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Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

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Abbreviations and Acronyms

AIDS	Acquired immune deficiency syndrome
BMI	Body mass index
CSI	Coping strategies index
DHS	Demographic and Health Survey
EA	Enumeration area
ENSURE	Enhancing Nutrition, Stepping Up Resiliency and Enterprise
FANTA	Food and Nutrition Technical Assistance III Project
FAO	U.N. Food and Agriculture Organization
FCS	Food consumption score
FEWSNET	Famine Early Warning Systems Network
FFP	USAID's Office of Food for Peace
GPS	Global positioning system
HAZ	Height-for-age Z-score
HDDS	Household dietary diversity score
HHS	Household hunger scale
HIV	Human immunodeficiency virus
IMC	International Medical Corps
MAD	Minimum acceptable diet
NGO	Non-governmental organization
NRM	Natural Resource Management
ORAP	Organization for Rural Associations for Progress
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
PICES	Poverty, Income, Consumption and Expenditures Survey
SPSS	Statistical Package for the Social Sciences
TPCPDL	Total per capita poverty datum line
UNICEF	U.N. Children's Fund
USAID	U.S. Agency for International Development
USD	United States dollar
WASH	Water, sanitation and hygiene
WEAI	Women's Empowerment in Agriculture Index
WFP	U.N. World Food Programme
WHO	U.N. World Health Organization

EXECUTIVE SUMMARY

Overview of the Baseline Study

In FY 2013, the U.S. Agency for International Development's (USAID) Office of Food for Peace (FFP) entered into two new cooperative agreements for Title II development food assistance programs in Zimbabwe: (1) the *Amalima* [1] Program in western and southwestern Zimbabwe, implemented by CNFA and its partners, Organization for Rural Associations for Progress (ORAP), International Medical Corps (IMC), The Manoff Group, Africare and Dabane Trust and (2) Enhancing Nutrition, Stepping Up Resiliency and Enterprise (ENSURE) in eastern Zimbabwe, implemented by World Vision and its partners: CARE, SNV USA, Southern Alliance for Indigenous Resources and International Crops Research Institute for the Semi-Arid Tropics.

The *Amalima* Program goal is to improve household nutrition and food security sustainably through increased resilience and growth guided by two strategic objectives: (1) to sustainably improve livelihood through improved productivity, marketing and access to financial services and (2) to sustainably improve household nutrition and health. The ENSURE Program has the following three objectives: (1) to improve nutrition among women of reproductive age, pregnant and lactating women and children under five years of age, (2) to increase household and micro-enterprise productivity and income through market-oriented approaches and (3) to increase household resilience to shocks.

In line with the USAID Evaluation Policy, FFP contracted with ICF International (ICF) to carry out a baseline study of Title II development food assistance programs. This baseline study, conducted in 2014, is the first phase of a pre-post evaluation cycle. The second phase will include a final evaluation to be conducted approximately five years later at the end of the Title II programs. The baseline study includes (1) a population-based household survey to collect data for key FFP and program-specific indicators and (2) a qualitative study to gather additional data that add context, richness and depth to the findings from the household survey. The results from the baseline study will be used for the following purposes:

- Provide a baseline for impact and outcome indicators to serve as a point of comparison for a final evaluation and
- Inform program targeting and, where possible, program design.

The sample for the population-based household survey was selected with a multistage clustered sampling approach to provide a statistically representative sample of program areas selected by each Title II program in its designated geographic region of operation. The household sample size was 2,610 households per program, or 5, 220 households overall. The survey questionnaire was developed through a series of consultations with FFP, the Food and Nutrition Technical Assistance III (FANTA) Project, Title II awardees and USAID/Zimbabwe. The qualitative study was designed based on a review of the preliminary unweighted midterm baseline dataset. ICF developed and finalized an interview guide after consulting with FFP and FANTA. In seven districts, three in the *Amalima* Program area and four in the ENSURE Program area, the qualitative team conducted 8 focus group discussions, 15 program-level interviews and 42 household-level interviews.

Study limitations and challenges included logistics and transportation, a prolonged process to obtain clearance to conduct fieldwork, the length and complexity of the household survey questionnaire and limitations resulting from possible biases in self-reported data and small sample sizes for children under 6 months and 6-23 months of age.

[1] *Amalima is* the Ndebele word for the social contract by which families come together to help each other engage in productive activities such as land cultivation, livestock tending, asset building and their own development initiatives.

Key Findings

The baseline study findings cover population characteristics; household hunger and coping strategies; dietary diversity and food consumption; poverty; water, sanitation and hygiene practices; agricultural practices; women's health and nutrition; children's health and nutrition; and gender equality.

Characteristics of the Study Population

The *Amalima* Program area is in the provinces of Matabeleland North and Matabeleland South in the districts of Tsholotsho, Bulilima, Mangwe and Gwanda. The ENSURE Program area is in the provinces of Manicaland and Masvingo in the districts of Chivi, Zaka, Bikita, Chipinge, Buhera and Chimanimani. The average household in the program area has 5.3 household members. Just over half of all households have children under five years of age. Nearly 50 percent of heads of household have completed primary school and 36 percent have completed secondary school. About 70 percent of households include an adult male and female and 25 percent include an adult female but no adult male.

Household Hunger and Coping Strategies

The household survey data show that 28 percent of households suffer from moderate or severe hunger and about 4 percent experience severe hunger. Households with an adult female and no adult male experience higher rates of severe hunger compared to households with an adult male present. Data from the qualitative study indicate that many households produce food for subsistence. Because the harvest was occurring during the baseline study, many respondents reported eating several meals a day, while few described periods of severe hunger, such as going a whole day without food.

The coping strategies index was used to measure the extent to which households use different consumption coping strategies during periods of limited access to food. The most frequently reported coping strategies included limiting portion size at meals, relying on less expensive or less preferred foods and reducing the number of meals eaten in a day. More stringent coping strategies, such as going an entire day without eating, harvesting immature crops, sending family members to eat elsewhere or to beg for food, were seldom reported and used infrequently.

Participants in the qualitative study described numerous coping strategies, such as sleeping hungry; eating less frequently or eating a smaller portion; receiving help from family members, friends or aid organizations; selling livestock; migrating to find food or work; performing casual labor to earn money to buy food; and planning or budgeting ahead. Findings from the qualitative study highlight the importance of mitigating the adverse effects of drought, and several respondents indicated that the lack of rain causes numerous individuals to go hungry.

Household Dietary Diversity and Food Consumption

The Household Dietary Diversity Score (HDDS) reflects the number of food groups consumed at the household level; however, it is not a nutritional indicator of dietary quality, but rather an indicator of food access. The HDDS overall score of 5.1 indicates that on average, each household in both program areas consumed 5 of the 12 food groups. The most accessed and consumed foods are cereals (98 percent), vegetables (77 percent) and miscellaneous food items such as tea, coffee and condiments (74 percent). The least accessed and consumed food items are eggs (6 percent), roots and tubers (8 percent) and fish and seafood (12 percent).

Qualitative data indicate that the primary drivers of food consumption at the household level are access and availability. Women are the primary decisionmakers for foods consumed, and although they attempt to diversify meals, availability and access limited by income affects the degree of dietary diversity. *Sadza* [cooked cornmeal] was identified most often as the standard Zimbabwean food, and participants usually described it as completing a meal when served with meat and vegetables. Although some participants own livestock, they tend to view it as an asset rather than a food source, which also limits diversity.

The Food Consumption Score (FCS), an indicator of dietary quality and frequency of consumption, is calculated using the number of days a household consumed food from eight food groups during the seven days preceding the survey. The FCS provides a standardized, objective and replicable tool to rate short-term food security.[2] FCS results indicate that 4 percent of households are in the "poor" food consumption category, 32 percent rated "borderline" and 64 percent rated "adequate."

In the qualitative study, respondents indicated a desire to consume nutrient-dense foods, such as meat and fish, and recognized the importance of those foods. Participants described cost and availability as primary hindrances to consuming nutrient-rich foods.

Poverty Levels

Across both program areas, 97 percent of the population lives in poverty, defined as less than the total consumption poverty line of U.S. dollar (USD) $3.35 per day,[3] which is substantially more than the 2012 estimate of 62.6 percent for Zimbabwe as a whole.[4] Daily per capita expenditures were on average constant 2010 USD $0.50 and 2014 USD $1.22 as reported by households. Daily per capita expenditures were lower in the *Amalima* Program area (USD $0.45) than in the ENSURE Program area (USD $0.53). The mean depth of poverty in the survey areas was 65.2 percent of the poverty line, at 68.5 percent in the *Amalima* Program area and 63.2 percent in the ENSURE Program area.

The qualitative data indicate that livelihood options fell into three categories: (1) casual labor, (2) agriculture, inclusive of farming and livestock rearing and (3) internal and external migration, inclusive of remittances earned from family migration. Much of these livelihood options are driven by the amounts of rain or irrigation and access to markets. Participants cited access to water for crop and livestock farming, market demand for crops produced and support services that facilitate a diversified production base as important factors for livelihood security. Further, although some positive reports of the migration emerged, generally the migration of able-bodied male family members also adversely affects household agricultural and livestock operations.

