 | Statement from SANI Project Manager | July 2020 | CARE Canada |
| Announcement of \$1.1 SANI Extension | CARE Canada Announcement of additional \$1.1 million in funding for SANI for COVID-19 Response | July 2020 | CARE Canada |
| COVID-19 Update | COVID-19: 5 things we can do to help in developing countries | April 2020 | CARE Canada |
| Gender Equality and Nutrition | 7 things to know about the relationship of gender quality and nutrition in Southern Africa | April 2020 | CARE Canada |
| Pivoting for COVID-19 | Statement from SANI Project Manager | July 2020 | CARE Canada |
| Announcement of \$1.1 SANI Extension | CARE Canada Announcement of additional \$1.1 million in funding for SANI for COVID-19 Response | July 2020 | CARE Canada |
| Margaret Bombeki : SANI Impact Story from CanWACH | A story of a retired teacher who has become a SANI Community Health Worker in Zambia | March 2021 | CARE Canada/CanWACH. |
| Voices from the Field: Emmanuel as the face of change in Zambia | Feed Her Future campaign story, written by Tanja Kisslinger, Public Engagement Officer, CARE Canada. | April 2020 | CARE Canada |
| Voices from the Field: Championing gender normative change in Zambia | Feed Her Future campaign story, written by Tanja Kisslinger, Public Engagement Officer, CARE Canada. | May 2020 | CARE Canada |
| Stephen Chilufya: Gender Champion | This video launched on #InternationalDayofFamilies2020 to celebrate Stephen Chilufya and the vital role he has played as a Gender Champion in the Southern African Nutrition Initiative (SANI). | May 6 2020 | CARE Canada |
| Mary Mwiche: Lead Farmer | Meet Mary Mwiche, one of SANI's incredible Lead Farmers in Zambia. In her rural community, Mary knows that climate-smart agriculture practices are key to increasing crop production and diversifying diets. | April 30, 2020 | CARE Canada |
| What difference has SANI made to you? | Leading up to the close of the Feed Her Future Campaign, the campaign created an uplifting video to highlight the impact of SANI on the lives of project beneficiaries. | April 30, 2020 | CARE Canada |
| Marriett Chanda: Water Point Management Leader | Meet Marriett Chanda, one of SANI's incredible Water Point Management Committee Leaders in Zambia. In her rural community, Marriett plays a key role, not only in ensuring the borehole is working properly, but also teaching households to follow new methods for water purification, sanitation and hygiene. | April 30, 2020 | CARE Canada |
| SANI Campaign Countdown, Week 8 – SANI Partnerships | An infographic video highlighting the partnerships SANI has with partners in Malawi, Mozambique, Zambia and Canada | June 18, 2020 | CARE Canada |
| SANI Campaign Countdown, Week 7 – SANI Key Project Interventions and Activities | An infographic video highlighting how SANI seeks to address the complex relationship of gender equality and nutrition through a holistic set of project interventions. | July 2, 2020 | CARE Canada |

Annex 2: Result and Risk Management Tools: Annex 2.1: Final logic model



Annex 2.2: Final PMF

| EXPECTED RESULTS | INDICATORS | Numerator /Denominator | BASELINE DATA | PROJECT TARGET | ENDLINE DATA | Cumulative against Project Target | |
|---|---|---|---|--|--|--|--|
| ULTIMATE OUTCOME | | | | | | | |
| 1000 Contribute to the reduction of maternal and child mortality in targeted regions | Wasting, : % of boy and girl children up to 59 months with weight-for-length < - 2 sd | # of boy and girl children 6 up to 59 months with weight-for-length < - 2 sd | Zambia: girls: 5% (n=16/d=297) boys: 7% (n=20/d=284) | Zambia: girls: 4.8% boys: 6.7% | Zambia: NA NA | Zambia: NA NA | |
| | | | Malawi: girls: 2% (n=6/d=292) boys: 4% (n=10/d=252) | Malawi: girls: 2.9% boys: 3.8% | Malawi: girls: 2% (n=6/d=302) boys: 4% (n=12/d=299) | Malawi: girls: difference not statistically significant boys: difference not statistically significant | |
| | | # of boy and girl children 6 to 59 months in sample | Mozambique: girls: 7% (n=34/d=513) boys: 7% (n=32/d=475) | Mozambique: girls: 6.7% boys: 6.7% | Mozambique: NA NA | Mozambique: NA NA | |
| | | | Zambia: girls: 42% (n=126/d=300) boys: 50% (n=144/d=288) | Zambia: girls: 40% boys: 48% | Zambia: NA NA | Zambia: NA NA | |
| | | Stunting: % of boy and girl children 6 up to 59 months with height-for-age < - 2 sd | # of boy and girl children 6 up to 59 months with height-for-age < - 2 sd | Malawi: girls: 34% (n=100/d=295) boys: 42% (n=109/d=259) | Malawi: girls: 32% boys: 41% | Malawi: girls: 35% (n=106/d=302) boys: 46% (n=138/d=300) | Malawi: girls: difference not statistically significant boys: difference not statistically significant |
| | | | | # of boy and girl children 6 to 59 months in sample | Mozambique: girls:26% (n=135/d=513) boys:34% (n=161/d=475) | Mozambique: girls: 25% boys: 32% | Mozambique: NA NA |
| | % of women with MUAC <23 cm | | # of pregnant or lactating WRA with MUAC <23 cm | Zambia: 10% (n=76/d=735) | Zambia: 9.5% | Zambia: NA | Zambia: NA |
| | | Malawi: 2% (n=12/d=595) | | Malawi: 1.9% | Women: 10% (n=65/d=651) | Malawi: 372% increase (target not met) | |

| EXPECTED RESULTS | INDICATORS | Numerator /Denominator | BASELINE DATA | PROJECT TARGET | ENDLINE DATA | Cumulative against Project Target |
|---|--|---|--|---|--|---|
| | | # of pregnant and lactating WRA in sample | Mozambique: 2% (n=26/d=1262) | Mozambique: 1.9% | Mozambique: NA | Mozambique: NA |
| INTERMEDIATE OUTCOMES | | | | | | |
| 1100 Improved nutrition practices for women of reproductive age and boys and girls under 5 | % of children 6-23 months with MAD by meeting MMF and MDD in the previous 24 hours | # of children 6 -23 months with MAD | Zambia: girls: 17% (n=40/d=225) boys: 24% (n=52/d=218) | Zambia: 6pp increase girls: 23% boys: 30% | Zambia: girls: 30% (n=52/d=172) boys: 31% (n=54/d=172) | Zambia: girls: 130% of project target boys: 103% of project target |
| | | | Malawi: girls: 5% (n=10/d=190) boys: 7% (n=13/d=181) | Malawi: 8pp increase girls: 15% boys: 15% | Malawi: girls: 31% (n=68/d=218) boys: 31% (n=61/d=197) | Malawi: girls: 207% of project target boys: 207% of project target |
| | % of children 0-5 months who are exclusively breastfed | # of children 6 – 23 months in sample | Mozambique: girls: 3% (n=10/d=362) boys: 1% (n=4/d=311) | Mozambique: 9pp increase girls:12% boys:10% | Mozambique: Girls: 3% (n=2/d=75) Boys: 1.5% (n=1/d=65) | Mozambique: girls: 25% of project target boys: 15% of project target |
| | | | # of children 0-5 months who are exclusively breastfed | Zambia: 70% (n=101/d=145) Malawi:61% (n=88/d=144) | Zambia: 77% Malawi: 75% | Zambia: 85% (n=105/d=124) Malawi: 86% (n=136/158) |
| | | # of children 0 – 5 months in sample | Mozambique: 65% (n=157/d=243) New calculation, 6-23 months: 65% (n=442/d=679) | Mozambique: 72% | Mozambique: New calculation, 6-23 months: 82% | Mozambique: 114% of project target |
| | | | % of women and children (boys and girls) 6 – 23 months who meet minimum diet diversity | # of women and children 6 – 23 months who meet minimum diet diversity | Zambia: women: 57% (n=413/d=735) girls: 37% (n=83/d=225) boys: 38% (n=84/d=218) | Zambia: Women: 65% (8pp increase) Girls: 41% (4pp increase) Boys: 42% (4pp increase) |
| Malawi: Women: 18% (n=127/d=708) | Malawi: Women: 30% (12pp increase) | Malawi: Women: 68% (n=524/d=770) | | | Malawi: women: 226% of project target | |

| EXPECTED RESULTS | INDICATORS | Numerator /Denominator | BASELINE DATA | PROJECT TARGET | ENDLINE DATA | Cumulative against Project Target |
|---|--|---|--|---|--|---|
| | | # of women and children 6 – 23 months in sample | girls: 9% (n=19/d=215) boys: 9% (n=19/d=209) | Girls: 20% (8pp increase) Boys: 21% (8pp increase) | girls: 43% (n=106/d=247) boys: 38% (n=83/d=219) | girls: 215% of project target boys: 181% of project target |
| | | | Mozambique: women: 21% (n=260/d=1262) | Mozambique: Women: 30% (9pp increase) | Mozambique: women: 22% (n=31/d=143) | Mozambique: women: 73% of project target |
| | | | girls: 13% (n=46/d=362) boys: 8% (n=24/d=311) | Girls: 20% (7pp increase) Boys: 15% (7pp increase) | girls: 8% (n=6/d=74) boys: 11% (n=7/d=64) | girls: 40% of project target boys: 73% of project target |
| | % of men and women using improved drinking water sources (piped on premises or other improved drinking water sources) | # of men and women using improved drinking water sources (piped on premises or other improved drinking water sources) | Zambia: 29% (n=217/d=735) | Zambia: 32% | Zambia: 48% (n=225/d=471) | Zambia: 150% of project target |
| | | # of men and women sample | Malawi: 77% (n=545/d=707) | Malawi: 85% | Malawi: 92% (n=708/770) | Malawi: 108% of project target |
| | | # of men and women sample | Mozambique: 66% (n=834/d=1262) | Mozambique: 73% | Mozambique: 66% (n=88/d=131) | Mozambique: 90% of project target |
| 1300 Strengthened governance and accountability of gender-equitable nutrition policies and programs for women of reproductive age and boys and girls under 5 | % of DNCC members and DNCC leaders who are female | # of DNCC members and DNCC leaders who are female | N/A | 30% of members / leaders | Zambia: 36% | Zambia: 120% of project target |
| | | # of DNCC members | | | Malawi: 30% | Malawi: 100% of project target |
| | % of District Nutrition Coordinating Committees with good governance practices in place that feed into national policy | # of DNCCs achieving high on governance scale | N/A | 80% of DNCCs | Zambia: 100% | Zambia: 125% of project target |
| | | # of DNCCs | | | Malawi: 100% | Malawi: 125% of project target |
| | | | | Mozambique: 100% | Mozambique: 125% of project target | |
| 1400 Increased active engagement of Canadian women and men, including youth and aboriginal peoples, in support of women's and | # of Canadian individuals and partners collaborating in research, publications, fora and project activities | | N/A | 10000 Canadians (disaggregated by sex and type) | | N/A [1] |
| | % of Canadian volunteers, students and partners | # of Canadian volunteers, students | N/A | 75% | | N/A [1] |

| EXPECTED RESULTS | INDICATORS | Numerator /Denominator | BASELINE DATA | PROJECT TARGET | ENDLINE DATA | Cumulative against Project Target |
|--|---|--|--|---|---|--|
| girl's development initiatives | conducting outreach activities in Canada | and partners conducting outreach activities in Canada | | | | |
| | | # of Canadian volunteers, students and partners in project | | | | |
| IMMEDIATE OUTCOMES | | | | | | |
| 1110 Increased knowledge of gender-sensitive MIYCN and caregiving practices for women of reproductive age and boys and girls under 5 | % change in knowledge of men and women of MIYCN practices | # of men and women with knowledge of MIYCN practices | Zambia: men: 72% (n=411/d=573) women: 80% (n=588/d=735) | Zambia: men: 79% women: 88% | Zambia: men: 86% (n=99/d=115) women: 92% (n=433/d=471) | Zambia: men: 109% of project target women: 105% of project target |
| | | | Malawi: men: 79% (n=416/d=526) women:90% (n=637/d=708) | Malawi: men: 87% women: 99% | Malawi: men: 85% (n=325/d=382) women:94% (n=724/d=770) | Malawi Men: 85% (98% of project target) Women: 94% (95% of project target) |
| | | # of men and women in sample | Mozambique: men: 53% (n=111/d=210) women:59% n=745/d=1262) | Mozambique: men: 58% women: 65% | Mozambique: men: NA Women: 71% (n=102/d=143) | Mozambique: men: NA [1] Women: 109% of project target |
| | | | | | | |
| 1120 Improved skills of Health Care Workers and Community Health Workers to deliver quality MIYCN counseling and treatment for acute malnutrition | % of women, boys and girls U5 completing CMAM treatment | # of WRA, boys and girls U5 absent from two consecutive weighing | N/A | >85% | Zambia: 95% (175/183) | Zambia: 113% of project target |
| | | # of WRA, boys and girls enrolled in CMAM | | | Malawi: 97% Mozambique: 92% (61/66) | Malawi: 114% of project target Mozambique: 108% of project target |
| | % of women, boys and girls U5 recovered from acute malnutrition | # WRA, boys and girls U5 discharged as recovered | N/A | >75% | Zambia: 75% (137/183) Malawi: 94% Mozambique: 100% (66/66) | Zambia: 100% of project target Malawi: 125% of project target Mozambique: 115% of project target |
| | | # WRA, boys and girls U5 total discharges | | | | |