Household Water, Sanitation and Hygiene Practices

The household survey data show that 44 percent of households use an improved drinking water source. About half of households with an improved water source reported using a tube well or borehole and 16 percent reported using a protected well. About a third of households reported using a non-shared improved sanitation facility, either a ventilated pit latrine or a pit latrine with a slab. Interviewers observed handwashing stations in 20 percent of households; but water and soap, detergent or another cleansing agent was observed at the handwashing station in only 2.2 percent of households.

Similar to the survey findings, the qualitative data indicate that most households reported collecting water from boreholes. Many participants were satisfied with the water and did not feel the need to take steps to reduce contamination. Those that did feel the need reported using contamination prevention practices, such as boiling water, using water purification tablets or WaterGuard, keeping storage containers closed, collecting flowing river water and digging deep to reach insect-free water. Participants

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[2] World Food Programme, Vulnerability Analysis and Mapping Branch (ODAV). (2008). Food consumption analysis - Calculation and use of the food consumption score in food security analysis. Rome, Italy.

[3] Zimbabwe has been a dollarized economy since 2009, when it abandoned the Zimbabwe dollar in favor of a multicurrency regime prominently featuring the U.S. dollar. This should not represent a problem if the USD $1.25 line could be adjusted using a purchasing power parity rate to account for the different purchasing power of a U.S. dollar in the United States and Zimbabwe. Unfortunately, neither the World Bank nor the IMF publishes data on purchasing power parity rates for Zimbabwe, either currently or for some baseline year. The chosen poverty line is the official Total Consumption Poverty Line published by ZIMSTAT. See Annex 5 for further details.

[4] According to the Poverty and Poverty Datum Line Analysis in Zimbabwe 2011/12. Available at www.zimstat.co.zw/dmdocuments/Finance/Poverty2011.pdf

in the qualitative study reported using a number of non-improved sanitation facilities in addition to their own or a neighbor's Blair[5] or ventilated improved pit latrine. Although participants indicated that having a latrine is highly desirable, households often cannot construct their own latrines because they lack materials, labor and funds. Respondents related that they always wash their hands before eating and after using the latrine or going to the bush. Driving factors for handwashing across both program areas included preventing disease and getting rid of germs, staying clean and leading a healthy life.

Agriculture

Of the 6,321 farmers interviewed for the household survey, 58 percent were female and 42 percent were male. Farmers reported the most commonly planted crops are maize, sorghum, millet, groundnuts and cow peas and the most commonly raised animals are chicken, goats, cattle and donkeys.

About 11 percent of farmers reported using financial services in the past 12 months, either through accessing agricultural credit or saving cash in formal institutions. The small percentage of farmers that access credit in both program areas indicates a need to make existing sources more accessible to farmers to achieve sustained improvements in agricultural productivity. In both program areas, 75.6 percent of farmers reported practicing at least one value-chain activity, most commonly drying and processing produce, using training and extension services and purchasing inputs.

In the *Amalima* Program area, 28 percent of farmers reported practicing at least five sustainable crop practices, compared to 41 percent of farmers in the ENSURE Program area. The most common crop practice reported is weed control, followed by intercropping, rotating crops, using manure and planting early or planting before the first rains. About 26 percent of farmers reported using at least three sustainable livestock practices, most commonly vaccinations, homemade animal feeds, improved animal shelters and deworming. Nearly 15 percent of farmers reported using at least three sustainable natural resource management practices, most frequently sustainable forest products harvesting, forest plantation management and agro-forestry. A total of 17.2 percent of all farmers reported using improved storage methods for sorghum or groundnuts. Improved storage methods include hermetic storage, improved granaries, warehousing or cereal banks, use of traps and grain bags treated with pesticides.

The qualitative data highlight several structural constraints to agricultural diversification and productivity. Respondents identified the need for improved water and soil management techniques, input supply and output marketing, agricultural and animal husbandry extension services and community processing of local foods and livestock. Challenges to improved storage practices include fear of theft and a lack of necessary materials.

Women's Health and Nutrition

The nutritional status of women between 15 and 49 years of age, as measured by body mass index (BMI), is generally satisfactory despite a lack of dietary diversity. A BMI below 18.5 indicates underweight or acute malnutrition and is associated with increased mortality. The *Amalima* Program area has more underweight women (13.9 percent) than the ENSURE Program area (5.9 percent). About two-thirds (65 percent) of women 15-49 years of age in the *Amalima* Program area have a BMI in the normal range (18.5 to 24.9) compared to 62 percent in the ENSURE Program area. About 21 percent of women 15-49 years of age in the *Amalima* Program area are overweight or obese (BMI ≥25), compared to 32 percent in the ENSURE Program area. Dietary diversity is low, with women consuming on average slightly more than three of nine basic food groups. Grains, roots and tubers (98 percent) and vitamin A dark green leafy vegetables (68 percent) are the most frequently consumed basic food groups, while organ meat (3.5 percent) and eggs (5 percent) are consumed least often.

[5] The Blair Latrine is a pit latrine that uses a screened vent pipe to control odors and flies.

Of the 979 mothers of children under two years of age, 5.6 percent reported not receiving antennal care during their pregnancy, and almost one-third of women (32.7 percent) did not have their first antenatal care visit until after their fifth month of pregnancy.

Qualitative data indicate that women have the primary responsibility for food preparation in the household. Respondents in both program areas were attentive to pregnant women's food intake. They were aware of the importance of eating nutritious foods during pregnancy, and yet they reported facing food access challenges. The respondents also indicated awareness of the importance of seeking antenatal care during pregnancy and cited distance as the most common barrier to seeking care.

Children's Health and Nutrition

The survey data reveal that 10.8 percent of children under five years of age in the project area show signs of being moderately or severely underweight. Children in the *Amalima* Program area have a higher rate for underweight (14.6 percent) than children in the ENSURE Program area (8.6 percent). About 29 percent of children under five years of age in the survey population show signs of being stunted.

About 22 percent of all children under five years of age had diarrhea in the two weeks preceding the survey, with lower rates in the *Amalima* Program area (15.8 percent) than in the ENSURE Program area (24.7 percent). About 58 percent of caregivers reported seeking advice or treatment for children with diarrhea, and 77 percent of those children were treated with oral rehydration therapy.

Overall, 39 percent of children under six months of age in the survey area were exclusively breastfed in the last 24 hours. The qualitative study participants in both program areas spoke of the importance of exclusive breastfeeding but mentioned several challenges in accomplishing it. A commonly cited reason for stopping exclusive breastfeeding before six months of age was a perceived lack of milk. Other challenges in exclusive breastfeeding were the mother needing to return to work, the mother being human immunodeficiency virus positive, and cultural practices, such as giving the child porridge from a young age.

Overall, only 4.7 percent of children 6-23 months of age are receiving a minimum acceptable diet. The proportion of children with a minimum dietary diversity of four or more food groups is low: 5 percent for breastfed children 6-8 months of age, 15 percent for breastfed children 9-23 months of age and 18 percent for non-breastfed children 6-23 months of age.

According to the qualitative data, the most common food introduced is a very weak porridge made with water, mealie-meal [maize meal] salt and sugar. A number of respondents said they give porridge if the mother cannot afford to buy milk or formula from the store. Other foods mentioned include milk from an unspecified source, boiled goat milk, fermented malt drink, *sadza*, bananas, water and juice.

Gender Equality

The household survey asked a series of questions adapted from the Access to Resources Module of Feed the Future's Women's Empowerment in Agriculture Index. These questions concerned ownership, access, and decision-making power about productive resources, such as land, livestock, agricultural equipment, consumer durables and credit. Males scored higher in adequacy (94 percent) for asset ownership and decision-making in the purchase, sale or ownership of assets (84 percent) compared to females (86 percent and 72 percent, respectively). The results by gendered-household type indicate that females in female-only households achieve higher rates of adequacy compared to females in households with an adult male and female present. The qualitative data indicate that cultural and religious beliefs strongly influenced perceptions of equality among men and women, their corresponding roles and responsibilities and household decision-making processes.

1. Introduction

In FY 2013, the U.S. Agency for International Development's (USAID) Office of Food for Peace (FFP) entered into two new cooperative agreements for Title II development food assistance programs in Zimbabwe, (1) the *Amalima* Program in western and southwestern Zimbabwe, implemented by CNFA and its partners: Organization for Rural Associations for Progress (ORAP), International Medical Corps (IMC), The Manoff Group, Africare and Dabane Trust and (2) the Enhancing Nutrition, Stepping Up Resiliency and Enterprise (ENSURE) Program in eastern Zimbabwe, implemented by World Vision and its partners: CARE, SNV USA, Southern Alliance for Indigenous Resources and International Crops Research Institute for the Semi-Arid Tropics.

The goal of the *Amalima* Program is to sustainably improve household nutrition and food security through increased resilience and growth guided by two strategic objectives: (1) to sustainably improve livelihood through improved productivity, marketing and access to financial services and (2) to sustainably improve household nutrition and health. The program will build on communal initiatives and solidarity to strengthen food and nutrition security and enhance households' and communities' resilience to shocks. The program will strengthen household and communal resilience by mobilizing people around ideas they own and share and by merging traditional concepts with innovation.

The ENSURE Program is guided by the following three objectives: (1) to improve nutrition among women of reproductive age, pregnant and lactating women and children under five; (2) to increase household and micro-enterprise productivity and income through market-oriented approaches and (3) to increase household resilience to shocks. The program will address many of the underlying causes of chronic food insecurity by improving knowledge, capacity and links to produce food and generate income, maintain and optimally use assets and facilitate household savings. It will address chronic malnutrition by targeting pregnant and lactating women and children under two years of age to receive immediate food rations, while improving nutritional intake, access and availability for the long term and addressing gender and power dynamics in households, which can limit mothers' time and access to resources.

In line with the USAID Evaluation Policy, FFP contracted with ICF International (ICF) to carry out a baseline study of Title II development food assistance programs (see Annex 1 for the Statement of Work). This baseline study, conducted in 2014, is the first phase of a pre-post evaluation cycle. The second phase will include a final evaluation to be conducted approximately five years later at the end of the Title II programs. The baseline study includes (1) a representative population-based household survey to collect data for key FFP and program-specific indicators and (2) a qualitative study to gather additional data that add context, richness and depth to the findings from the household survey. The results from the baseline study will be used for the following purposes:

- Provide a baseline for impact and outcome indicators to serve as a point of comparison for a final evaluation and
- Inform program targeting and, where possible, program design.

FFP defines food security as "all people at all times hav[ing] both physical and economic access to sufficient food to meet their dietary needs for a productive and healthy life." Food security depends on four main factors: (1) availability of food, (2) access to food, (3) use of food and (4) stability. Availability of food refers to the physical presence of food in the region, whether in markets, on farms or through food assistance. Access to food refers to the ability of households to procure a sufficient quality and quantity of food. Use of food refers to the ability of individuals to properly select and absorb nutritious food. Stability in this context is the capacity to sustain acceptable nutrition over time.

The baseline study of the Title II development food assistance programs in Zimbabwe was designed to provide information on all four aspects of food security. The study investigates household food access, household expenditures and assets, agriculture practices, dietary diversity, anthropometry among women and children, gender equality; and water, sanitation and hygiene (WASH) practices.

This report begins with an overview of the study methods for the population-based household survey and qualitative study, followed by a summary of the current food security situation in Zimbabwe. The findings from the population-based household survey are presented for all FFP and program-specific indicators. The qualitative study results are integrated with these findings to provide context and understanding. The report closes with a summary of key findings.

2. Methodology

2.1 Methods for Population-based Household Survey

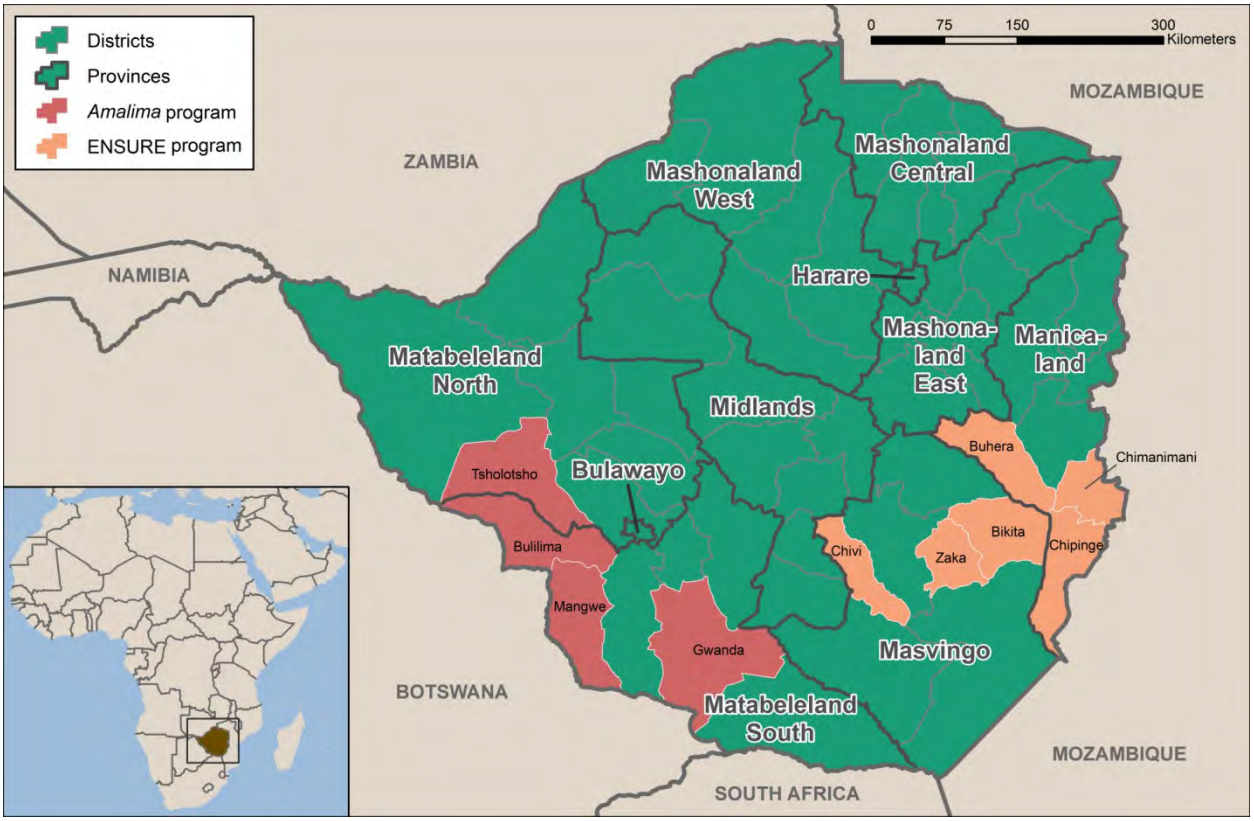
A. Study Design and Objectives

The primary objective of the population-based household survey is to assess the status of key FFP and program indicators before program implementation. The baseline measurements will be used to calculate change in these indicators and undertake a statistical test of differences in the indicators at completion of the five-year Title II program cycle, when the same survey will be conducted again in the program areas. This pre-post design will enable the measurement of changes in indicators between the baseline and final evaluation, but will not allow statements about attribution or causation to be made.

B. Sample Design

The sample for the population-based household survey was selected using a multistage clustered sampling approach to provide a statistically representative sample of the program areas selected by each Title II program in its designated geographic region of implementation (see Figure 2.1). The *Amalima* Program area is in the provinces of Matabeleland North and Matabeleland South in the districts of Tsholotsho, Bulilima, Mangwe and Gwanda. The ENSURE Program area is in the provinces of Manicaland and Masvingo in the districts of Chivi, Zaka, Bikita, Chipinge, Buhera and Chimanimani.

Figure 2.1. *Amalima* and ENSURE Program Areas



The sampling frame was constructed from the 2012 Zimbabwe census enumeration areas (EAs) in the selected districts for each program area. The EA is the lowest census administrative level that typically includes about 100-200 households. Each Title II program provided ICF with a list of selected wards in each district, and ICF used these wards to identify all EAs in the program area for inclusion in the sampling frame.

The sample sizes for each program were based on adequately powering a test of differences in the prevalence of stunting because stunting is one of several key measures for food insecurity.

The following criteria were used for deriving the baseline study sample size:

- Design effect of 2
- Confidence level of 95 percent
- Power level of 80 percent
- Expected reduction in stunting over the life of the program of 6.5 percentage points
- Use of the Stukel/Deitchler Inflation and Deflation Factors (see Appendix A of the Food and Nutrition Technical Assistance III Project [FANTA Sampling Guide]6) to determine the number of households with children under five years of age
- Inflation of the sample size of households by 10 percent to account for estimated household non-response

Based on these criteria, ICF sampled 87 EAs (clusters) for each program with 30 households sampled per EA. The household sample size was 2,610 households per program, or 5,220 households overall. A more detailed description of the sampling methodology, including household definitions and specific household selection procedures, can be found in the "Sampling Plan for Baseline Studies of Title II Development Food Assistance Programs" (see Annex 2). The following section provides an overview of the sample selection procedures.

The sample selection was done in four stages. For the first stage, 87 EAs were randomly selected using simple random sampling from the sampling frame for each program. To ensure representation in each district, the universe of EAs for each program was stratified by district and a fraction of the total EAs was allocated proportionately to each stratum for sampling based on the overall distribution of EAs in the program area.[7] Table 2.1 provides the counts of sampled EAs and households for each district. A separate sample of alternate EAs was selected using simple random sampling in case an EA in the primary sample was inaccessible and needed to be replaced. The sample of alternate EAs was used as a back-up from which individual replacement EAs were drawn as needed.