| EXPECTED RESULTS | INDICATORS | Numerator /Denominator | BASELINE DATA | PROJECT TARGET | ENDLINE DATA | Cumulative against Project Target |
|--|---|---|--|---|---|--|
| | % change in satisfaction of services | (Current score – original score)/Original score *100 | N/A | 10% increase | Zambia: 26% increase Malawi: 24% increase Mozambique: 1% increase | Zambia: 260% of project target Malawi: 240% of project target Mozambique: 10% of project target |
| 1210 Increased access of women of reproductive age and boys and girls U5 to hygiene and sanitation facilities and safe drinking water for domestic and productive use | # and % of communities ODF | # of communities ODF # of communities participating in CLTS | N/A | 80% of communities | Zambia: 35% (138/409) Malawi: 100% of Tas Mozambique: 9% (4 / 46) | Zambia: 40% of project target Malawi: 125% of project target Mozambique: 11% of project target |
| | % of boys and girls under five with diarrhea | # of boys and girls under five with diarrhea in the previous two weeks | Zambia: girls: 24% (n=90/d=379) boys: 24% (n=86/d=356) Malawi: girls: 54% (n=198/d=366) boys: 54% (n=185/d=342) Mozambique: girls: 20% (n=129/d=640) boys: 19% (n=116/d=622) | Zambia: 6pp decrease girls: 18% boys: 18% Malawi: 9pp decrease girls: 45% boys: 45% Mozambique: 5pp decrease girls: 15% boys: 14% | Zambia: girls: 21% (n=48/d=234) boys: 20% (N=48/d=237) Malawi: girls: 34% (n=130/d=383) boys: 36% (n=139/d=387) Mozambique: girls: 15% (n=11/d=71) boys: 10% (n=6/d=62) | Zambia: Girls: 3pp decrease (50% of project target) Boys: 4pp decrease (67% of project target) Malawi: girls: 20pp decrease (222% of project target) boys: 18pp decrease (200% of project target) Mozambique: girls: 100% of project target boys: 180% of project target |
| | % of women with access to safe drinking water | # of women with access to safe drinking water # of women in the sample | Zambia: 24% (n=179/d=735) Malawi: 31% (n=219/d=708) Mozambique: 8% (n=99/d=1262) | Zambia: 26% Malawi: 34% Mozambique: 9% | Zambia: 74% (n=348/d=471) Malawi: 41% (n=318/d=770) Mozambique: 25% (n=33/d=134) | Zambia: 285% of project target Malawi: 121% of project target Mozambique: 278% of project target |
| | 1220 Increased ability of women and men to | # of HHs with improved homestead gardens | | N/A | Malawi: 3500 | Malawi: 4105 |

| EXPECTED RESULTS | INDICATORS | Numerator /Denominator | BASELINE DATA | PROJECT TARGET | ENDLINE DATA | Cumulative against Project Target |
|---|---|---|--|---|---|--|
| produce, store, preserve and process high nutrient food for women of reproductive age and boys and girls U5 | | | | Zambia: 2500 Mozambique: 1500 | Zambia 3185 Mozambique 846 | Zambia: 127% of project target Mozambique: 56% of project target |
| 1230 Improved attitudes of women and men toward gender issues that influence nutrition practices for WRA and boys and girls under 5 | % of VSLA members who are female | # of female VSL # of VSLA members | N/A | >70% of VSLA members | Malawi: 78% | Malawi: 111% of project target |
| | % change in attitudes of men and women toward gender issues that influence nutrition practices | # men and women toward gender issues that influence nutrition practices # of men and women in survey | Zambia: 33% n=147/d=451) Malawi: 42% n=269/d=628) Mozambique: 70% (n=657/d=943) | 10% increase Zambia: 36% Malawi: 46% Mozambique: 77% | 42% (22% wife + 20% both husband and wife) [2] Malawi: 50% (n=311/d=626) Mozambique: 53% (n=69/d=131) | 116% of the target Malawi: 109% of project target Mozambique: 69% of project target |
| 1310 Improved ability of regional, national, district governments and stakeholders to plan and scale up gender-sensitive evidenced-based MIYCN | % of districts with gender-sensitive multi-sectoral joint action plans | # of districts with gender –sensitive multi-sectoral joint action plans # of districts | N/A | 80% of districts and regions | Zambia: 100% Malawi: 100% Mozambique: 100% | Zambia: 125% of project target Malawi: 125% of project target Mozambique: 125% of project target |
| | # of gender-sensitive nutrition policies and programs drafted for WRA, PLW and boys and girls U5 with project support | | N/A | 2/districts | Malawi: 3 Zambia: 1 Mozambique: 1 | Malawi: 150% of project target Zambia: 50% of project target Mozambique: 50% of project target |
| 1320 Improved responsiveness of health service providers for gender-sensitive MIYCN and global acute malnutrition | % change in CSC | (Current score – original score)/Original score *100 | N/A | 10% increase | Malawi: 25% increase = (73-58)/58 Mozambique: 8% increase = (2.78-2.571)/2.571 Zambia: 7% increase = (3.89-3.55)/3.55 | Malawi: 250% of project target Mozambique: 80% of project target Zambia: 70% of project target |
| 1410 Increased knowledge of Canadian women and men of women and girls nutrition and development issues | % of Canadians reached who report increase in knowledge of women and girls development and nutrition issues | # of Canadians with increased knowledge of women and girls development and nutrition issues | N/A | 80% | | N/A[3] |

| EXPECTED RESULTS | INDICATORS | Numerator /Denominator | BASELINE DATA | PROJECT TARGET | ENDLINE DATA | Cumulative against Project Target |
|---|--|-------------------------|---------------|---|--------------|-----------------------------------|
| | | # of Canadians surveyed | | | | |
| OUTPUTS | | | | | | |
| 1111 Female and male Community Health Workers trained on gender-sensitive maternal, infant and young child nutrition | # and sex of CHWs trained on gender-sensitive MIYCN | | N/A | Malawi: 113 (79 male, 34 female) | | 226(146m, 80f) |
| | | | | Zambia: 50 (32 male, 18 female) | | 212(126m &86f)424% |
| | | | | Mozambique: 265 CHWs (115 male, 150 female) | | 346 (116m, 260f)/131% |
| | # of trainings conducted for CHWs gender-sensitive MIYCN | | N/A | Malawi: 7 trainings | | 6 |
| | | | | Zambia:12 trainings | | 8 (133%) |
| | | | | Mozambique: 12 trainings | | 42 (350%) |
| 1112 Female and male Community Health Care workers and groups trained on Growth Monitoring and Promotion | # and sex of GMPs trained on Growth Monitoring and Promotion | | N/A | Malawi: 226 GMVs (102 male, 124 female) | | 226(146m,80f) |
| | | | | Zambia: 210 GMPs (105 male, 105 female) | | 224 (129m&95f)106% |
| | | | | Mozambique: 265 GMPs (115 male, 150 female) | | 346 (116m, 260f)/131% |
| | # of trainings conducted for CHWs on Growth Monitoring and Promotion | | N/A | Malawi: 6 trainings | | 6 |
| | | | | Zambia: 14 trainings | | 8 (57%) |
| | | | | Mozambique: 12 trainings | | 42/350% |
| 1113 Gender-sensitive cooking and feeding demonstrations conducted at community level by Community Health Workers and community groups | # of cooking and feeding demonstrations conducted | | N/A | Malawi: 678 demonstrations | | 1187 |
| | | | | Zambia: 1,800 demonstrations | | 3,212 (178%) |
| | | | | Mozambique: 56 demonstrations | | 60(107%) |
| | # of trainings on cooking and feeding demonstrations conducted | | N/A | Malawi: 36 trainings | | 8 |
| | | | | Zambia: 14 trainings | | 44(314%) |
| | | | | Mozambique: 8 trainings | | 16/200% |
| 1114 Gender-sensitive community MIYCN awareness initiatives conducted through radio, theatre, religious and other community groups | # and type of gender-sensitive community awareness initiatives conducted | | N/A | Malawi: 60 PET performances | | 722 |
| | | | | Zambia: 64 radio spots | | 71 (111%) |
| | | | | Mozambique: 54 radio spots | | 46 (85%) |
| | | | | | | |
| 1121 Female and male Health Care Workers trained on gender-sensitive maternal, infant and young child nutrition | # and sex of HCWs trained on gender-sensitive MIYCN disaggregated by cadre | | N/A | Malawi: 113 HCWs (43 male, 70 female) | | 199 (121m, 78f) |
| | | | | Zambia: 56 HCWs (20 female, 36 male) | | 31 (18f &13m)/55% |
| | | | | Mozambique: 28 HCWs (7 male/11 female) | | 33 (118%) |
| | | | N/A | Malawi: 4 trainings | | 6 (150%) |
| | | | | Zambia: 2 trainings | | 2 (100%) |

| EXPECTED RESULTS | INDICATORS | Numerator /Denominator | BASELINE DATA | PROJECT TARGET | ENDLINE DATA | Cumulative against Project Target |
|---|---|------------------------|---------------|---|--------------|-----------------------------------|
| | # of trainings for HCWs conducted on gender-sensitive MIYCN | | | Mozambique: 12 trainings | | 2(17%) |
| 1122 Female and male Health Care Workers, Community Health Care Workers, Growth Monitoring Promoters and Nutrition staff trained on gender-sensitive CMAM/IMAM | # and type of men and women trained in CMAM/IMAM | | N/A | Malawi: 125 (87 male, 38 female) | | 163(84m,79f) / 130% |
| | | | | Zambia: 224 (104 male, 116 female) | | 196 (102f,94m)/ 88% |
| | | | | Mozambique: 126 (50 male, 76 female) | | 379 (248f 131m) /300% |
| | # of trainings conducted on CMAM/ IMAM | | N/A | Malawi: 4 trainings | | 4 |
| | | | | Zambia: 14 trainings | | 9 / 64% |
| | | | | Mozambique: 6 trainings | | 46/766,66% |
| 1123 Female and male nutrition staff trained and mentored on collection and analysis of sex disaggregated HIS | # and sex of nutrition staff trained and mentored on collection and analysis of sex disaggregated HIS | | N/A | Malawi: 125 (87 male, 38 female) | | 376 (217m,159f) / 300% |
| | | | | Zambia: 60 (30 male, 30 female) | | 32 (22f & 10m) / 53% |
| | | | | Mozambique: 45 (20 male, 25 female) | | 5 / 11 % |
| | # of trainings conducted for nutrition staff on collection and analysis of sex disaggregated HIS | | N/A | Malawi: 4 trainings | | 10 |
| | | | | Zambia: 4 trainings | | 2/50% |
| | | | | Mozambique: 3 trainings | | 1 / 33% |
| 1211 Nutrition and gender sensitive CLTS implemented in selected communities | # and sex of community members trained on CLTS | | N/A | Malawi: 450 community leaders (360 male, 90 female) | | 467(254m,213f) |
| | | | | Zambia: 280 community members (100 female, 180 male) | | 272 (61f &211m)/97% |
| | | | | Mozambique: 350 (170 male, 180 female) | | 381 /109% |
| | # of gender issues related to hygiene and sanitation addressed through CLTS | | N/A | 2 per district | | 2 |
| 1212 Functionality and sustainability of existing water points assessed | # of villages mapped and assessed | | N/A | Malawi: 100 | | 2149 / 2149% |
| | | | | Zambia: 331 | | 344 / 104% |
| | | | | Mozambique: 31 | | 55 (177%) |
| | # and sex of community members trained on community water point mapping and action planning | | N/A | Malawi: 1000 VHC members (700 male,300 female) | | 1085 (700m, 385f) / 108% |
| | | | | Zambia: 140 WASH committee members (80 male, 60 female) | | 168 (58 f, 110 m) / 120% |
| | | | | Mozambique: 0 | | N/A |
| 1213 Water points constructed or rehabilitated by community groups | # of water points rehabilitated or constructed | | N/A | Malawi: N/A | | N/A |
| | | | | Zambia: 30 | | 47 / 157% |
| | | | | Mozambique: 24 | | 24/100% |

| EXPECTED RESULTS | INDICATORS | Numerator /Denominator | BASELINE DATA | PROJECT TARGET | ENDLINE DATA | Cumulative against Project Target |
|---|---|------------------------|---------------|---|--------------|-----------------------------------|
| 1214 Male and female water committee members trained on water point management and maintenance | # and sex of WPC members trained on water point management and maintenance | | N/A | Malawi: 96 WPC members (50 male, 46 female) | | 180 (100m,80 f) / 187% |
| | | | | Zambia: 180 WPC members (100 male, 80 female) | | 210 (78f & 132m) / 117% |
| | | | | Mozambique: 350 (170 male, 180 female) | | 240 (120m, 120 f)/69% |
| 1221 Farmer groups established or strengthened | # farmer groups established or strengthened | | N/A | Malawi: 90 farmer groups | | 180 / 200% |
| | | | | Zambia: 200 farmer groups | | 224 / 112% |
| | | | | Mozambique: 135 farmers groups | | 66 (49%) |
| | # and sex of farmer group members | | N/A | Malawi: 3500 (1400 male, 2100 female) | | 4105 (1768m,2337f) / 117% |
| | | | | Zambia: 4,000 (2300 male, 1700 female) | | 4120 (1882m,2238 f) / 103% |
| | | | | Mozambique: 4050 (1620 male, 2430 female) | | 1960 (358m, 1602f)/48% |
| 1222 Female and male Agritex officers, Farmers field schools and VSLA members trained and mentored on nutrition-sensitive climate-smart agriculture | # and sex of Agritex officers, farmer field school members, VSLA members trained on nutrition-sensitive climate-smart agriculture | | N/A | Malawi: 3740 (1580 male, 2160 female) | | 4,105 (1,768m, 2,337f) / 109% |
| | | | | Zambia: 210 (105 male, 105 female) | | 444 (257f & 187m) /211% |
| | | | | Mozambique: 4050 (1620 male, 2430 female) | | 1973 (368m, 1605f)/49% |
| | # and (vulnerability) type of HHs provided with appropriate agricultural inputs disaggregated by sex | | N/A | Malawi:3500 HHs | | 4,105 (1,768m, 2,337f) / 117% |
| | | | | Zambia: 5000 HHs | | 8,071(4960f &3,41m) /161% |
| | | | | Mozambique: 371 HHs | | 1724 HH (321m, 1403f)/465% |
| | # of farmers field schools established or strengthened | | N/A | Malawi: 90 farmer field schools | | 180 / 200% |
| | | | | Zambia: 50 farmer field schools | | 93 / 186% |
| | | | | Mozambique: 135 farmer field schools | | 66/49% |
| 1223 Nutrition and gender-sensitive home gardens and school demonstration plots established using climate-smart agriculture | # of home garden demonstration plots established | | N/A | Malawi: 90 plots | | 180 / 200% |
| | | | | Zambia: 14 plots | | 91 / 650% |
| | | | | Mozambique: 70 plots | | 106/151% |