The second-stage selection of dwellings was completed using a systematic sampling approach in each sampled EA. Before the second-stage selection of households, a household listing exercise was completed in each of the selected EAs to determine the total number and location of dwellings (see Section (see Section 2.1D for a description of the listing exercise).

The field team supervisor was trained on how to implement the systematic sampling method before entering the field. Global Positioning System (GPS) units determined the longitude and latitude at the center of each community. Households in which no survey was conducted due to absence or refusals after three attempts were not replaced; therefore, the target of 30 households per cluster was not always achieved. The total number of households with completed interviews and response rates for each program are provided in Table 2.2 of Section 2.1E.

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[6] Magnani, Robert. *Sampling Guide (1999) and Addendum (2012).* Washington, D.C.: FHI 360/ Food and Nutrition Technical Assistance III Project. Available at http://www.fantaproject.org/monitoring-and-evaluation/sampling.

[7] The distribution of the number of EAs and the number of households by district in the sampling frame are similar.

Table 2.1: Sampled EAs and Households for the Baseline Study

PROVINCE/District	Number of EAs in Program Area	Number of EAs Sampled	Number of Households in Program Area	Number of Households Sampled
***Amalima* Program Area**				
MATABELELAND SOUTH				
Bulilima	137	22	13,120	660
Mangwe	103	17	10,095	510
Gwanda	126	21	12,189	630
MATABELELAND NORTH				
Tsholotsho	163	27	16,488	810
Total	**529**	**87**	**51,892**	**2,610**
ENSURE Program Area				
MASVINGO				
Chivi	141	13	13,834	390
Zaka	145	13	13,743	390
Bikita	132	12	13,097	360
MANICALAND				
Chipinge	317	28	33,912	840
Buhera	103	9	11,526	270
Chimanimani	131	12	11,400	360
Total	**969**	**87**	**97,512**	**2,610**

The third stage of sampling involved selection of one household when multiple households were living in one dwelling unit or compound. For sampling purposes, a dwelling and a compound were considered the same thing, such as in polygamous situations, where more than one household could be present in the dwelling (or compound). In cases where we found that several polygamous households occupied the dwelling, the interviewer used a Kish grid to randomly select one of the households.

The fourth stage of sampling was done at the individual level to select one woman 15-49 years of age in households where multiple women were eligible to be interviewed for questionnaire module E (women's nutrition and health) and one non-pregnant or postpartum woman 15-49 years of age for anthropometry measurements. For these modules, a Kish grid was used to randomly select the woman to be interviewed. For the children's module, care givers of all children under five years of age were interviewed and all children under five years of age were included in the anthropometry measurements. For the agriculture module, all farmers with decision-making power over land or livestock were interviewed. For the gender module, the primary male and female decisionmakers in each household were interviewed. Further details of sampling at the individual level are provided in the Sampling Plan for Baseline Studies of Title II Development Food Assistance Programs (see Annex 2).

C. Questionnaire

The survey questionnaire (see Annex 3) was developed through a series of consultations with FFP, FANTA, the Title II awardees and USAID/Zimbabwe before, during and after the in-country planning workshop held in December 2013. During the workshop, all stakeholders shared information about the baseline study and Title II programs and worked collaboratively on finalizing the study design and survey instrument.

A preliminary questionnaire was developed before the workshop, based on the selected FFP indicators and guidelines described in the *FFP Standard Indicators Handbook*.[8] Definitions for program-specific indicators were discussed and confirmed during the workshop. Questions that required adaptation to the local country context, such as those that involved foods as part of modules C, E and H and types of sanitation facilities as part of module F, were also defined in consultation with the Title II awardees, USAID/Zimbabwe, FFP and FANTA.

The questionnaire consisted of separate modules for the following topics:

- Module A: Household identification and informed consent
- Module B: Household roster
- Module C: Household food diversity and hunger
- Module D: Children's nutrition and health
- Module E: Women's nutrition and health
- Module F: Household water, sanitation and hygiene practices
- Module G: Agriculture
- Module H: Household expenditures
- Module J: Gender equality
- Anthropometry

Questions for Modules A through G were adapted using questions from the *FFP Standard Indicators Handbook* and the Demographic and Health Surveys (DHS) questionnaire.[9] Questions for Module H were adapted from the Zimbabwe Poverty, Income, Consumption and Expenditure Survey (PICES).[10] The gender equality questions were adapted from Feed the Future's Women's Empowerment in Agriculture Index (WEAI).[11]

D. Field Procedures

Listing Exercise

ICF obtained detailed boundary maps for each sampled EA from the Zimbabwe National Statistics Agency, which included household counts from the 2012 census. Before the data collection began in the EAs, survey teams conducted a walk-through exercise to count the dwelling units and describe the dwelling structures and layouts. The survey teams also recorded GPS coordinates at the center of each EA.

Training, Piloting and Pretesting

For training and fielding, ICF developed three training manuals based on FFP and DHS guidelines:

- **Supervisor Manual** addresses topics to prepare supervisors and field editors for fieldwork: introduction to the study and objectives, survey organization, supervisor roles and responsibilities, rules and regulations, ethics, fieldwork preparations and quality control requirements and procedures.

[8] USAID. (2011). *Food for Peace Standard Indicators Handbook (Baseline-Final Indicators)*. Available at http://pdf.usaid.gov/pdf_docs/pnadz580.pdf.

[9] DHS Model Questionnaire–Phase 6. (2008-2013). (English, French) Available at http://www.measuredhs.com/publications/publication-dhsq6-dhs-questionnaires-and-manuals.cfm.

[10] Poverty, Income, Consumption and Expenditures Survey. (2013). Available at http://www.zw.undp.org/content/zimbabwe/en/home/library/poverty/poverty-income-consumption-and-expenditure-and-survey-2011-12/.

[11] Available at http://www.feedthefuture.gov/sites/default/files/resource/files/ftf_vol8_populationbasedsurveyinstrument_oct2012.pdf.

- **Interviewer Manual** provides guidelines for survey and fieldwork procedures, such as interviewing techniques and procedures for completing the questionnaires. This manual also includes detailed explanations and instructions for each question in the questionnaire.
- **Anthropometry Manual** includes procedures adapted from the DHS biomarker manual for all DHS surveys worldwide. The procedures in the DHS biomarker manual were adapted from *How to Weigh and Measure Children*[12] and approved by FFP for this survey.

The supervisor and editor training, held in Harare at the local data collection subcontractor PROBE's offices from February 10 to 16, was attended by 50 supervisors and field editors. The training sessions covered topics on supervisor roles and responsibilities, rules, behaviors and ethics, household and respondent selection, use of the field control sheet, maps and GPS data collection. It included a detailed review of the household survey questionnaire with group practices, mock interviews and role playing and a review of the methodology for callbacks and field editing.

Following supervisor and editor training, supervisors and field editors piloted the questionnaire in Buhera, a Shona-speaking district, and Gwanda, a Ndebele-speaking district, from February 17 to 21. The purpose of the pilot test was to check the questionnaire translations into the local languages (Shona and Ndebele),to identify potential problem areas, such as skip patterns, wording, sequence of questions and clarity of the questionnaires for coding, and to identify any particularly difficult or sensitive questions.

The anthropometry training took place from February 21 to March 1 in Harare and included classroom and practical training. ICF's anthropometry expert and his Zimbabwean counterpart trained 30 individuals as anthropometrists and all interviewers as anthropometry assistants. An assistant's role mainly required holding children two to five years of age in the correct positions for feet and knees to get a standing height and holding children under two years of age to correctly position the head for recumbent length measurement. They were also trained to record measurements to prevent recording errors.

Supervisors were also trained in the use of the U.N. World Health Organization's (WHO) growth charts to determine if a child's weight or height measurement appeared to be reasonable and acceptable and if the child should be referred in the field to a local health clinic for weight-for-height Z-score below -2 or bilateral pedal edema.

Anthropometry standardization was conducted at an orphanage and a school in Harare from March 3 to 9. The trained anthropometrists took independent replicate measures of 10 subjects for maternal height and weight and children's standing and recumbent height and weight. All anthropometrists passed the standardization tests.

Interviewer training occurred concurrently with anthropometry standardization from March 3 to 8. ICF field managers and PROBE field coordinators led the training, beginning with an explanation of survey objectives, sampling design and methods for selecting households and respondents in the households. The training provided a detailed explanation of the questionnaire, question by question, including routing and filtering and a discussion of directive and non-directive probing. This session was followed by mock interviews among interviewers and discussions of any problems.

Pre-tests with the full teams were conducted in Bikita (Shona-speaking) and Tsholotsho (Ndebele-speaking) from March 10 to 13 after the supervisor, anthropometry and interviewer training. The pre-tests, designed to ensure that field teams were ready for data collection, covered all questionnaire modules and included field coordinators, supervisors, field editors, interviewers and anthropometrists. Survey teams conducted live interviews in a non-sampled EA to test-run team coordination, field logistics and readiness of interviewers to begin data collection. ICF field managers also observed the pre-tests and provided feedback. During a debriefing session, field coordinators, supervisors, interviewers and anthropometrists shared their pre-testing experiences, identified and addressed problems on

[12] Shorr, I.J. (1986, modified 1998). *How to weight and measure children.* UN: New York.

preparedness, field procedures, contact strategies, logistics arrangements and other issues concerning the fieldwork implementation.