| EXPECTED RESULTS | INDICATORS | Numerator /Denominator | BASELINE DATA | PROJECT TARGET | ENDLINE DATA | Cumulative against Project Target |
|---|---|------------------------|---------------|---|--------------|-----------------------------------|
| 1231 VSLA groups established or strengthened | # VSLA groups established or strengthened | | N/A | Malawi: 900 VSLA groups | | 846 / 94% |
| | | | | Zambia: 14 VLSA groups | | N/A |
| | | | | Mozambique: N/A | | N/A |
| | # and sex of VSLA group members | | N/A | Malawi: 18,000 VSLA members (3600 male, 14400 female) | | 18267 (4047m,14220f) / 101% |
| | | | | Zambia: 140 VSLA members (120 male, 120 female) | | N/A |
| | | | | Mozambique: N/A | | N/A |
| 1232 Community dialogue on gender norms and behaviors related to intra-HH distribution of food, resources and assets conducted | # of community dialogues conducted | | N/A | Malawi: 226 dialogues | | 1868 / 826% |
| | | | | Zambia: 140 dialogues | | 30 / 21% |
| | | | | Mozambique: 225 dialogues | | 284/126,22% |
| 1311 New or existing inter-sectoral, MIYCN committees meet regularly | # of inter-sectoral MIYCN committee meetings conducted | | N/A | Malawi: 44 meetings | | 52 / 118% |
| | | | | Zambia: 44 meetings | | 90 / 205% |
| | | | | Mozambique: 44 meeting | | 43/97,7% |
| 1312 Gender and nutrition sensitive research conducted | # of gender and nutrition-sensitive MIYCN issues researched | | N/A | 2 topics | | Malawi: 2 |
| 1313 Gender sensitive MIYCN policy briefs developed and disseminated | # of gender-sensitive MIYCN policy briefs disseminated | | N/A | 2 briefs per country | | Malawi: 2 |
| 1314 Nutrition policy consultations and workshops held at the regional and national levels | # of nutrition consultations and workshops held at regional and national levels | | N/A | 2 workshops | | Malawi: 2 |
| 1315 Volunteer MIYCN policy and technical experts deployed | # of volunteer technical experts placed in target countries | | N/A | 25 volunteers across 3 countries | | 35 |
| | # of local partners supported to provide targeted MIYCN support to especially vulnerable groups | | N/A | Malawi: 2 local partners | | 2 |
| | | | | Zambia: 2 local partners | | 3 / 150% |
| | | | | Mozambique: 3 local partners | | 3 / 100% |

| EXPECTED RESULTS | INDICATORS | Numerator /Denominator | BASELINE DATA | PROJECT TARGET | ENDLINE DATA | Cumulative against Project Target |
|--|--|------------------------|--------------------------------|---|--------------|--|
| 1321 Facilitators trained on gender inclusive, participatory Community Score Cards | # of m/f facilitators trained on gender-inclusive participatory CSC | | N/A | Malawi: 60 facilitators (24 male, 36 female) | | 152 (71m,81f) |
| | | | | Zambia: 140 facilitators (70 male, 70 female) | | 17 (13m, 4f) |
| | | | | Mozambique: 112 (56 male, 56 female) | | 29 / 26% |
| 1322 Gender-inclusive MIYCN Community Score Card cycle implemented in health center catchment areas | # of gender-sensitive MIYCN community scorecard interface meetings conducted | | N/A | Malawi: 48 meetings | | 34 |
| | | | | Zambia: 8 meetings | | 12/50% |
| | | | | Mozambique: 4 meetings | | 8/200% |
| | # of gender-specific items per scorecard | | N/A | Malawi: 6 items in total | | 5 |
| | | | | Zambia: 3 items per CSC process | | 3/100% |
| | | | | Mozambique: 3 per CSC process | | (10/12) 83% |
| # of gender-sensitive MIYCN CSC action plans implemented | | N/A | Malawi: 16 CSC action plans | | 20 | |
| | | | Zambia: 10 CSC action plans | | 12/120% | |
| | | | Mozambique: 8 CSC action plans | | 8/100% | |
| 1411 Canadian public outreach activities conducted | # of public engagement activities | | N/A | 12 activities | | 27 |
| 1412 Resources on nutrition of WRA and boys and girls under 5 developed | # and type of resources on nutrition of WRA and boys and girls under 5 | | N/A | 3 videos, 3 publications / reports, 1 website | | 21 videos, 112 publications/reports, 1 bilingual website |
| 1421 Canadian partner collaborations | # and quality of Canadian partner collaboration | | N/A | 6 | | 8 |
| 1422 Presentations at conferences and workshops delivered | # of presentations delivered at separate workshops and conferences in Canada | | N/A | 16 presentations | | 19 |

[1] Measurement for men not available due to insufficient sample (7 observations)

[2] Consultant included "joint decision" category and endline data is no longer comparable to baseline

[3] See SAR Y5 Campaign Report for detailed public engagement results for outcome series 1400.

Annex 2.3: Risk Register

| Risk Name | Risk Definition | Risk Response | Investment Logic Model Result Statement | Risk Level | |
|--------------------------|--|--|---|----------------|----------------|
| | | | | June/16 | March/21 |
| Operational Risks | | | | | |
| | Changing policy environment for non-state actors could delay or restrict the ability to implement project activities | <ul style="list-style-type: none"> CARE Country Offices maintains government relations personnel and regular contact with Government. CARE COs' operations are updated regularly to reflect changes in policy environment. | 1100 Improved nutrition practices and services of women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia | L = 2 I = 1 | L = 2 I = 3 |
| | Currently it is difficult for non-Mozambique citizens to receive work permits for Mozambique, including for volunteers. This may lead to delays in placing volunteers in Mozambique, or limitations on the length of their placements. | <ul style="list-style-type: none"> CARE allows as long lead time as possible and ensures compliance with business immigration requirements. | 1315 Volunteer MIYCN policy and technical experts deployed | L = 2 I = 1 | N/A |
| | Security risks surrounding the Zambia 2021 election could delay the implementation of project activities | <ul style="list-style-type: none"> CARE Zambia country office maintains a risk management plan that continually monitors and assesses risk of violence and instability surrounding elections. If security protocols need to be activated, project activities will be reviewed and adapted to ensure the greatest degree of continuity for SANI programming. | All outcomes | N/A | L = 2 I = 3 |
| Financial Risks | | | | | |
| | Fund misuse or mismanagement | <ul style="list-style-type: none"> CARE maintains rigorous financial controls (procurement policies, minimizing cash transactions) and whistleblowing policies, which are regularly updated. | All outcomes | | |
| | Recent trend of hyperinflation local market is that is increasing costs and affecting the CAD/USD exchange rate and can impact programming. | <ul style="list-style-type: none"> CARE procures as much as possible in USD and monitor costs of goods on the market closely. | All outcomes | L = 2 I = 3 | L = 2 I = 3 |
| Development Risks | | | | | |
| | There is a risk that drought, pests, disease, or other natural disasters will affect our ability to achieve nutrition results due to decreased diversity and availability of food | <ul style="list-style-type: none"> CARE Country Offices monitor early warning detection and links with emergency preparedness sections Resiliency strategies in support of climate smart agriculture built into Project design | 1220 Women and men are able to produce, store, preserve and process high nutrient food for women of reproductive age and boys and girls U5 | L = 3 I = 3 | L = 3 I = 3 |

| Risk Name | Risk Definition | Risk Response | Investment Logic Model Result Statement | Risk Level | |
|---------------------------|---|--|---|----------------|----------------|
| | There is a risk that existing gender division of labour, social norms and stereotypes are deeply entrenched, and may affect not only the rate of change but the degree to which women, girls, men and boys are able to avail themselves of Project assets and benefits | <ul style="list-style-type: none"> Conduct Social Analysis and Action community dialogues to identify and address gender-based barriers to improving nutrition Deliberate engagement of men on maternal, infant and young child education Gender specialist Country Offices and Gender Project Officer C/Canada to implement and monitor gender strategy | <p>1110 Increased knowledge of gender-sensitive maternal, infant and young child nutrition and caregiving practices for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia</p> <p>All outcomes</p> | L = 3 I = 3 | L = 3 I = 3 |
| | There is a risk of increased exposure to existing GBV related risks/burden, SEA, or marginalization of survivors. | <ul style="list-style-type: none"> CARE will follow 'Do no Harm' principles and work with district and community structures, organizations, and HFs to raise awareness about GBV risks and ensure that project stakeholders are aware of referral pathways. CARE will also uphold its PSHEA-CP policy. | All outcomes | N/A | L = 3 I = 3 |
| | Government departments at the Provincial and District levels do not have the capacity in terms of resources and skills to support the program at scale | <ul style="list-style-type: none"> Project planning will be conducted in collaboration with relevant Provincial and District departments Project will undertake capacity building activities such as training and mentoring through volunteers to support government employees | <p>1300 Strengthened governance and accountability of gender- equitable nutrition policies and programs for women of reproductive age and boys and girls under 5 in Malawi, Mozambique and Zambia</p> | L = 2 I = 2 | L = 1 I = 2 |
| | <p>Disregard for COVID-19 protocols increase risk to CARE staff and beneficiaries and others</p> <p>COVID-19 hazard and risks concerns result in anxiety, stress, and inability to participate in project activities</p> <p>Risk of another wave that reduces implementation capacity</p> | <ul style="list-style-type: none"> CARE country offices adhere to national COVID-19 prevention measures and restrict work with persons with disregard for protocols. CARE staff share adequate information and communication on safety protocols observed during project activities. CARE monitors COVID-19 rates closely, and regularly adapts implementation plans to capitalize on periods of reduced risk of transmission. In the event that new restrictions prevent staff movement or in-person gatherings, contingency activity plans will be activated – these may include reducing staff travel, shifting gatherings to online or telephone meetings, or reducing numbers of people at gatherings. | <p>All outcomes</p> <p>All outcomes</p> <p>All outcomes</p> | N/A | L = 3 I = 3 |
| Reputational Risks | | | | | |

| Risk Name | Risk Definition | Risk Response | Investment Logic Model Result Statement | Risk Level | |
|-----------|--|--|---|----------------|----------------|
| | Canadian stakeholders and public may not support the project | <ul style="list-style-type: none"> • CARE Canada will develop public engagement strategy for both the GROW and Southern African Regional Initiative projects • Ongoing media engagement with regards to specific crisis (e.g., El Nino) • CARE maintains a well-organized communications strategy led by CARE International | 1411 Canadian public outreach activities conducted | L = 1 I = 2 | L = 1 I = 2 |

Annex 3: Annex on Outputs and Outcomes:

Annex 3.1.1: Outcome Reporting Matrix - Malawi

| PROJECT TITLE | Southern African Nutrition Initiative - SANI | Project No. | 7062252 D-002000 | EXECUTING AGENCY: CARE Canada |
|---|---|--|---|---|
| COUNTRY/REGIONS | Malawi | BUDGET | \$29,487,135 CAD | DURATION: 6 years (2016-2022) |
| Indicators | Baseline | Target | Actual data (cumulative) | Analysis of Progress/Variance |
| Ultimate Outcome 1000 | | | | |
| Increased knowledge of gender-sensitive MIYCN and caregiver practices for mothers, pregnant women, newborns and children U5 in Southern Africa | | | | |
| Wasting: % of boy and girl children 6 up to 59 months with weight-for-length < - 2 sd | girls: 3% (n=9/d=296) boys: 4% (n=11/d=259) | 5% decrease girls: 2.9% boys: 3.8% | girls: 2% (n=6/d=302) boys: 4% (n=12/d=299) | girls: difference not statistically significant boys: difference not statistically significant |
| Stunting: % of boy and girl children 6 up to 59 months with height-for-age < - 2 sd | girls: 34% (n=101/d=297) boys: 43% (n=113/d=263) | 5% decrease girls: 32% boys: 41% | girls: 35% (n=106/d=302) boys: 46% (n=138/d=300) | girls: difference not statistically significant boys: difference not statistically significant |
| % of women with MUAC <23 cm | 2% (n=12/d=707) | 5% decrease 1.90% | 372% increase | Target not achieved |
| Intermediate Outcome 1100 | | | | |
| Improved nutrition practices and services of women of reproductive age and boys and girls under 5 in Malawi | | | | |
| % of children 6-23 months with MAD by meeting MMF and MDD in the previous 24 hours | girls: 7% (n=16/d=207) boys: 7% (n=16/d=201) | 8pp increase girls: 15% boys: 15% | Girls: 31% (n=68/d=218) Boys: 31% (n=61/d=97) | Girls: 207% of project target Boys: 207% of project target |
| % of children 0-5 months who are exclusively breastfed | Malawi:68% (n=100/d=147) | 10% increase Malawi: 75% | 86% (n=136/158) | Malawi: 115% of project target |
| Immediate Outcome 1110 | | | | |
| Increased knowledge of gender-sensitive maternal, infant and young child nutrition and caregiving practices for women of reproductive age and boys and girls under 5 in Malawi | | | | |
| % change in knowledge of men and women of MIYCN practices | men: 79% (n=417/d=526) | 10% increase men: 87% | Men: 85% (n=325/d=382) | Men: 98% of project target |

| | | | | |
|---|---|---|---|--|
| | women:90% (n=640/d=708) | women: 99% | Women: 94% (n=724/d=770) | Women: 95% of project target |
| Immediate Outcome 1120 | Improved skills of Health Care Workers and Community Health Workers to deliver quality MIYCN counseling and treatment for acute malnutrition | | | |
| % of women, boys and girls U5 completing CMAM treatment | N/A | >85% | 97% | 114% of project target |
| % of women, boys and girls U5 recovered from acute malnutrition | N/A | >75% | 94% | 125% of project target |
| % change in satisfaction of services | N/A | 10% increase | 24% | 240% of project target |
| Intermediate Outcome 1200 | Improved maternal, infant and young child nutrition and gender sensitive practices for women of reproductive age and boys and girls under 5 in Malawi | | | |
| % of women and children (boys and girls) 6 – 23 months who meet minimum diet diversity | women: 18% (n=130/d=708) girls: 12% (n=27/d=207) boys: 13% (n=25/d=201) | Women: 30% (12pp increase) Girls: 20% (8pp increase) Boys: 21% (8pp increase) | Women: 68% (n=524/d=770) girls: 43% (n=106/d=247) boys: 38% (n=83/d=219) | women: 226% of project target girls: 215% of project target boys: 181% of project target |
| % of men and women using improved drinking water sources (piped on premises or other improved drinking water sources) | Malawi: 77% n=543/d=708 | 10% increase Malawi: 85% | 92% (n=708/770) | 108% of project target |
| Immediate Outcome 1210 | Increased access of women of reproductive age and boys and girls U5 to hygiene and sanitation facilities and safe drinking water for domestic and productive use | | | |
| # and % of communities ODF | N/A | 80% of communities | 100% (4 TAs all certified) | 125% of project target |
| % of boys and girls under five with diarrhea | girls: 54% (n=197/d=366) boys: 54% (n=183/d=342) | Malawi: 9pp decrease girls: 45% boys: 45% | girls: 34% (n=130/d=383) boys: 36% (n=139/d=387) | girls: 20pp decrease (222% of project target) boys: 18pp decrease (200% of project target) |
| % of women with access to safe drinking water | Malawi: 31% (n=219/d=708) | 10% increase Malawi: 34% | 41% (n=318/d=770) | 121% of project target |
| Immediate Outcome 1220 | Increased ability of women and men to produce, store, preserve and process high nutrient food for women of reproductive age and boys and girls U5 | | | |
| # of HHs with improved homestead gardens | N/A | Malawi: 3500 | 4, 105 | 117% |
| Immediate Outcome 1230 | Improved attitudes of women and men toward gender issues that influence nutrition practices for women of reproductive age and boys and girls under 5 | | | |

| | | | | |
|--|--|------------------------------|--|------------------------|
| % of VSLA members who are female | N/A | >70% of VSLA members | 18,267 (4047m, 14220f) | 111% |
| % change in attitudes of men and women toward gender issues that influence nutrition practices | | 10% increase | 50% (n=311/d=626) | 109% of project target |
| | Malawi: 42% n=269/d=628) | Malawi: 46% | | |
| Intermediate Outcome 1300 | Strengthened governance and accountability of gender-equitable nutrition policies and programs for women of reproductive age and boys and girls under 5 | | | |
| % of NCC members and NCC leaders who are female | N/A | 30% of members / leaders | 30% | 100% |
| % of District Nutrition Coordinating Committees with good governance practices in place that feed into national policy | N/A | 80% of DNCCs | 100% | 125% of project target |
| Immediate Outcome 1310 | Improved ability of regional, national, district governments and stakeholders to plan and scale up gender-sensitive evidenced-based MIYCN | | | |
| % of districts with gender- sensitive multi-sectoral joint action plans | N/A | 80% of districts and regions | 100% | 125% of project target |
| # of gender-sensitive nutrition policies and programs drafted for WRA, PLW and boys and girls U5 with project support | N/A | 2/districts | 3 policies implemented in both districts | 150% of project target |
| Immediate Outcome 1320 | Improved responsiveness of health service providers for gender-sensitive MIYCN and global acute malnutrition | | | |
| % change in CSC | N/A | 10% increase | 25% | 250% of project target |

Annex 3.1.2: Outcome Reporting Matrix – Mozambique

| PROJECT TITLE | Southern African Nutrition Initiative - SANI | Project No. | 7062252 D-002000 | EXECUTING AGENCY: CARE Canada |
|---|---|--|---|--|
| COUNTRY/REGIONS | Mozambique | BUDGET | \$29,487,135 CAD | DURATION: 6 years (2016-2022) |
| Indicators | Baseline | Target | Actual data (cumulative) | Analysis of Progress/Variance |
| Ultimate Outcome 1000 | Increased knowledge of gender-sensitive MIYCN and caregiver practices for mothers, pregnant women, newborns and children U5 in Southern Africa | | | |
| Wasting: % of boy and girl children 6 up to 59 months with weight-for-length < - 2 sd | girls: 7% (n=34/d=513) boys: 7% (n=32/d=475) | 5% decrease girls: 6.7% boys: 6.7% | N/A | N/A as explained in the Endline Briefing Report submitted to GAC Oct. 2020 |
| Stunting: % of boy and girl children 6 up to 59 months with height-for-age < - 2 sd | girls:26% (n=135/d=513) boys:34% (n=161/d=475) | 5% decrease girls: 25% boys: 32% | N/A | N/A as explained in the Endline Briefing Report submitted to GAC Oct. 2020 |
| % of women with MUAC <23 cm | | 5% decrease | N/A | N/A as explained in the Endline Briefing Report submitted to GAC Oct. 2020 |
| | Mozambique: 2% (n=26/d=1262) | Mozambique: 1.9% | | |
| Intermediate Outcome 1100 | Improved nutrition practices and services of women of reproductive age and boys and girls under 5 in Mozambique | | | |
| % of children 6-23 months with MAD by meeting MMF and MDD in the previous 24 hours | girls: 3% (n=10/d=362) boys: 1% (n=4/d=311) | Mozambique: 9pp increase girls:12% boys:10% | girls: 3% (n=2/d=75) boys: 1.5% (n=1/d=65) | girls: 25% of project target boys: 15% of project target |
| % of children 0-5 months who are exclusively breastfed | Mozambique: 65% (n=157/d=243) | 10% increase Mozambique: 72% | Mozambique: : 82% | Mozambique: 114% of project target |
| Immediate Outcome 1110 | Increased knowledge of gender-sensitive maternal, infant and young child nutrition and caregiving practices for women of reproductive age and boys and girls under 5 in Mozambique | | | |
| % change in knowledge of men and women of MIYCN practices | men: 53% (n=111/d=210) women:59% (n=745/d=1262) | 10% increase men: 58% women: 65% | Men: N/A Women: 71% (n=102/d=143) | men: NA [1] Women: 109% of project target |
| Immediate Outcome 1120 | Improved skills of Health Care Workers and Community Health Workers to deliver quality MIYCN counseling and treatment for acute malnutrition | | | |

| | | | | |
|---|---|--|--|--|
| % of women, boys and girls U5 completing CMAM treatment | N/A | >85% | Mozambique: 92% (61/66) | 108% of project target |
| % of women, boys and girls U5 recovered from acute malnutrition | N/A | >75% | Mozambique: 100% (66/66) | Mozambique: 115% of project target |
| % change in satisfaction of services | N/A | 10% increase | Mozambique: 1% increase | 10% of project target |
| Intermediate Outcome 1200 | Improved maternal, infant and young child nutrition and gender sensitive practices for women of reproductive age and boys and girls under 5 in Mozambique | | | |
| % of women and children (boys and girls) 6 – 23 months who meet minimum diet diversity | women: 21% (n=260/d=1262) | Women: 30% (9pp increase) | women:22% (n=31/d=143) | women: 73% of project target |
| | girls: 13% (n=46/d=362) boys: 8% (n=24/d=311) | Girls: 20% (7pp increase) Boys: 15% (7pp increase) | Girls: 8% (n=6/d=75) boys: 11% (n=7/d=65) | girls: 40% of project target boys: 73% of project target |
| % of men and women using improved drinking water sources (piped on premises or other improved drinking water sources) | Mozambique: 66% (n=834/d=1262) | 10% increase Mozambique: 73% | 69% (n=99/d=144) | Mozambique: 90% of project target |
| Immediate Outcome 1210 | Increased access of women of reproductive age and boys and girls U5 to hygiene and sanitation facilities and safe drinking water for domestic and productive use | | | |
| # and % of communities ODF | N/A | 80% of communities | 4 /46 communities | 9% of project target |
| % of boys and girls under five with diarrhea | Mozambique: girls: 20% (n=129/d=640) boys: 19% (n=116/d=622) | Mozambique: 5pp decrease girls: 15% boys: 14% | girls: 15% (n=11/d=75) boys: 10% (n=6/d=62) | girls: 100% of project target boys 180% of project target |
| % of women with access to safe drinking water | Mozambique: 8% (n=99/d=1262) | 10% increase Mozambique: 9% | 25% (n=38/d=134) | Mozambique: 278% of project target |
| Immediate Outcome 1220 | Increased ability of women and men to produce, store, preserve and process high nutrient food for women of reproductive age and boys and girls U5 | | | |
| # of HHs with improved homestead gardens | N/A | Mozambique: 1500 | 846 | 56.4% of project target |
| Immediate Outcome 1230 | Improved attitudes of women and men toward gender issues that influence nutrition practices for women of reproductive age and boys and girls under 5 | | | |
| % change in attitudes of men and women toward gender issues that influence nutrition practices | Mozambique: 70% (n=657/d=943) | 10% increase Mozambique: 77% | Mozambique: 53% | Mozambique: 69% of project target |
| Intermediate Outcome 1300 | Strengthened governance and accountability of gender-equitable nutrition policies and programs for women of reproductive age and boys and girls under 5 | | | |

| | | | | |
|--|--|------------------------------|-------------------------------|---------------------------|
| % of DNCC members and DNCC leaders who are female | N/A | 30% of members / leaders | 17/44 female - 38% | 127% of project target |
| % of District Nutrition Coordinating Committees with good governance practices in place that feed into national policy | N/A | 80% of DNCCs | 2/2 DNCC's 100% | 125% of project target |
| Immediate Outcome 1310 | Improved ability of regional, national, district governments and stakeholders to plan and scale up gender-sensitive evidenced-based MIYCN | | | |
| % of districts with gender-sensitive multi-sectoral joint action plans | N/A | 80% of districts and regions | 2/2 DNCC's 100% | 125% of project target |
| # of gender-sensitive nutrition policies and programs drafted for WRA, PLW and boys and girls U5 with project support | N/A | 2/districts | 1 | 50% of the project target |
| Immediate Outcome 1320 | Improved responsiveness of health service providers for gender-sensitive MIYCN and global acute malnutrition | | | |
| % change in CSC | N/A | 10% increase | 8% = $(2.78 - 2.571) / 2.571$ | 80% of project target |

Annex 3.1.3: Outcome Reporting Matrix – Zambia

| PROJECT TITLE | Southern African Nutrition Initiative - SANI | Project No. | 7062252 D-002000 | EXECUTING AGENCY: CARE Canada |
|---|---|---|---|--|
| COUNTRY/REGIONS | Zambia | BUDGET | \$29,487,135 CAD | DURATION: 6 years (2016-2022) |
| Indicators | Baseline | Target | Actual data (cumulative) | Analysis of Progress/Variance |
| Ultimate Outcome 1000 | Increased knowledge of gender-sensitive MIYCN and caregiver practices for mothers, pregnant women, newborns and children U5 in Southern Africa | | | |
| Wasting: % of boy and girl children 6 up to 59 months with weight-for-length < - 2 sd | girls: 5% (n=16/d=297) boys: 7% (n=20/d=284) | 5% decrease girls: 4.8% boys: 6.7% | N/A | N/A as explained in the Endline Briefing Report submitted to GAC Oct. 2020 |
| Stunting: % of boy and girl children 6 up to 59 months with height-for-age < - 2 sd | girls: 42% (n=126/d=300) boys: 50% (n=144/d=288) | 5% decrease girls: 40% boys: 48% | N/A | N/A as explained in the Endline Briefing Report submitted to GAC Oct. 2020 |
| % of women with MUAC <23 cm | Zambia: 10% (n=76/d=735) | 5% decrease Zambia: 9.5% | N/A | N/A as explained in the Endline Briefing Report submitted to GAC Oct. 2020 |
| Intermediate Outcome 1100 | Improved nutrition practices and services of women of reproductive age and boys and girls under 5 in Zambia | | | |
| % of children 6-23 months with MAD by meeting MMF and MDD in the previous 24 hours | girls: 17% (n=40/d=225) boys: 24% (n=52/d=218) | Zambia: 6pp increase girls: 23% boys: 30% | girls: 30% (n=52/d=172) boys: 31% (n=54/d=172) | girls: 130% of project target boys: 103% of project target |
| % of children 0-5 months who are exclusively breastfed | Zambia: 70% (n=101/d=145) | 10% increase Zambia: 77% | Zambia: 85% (n=105/d=124) | Zambia: 110% of project target |
| Immediate Outcome 1110 | Increased knowledge of gender-sensitive maternal, infant and young child nutrition and caregiving practices for women of reproductive age and boys and girls under 5 in Zambia | | | |
| % change in knowledge of men and women of MIYCN practices | men: 72% (n=411/d=573) | 10% increase men: 79% | men: 86% (n=99/d=115) women: 92% (n=433/d=471) | men: 109% of project target women: 105% of project target |
| | women: 80% (n=588/d=735) | women: 88% | | |

| Immediate Outcome 1120 | Improved skills of Health Care Workers and Community Health Workers to deliver quality MIYCN counseling and treatment for acute malnutrition | | | |
|---|--|--|--|--|
| % of women, boys and girls U5 completing CMAM treatment | N/A | >85% | Zambia: 95% (175/183) | Zambia: 113% of project target |
| % of women, boys and girls U5 recovered from acute malnutrition | N/A | >75% | Zambia: 75% (137/183) | Zambia: 100% of project target |
| % change in satisfaction of services | N/A | 10% increase | 26% increase | Zambia: 260% of project target |
| Intermediate Outcome 1200 | Improved maternal, infant and young child nutrition and gender sensitive practices for women of reproductive age and boys and girls under 5 in Zambia | | | |
| % of women and children (boys and girls) 6 – 23 months who meet minimum diet diversity | women: 57% (n=413/d=735) girls: 37% (n=83/d=225) | Women: 65% (8pp increase) Girls: 41% (4pp increase) | Women: 77% (n=362/d=471) girls: 56% (n=96/d=172) boys: 55% (=95/d=172) | Women: 118% of project target girls:136% of project target boys:131% of project target |
| | boys: 38% (n=84/d=218) | Boys: 42% (4pp increase) | | |
| % of men and women using improved drinking water sources (piped on premises or other improved drinking water sources) | Zambia: 29% (n=217/d=735) | 10% increase Zambia: 32% | 48% | 150% of project target |
| Immediate Outcome 1210 | Increased access of women of reproductive age and boys and girls U5 to hygiene and sanitation facilities and safe drinking water for domestic and productive use | | | |
| # and % of communities ODF | N/A | 80% of communities | 139/409 villages | 32% of project target |
| % of boys and girls under five with diarrhea | girls: 24% (n=90/d=379) boys: 24% (n=86/d=356) | Zambia: 6pp decrease girls: 18% boys: 18% | girls: 21% (n=48/d=234) boys: 20% (N=48/d=237) | Girls: 3pp decrease (50% of project target) Boys: 4pp decrease (67% of project target) |
| % of women with access to safe drinking water | Zambia: 24% (n=179/d=735) | 10% increase Zambia: 26% | Zambia: 74% (n=348/d=471) | 285% of project target |
| Immediate Outcome 1220 | Increased ability of women and men to produce, store, preserve and process high nutrient food for women of reproductive age and boys and girls U5 | | | |
| # of HHs with improved homestead gardens | N/A | Zambia: 2500 | 3,185 | 127% of project target |
| Immediate Outcome 1230 | Improved attitudes of women and men toward gender issues that influence nutrition practices for women of reproductive age and boys and girls under 5 | | | |
| % change in attitudes of men and women toward gender issues that influence nutrition practices | | 10% increase | 42% (22% wife + 20% both husband and wife)[1] | 116% of the target* |

| | | | | |
|--|--|------------------------------|-----------------------|------------------------|
| | Zambia: 33% n=147/d=451) | Zambia: 36% | | |
| Intermediate Outcome 1300 | Strengthened governance and accountability of gender-equitable nutrition policies and programs for women of reproductive age and boys and girls under 5 | | | |
| % of DNCC members and DNCC leaders who are female | N/A | 30% of members / leaders | (44/123) 36% | 120% of project target |
| % of District Nutrition Coordinating Committees with good governance practices in place that feed into national policy | N/A | 80% of DNCCs | 3/3 Districts 100% | 125% of project target |
| Immediate Outcome 1310 | Improved ability of regional, national, district governments and stakeholders to plan and scale up gender-sensitive evidenced-based MIYCN | | | |
| % of districts with gender- sensitive multi-sectoral joint action plans | N/A | 80% of districts and regions | 3/3 Districts 100% | 125% of project target |
| # of gender-sensitive nutrition policies and programs drafted for WRA, PLW and boys and girls U5 with project support | N/A | 2/districts | 1/2(50%) | 50% of project target |
| Immediate Outcome 1320 | Improved responsiveness of health service providers for gender-sensitive MIYCN and global acute malnutrition | | | |
| % change in CSC | N/A | 10% increase | 7%= (3.89-3.55)/3.55 | 70% of project target |