Fieldwork

Fieldwork in Zimbabwe started after the pretest on March 24 and lasted approximately six weeks, ending May 1. Data collection for the baseline study was done in Shona and Ndebele.

The Title II data collection team members in Zimbabwe included 1 project director, 1 project manager, 1 national coordinator, 3 field coordinators, 24 supervisors, 24 field editors, 2 anthropometry supervisors, 24 anthropometrists and 96 interviewers. Each of the 24 interview teams comprised one supervisor, one field editor, four interviewers and one anthropometrist. In each team, a supervisor conducted field editing of the questionnaires.

Three ICF field managers rotated and oversaw the trainings and fieldwork in Zimbabwe. During critical periods, including training, anthropometry standardization, questionnaire piloting, pre-tests and beginning of fieldwork, at least two ICF managers were in-country at the same time to coordinate and supervise activities. ICF managers provided supervision during the entire fieldwork period. Collectively the two ICF managers visited all interview teams in the 10 districts to observe interviews, identify and correct mistakes and provide feedback and guidance for improvement, especially at the beginning of fieldwork.

For quality control, supervisors were required to keep fieldwork control sheets to record contacts with households and GPS data for each EA. These sheets were used to record the number of attempts to reach each household, number of households and individuals interviewed in each household and reasons for non-response in households where interviews were not obtained.

Supervisors conducted spot checks to verify information in at least 15 percent of the interviews. Supervisors verified that (1) the interview took place, (2) the approximate duration of the interview, (3) information on the household roster, (4) proper administration of the various sections of the questionnaires and (5) interviewers' general adherence to professional standards. In addition, field editors in each team conducted field editing to review every completed questionnaire on the same day of data collection to check for adequate completion of all fields, presence of missing data and legibility of open-ended items. Interviewers were required to make corrections or return for re-interview, if necessary.

ICF implemented additional anthropometry supervision by designating two anthropometry supervisors to monitor anthropometry activities during the entire fieldwork. The anthropometry supervisors reported to the ICF anthropometry expert and field managers on all issues related to anthropometry during fieldwork.

Data Entry and Processing

When all survey forms for an EA were cleared through the field quality control procedures, the forms were packaged and forwarded to the central data entry office in Harare. The forms were entered by a team of trained data entry personnel using CSPro data entry software customized to fit the survey form. The ICF survey specialist worked directly with the data entry team to ensure that the data entry program was thoroughly tested and matched the survey form. ICF reviewed the data entry program to ensure that only valid data ranges were allowed for each question and that the program included checks for questionnaire logic (e.g., skips and filters) and flagged any data inconsistencies. All questionnaires were double-entered and the data processing team manager compared the two datasets to identify and correct all conflicting data. ICF developed a common Statistical Package for the Social Sciences (SPSS) database structure to share with the in-country data processing team. The data processing team used this database structure to deliver all data to ICF.

PROBE submitted a dataset of the first 100 survey forms two weeks after the start of data entry and a dataset midway through the data entry (about 2,600 household records) to ICF for quality review. For

each dataset, ICF checked the raw data and converted SPSS data files to ensure that the data were complete and accurate and to determine that protocols for data conversion and the database structure were followed. For each review, ICF provided feedback and PROBE incorporated changes to the data entry software or SPSS database as needed.

ICF reviewed the final dataset, which included all survey forms, and conducted the following data quality checks: EA number matched to sampled EA numbers, household roster consistency with individuals interviewed for each module, duplicate records, data completeness (e.g., variables, labels and missing data); data validity (e.g., frequency distribution anomalies and out-of-range values) and data consistency (e.g., correspondence between the number of interviews at each level and skip patterns). ICF forwarded identified data inconsistencies to the in-country data teams for review and correction. Final data review and preparation for analysis took place at ICF after receipt of the cleaned dataset.

E. Data Analysis

Sampling Weights

Sample weights were computed for each indicator corresponding to a unique sampling scheme. The sampling weight consists of the inverse of the product of the probabilities of selection from each of the stages of sampling (EA selection, dwelling selection, and, when relevant, household selection and individual selection). Separate weights were derived for indicators and adjusted to compensate for household and individual non-response as shown in Table 2.2. Given that all eligible individuals are selected for Modules D, G and J, the sampling weights for these modules differ from those for households (used in Modules C, F, and H) by an individual non-response adjustment only. Single questionnaire items that were missing responses were not imputed for or included in the calculations for relevant indicators.

Table 2.2: Survey Response Rates

	Number Sampled	Number Surveyed	Response Rate
Households (Modules C, F and H)	5,236	5,006	95.6%
Children 0-59 months (Module D)	3,811	3,794	99.6%
Women 15-49 years of age (Module E)	3,828	3,481	90.9%
Women 15-49 years of age who were not pregnant or were two months postpartum	3,566	3,160	88.6%
Farmers (Module G)	6,363	6,361	99.9%
Primary male decisionmakers (Module J)	3,075	2,626	85.4%
Primary female decisionmakers (Module J)	4,746	4,567	96.2%

Indicator Definitions and Tabulations

FFP indicators were calculated using tabulation methods documented in the *FFP Standard Indicators Handbook*. Table A4.1 in Annex 4 presents the specific definition and disaggregation for each indicator. Child stunting and underweight indicators are derived from the WHO child growth standards and associated software.[13] Consumption aggregates—to compute prevalence of poverty, mean depth of poverty, and per capita expenditure indicators—follow the World Bank's Living Standards Measurement

[13] WHO. (2011). WHO Anthro and macros, version 3.2.2. Available at http://www.who.int/childgrowth/software/en/.

Study[14] methodology for the design of the expenditure modules in the questionnaire and estimation of daily per capita consumption of goods and services (see Annex 5 for more detail). The lack of purchasing power parity exchange rates for Zimbabwe, however, meant the poverty line needed to be set to the national definition instead of the standard USD $1.25 poverty line. The national poverty line is based on Zimbabwe's Total Per Capita Poverty Datum Line (TPCPDL), which in turn is based on data collected from the 2011 PICES survey. Definitions for program-specific indicators are provided in Table A4.2 of Annex 4.

Results for all indicators are weighted to represent the full target population for each Title II program and overall. Point estimates and variance estimation are derived using Taylor series expansion and take into account the design effect associated with the complex sampling design; 95 percent confidence intervals are provided for all FFP indicators. The tables in Annex 6 present a tabular summary of all FFP and program-specific indicators, confidence intervals, standard errors, design effects and weighted population estimates for each Title II program and the overall Title II implementation area.

Handling of Missing or Erroneous Data

Missing data points were excluded from the denominator and numerator for all FFP and program-specific indicator calculations. "Don't Know" responses, recoded to the null value, were included in the denominator. For example, for the household dietary diversity component, "Yes," "No" and "Don't Know" responses were included in the denominator, but only "Yes" responses were counted in the numerator.

For anthropometry indicators, the WHO software flagged biologically implausible cases according to WHO criteria,[15] and only those children with valid weight and height scores were included in the analysis for the stunting and underweight indicators. Implausible cases were excluded from the analysis but left in the dataset.

Multivariate Models

Multivariate analyses were performed to broaden the understanding of the causes of malnutrition in children using the height-for-age Z score (HAZ) in children under 24 months of age, a measure of stunting and a critical malnutrition indicator. An ordinary least squares regression approach was used to develop the model. Independent variables were selected based on the availability of variables from survey data and their theoretical relevance as predictors, which was established through relevant literature review and comparison to previous study results. Annex 7 gives a full description of the rationale for the model, independent variables included in the model, references and detailed results. It is worth noting that this model is exploratory rather than causal and that the possibility of unobserved variable bias cannot be ruled out.

2.2 Methods for Qualitative Study

A. Objectives, Design and Topical Focus Areas

In undertaking a qualitative study as part of the baseline study, ICF worked toward two objectives. First, identify, examine and contextualize the challenges *Amalima* and ENSURE teams might face in achieving their program goals. Second, collect and analyze data to complement the household survey and provide clarity and enhance interpretation of the survey's quantitative data.

[14] Living Standards Measurement Study. Available at http://econ.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTRESEARCH/EXTLSMS/0,,menuPK:3359053~pagePK:64168427~piPK:64168435~theSitePK:3358997,00.html.

[15] WHO Multicentre Growth Reference Study Group. (2006). WHO child growth standards: Length/height-for-age, weight-for-age, weight-for-length, weight-for-height and body mass index-for-age: Methods and development. Geneva: World Health Organization.