Annex 3.2.1: Output Reporting Matrix – Malawi

| IMMEDIATE OUTCOME 1110 | | | |
|---|---------------------------------|-----------------------------------|--|
| Output 1111: Female and male Community Health Workers trained on gender-sensitive maternal, infant and young child nutrition | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of CHWs trained on gender-sensitive MIYCN | 113 (79 male, 34 female) | 226(146m, 80f) | 200% |
| # of trainings conducted for CHWs gender-sensitive MIYCN | 7 trainings | 6 trainings | 86% |
| Variance Explanation | | | |
| SANI Malawi surpassed the target due to a request for additional CHW to be trained by the MoH. A larger number of CHWs were trained in fewer training cohorts. | | | |
| Output 1112: Female and male Community Health Care workers and groups trained on Growth Monitoring and Promotion | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of GMPs trained on Growth Monitoring and Promotion | 226 GMVs (102 male, 124 female) | 226(146m,80f) | 100% |
| # of trainings conducted for CHWs on Growth Monitoring and Promotion | 6 trainings | 6 trainings | 100% |
| Output 1113: Gender-sensitive cooking and feeding demonstrations conducted at community level by Community Health Workers and community groups | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of cooking and feeding demonstrations conducted | 678 demonstrations | 1187 demonstrations | 175% |
| # of trainings on cooking and feeding demonstrations conducted | 36 trainings | 8 trainings | 22% |
| Variance Explanation | | | |
| Only 8 Cooking Demonstration trainings were conducted to reach 376 (106f, 217m) volunteers, which was determined by the project team as a sufficient number of volunteers to carry out the number of demonstrations targeted by the project. | | | |
| Output 1114: Gender-sensitive community MIYCN awareness initiatives conducted through radio, theatre, religious and other community groups | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and type of gender-sensitive community awareness initiatives conducted | 60 PET performances | 722 PET performances | 1203% |
| Variance Explanation | | | |
| SANI Malawi surpassed the project target of PET performances due to a change in implementation strategy: groups were trained in smaller geographical locations than initially planned to ease PET groups' reach in communities. This resulted in far more performances than targeted. | | | |

| IMMEDIATE OUTCOME 1120 | | | |
|---|---|-----------------------------------|--|
| Output 1121: Female and male Health Care Workers trained on gender-sensitive maternal, infant and young child nutrition | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of HCWs trained on gender-sensitive MIYCN disaggregated by cadre | 113 HCWs (43 male, 70 female) | 199 HCWs (121m, 78f) | 176% |
| # of trainings for HCWs conducted on gender-sensitive MIYCN | 4 trainings | 6 trainings | 150% |
| Variance Explanation | | | |
| Achieved in Y4. CARE conducted MIYCN refresher training to HCWs and VNCC members to share knowledge on MIYCN and support supervision, monitoring and coaching of Care Promoters on the same modules. | | | |
| Output 1122: Female and male Health Care Workers, Community Health Care Workers, Growth Monitoring Promoters and Nutrition staff trained on gender-sensitive CMAM/IMAM | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and type of men and women trained in CMAM/IMAM | 125 (87 male, 38 female) | 163(84m,79f) | 130% |
| # of trainings conducted on CMAM/ IMAM | 4 trainings | 4 trainings | 100% |
| Variance Explanation | | | |
| Target was over-achieved. Training on ICT referral tools was dropped in Y4 because CARE supported only 4 TAs, but District Officials opposed this activity if it was not possible to reach all TAs in Malawi. | | | |
| Output 1123: Female and male nutrition staff trained and mentored on collection and analysis of sex disaggregated health information system | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of nutrition staff trained and mentored on collection and analysis of sex disaggregated HIS | 125 (87 male, 38 female) | 376 (217m,159f) | 300% |
| # of trainings conducted for nutrition staff on collection and analysis of sex disaggregated HIS | 4 trainings | 10 trainings | 40% |
| Variance Explanation | | | |
| Achieved in Y3. Though activities were planned for Y4, they were dropped as the main data management challenges in Ntchisi and Dowa are outside the scope and capacity of SANI project. | | | |
| IMMEDIATE OUTCOME 1210 | | | |
| Output 1211: Nutrition and gender sensitive CLTS implemented in selected communities | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of community members trained on CLTS | 450 community leaders (360 male, 90 female) | 467 (254m,213f) | 103% |

| | | | |
|---|---|-----------------------------------|--|
| # of gender issues related to hygiene and sanitation addressed through CLTS | 2 per district | 2 | 100% |
| Variance Explanation | | | |
| This output had a delayed start-up but was achieved in Y4 with activities modified: to support CLTS triggering in selected GVS and holding quarterly review meetings with Village Health Committees (VHCs) in triggered communities to assess progress and facilitate corrective actions. | | | |
| Output 1212: Functionality and sustainability of existing water points assessed | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of villages mapped and assessed | 100 | 2,149 | 2149% |
| # and sex of community members trained on community water point mapping an action planning | 1,000 VHC members (700 male,300 female) | 1,085 (700m, 385f) | 108% |
| Variance Explanation | | | |
| Achieved in Y3 and activities continued in Y3. CARE continued to monitor 120 WPCs to ensure progress towards developed action plan. | | | |
| Output 1214: Male and female water committee members trained on water point management and maintenance | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of WPC members trained on water point management and maintenance | Malawi: 96 WPC members (50 male, 46 female) | 180 (100m,80 f) | 187% |
| Variance Explanation | | | |
| This output was dependent on 1212 and 1213 and was overachieved in Y4 with all WPC members trained on water point management and maintenance. | | | |
| IMMEDIATE OUTCOME 1220 | | | |
| Output 1221: Farmer groups established or strengthened | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # farmer groups established or strengthened | 90 farmer groups | 180 farmer groups | 200% |
| # and sex of farmer group members | 3500 (1400 male, 2100 female) | 4,105 (1768m,2337f) | 117% |
| Variance Explanation | | | |
| Achieved in Y3. Farmer groups are the channel through which agricultural advice and coaching is made more available to a larger number of farmers. | | | |
| Output 1222: Female and male Agritex officers, Farmers field schools and VSLA members trained and mentored on nutrition-sensitive climate-smart agriculture | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of Agritex officers, farmer field school members, VSLA members trained on nutrition-sensitive climate-smart agriculture | 3,740 (1580 male, 2160 male) | 4,105 (1,768m, 2,337f) | 109% |

| | | | |
|--|--|-----------------------------------|--|
| # and (vulnerability) type of HHs provided with appropriate agricultural inputs disaggregated by sex | 3,500 HHs | 4,105 HHs (1,768m, 2,337f) | 117% |
| # of farmers field schools established or strengthened | 90 farmer field schools | 180 FFS | 200% |
| Variance Explanation | | | |
| Achieved in Y3. A cascade model was used for trainings so that the Lead Farmers, who were trained by government agriculture extension workers, trained Agritex officers, farmer club members, VSLA members on nutrition-sensitive climate-smart agriculture and these trainings are carried on down to other farmers in the communities. | | | |
| Output 1223: Nutrition and gender-sensitive home gardens and school demonstration plots established using climate-smart agriculture | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of home garden demonstration plots established | 90 plots | 180 | 200% |
| Variance Explanation | | | |
| Output 1223 was achieved during Y2 of the project, though continued progress was made in Year 3. | | | |
| IMMEDIATE OUTCOME 1230 | | | |
| Output 1231: VSLA groups established or strengthened | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # VSLA groups established or strengthened | 900 VSLA groups | 846 | 94% |
| # and sex of VSLA group members | 18,000 VSLA members (3600 male, 14400 female) | 18267 (4047m, 14220f) | 101% |
| Variance Explanation | | | |
| The target number for VSLA groups was not reached, though the number of VSLA participants targeted was reached in a smaller number of groups. | | | |
| Output 1232: Community dialogue on gender norms and behaviors related to intra-HH distribution of food, resources and assets conducted | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of community dialogues conducted | 226 dialogues | 1,868 dialogues | 826% |
| Variance Explanation | | | |
| Gender dialogue sessions were integrated into multiple project activities such as cooking demonstrations and open days. Additionally, community volunteers developed such a passion for SAA that Care Promoters wanted to increase the frequency of dialogues and every Care Promoter conducted one per month. | | | |
| IMMEDIATE OUTCOME 1310 | | | |
| Output 1311: New or existing inter-sectoral, MIYCN committees meet regularly | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of inter-sectoral MIYCN committee meetings conducted | 44 meetings | 52 | 118% |
| Variance Explanation | | | |

| | | | |
|--|--------------------------------------|-----------------------------------|--|
| Achieved in Y3. CARE continued to attend monthly DNCC and DEC meetings until end of Y4. | | | |
| Output 1312: Gender and nutrition sensitive research conducted | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of gender and nutrition-sensitive MIYCN issues researched | 2 topics | 2 | 100% |
| Variance Explanation | | | |
| CARE Malawi, in collaboration with CSONA conducted lobbying meetings with relevant ministries (Department of Nutrition and HIV/AIDS, and Ministry of Finance.) | | | |
| Output 1313: Gender sensitive MIYCN policy briefs developed and disseminated | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of gender-sensitive MIYCN policy briefs disseminated | 2 briefs per country | 2 | 100% |
| Output 1314: Nutrition policy consultations and workshops held at the regional and national levels | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of nutrition consultations and workshops held at regional and national levels | 2 workshops | 2 | 100% |
| Output 1315: Volunteer MIYCN policy and technical experts deployed | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of volunteer technical experts placed in target countries | 25 volunteers across 3 countries | 35 | 140% |
| # of nutrition consultations and workshops held at regional and national levels | 2 local partners | 2 | 100% |
| IMMEDIATE OUTCOME 1320 | | | |
| Output 1321: Facilitators trained on gender inclusive, participatory Community Score Cards | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of m/f facilitators trained on gender-inclusive participatory CSC | 60 facilitators (24 male, 36 female) | 152 facilitators (71m,81f) | 253% |
| Variance Explanation | | | |
| Achieved in Y3, and over-achieved as it was determined important to train facilitators in pairs. | | | |
| Output 1322: Gender-inclusive MIYCN Community Score Card cycle implemented in health center catchment areas | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of gender-sensitive MIYCN community scorecard interface meetings conducted | 48 meetings | 34 meetings | 71% |
| # of gender-specific items per scorecard | 6 items in total | 5 items | 83% |
| # of gender-sensitive MIYCN CSC action plans implemented | 16 CSC action plans | 20 CSC action plans | 125% |

Annex 3.2.2: Output Reporting Matrix – Mozambique

| IMMEDIATE OUTCOME 1110 | | | |
|---|---------------------------------|-----------------------------------|--|
| Output 1111: Female and male Community Health Workers trained on gender-sensitive maternal, infant and young child nutrition | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of CHWs trained on gender-sensitive MIYCN | 265 CHWs (115 male, 150 female) | 346 CHWs (116m, 260f) | 131% |
| # of trainings conducted for CHWs gender-sensitive MIYCN | 12 trainings | 42 trainings | 350% |
| Variance Explanation | | | |
| 290 CHWs received training in Y3, and 9 trainings took place in Y4. | | | |
| Output 1112: Female and male Community Health Care workers and groups trained on Growth Monitoring and Promotion | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of GMPs trained on Growth Monitoring and Promotion | 265 GMPs (115 male, 150 female) | 346 GMPs (116m, 260f) | 131% |
| # of trainings conducted for CHWs on Growth Monitoring and Promotion | 2 trainings | 42 trainings | 350% |
| Variance Explanation | | | |
| Training of CHWs on GMP was a core focus of the nutrition-specific strategy in Mozambique, so additional training was held to reach a higher number of CHW | | | |
| Output 1113: Gender-sensitive cooking and feeding demonstrations conducted at community level by Community Health Workers and community groups | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of cooking and feeding demonstrations conducted | 56 demonstrations | 60 demonstrations | 107% |
| # of trainings on cooking and feeding demonstrations conducted | 8 trainings | 16 trainings | 200% |
| Variance Explanation | | | |
| Additional training on cooking and feeding demonstrations was carried out to ensure enough facilitators to carry out the required number of demonstrations. | | | |
| Output 1114: Gender-sensitive community MIYCN awareness initiatives conducted through radio, theatre, religious and other community groups | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and type of gender-sensitive community awareness initiatives conducted | 54 radio spots | 46 radio spots | 85% |
| Variance Explanation | | | |
| Funhalouro community radio station experienced technical difficulties and eventually closed In January 2020, dissemination of messages were suspended in this area. | | | |

| IMMEDIATE OUTCOME 1120 | | | |
|---|----------------------------|-----------------------------------|--|
| Output 1121: Female and male Health Care Workers trained on gender-sensitive maternal, infant and young child nutrition | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of HCWs trained on gender-sensitive MIYCN disaggregated by cadre | 28 HCWs (7 male/11 female) | 33 HCWs | 118% |
| # of trainings for HCWs conducted on gender-sensitive MIYCN | 12 trainings | 2 trainings | 17% |
| Variance Explanation | | | |
| Two trainings (over 5 days) were held in Homoine and Funhalouro respectively. This is the same training referenced in output 1122. | | | |
| Output 1122: Female and male Health Care Workers, Community Health Care Workers, Growth Monitoring Promoters and Nutrition staff trained on gender-sensitive CMAM/IMAM | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and type of men and women trained in CMAM/IMAM | 126 (50 male, 76 female) | 379 (248f, 131m) | 300% |
| # of trainings conducted on CMAM/ IMAM | 6 trainings | 46 | 767% |
| Variance Explanation | | | |
| In Y5, CARE and the provincial department visited HCs to monitor nutrition data, support district health technicians, and assess linkages between CHWs and health committees to Health Workers. 21 trainings were conducted thus surpassing the target. | | | |
| Output 1123: Female and male nutrition staff trained and mentored on collection and analysis of sex disaggregated health information system | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of nutrition staff trained and mentored on collection and analysis of sex disaggregated HIS | 45 (20 male, 25 female) | 5 | 11% |
| # of trainings conducted for nutrition staff on collection and analysis of sex disaggregated HIS | 3 trainings | 1 training | 33% |
| Variance Explanation | | | |
| Completed in Y3. Only SANI staff were trained on a new data management tool. | | | |
| IMMEDIATE OUTCOME 1210 | | | |
| Output 1211: Nutrition and gender sensitive CLTS implemented in selected communities | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of community members trained on CLTS | 350 (170 male, 180 female) | 381 | 109% |
| # of gender issues related to hygiene and sanitation addressed through CLTS | 2 per district | 2 per district | 100% |

| Output 1212: Functionality and sustainability of existing water points assessed | | | |
|--|-----------------------------------|-----------------------------------|--|
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of villages mapped and assessed | 31 | 55 | 177% |
| # and sex of community members trained on community water point mapping an action planning | 0 | N/A | N/A |
| Variance Explanation | | | |
| Review included consultations and meetings with local and government leaders as well as water committee members. | | | |
| Output 1213: Water points constructed or rehabilitated by community groups | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of water points rehabilitated or constructed | 24 | 24 | 100% |
| Output 1214: Male and female water committee members trained on water point management and maintenance | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of WPC members trained on water point management and maintenance | 350 (170 male, 180 female) | 240 (120m, 120 f) | 69% |
| Variance Explanation | | | |
| Completed in Y4 by WASH officer under DNCC. Only 4 Water Committees (WPCs) (240 members in total) were trained on maintenance and operation of water points. | | | |
| IMMEDIATE OUTCOME 1220 | | | |
| Output 1221: Farmer groups established or strengthened | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # farmer groups established or strengthened | 135 farmers groups | 66 farmer groups | 49% |
| # and sex of farmer group members | 4,050 (1,620 male, 2,430 female) | 1,960 (358m, 1,602f) | 48% |
| Variance Explanation | | | |
| Due to the drought, some farmer groups were suspended as members sought non-agricultural livelihoods, thus, CARE could only work with a limited number of groups. | | | |
| Output 1222: Female and male Agritex officers, Farmers field schools and VSLA members trained and mentored on nutrition-sensitive climate-smart agriculture | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of Agritex officers, farmer field school members, VSLA members trained on nutrition-sensitive climate-smart agriculture | 4050 (1620 male, 2430 female) | 1,973 (368m, 1605f) | 49% |
| # and (vulnerability) type of HHs provided with appropriate agricultural inputs disaggregated by sex | 371 HH's (148m, 223f) | 1,724 HHs (321m, 1403f) | 465% |
| # of farmers field schools established or strengthened | 135 farmer field schools | 66 FFS | 49% |
| Variance Explanation | | | |

| | | | |
|--|--------------------------|-----------------------------------|--|
| Training and mentorship in nutrition-sensitive climate smart agriculture was challenging due to lack of rain and access to technical assistance from government extension personnel and certified seeds. | | | |
| Output 1223: Nutrition and gender-sensitive home gardens and school demonstration plots established using climate-smart agriculture | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of home garden demonstration plots established | 70 plots | 106 plots | 151% |
| Variance Explanation | | | |
| Seeds were purchased and distributed to 20 new FFSs (10 in each district) in an effort to ensure that the curriculum was completed and to support households to adopt climate smart agriculture. | | | |
| IMMEDIATE OUTCOME 1230 | | | |
| Output 1232: Community dialogue on gender norms and behaviors related to intra-HH distribution of food, resources and assets conducted | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of community dialogues conducted | 225 dialogues | 284 dialogues | 126% |
| IMMEDIATE OUTCOME 1310 | | | |
| Output 1311: New or existing inter-sectoral, MIYCN committees meet regularly | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of inter-sectoral MIYCN committee meetings conducted | 44 meeting | 43 | 97% |
| Variance Explanation | | | |
| Due to COVID-19, these meetings were deemed non-essential and therefore suspended for a time. | | | |
| IMMEDIATE OUTCOME 1320 | | | |
| Output 1321: Facilitators trained on gender inclusive, participatory Community Score Cards | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of m/f facilitators trained on gender-inclusive participatory CSC | 112 (56 male, 56 female) | 29 | 26% |
| Variance Explanation | | | |
| CARE decided to train partner and CARE staff as main facilitators of CSC instead of training community facilitators as initially planned. | | | |
| Output 1322: Gender-inclusive MIYCN Community Score Card cycle implemented in health center catchment areas | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of gender-sensitive MIYCN community scorecard interface meetings conducted | 4 meetings | 8 meetings | 200% |
| # of gender-specific items per scorecard | 3 per CSC process | (10/12) per CSC process | 83% |
| # of gender-sensitive MIYCN CSC action plans implemented | 8 CSC action plans | 8 CSC action plans | 100% |
| Variance Explanation | | | |
| Gender inclusive maternal, infant, young child nutrition Community Score Card was successfully implemented in 4 health center catchment areas | | | |

Annex 3.2.3: Output Reporting Matrix – Zambia

| IMMEDIATE OUTCOME 1110 | | | |
|---|---------------------------------|-----------------------------------|--|
| Output 1111: Female and male Community Health Workers trained on gender-sensitive maternal, infant and young child nutrition | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of CHWs trained on gender-sensitive MIYCN | 50 (32 male, 18 female) | 212(126m, 86f) | 424% |
| # of trainings conducted for CHWs gender-sensitive MIYCN | 12 trainings | 8 trainings | 133% |
| Variance Explanation | | | |
| Achieved in Y3 and in Y4 SANI partnered with the MoH to conduct 3-day refresher trainings on MIYCN. | | | |
| Output 1112: Female and male Community Health Care workers and groups trained on Growth Monitoring and Promotion | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of GMPs trained on Growth Monitoring and Promotion | 210 GMPs (105 male, 105 female) | 224 (129m,95f) | 106% |
| # of trainings conducted for CHWs on Growth Monitoring and Promotion | 14 trainings | 8 trainings | 57% |
| Variance Explanation | | | |
| Partially achieved in Y3. HCWs training on GMP/CBGMP was dropped as focus shifted to SAA training of gender dialogue facilitators in Y4. | | | |
| Output 1113: Gender-sensitive cooking and feeding demonstrations conducted at community level by Community Health Workers and community groups | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of cooking and feeding demonstrations conducted | 1,800 demonstrations | 3,212 demonstrations | 178% |
| # of trainings on cooking and feeding demonstrations conducted | 14 trainings | 44 trainings | 314% |
| Variance Explanation | | | |
| Over-achieved in Y4 and continued in Y5. CHWs continued cooking demonstrations following COVID-19 guidelines. 6,905 people (5190w & 1715m) attended. | | | |
| Output 1114: Gender-sensitive community MIYCN awareness initiatives conducted through radio, theatre, religious and other community groups | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and type of gender-sensitive community awareness initiatives conducted | 64 radio spots | 71 | 111% |
| Variance Explanation | | | |
| Achieved in Y3. CARE worked with the Ministry of Health in Mpika after an approval from NFNC to adopt the MIYCN key messages into two languages (English and Bemba) in audio and air them on the local radio station in Mpika district. | | | |

| IMMEDIATE OUTCOME 1120 | | | |
|---|--|-----------------------------------|--|
| Output 1121: Female and male Health Care Workers trained on gender-sensitive maternal, infant and young child nutrition | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of HCWs trained on gender-sensitive MIYCN disaggregated by cadre | 56 HCWs (20 female, 36 male) | 31 HCWs (18f,13m) | 55% |
| # of trainings for HCWs conducted on gender-sensitive MIYCN | 2 trainings | 2 trainings | 100% |
| Variance Explanation | | | |
| Completed in Y3. This activity was revised following the completion of the initial training, as there was no identified gaps requiring additional training of HCW. | | | |
| Output 1122: Female and male Health Care Workers, Community Health Care Workers, Growth Monitoring Promoters and Nutrition staff trained on gender-sensitive CMAM/IMAM | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and type of men and women trained in CMAM/IMAM | 224 (104 m, 110 f) | 196 (102f,94m) | 88% |
| # of trainings conducted on CMAM/ IMAM | 14 trainings | 9 trainings | 64% |
| Variance Explanation | | | |
| Completed in Y4. CARE worked with the MoH to strengthen CMAM in HFs because previously the OTP was not active. CARE and the MoH addressed some of the gaps in the management of the OTP such as lack of capacity among HCWs and CHWs and weak data collection, compilation and reporting mechanisms. | | | |
| Output 1123: Female and male nutrition staff trained and mentored on collection and analysis of sex disaggregated health information system | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of nutrition staff trained and mentored on collection and analysis of sex disaggregated HIS | 60 (30 male, 30 female) | 32 (22f,10m) | 53% |
| # of trainings conducted for nutrition staff on collection and analysis of sex disaggregated HIS | 4 trainings | 2 trainings | 50% |
| Variance Explanation | | | |
| Activities were revised to focus on some of the gaps identified in MIS/M&E at district level. The identified gaps include under-reporting or double counting, inconsistent data and lack of data analysis and use by HCWs and CHWs. Additionally, activities were delayed in early 2018 because the MoH included new indicators on the GMP reporting form, for instance- stunting and wasting/obesity, in the HMIS data system. | | | |
| IMMEDIATE OUTCOME 1210 | | | |
| Output 1211: Nutrition and gender sensitive CLTS implemented in selected communities | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of community members trained on CLTS | 280 community members (100 female, 180 male) | 272 (61f, 11m) | 97% |
| # of gender issues related to hygiene and sanitation addressed through CLTS | 2 per district | 2 | 100% |

| Output 1212: Functionality and sustainability of existing water points assessed | | | |
|--|---|--|--|
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of villages mapped and assessed | 331 | 344 | 104% |
| # and sex of community members trained on community water point mapping an action planning | 140 WASH committee members (80 male, 60 female) | 168 WASH committee members (58 f, 110 m) | 120% |
| Output 1213: Water points constructed or rehabilitated by community groups | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of water points rehabilitated or constructed | 30 | 47 | 157% |
| Variance Explanation | | | |
| Completed in Y5. The Local Authority in Shiwang'andu engaged and supported Area Pump Minders (APM) to rehabilitate boreholes. | | | |
| Output 1214: Male and female water committee members trained on water point management and maintenance | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of WPC members trained on water point management and maintenance | 180 WPC members (100 m, 80 w) | 210 WPC members (78w & 132m) | 117% |
| Variance Explanation | | | |
| Completed in Y5. The initial plan was to support the formation of WMPCs in sites where the CARE will sink or rehabilitate boreholes. However, in Y4, some communities felt there was need to have WPMCs in their respective communities where they have a water point so, this meant that more WPMC were formed than targeted, however, SANI only supported 45 WPMCs, the extra 11 WPMCs were supported by the local government. | | | |
| IMMEDIATE OUTCOME 1220 | | | |
| Output 1221: Farmer groups established or strengthened | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # farmer groups established or strengthened | 200 farmer groups | 224 farmer groups | 112% |
| # and sex of farmer group members | 4,000 (2300 m 1700 w) | 4,120 (1,882m,2,238 w) | 103% |
| Variance Explanation | | | |
| Achieved in Y3. Additional members joined existing farmer groups in Y4. | | | |
| Output 1222: Female and male Agritex officers, Farmers field schools and VSLA members trained and mentored on nutrition-sensitive climate-smart agriculture | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # and sex of Agritex officers, farmer field school members, VSLA members trained on nutrition-sensitive climate-smart agriculture | 210 (105 male, 105 female) | 444 (257f & 187m) | 211% |
| # and (vulnerability) type of HHs provided with appropriate agricultural inputs disaggregated by sex | 5,000 HHs | 8,071 HHs (4,960f,3,41m) | 161% |

| | | | |
|--|---|-----------------------------------|--|
| # of farmers field schools established or strengthened | 50 farmer field schools | 93 farmer field schools | 186% |
| Output 1223: Nutrition and gender-sensitive home gardens and school demonstration plots established using climate-smart agriculture | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of home garden demonstration plots established | 14 plots | 91 plots | 650% |
| Variance Explanation | | | |
| Achieved in Y3. Using the FFS/Interest group model enabled the project to achieve a higher number of demonstration plots. | | | |
| IMMEDIATE OUTCOME 1230 | | | |
| Output 1231: VSLA groups established or strengthened | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # VSLA groups established or strengthened | 14 VSLA groups | N/A | N/A |
| # and sex of VSLA group members | Zambia: 140 VSLA members (120 male, 120 female) | N/A | N/A |
| Variance Explanation | | | |
| In Y4, SANI Zambia made the decision to remove Village, Saving and Loan Association Output 1231 and focus was redirected to scaling up the implementation of the Care group model. | | | |
| Output 1232: Community dialogue on gender norms and behaviors related to intra-HH distribution of food, resources and assets conducted | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of community dialogues conducted | 140 dialogues | 30 | 21% |
| Variance Explanation | | | |
| In Y4, 17 facilitators were trained to conduct the SAA dialogues in the communities and SAA dialogues took place in January and February 2020 with 396 (223w & 173m) people in attendance. The roll-out of the SAA dialogues was negatively impacted by COVID 19 and gassing incidences, as well as the COVID-19 outbreak and related restrictions on gathering. | | | |
| IMMEDIATE OUTCOME 1310 | | | |
| Output 1311: New or existing inter-sectoral, MIYCN committees meet regularly | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of inter-sectoral MIYCN committee meetings conducted | 44 meetings | 90 | 205% |
| Variance Explanation | | | |
| This target was over-achieved as the MIYCN committee meetings were conducted more frequently than anticipated. | | | |
| Output 1313: Gender sensitive MIYCN policy briefs developed and disseminated | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of gender-sensitive MIYCN policy briefs disseminated | 2 | 1 | 50% |