The household survey FFP indicators collected data used to inform the qualitative study design. In particular, the preliminary unweighted midterm baseline dataset (collected midway through the data collection cycle, representing half of the full dataset) was reviewed as part of the qualitative study design. The data review provided context and confidence in assessing the food security situation in the *Amalima* and ENSURE Program areas. Examining preliminary unweighted indicator estimates for health and WASH guided the organization of the qualitative study around broad themes and the identification of specific topics and multilayered investigatory questions. Table 2.3 is an overview of the topical focus areas for the qualitative work, organized in four broad themes with topics and investigatory questions under each theme. The topical focus areas were an important underpinning for development of the qualitative study interview guide. The English/Ndebele and English/Shona versions of the interview guide appear in Annexes 8 and 9, respectively.

Table 2.3: Topical Focus Areas for the Qualitative Study

1. Household Vulnerabilities and Food Insecurity	
Livelihoods **Access to Food** **Food Allocations** **Family Dynamics** **Migration**	What economic and behavioral factors inform the different attributes and drivers of vulnerability? How do household members navigate varying cycles of vulnerability and build resiliency? What types of individual and shared coping mechanisms exist in general and in relation to food security shocks and stressors?
2. Maternal, Child Health and Nutrition	
WASH **Pregnancy** **Breastfeeding** **Childcare** **Access to Services**	What existing structures, traditions and practices [positively and negatively] inform health decisions? Are there ways men and women and families work to adopt a more preventive approach to health and nutrition? At individual and household levels, what are some of the motivations behind health positive choices?
3. Livelihood Options and Agricultural Productivity	
Sustainability **Resource Accessibility** **Farming Techniques** **Agricultural Challenges** **Livestock Management**	What influences and impacts the livelihood options (including non-agricultural and non-livestock sectors) and choices at the household level? What are the decision-making processes around agricultural production and livestock management? How do individuals address challenges to maintaining sustainable agricultural productivity?
4. Gender Equality and Empowerment	
Roles **Responsibilities** **Decision-making** **Equality and Justice** **Societal Perceptions**	What are the dynamics around gender at the household level? How do men and women—similarly or differently—see disparities in households? In what ways are decision-making options and skill-building opportunities for women perceived, valued, enhanced or devalued?

B. Site Selection

The household survey sample is an important backdrop to the qualitative component; however, the component is not designed to work with a sample size as large as the household survey or across all *Amalima* and ENSURE Program areas. The objectives for the qualitative component do not lend themselves to across-the-board coverage, but rather to a targeted approach, specifically, one that is purposeful and strategically inclusive. ICF deliberately selected districts, wards and individuals for interviews and focus group discussions to collect data that address the overall objectives of the qualitative work.

The district and wards selection process for qualitative data collection in the seven districts was largely guided by a review of preliminary unweighted baseline data, based on the following factors:

- Collect data in at least one district in each of the four provinces that are the focus areas for the *Amalima* and ENSURE Programs.
- Collect data in districts from which at least 50 percent of the households are represented by the preliminary data, when possible.
- Represent variations in cultural practices, in particular in districts where polygamous households are represented.
- Include districts that border Botswana, South Africa or Mozambique to examine the impacts of migration and crossborder trading.
- Consider travel, logistics, ease of access, and working with a tight budget and short timeframe.

The seven districts selected for the qualitative study are listed in Table 2.4. In undertaking focus group discussions and program- and household-level interviews, the qualitative team worked in two wards in each district, both of which were part of the household survey sample. The selection of the wards was pre-determined based on review of the household survey data and selection criteria.

Table 2.4: Geographical Focus Areas for the Qualitative Study

	Province	District	Wards Selected
Amalima Program Areas	Matabeleland South	Bulilima	7 and 21
		Gwanda	17 and 18
	Matabeleland North	Tsholotsho	2 and 15
ENSURE Program Areas	Manicaland	Buhera	17 and 29
		Chimanimani	4 and 5
	Masvingo	Bikita	2 and 4
		Chivi	14 and 25

C. Study Participants, Interviewing and Data Collection

The household survey questionnaire is broken into several modules with different respondents according to the FFP indicators. The three respondent groups are (1) head of household or responsible adult, (2) women 15-49 years of age and (3) primary caregiver or mother of children under five years of age. Logically, not all respondent groups were present in each sampled household. The three respondent groups, however, were each relevant to the qualitative study, individually and as overlapping categories. The qualitative team also ensured inclusion of pregnant women, mothers with newborns, mothers with infants 6-23 months of age and men. Three types of interviews were conducted:

- *Focus group discussions*: Groups of women only, men only and men and women together.
- *Program-level interviews*: Village health workers, para-veterinary facilitators, leader of farmers groups (lead farmers), leaders of mother groups (lead mothers), environmental health technicians, organizers of village savings and loan groups, WASH officers, nutrition specialists, agricultural and livelihoods specialists and gender advisors.
- *Household-level interviews*: Household heads, farmers, mothers with children (0-23 months of age), fathers with children (0-23 months of age) and pregnant women.

To implement the qualitative study, ICF worked in collaboration with the local subcontracting firm, M-Consulting Group. The ICF qualitative expert travelled to Zimbabwe before data collection started to work with the subcontractor in the final design decisions, discussion of logistical matters and translations and training for the research assistants, transcribers and translators. Two data collection teams, one Ndebele-speaking (*Amalima*) and one Shona-speaking (ENSURE), each comprising four research assistants, conducted the interviews.

Gaining permission to conduct interviews in the various wards was required in all districts. This process varied by district and the time required to gain access, which ranged from a few hours to one-and-a-half

days. In general, after arriving in the district and before data collection, the ICF and M-Consulting qualitative experts made in-person visits to various authorities (security official, district administrators and rural district council) and local leaders (chiefs, headmen and ward councilors). During these visits, the purpose of the study and copies of the questionnaire and field movement plan were explained. Authorities then provided verbal approval or stated additional procedures needed during the interviews. Police intelligence officer observation of one focus group discussion and household-level interview was required as part of the approval process for Chimanimani.[16] After following necessary protocols, the qualitative team received permission to conduct interviews in all pre-selected wards.

Data collection was staggered between the two program areas, which allowed the ICF and M-Consulting qualitative experts to be with data collection teams for the pilot interviews and beginning of data collection. It also allowed the necessary permissions to be obtained before data collection. The two qualitative experts and the first research team arrived in the *Amalima* Program area on July 22. Two pilot focus group discussions were conducted on July 23 in a peri-urban settlement outside of Bulawayo. After some slight post-pilot revisions to the interview guide, data collection in Gwanda, Tsholotsho and Bulilima, respectively, took place from July 24 to August 10. The two qualitative leads and the second research team arrived in the ENSURE Program area on August 4 and two pilot focus group discussions were conducted in Chimanimamni Ward 8 on August 5. Data collection took place in Chimanimani and Bikita from August 6 to 9. The research team then took a break for the public holidays on August 11 and 12 and then returned with the M-Consulting qualitative lead on August 13. Data collection was conducted in Buhera and Chivi from August 13 to 16.

Overall, the teams conducted 41 household-level interviews, 8 focus group discussions and 15 program-level interviews, which yielded an overall sample of 44 men and 79 women, or 123 individuals. Participants in the eight focus groups were purposely selected to meet specific criteria and focus group discussions were conducted with the following groups: mothers and fathers with children under two years of age, farmers, pregnant women, village health workers, women 15-49 years of age and potential male migrants.

The 15 program-level interviews were with 5 men and 10 women; of the 41 household-level interviews, 13 were with men and 28 with women; and for the 8 focus group discussions, 3 were with women only, 2 were with men only and 3 were with both men and women. Each focus group discussion lasted approximately two hours and thirty minutes. Each program-level interview lasted approximately 40 minutes. Each household-level interview lasted approximately one hour fifteen minutes. All focus group discussions and interviews were digitally recorded. (See Annex 10 for the full tally sheet of all 64 focus group discussions and interviews).

D. Data Preparation, Coding and Analysis

Before completion of the data collection, M-Consulting Group began transcribing and translating the digitally recorded focus group discussions and interviews. ICF worked closely with M-Consulting to ensure that the transcripts from spoken Shona and Ndebele to written Shona and Ndebele were verbatim and that the translations from written Shona and Ndebele to written English were carefully considered for linguistic nuances, particularly because much of the subject matter relates to sensitive topics on food security, nutrition, maternal health, agriculture and gender.

While the transcription and translation proceeded, the ICF qualitative lead established protocols for coding each transcript—the data—in ATLAS.ti software. The goal of data coding was to topically categorize and organize the content of the transcripts, which was the first step in identifying themes. Codebook development was an iterative process, with both the organization and specific codes informed by the goals of the *Amalima* and ENSURE Programs, content of the interview guide and

[16] The ICF and M-Consulting qualitative experts conducted debriefings with the interview team after each interview and assessed responses for bias. Discussions with interviewers and transcript reviews where intelligence offices were present indicated that responses were tainted or biased by the presence of the intelligence officers.

knowledge of the preliminary indicator values. The ICF qualitative lead and three ICF analysts conducted a pilot coding exercise to establish coder consistency protocols and further develop the organization of document families, code families and individual codes in ATLAS.ti. The codebook is presented in Annex 11.