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|---|---------------------------------------|-----------------------------------|--|
| Variance Explanation | | | |
| The SANI team developed one policy brief on the Care group model given the successful use and potential for scale of this model in Zambia. | | | |
| IMMEDIATE OUTCOME 1320 | | | |
| Output 1321: Facilitators trained on gender inclusive, participatory Community Score Cards | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of m/f facilitators trained on gender-inclusive participatory CSC | 140 facilitators (70 male, 70 female) | 17 (13m, 4f) | 12% |
| Variance Explanation | | | |
| The target for this output was revised from 140 to 20 because the approach of implementing CSC was revised due to limited time, due in part to the COVID-19 pandemic limitations on meetings. It was decided that implementation would be in four (4) selected wards instead of the 10. | | | |
| Output 1322: Gender-inclusive MIYCN Community Score Card cycle implemented in health center catchment areas | | | |
| Indicators | Project Target | End of Project Achievement | End of Project % of achievement |
| # of gender-sensitive MIYCN community scorecard interface meetings conducted | 8 meetings | 12 meetings | 150% |
| # of gender-specific items per scorecard | 3 items per CSC process | 3 items per CSC process | 100% |
| # of gender-sensitive MIYCN CSC action plans implemented | 10 CSC action plans | 12 CSC action plans | 120% |

Annex 4: List of Partners:

| | Ministry/Agency/ Organization | Name of Contact person | Contact details | Role in the Project |
|------------|--|---|---|---|
| Mozambique | Ministry of Health | Provincial Head of Nutrition | Amilcar Petim amipetim@gmail.com | Responsible for overseeing all nutrition activities and contributing to the adaptation of contents |
| | Ministry of Gender and Social Welfare | Officer | Adelio Maulidio adeliomaulidio@gmail.com | Responsible for overseeing gender activities conducted by Inhambane government partners |
| | Ministry of Agriculture | PNCC Coordinator | Jorge Pambi jorgepambi@gmail.com | PNCC coordinator responsible for overseeing agriculture activities |
| | Ministry of Infrastructure | Officer | Francisco Milice +258 847900400 | Ensure that the design and construction of buildings and related works comply with the building code and/or standards and technical norms in effect in Mozambique |
| | Homoine District authority | Officer | Isabel Matimbe +258 872113229 | Ensure the link between volunteers and Health Facilities and ensure technical support from health personnel to volunteers |
| | Funhalouro District authority | Officer | Aida Bila +258 879067860 | |
| | MAHLAHLE -Association for the Promotion and Advancement of Women | Team Supervisor | Adriano Marrengula Marrengulaadriano@gmail.com | Implementing partner organization |
| | CCM - Conselho Cristão de Moçambique (a faith-based community organization) | Finance Officer | Orlanda Mucambe oeuricoradio@gmail.com | Implementing partner organization |
| | HOPEM - Rede de Homens Pela Mudança (Male engagement organization for women empowerment) | Program Manager | Alberto Cumbe Acumbi232@gmail.com | Implementing partner organization |
| Malawi | Ministry of Health - Ntchisi | District Environment al Health Officer | James Mtonga +265999557210 James_mtonga@gmail.com | Focal person in coordinating all SANI health related activities under nutrition specific which include CMAM, NECs, growth monitoring and WASH. |
| | Ministry of Health- Dowa | District Environment al Health Officer | Ellen Ndlovu +265999359564 ellenthembi@gmail.com | Focal person in coordinating all SANI health related activities under nutrition specific which include CMAM, NECs, growth monitoring and WASH. |
| | Ministry of Gender and Social Welfare- Ntchisi | Gender Development Officer | Hanna Kisyombe +265881659270 hankisyombe@gmail.com | District Focal person in providing technical support on gender, Promoting harmonization among all sectors involved in Gender Mainstreaming and women empowerment in the district. |

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|---|--|--|--|
| Ministry of Gender and Social Welfare- Dowa | Gender Development Officer | Zuwere Ross Mwale +265882867948 zuwereross@yahoo.co.uk | District Focal person in providing technical support on gender, Promoting harmonization among all sectors involved in Gender Mainstreaming and women empowerment in the district. |
| Ministry of Agriculture- Ntchisi | Food Agriculture and Nutrition Officer | Pauline Chifika +265884003238 pchifika@gmail.com | Coordinating all care group related structures and activities at district and community levels. Providing technical support to all project staff, government extension workers and project volunteers. Coordinating all nutrition partners in the district by facilitating joint planning and implementation of nutrition activities. |
| Ministry of Agriculture - Dowa | Food Agriculture and Nutrition Officer | Violet Muyande +265999399029 violetmuyande@gmail.com | Coordinating all care group related structures and activities at district and community levels. Providing technical support to all project staff, government extension workers and project volunteers. Coordinating all nutrition partners in the district by facilitating joint planning and implementation of nutrition activities. |
| Ntchisi District authority | Principal Nutrition and HIV AIDS | Edina Nakanga +265999615696 Nakangaedna9@gmail.com | District Focal person for Providing technical support on all agriculture related interventions. Building capacity of staff and volunteers. Providing all extension services to farm clubs, volunteers and project staff. |
| Dowa District authority | Principal Nutrition and HIV AIDS | Lisungu Kamkondo +265992239864 louorg@gmail.com | District Focal person for Providing technical support on all agriculture related interventions. Building capacity of staff and volunteers. Providing all extension services to farm clubs, volunteers and project staff. |
| CSONA | National coordinator | Bessie Ndovi +265999959627 bessie.ndovi@csona.org | Local project implementation partner to strengthen the governance and accountability of nutrition policies and budgets that will work to improve the nutrition status of the most vulnerable, especially women of reproductive age and under five children |
| ELDS | Program Manager | Alick Kaonda 265888316744 alickkaonda@yahoo.co.uk | Local Project implementation partner in Dowa district |

| | | | | |
|--------|--|---|---|---|
| Zambia | Ministry of Health | District Health Director-Kanchibiya | Mr. Paul Muma- pmuma03@yahoo.com | MoH supported care group implementation model, GMP, Cooking and feeding demonstrations, and Community Management of Acute Malnutrition (CMAM). |
| | | District Health Director-Shiwang'andu | Gibson Mweemba 0961849255 mweembagibson@gmail.com | |
| | Ministry of Agriculture | District Coordinator Agriculture - Kanchibiya | Hara Rainford rainfordhara@yahoo.com 0977693208 | MoA provided technical guidance on the implementation of FFBS and climate smart agriculture. |
| | | District Coordinator Agriculture-Shiwang'andu | Moses Mulenga- 0977582208 mulengaccmoses@yahoo.co.uk | |
| | Ministry of community development and social services | Social Welfare Officer - Kanchibiya | Hellen Lungu hellnishfr@yahoo.com 0977534695 | The ministry facilitated trainings on VSLA and provided technical support. SAA facilitators were drawn from this ministry and the were involved in promoting GE. |
| | | Social welfare Officer-Shiwang'andu | Christious Mwanza- 0977410199 ccllm40@yahoo.com | |
| | National Food and Nutrition Commission(NFNC) | District Nutrition Coordinator | Kabwe Sandra,Phone: +260971600763 sandrakabwe@gmail.com | SANI worked with NFNC to scale up nutrition strategies to Mpika and Shiwang'andu and for implementation of project activities |
| | Ministry of traditional and Chief Affairs | Traditional Affairs Officer | Stephen Juma: Phone : +260975991575 stephenjuma795@gmail.com | The Ministry worked as a link between Partners like CARE to the traditional leadership. It was involved in community mobilization and the traditional leadership provide the needed support and leadership at community level |
| | Ministry of Water Development and Environment protection | District Assistant Water Development Officer | Bupe Mulenga; Phone: +260977352966 mulengabupe53@yahoo.com | The Ministry was responsible to provide technical support and policy guidance on the construction and rehabilitation of boreholes and ensured all the procedures were done according to the set standards by Water Resources Management Authority (WARMA) |
| | Ministry of Local Government | District Water Coordinator-Mpika | Margaret Manzi. Phone: +260977118428 magdariah12@gmail.com | The Ministry was involved in the bidding process-assessment and awarding of contract to the selected contractor and certification of works completed. In additional, it was responsible in the supervision, monitoring and technical support in the |

| | | | | |
|--------|--|-------------------------------------|---|--|
| | | | | overall management of WASH interventions. |
| | Child Participation Inclusive Education in Mpika (CPIEM): | Program Officer-Mpika | Febby Chisanga. Phone: +260099600843 cpiem80@gmail.com | CPIEM was one of the local NGOs contracted under twinning agreement with ICAD. CPIEM was responsible in promoting improved nutrition status among supporting households HHs with under five and Women in the reproductive age group (15-49 years and HHs affected as a result of HIV/AIDS. It supported communities in capacity building gardening, and rearing chicken. |
| | Program for Vulnerable Children and Women (PVCW)- | Executive Director-Mpika | Joyce Ngoma. Phone: +2600977860070 pvcmpika@gmail.com | PVCM was involved in supporting Gender Equality and Elimination of Mother to Child Transmission (EMTCT) through training of Male Champions and sensitization of community members and intervention around nutrition-promoting garden and rearing of chickens. |
| | Chikanjebela Women's Club: | Project Officer | Prayreen Chisanga Prayreen@gmail.com | A local NGO contracted under the twinning agreement with ICAD. It was involved in supporting HHs with under five and Women in the reproductive age group (15-49 years) with livelihood interventions like-gardening, rearing of chickens and supporting HIV/AIDS affected households. |
| Canada | CUSO | Manager, International Volunteering | Yvette Macabuag Yvette.mucabuag@cusointernaitonal.org | Recruitment and matching of volunteers for SANI |
| | Inter-agency Coalition on HIV/AIDS and Development (ICAD) | Senior Program Officer | Shayna Buhler 613 233 7440 x 114 sbuhler@icad.cisd.com | Establishing and managing a twinning program with local organizations in Canada, Zambia, Malawi |
| | McGill University – Margaret A. Gilliam Institute for Global Food Security | Managing Director | Patrick Cortbaoui info.gfs@mcgill.ca +1 514 398-7765 | Conducted research integrated with SANI project |

Annex 5: List of volunteers:

| Volunteer | Gender | Country | Job title | Employer Name | Days completed |
|-----------------------------------|--------|------------|------------------------------------|--|----------------|
| Laurent-Charles Tremblay Lévesque | M | Malawi | WASH Advisor | CARE | 81 |
| Fiona Wallace | F | Malawi | Nutrition Policy Advisor | CARE | 148 |
| Marine Celeste Kromera | F | Malawi | Monitoring and Evaluation Advisor | CARE | 174 |
| Lynn Thorsell | F | Malawi | Organizational Development Advisor | CARE | 233 |
| Jonathan Chambers | M | Malawi | GIS ADVISOR | CARE | 191 |
| Katie Janhunen | F | Malawi | Business Development Advisor | CARE | 100 |
| Briana Hogg | F | Malawi | Program Management Support | CARE | 206 |
| Gillian Reid-Schachter | F | Malawi | Monitoring & Evaluation Advisor | CARE | 172 |
| Chenai Kadungure | F | Malawi | Program Management Advisor | Coalition of Women Living with HIV/AIDS (COWLHA) | 197 |
| Sheriff Wiredu | M | Malawi | Program Management Advisor | Coalition of Women Living with HIV/AIDS (COWLHA) | 148 |
| Sabrina Neto | F | Mozambique | Communications Advisor | CARE | 39 |
| Mwangala Matakala | F | Mozambique | Gender Advisor | CARE Mozambique | 219 |
| Fernando Cerda | M | Mozambique | Monitoring and Evaluation Officer | CARE Mozambique | 137 |
| Mariame Dramé | F | Mozambique | Nutrition Policy Advisor | CARE Mozambique | 71 |
| Haile Hailemichael | M | Mozambique | WASH Officer | CARE Mozambique | 125 |
| Kristy Baron | F | Mozambique | Public Health Officer | CARE Mozambique | 89 |
| Marc-Antoine Dion | M | Zambia | Gender Support Officer | CARE | 143 |

| Volunteer | Gender | Country | Job title | Employer Name | Days completed |
|------------------------|--------|---------|---|---------------|----------------|
| Haile Hailemichael | M | Zambia | Water, Sanitation And Hygiene Advisor | CARE | 59 |
| Césarée Morier-Gxoyiya | F | Zambia | Horticulture Advisor | CARE | 165 |
| Aston Chipanshi | M | Zambia | Horticulture Support Officer | CARE | 120 |
| Tegan Holmes | F | Zambia | Program Support Officer-Communication | CARE | 161 |
| Christopher Forget | M | Zambia | Program Management Support | CARE | 98 |
| Sunisha Neupane | F | Zambia | Monitoring and Evaluation Support Officer | CARE | 73 |

Annex 6: List of all Project and technical reports:

| Report Name | Date of Report |
|---|-------------------------------|
| Project Implementation Plan and Baseline Report | June 30, 2016 & July 12, 2017 |
| 1 st year Semi-annual report | November 15, 2016 |
| 1 st year Annual report | June 22 nd 2017 |
| 2 nd year Semi-annual report | November 22, 2017 |
| 2 nd year Annual Report | May 31, 2018 |
| 3 rd year Semi-annual report | November 15, 2018 |
| 3 rd year Annual report | May 20, 2019 |
| 4 th year Semi-annual report | November 29, 2019 |
| 4 th year Annual report | June 30, 2020 |
| 5 th year Semi-annual report | November 30, 2020 |
| 5 th year COVID report | November 30, 2020 |
| 5 th year Annual report | May 30, 2021 |
| Final Report | July 2 nd , 2021 |

Annex 7: List of all Subcontractors:

| Sub-contractor | Type: Canadian, International, or Local | Service Provided | Date |
|---|---|--|---|
| Elizabeth Dyke | Canadian | Qualitative baseline and endline studies | October 2016 and June 2020 |
| Forcier Consultants | Local (Mozambique) | Baseline study in Mozambique | October 2016 - June 2017 |
| Palm Associates | Local (Zambia) | Baseline study in Zambia | October 2016 - January 2017 |
| Dr. William Kasapila | Local (Malawi) | Baseline and Endline studies in Malawi | October 2017- January 2017, January 2020. |
| Sustainable Urban Environmental Solutions (SUES Consult) | Local (Zambia) | Environmental Assessment and Construction Plan - Zambia | November 2017 |
| Hidroconsult – Consultoria e Prestacao de Servicos em Recursos Hidricos | Local (Mozambique) | Environmental Assessment and Construction plan - Mozambique | November 2017 |
| HealthBridge (Peter Berti) | Canadian | Technical support on ongoing implementation of nutrition monitoring and digital data collection system | June 2016 to February 2017 |
| Logical Outcomes | Canadian | DHIS set-up and training | July 2017 to February 2018 |
| National Public Relations | Canadian | Design and management of public engagement campaign, social media content creation, engagement & monitoring. | December 2017 - March 31 st 2020 |
| Cardiff University | International | Endline research | April 2019 – December 2020 |
| Colibri | Local (Mozambique) | Design and implementation of MIYCN outreach/home visiting model in Mozambique | April 2018 – December 2018 |
| Chasqui (Adam Mileusnic) | Canadian | Information design of 5 infographics | November 2018 to February 2018 |
| KNOWARTH Technologies | International | Hosting services for website application on AWS. | September 2018 |
| IMPACT Research, Zambia Ltd. | Local (Zambia) | Endline study Zambia | October 2021 |
| Apolowil Consultants | Local (Mozambique) | Endline study Mozambique | November 2021 |
| LUSITU Drilling and Exploration Limited | Local (Zambia) | Drilling and installation of hand pumps/civil works | March to June 2019 |
| PALMONTT LDA | Local (Mozambique) | Construct a Water Supply System powered by Solar Panels in Homoine district | Jun 2018 to March 2020 |

| | | | |
|---------------------|--------------------|---|---------------------------|
| AFRIDEV MATI, LDA | Local (Mozambique) | Construct a Water Supply System powered by Solar Panels Funhalouro district | Jun 2018 to December 2019 |
| FAG Consultores LDA | Local (Mozambique) | Supervise the construction of Water Supply Systems powered by Solar Panels | August 2018 to March 2020 |
| HMR Consultores LDA | Local (Mozambique) | Supervise the construction of 9 boreholes equipped with Hand pumps | August 2018 to June 2020 |

Annex 8: Intellectual Property Rights:

All data gathered and all research contracted by CARE under the SANI project remains the intellectual property of CARE Canada.

The following academic research projects were conducted alongside the SANI project, and papers or reports generated and/or published remain the intellectual property of their authors and their respective institutions and publishers:

McGill University:

- Pauley Tedoff - Measuring Women's Empowerment in the Context of the Southern African Nutrition Initiative (SANI) and Growing Nutrition for Mothers and Children (GROW) Projects (Paper, December 2019)
- Pauley Tedoff - Women's Agency, Nutrition Status, and Food Security: A Four-Country Cross-Sectional Study of Women and Children in Sub-Saharan Africa (Poster)
- Pauley Tedoff – Determinants of Spousal Concordance in Ethiopia, Malawi, Mozambique, and Zambia; An analysis of cross-sectional data collected during a household survey for the SANI and GROW projects in 2017/2018 (Paper, November 2019)
- Akankasha Sen - Psychometric Properties of Food Insecurity Experience Scale (FIES) as Applied in Eastern Africa (Report, June 2018)
- Akankasha Sen - Psychometric Properties of Food Insecurity Experience Scale (FIES) as Applied in Eastern Africa (Poster, June 2018)
- Arlette SaintVille - Political economy analysis on SANI and GROW projects with a focus on adaptiveness of national and lower level governance structures (Draft report, July 2018)
- Nnedimma Nnebe - Producing nutritious complementary foods from locally sourced ingredients in Zambia (Proposal, March 2020)
- Nnedimma Nnebe – IDRC Grant technical report (Report, March 2020)
- Nnedimma Nnebe- Hidden Spores: a global review of the contributions of wild mushrooms to rural livelihoods (Abstract, March 2020)
- Nnedimma Nnebe – Gender Analysis of Post-harvest management in Zambia (Abstract, March 2020)

Milwaukee College of Nursing

- Elizabeth Mkandawire - A qualitative Assessment of Men and Women's Household Roles and Implications for Child Nutrition in Rural Central Malawi (Paper, November 2020)
- Anne Dressel - A Black Dog Enters the Home: Hunger and Climate Change in Malawi (Paper, December 2020)
- Lucy Mkandawire-Valhmu - The gendered dynamics of ganyu labor in the changing rural economy in Malawi (Paper, February 2021)

Annex 9: Distribution and Transfer of Project Assets

As activities in Malawi came to a close in late 2019, a disposal of assets plan was submitted by CARE on December 19th 2019 and approved by Global Affairs Canada. The CARE Country Office in Malawi supported by CARE Canada, used two different methods of asset transfers:

1. Transfer to local partners of SANI
2. Transfer to other projects within the country (Malawi) for another Food and Nutrition Security project

All assets transfers were completed by the end date of the initial SANI activities at the country level by March 31, 2020. The assets of the SANI project in Mozambique and Zambia, along with any additional assets procured in Malawi as part of the COVID-19 activities will be disposed of using the procedures outlined in the SANI contribution agreement when the extension phase of the project comes to a close.

| Description of Capital Asset | Category | Serial # | Date of acquisition | Budget line charged | Original value USD | Value CAD | Current Value after depreciation (CAD) | Current status functional/dysfunctional | Current location | Description of disposal | Means of verification |
|--|----------|-------------------|---------------------|---------------------|--------------------|-----------|--|---|-------------------------------|--|--|
| Ford Ranger registration number BU5672 | Vehicle | 6FPPXXMJ2PGE05246 | 16.11.16 | 1.6.6 | 46,908.66 | 62,325.66 | 31,162.83 | Functional | CARE-Mponela field office | Transferred to local nutrition network CSONA secretariat | Letter of asset transfer signed by CARE Malawi and CSONA |
| Ford Ranger registration number BU5671 | Vehicle | 6FPPXXMJ2PGE05476 | 16.11.16 | 1.6.6 | 46,908.66 | 62,325.66 | 31,162.83 | Functional | CARE-Mponela field office | CARE Malawi retained to be used on another Food and Nutrition Security programme | N/A |
| Lenovo ThinkPad | Laptop | PC-0FD49S | 29.11.16 | 1.6.6 | 939.9 | 1,248.81 | 499.52 | Functional | CARE-Mponela field office | Transferred to local NGO NAPHAM | Letter of asset transfer signed by CARE and NAPHAM |
| Lenovo ThinkPad | Laptop | PC-0FD49T | 29.11.16 | 1.6.6 | 939.9 | 1,248.81 | 499.52 | Functional | CARE Mponela field office | Transferred to Partner local NGO CEWAG | Letter of asset transfer signed by CARE and CEWAG |
| Lenovo ThinkPad | Laptop | PC-0FD49V | 29.11.16 | 1.6.6 | 939.9 | 1,248.81 | - | Non-Functional | CARE Mponela field office | Dispose as Scrap | |
| Lenovo ThinkPad | Laptop | PC-0FD490 | 29.11.16 | 1.6.6 | 939.9 | 1,248.81 | - | Non-Functional | CARE Mponela field office | Dispose as Scrap | |
| Lenovo ThinkPad | Laptop | PC-0FD49R | 29.11.16 | 1.6.6 | 939.9 | 1,248.81 | 499.52 | Functional | PACHI –Ntchisi partner office | Transferred to local NGO PACHI | Letter of asset transfer signed by CARE and PACHI |
| Lenovo ThinkPad | Laptop | PC-0FD49Y | 29.11.16 | 1.6.6 | 939.9 | 1,248.81 | 499.52 | Functional | CARE Mponela field office | Transferred to local NGO COWHLA | Letter of asset transfer signed by CARE and COWHLA |
| Lenovo ThinkPad | Laptop | PC-0FD4A2 | 29.11.16 | 1.6.6 | 939.9 | 1,248.81 | 499.52 | Functional | CARE Mponela field office | Transferred to local NGO PAWOC | Letter of asset transfer signed by CARE and PAWOC |
| Lenovo ThinkPad | Laptop | PC-0FD4A1 | 29.11.16 | 1.6.6 | 939.9 | 1,248.81 | 499.52 | Functional | CARE- Mponela filed office | CARE Malawi retained to be used on another Food and Nutrition Security programme | N/A |

| | | | | | | | | | | | |
|----------------------------------|-------------|-------------------|----------|-------|----------|----------|----------|------------|--------------------------------|--|--|
| Lenovo ThinkPad | Laptop | PC-0D8SHU | 29.11.16 | 1.6.6 | 939.9 | 1,248.81 | 499.52 | Functional | CARE Mponela filed office | To be transferred to Ntchisi district council - Principal Nutrition, HIV and AIDS office | Letter of asset transfer signed by CARE and Ntchisi District Council |
| Lenovo ThinkPad | Laptop | PC-0FD49P | 29.11.16 | 1.6.6 | 939.9 | 1,248.81 | 499.52 | Functional | CARE Mponela Field office | To be transferred to Dowa district council - Principal Nutrition, HIV and AIDS office | Letter of asset transfer signed by CARE and Dowa District council |
| Lenovo ThinkPad | Laptop | PC-0FD4A8 | 29.11.16 | 1.6.6 | 939.9 | 1,248.81 | 499.52 | Functional | PACHI –Ntchisi partner office | To be transferred to local NGO PACHI | Letter of asset transfer signed by CARE and PACHI |
| Sharp MX-M453N copier | Photocopier | 23000775 | 29.11.16 | 1.6.6 | 5,455.85 | 7,248.97 | - | Functional | CARE Mponela office | CARE Malawi to retain and be used on another Food and Nutrition Security programme | N/A |
| Sharp MX-M453N copier | Photocopier | 63015416 | 29.11.16 | 1.6.6 | 2587.78 | 3,438.28 | - | Functional | PACHI –Ntchisi partner office | To be transferred to local NGO PACHI | Letter of asset transfer signed by CARE and PACHI |
| SharpAR-6023n Copier | Photocopier | 63016136 | 12.12.16 | 1.6.6 | 2587.78 | 3,438.28 | - | Functional | CARE Mponela office | To be transferred to local nutrition network CSONA secretariat | Letter of asset transfer signed by CARE and CSONA |
| CAMCO | Generator | KDE12STA | 24.04.17 | 1.6.6 | 4,965.59 | 6,597.58 | 916.33 | Functional | CARE –Mponela field office | To be transferred to CSONA | Letter of asset transfer signed by CARE and CSONA |
| Honda registration number CA2950 | Motorcycle | LTMJD2195J5500455 | 12.06.18 | 1.6.6 | 2,368.43 | 3,146.84 | 2,359.00 | Functional | PACHI –Ntchisi partner office | To be transferred to local NGO PACHI | Letter of asset transfer signed by CARE and PACHI |
| Honda registration number CA2948 | Motorcycle | LMTJD2194J5500222 | 12.06.18 | 1.6.6 | 2,368.43 | 3,146.84 | 2,359.00 | Functional | PACHI- Ntchisi partner office | To be transferred to local NGO PACHI | Letter of asset transfer signed by CARE and PACHI |
| Honda registration number CA2954 | Motorcycle | LMTJD2192J5500509 | 12.06.18 | 1.6.6 | 2,368.43 | 3,146.84 | 2,359.00 | Functional | CARE – Mponela field office | To be transferred to local NGO PAWOC | Letter of asset transfer signed by CARE and PAWOC |
| Honda registration number CA2953 | Motorcycle | LMTJD2190J5500444 | 12.06.18 | 1.6.6 | 2,368.43 | 3,146.84 | 2,359.00 | Functional | CARE – Mponela field office | To be transferred to local NGO COWHLA | Letter of asset transfer signed by CARE and COWHLA |
| Honda registration number CA2952 | Motorcycle | LMTJD219XJ5500516 | 12.06.18 | 1.6.6 | 2,368.43 | 3,146.84 | 2,359.00 | Functional | CARE- Mponela field office | To be transferred to Ntchisi District Health Office - M & E department | Letter of asset transfer signed by CARE and Ntchisi District Health Office |
| Honda registration number CA2951 | Motorcycle | LMTJD2193J5500258 | 12.06.18 | 1.6.6 | 2,368.43 | 3,146.84 | 2,359.00 | Functional | CARE-Mponela field office | To be transferred to Dowa District Health Office - M & E department | Letter of asset transfer signed by CARE and Dowa district health office |
| Honda registration number CA2949 | Motorcycle | LMTJD2194J5500270 | 12.06.18 | 1.6.6 | 2,368.43 | 3,146.84 | 2,359.00 | Functional | PACHI – Ntchisi partner office | To be transferred to Partner local NGO CEWAG | Letter of asset transfer signed by CARE and CEWAG |
| Dell- latitude | Laptop | 99Z8MH2 | 13.06.18 | 1.6.6 | 1955.58 | 2,598.30 | 1,818.81 | Functional | CARE -Lilongwe office | CARE Malawi to retain and be used on another | N/A |

| | | | | | | | | | | | |
|----------------|--------|-----------|----------|-------|--------------|-------------------|-------------------|------------------|---------------------------|--|---|
| | | | | | | | | | | Food and Nutrition Security programme | |
| Dell- latitude | Laptop | PC-0FD4A2 | 13.06.18 | 1.6.6 | 1955.58 | 2,598.30 | 1,818.81 | Functional | CARE-Mponela field office | To be transferred to local nutrition network CSONA secretariat | Letter of asset transfer signed by CARE and CSONA |
| Dell- latitude | Laptop | 57RRL72 | 29.11.18 | 1.6.6 | 1172.92 | 1,558.41 | 1,246.73 | Functional | CARE-Mponela field office | To be transferred to local nutrition network CSONA secretariat | Letter of asset transfer signed by CARE and CSONA |
| Dell- latitude | Laptop | HDQWL72 | 29.11.18 | 1.6.6 | 1172.92 | 1,558.41 | 1,246.73 | Functional | CARE-Mponela field office | To be transferred to local nutrition network CSONA secretariat | Letter of asset transfer signed by CARE and CSONA |
| | | | | | Total | 142,589.23 | 189,452.61 | 90,381.78 | | | |

These assets were originally transferred from the GAC funded Maziko project in Malawi:

| Description of Capital Asset | Category | Serial # | Date of acquisition | Budget line charged | Original value USD | Value CAD | Current status (functional/dysfunctional) | Current location | Description of Plan for disposal | Means of verification |
|--|----------|-------------------|---------------------|-------------------------------|--------------------|------------------|---|-------------------------------|--|---|
| Toyota Land Cruiser 4X4 registration number NS7882 | Vehicle | AHTFR22G X0604693 | 30.09.12 | 1.6.6 goods, assets, supplies | 35,859.79 | 47,645.47 | Functional | CARE Lilongwe office | CARE Malawi to retain and be used on another Food and Nutrition Security programme | N/A |
| Toyota Double Cab registration number BR9708 | Vehicle | JTEEB7140 7016771 | 30.09.12 | 1.6.6 goods, assets, supplies | 41,650.21 | 55,338.97 | Functional | PACHI— Ntchisi partner office | To be transferred to local NGO PACHI | Letter of asset transfer signed by CARE and PACHI |
| | | | | | Total | 77,510.00 | 102,984.44 | | | |

Annex 10: Completion of Structural Construction Work:

Certificates of completion for all structural work completed by SANI have been obtained from relevant authorities in Zambia and Mozambique, and are attached in a zipped folder to this report.