The 64 transcripts were coded by the ICF qualitative lead and three ICF analysts from September 2 to 21. The team was in regular communication to facilitate consistency in the application of the codes. After the coding was complete, the ICF qualitative lead ran queries on the coded data to analyze the content and themes emerging from the qualitative study, draw out data that would work to interpret and triangulate findings from the household survey and identify data related to the overall food security and malnutrition situation in the program area.

2.3 Study Limitations and Issues Encountered

This section summarizes study limitations and issues encountered during the baseline study.

Logistics and Transportation Constraints

The data collection team experienced significant challenges with the geography and road conditions in some districts. In some instances, travel from one EA to another took several hours. Flooding in the Tsholotsho district during the last month of fieldwork made the roads treacherous and the teams experienced great difficulty in accessing some EAs; two EAs in Chivi district were replaced because flooding required entire villages to relocate.

Process of Obtaining Clearance for Fieldwork

The protocols for obtaining approval for fieldwork, locally referred to as the "sensitization process," usually involved clearance from the district government, police authorities and intelligence offices. After obtaining central government approval, completing the sensitization process for the household survey in each district took anywhere from several days to two weeks. The qualitative study followed similar sensitization processes, and gaining clearance took one day on average. Local intelligence officers usually accompanied the field teams to observe the interviews, often at the beginning of fieldwork, although they did not have a continued presence in the surveyed areas throughout the fieldwork and the number of interviews they observed was limited.

Length and Complexity of the Questionnaire

The length and complexity of the questionnaire made interviews difficult. Interviewers often needed to explain survey questions. To maintain consistency, each interviewer carried a printed manual to use as a reference. The questionnaire was divided into three separate components that were not always conducted simultaneously in each household: (1) general questionnaire of FFP and program-specific indicators, (2) the WEAI access to resources module and (3) anthropometry module. The three separate components took approximately two hours, but could take up to three hours in some cases, to complete in each household. In addition, the survey required responses from multiple household members, which added to the time required to complete the questionnaire because interviewers often needed to wait or return to households later to interview appropriate respondents. The lengthy questionnaires increased the risk of interviewer and respondent fatigue and were burdensome for many households.

Validity and Reliability of Self-reported Data

Most of the data collected for the indicators rely on self-reporting. Self-reporting has several limitations, such as the possibility of exaggeration or omission of information, inaccurate recollection of experiences or events, social-desirability bias or reporting of untruthful information and reduced validity when respondents do not fully understand a question.

Small Sample Sizes for Minimum Acceptable Diet and Exclusive Breastfeeding

The sample size for children 6-23 months of age for the minimum acceptable diet (MAD) indicator and for children under six months for the exclusive breastfeeding indicator are small compared to the sample sizes for all other indicators. Thus, the subgroup analyses for these children presented in Sections 4.5C and 4.5D should be interpreted with caution because the small sample sizes yield unreliable estimates for these subgroups.

3. Overview of the Food Security Situation in Zimbabwe

Background

Food security is a significant challenge for Zimbabwe, where the 2013 Global Hunger Index[17] is classified as "serious" at 16.5.[18] The food security situation in Zimbabwe in 2008 was likely the worst ever on record when approximately 5.1 million people (approximately 45 percent of the population) were in need of food aid as estimated by the June 2008 U.N. Food and Agriculture Organization (FAO) and U.N World Food Programme's (WFP) joint Crop and Food Supply Assessment (CFSAM). From 2009 to 2013, the percentage of food-insecure[19] households during the lean season ranged from a low of 12 percent to a high of 19 percent.[20]

According to the most recent DHS, conducted in 2010-2011, 10 percent of children under five years of age are underweight and the rate of wasting for this population is 3 percent. Nearly one-third of children under five years of age are stunted. Zimbabwe also has high anemia levels. More than half of children under five years of age and one-quarter of women of reproductive age are anemic and the rates of HIV and acquired immune deficiency syndrome (AIDS) (15 percent of adults) are high.[21] Proper nutrition is a critical element of care for people living with HIV/AIDS and evidence indicates that AIDS-affected households experience greater food insecurity and resort to detrimental coping strategies more often than other households.[22]

The food security challenges in Zimbabwe are related to all four pillars of food security: (1) availability of food, (2) access to food, (3) use of food and (4) stability. In 2000, the country embarked on a monumental land reform process during which the government redistributed land belonging to large commercial farmers to small- and medium-sized farmers. Demand for farmland is considerable because only 11 percent of Zimbabwe's land is arable.[23] As a result of this reform and the enduring political and economic turmoil, Zimbabwe's agricultural productivity decreased dramatically in the ensuing years, severely affecting food access. Persistent uncertainty about land tenure has resulted in limited investment in farms and reduced ability to secure loans because land may not be accepted as collateral. Irrigation systems have fallen into disrepair, and now 70 percent of the population relies on rain-fed

[17] The Global Hunger Index is a tool designed to comprehensively measure and track hunger globally and by region and country.

[18] International Food Policy Research Institute. (2013). *2013 Global Hunger Index: The challenge of hunger: Building resilience to achieve food and nutrition security*. Available at http://www.ifpri.org/sites/default/files/publications/ghi13.pdf.

[19] Household food security status was determined by measuring the household's potential access to enough food to give each member a minimum of 2100 kilocalories per day in the consumption period April 1, 2013, to March 31, 2014.

[20] Food and Nutrition Council, Scientific and Industrial Research and Development Centre. (2013). *Zimbabwe Vulnerability Assessment Committee (ZimVAC) 2013 Rural Livelihoods Assessment: Draft Report.* Available at http://www.humanitarianresponse.info/operations/zimbabwe/document/zimvac-rural-livelihoods-assessment-draft-report2013.

[21] Zimbabwe National Statistics Agency & ICF International. (2012). *Zimbabwe Demographic and Health Survey 2010-2011*. Calverton, Maryland: ZIMSTAT & ICF International. Available at http://dhsprogram.com/pubs/pdf/FR254/FR254.pdf.

[22] Mazzeo, J. (2011). "Cattle, livelihoods, and coping with food insecurity in the context of drought and HIV/AIDS in rural Zimbabwe." *Human Organization*, *70*(4), 405-415.

[23] Famine Early Warning Systems Network. (2014). *Zimbabwe food security brief*. Available at http://www.fews.net/sites/default/files/documents/reports/Zimbabwe_Food_Security_Brief_2014_0.pdf.

agriculture. Rainfall, however, is highly erratic and causes crop failures three out of five years.[24] Productivity is also limited by the high cost of critical inputs and insufficient agricultural extension services. The low productivity is exacerbated by high rates of post-harvest loss.

The most important food crops include maize, sorghum, millet and groundnuts; however, maize is by far the most produced and consumed crop throughout the country, grown by 80 percent of rural households. After maize, groundnuts are the most frequently produced crop, planted by one-third of households.[25] Production is limited by the use of outdated seed varieties, lack of credit availability for legumes and reluctance to use appropriate fertilizers.[26] Efforts have been undertaken to increase production of millet and sorghum due to their drought tolerance; however, only one-fifth of rural households planted sorghum in the 2012-2013 season.[27] The reluctance to plant small grains stems from their low yield compared to maize, taste preferences, concerns over bird damage, the labor intensity of post-harvest processing and limited marketing opportunities for small grains.[28]

Agricultural productivity is one limiting factor in the availability of food, reflected in a scarcity of food in the markets in some areas or availability only at inflated prices. The country struggles with weak import capacity[29] and is vulnerable to international price instability. Food must be purchased with cash, which many families are unable to access. While the economy is much better than in 2008 when it collapsed after a period of hyperinflation, poverty remains widespread. An estimated 95 percent of the population is either unemployed or underemployed.[30] According to the National Statistics Office, 76 percent of rural households are poor, and of these, 30 percent are very poor (compared to 38 percent and 6 percent, respectively, for urban households).[31] The average rural household income for April 2013 was USD $95.[32]

Families also suffer from inefficient food use due to poor sanitation and child feeding practices. DHS found that while most urban households have access to an improved water source, more than one in four rural households does not. Approximately one-third of households have access to an improved, non-shared toilet facility. DHS results for all of Zimbabwe indicate that only 5 percent of non-breastfed children and 13 percent of breastfed children 6-23 months of age receive appropriate complementary nutrition and approximately one-third of children under six months of age are breastfed exclusively.[33]

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[24] Mugabe, F., Thomas, T., Hachigonta, S., & Sibanda, L. (2013). Zimbabwe. In S. Hachigonta, G. Nelson, T. Thomas, & L. Sibanda (Eds.), *Southern African agriculture and climate change: A comprehensive analysis* (289-324). Washington, DC: International Food Policy Research Institute.

[25] Food and Nutrition Council, Scientific and Industrial Research and Development Centre. (2013). op. cit.

[26] Chabata, I., & Chipomho, C. (2013). *Limitations in the production of legume crops in Zimbabwe.* Wageningen, Netherlands: N2Africa. Available at http://www.n2africa.org/content/limitations-production-legume-crops-zimbabwe.

[27] Food and Nutrition Council, Scientific and Industrial Research and Development Centre. (2013). op. cit.

[28] Zishiri, C. (n.d.). *Small grains and food and nutrition security.* Harare: Ministry of Agriculture, Mechanisation, and Irrigation Development. Available at http://www.moa.gov.zw/index.php/departments/agritex/agronomy-crops/small-grains.

[29] WFP. (2013). *Special focus: Zimbabwe*. Available at http://documents.wfp.org/stellent/groups/public/documents/ena/wfp260895.pdf.

[30] Government of the Republic of Zimbabwe & Food and Agriculture Organization of the United Nations. (2011). Country programme framework 2012-2015. Available at http://www.unicef.org/about/execboard/files/Zimbabwe_final_approved_2012-2015_20_Oct_2011.pdf.

[31] ZIMSTATs "approach mainly uses per capita consumption expenditure indices combined with other measures of well-being such as household characteristics, asset ownership and access to social services in measuring well-being" (p. 74).

Zimbabwe National Statistics Agency. (2013, April). *Poverty Income Consumption and Expenditure Survey 2011/12 Report*. Available at http://catalog.ihsn.org/index.php/catalog/4658/download/58930.

[32] Food and Nutrition Council, Scientific and Industrial Research and Development Centre. (2013). op. cit.

[33] Zimbabwe National Statistics Agency & ICF International. (2012). op. cit.

Reasons for the low rate of exclusive breastfeeding include beliefs that the supply of breast milk is inadequate and beliefs in the necessity of supplementing with traditional foods to prevent illness.[34]

Stability is another challenge for food security in Zimbabwe. The country's agricultural productivity is vulnerable to droughts and flooding, as well as political conflict and international economic fluctuation. Variations in productivity also occur as a result of plant and animal disease and pest outbreaks and wildfires. To cope with economic downturns and land reform, some families turn to practices such as logging and illegal mining, which increase the country's vulnerability to natural disasters and reduce the productivity of the land. Zimbabwe faces a range of environmental issues, including desertification, low soil fertility, water pollution, significant soil erosion and depleted soil fertility.[35]

Current Food Security Summary

The Famine Early Warning Systems Network (FEWSNET) reported that households across the country were expected to experience minimal food insecurity during the period from April to September 2014 due to early harvests and decreasing food prices.[36] For most of the country, January through March is the lean season.[37] Data collection for the Title II baseline survey took place starting in late March and concluded on May 1. This period represents the end of the lean season and the beginning of the green harvest period. While most areas exhibited minimal food insecurity during this period, some areas in the southwest met the criteria of stressed, according to FEWSNET.[38] For most of the country, rain during the previous months (October 2013 to March 2014) was abundant and well distributed, allowing for the early harvest of early-planted crops. Most poor households had access to maize, groundnuts, pumpkin and cowpeas during the data collection period; however, flooding destroyed crops in some areas, including parts of Tsholotsho and Chivi.[39] Overall, seasonal performance was expected to be above average in most of the country, including Mangwe, Gwanda, Chivi, Bikita, Buhera and Zaka.[40]

A variety of programs in addition to the Title II programs are being implemented across the country to improve Zimbabwe's long-term food security, including the following examples:

- The Government of Zimbabwe launched the National Food and Nutrition Security Policy in May 2013 "to ensure adequate food and nutrition security in Zimbabwe for all people at all times."[41] The multisectoral policy is intended to support a coordinated, integrated program to address food insecurity. Initial planned activities included maize distribution to address shortages. The policy guides the Food and Nutrition Council, which coordinates activities among relevant government bodies and ensures adequate collection and analysis of food security data.
- WFP's annual Productive Asset Creation project provides food rations or cash transfers to food-insecure individuals in exchange for work on community projects. The project is implemented in selected wards throughout the country.

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[34] Desai, A., Mbuya, M. N., Chigumira, A., Chasekwa, B., Humphrey, J. H., Moulton, L. H., & Stoltzfus, R. J. (2014). Traditional oral remedies and perceived breast milk insufficiency are major barriers to exclusive breastfeeding in rural Zimbabwe. *The Journal of Nutrition, 144*, 1113-1119.

[35] Government of the Republic of Zimbabwe & Food and Agriculture Organization of the United Nations. (2011). op. cit.

[36] FEWSNET. (2014). Zimbabwe: Food security outlook: April 2014 to September 2014. Available at http://www.fews.net/print/southern-africa/zimbabue/food-security-outlook/wed-2014-04-30-tue-2014-09-30.

[37] WFP. (2014). Zimbabwe food security outlook, January-March 2014. Available at http://www.wfp.org/sites/default/files/Zimbabwe%20Food%20Security%20Outlook_Jan_March%202014%20(2).pdf.

[38] FEWSNET. (2014). *Zimbabwe: Food security outlook update*. Available at http://www.fews.net/southern-africa/zimbabue/food-security-outlook-update/mon-2014-03-24.

[39] Ibid.

[40] FEWSNET. (2014). *Zimbabwe: Food security outlook: April 2014 to September 2014.* Available at http://www.fews.net/southern-africa/zimbabwe/food-security-outlook/april-2014.

[41] United Nations Zimbabwe. (2013). *National Food and Nutrition Security Policy Launched*. Available at http://www.zw.one.un.org/newsroom/news/national-food-and-nutrition-security-policy-launched.

- With USAID funding, Fintrac is implementing Zim-AIED, a project intended to improve food security by increasing incomes and employment and developing market linkages. The project works throughout the country and runs from 2010 to 2015.
- With USAID funding, Development Alternatives Inc. (DAI) is working to improve Zimbabwean food production through the Agricultural Competitiveness Program, which runs from 2010 to 2015. The project works throughout Zimbabwe and includes activities such as improving market infrastructure and building agribusiness skills.
- With funding from the Danish International Development Agency, SNV Netherlands Development Organization began the latest phase of the Rural Agriculture Revitalization Project, Commercialization of Smallholder Farming in 2014. The three-year project works throughout rural Zimbabwe to develop value chains to boost agriculture.

4. Findings

The baseline study findings are organized in six content categories: (1) characteristics of the population; (2) household indicators, which include food access indicators, poverty indicators and WASH indicators; (3) agricultural indicators; (4) women's health and nutrition; (5) children's health and nutrition; and (6) gender equity. Each section includes results for FFP and program-specific indicators, along with relevant results from the qualitative study. The findings are presented for the *Amalima* and ENSURE Program areas separately and combined.

4.1 Characteristics of the Study Population

This section gives an overview of the *Amalima* and ENSURE Program areas. Estimates of the total population in the program areas and household characteristics are presented from the household survey.

A total of 5,006 household interviews were completed in the Title II program areas: 2,483 in the *Amalima* Program area and 2,523 in the ENSURE Program area. Table 4.1a provides weighted estimates of the overall populations and various subgroups of the population for the Title II program area overall and each Title II program separately. The *Amalima* Program area includes an estimated 284,785 people and 51,820 households and the ENSURE Program area includes an estimated 486,980 people and 95,020 households.

Table 4.1a. Total Population in the Title II Area by Program
[Zimbabwe, 2014]

	Total	Amalima	ENSURE
Total population	771,765	284,785	486,980
Male	367,172	135,940	231,232
Female	404,593	148,845	255,748
Total households (HH)	146,840	51,820	95,020
Male and female adults	103,012	35,473	67,539
Female adults only	37,347	13,325	24,022
Male adults only	6,056	2,793	3,263
Child no adults	425	229	196
Women of reproductive age (15-49 years)	158,321	56,643	101,678
Women 15-49 who are not pregnant or post-partum	146,682	52,996	93,686
Women who gave birth to a child within the past two years	44,309	13,849	30,460
Children under five years	111,980	39,429	72,551
Males under five years	56,860	20,738	36,122
Females under five years	55,120	18,691	36,429
Children under six months	21,553	12,645	8,908
Males under six months	11,424	6,712	4,712
Females under six months	10,129	5,933	4,196
Children 6-23 months	32,308	10,751	21,557
Males 6-23 months	15,758	5,398	10,360
Females 6-23 months	16,550	5,353	11,197

Source: USAID Title II baseline survey in Zimbabwe (2014), weighted population estimates

Table 4.1b shows the characteristics of these households. The average household includes 5.3 household members. Children under five years of age are household members in just over half of all households. About one in five households includes a child 6-23 months of age, and children under six months of age are household members in 6 percent of households. Nearly 50 percent of heads of household have completed primary school and 36 percent have completed secondary school. Secondary education levels are lower in the *Amalima* Program area (26 percent) than in the ENSURE Program area (42 percent).

About 70 percent of households included an adult male and female and 25 percent of households included an adult female but no adult male.

Table 4.1b. Household Characteristics
Household characteristics by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Average household size (number of persons)	5.3	5.5	5.1
Percent of households with children under five years	54.7	53.3	55.4
Percent of households with a child 6-23 months	20.8	19.5	21.5
Percent of households with a child under 6 months	6.3	6.8	6.0
Household headship (percent male)	58.2	52.0	61.5
Education level of head of household (percent of households)			
No formal education	13.6	15.8	12.5
Pre-primary	0.0	0.0	0.0
Primary	48.6	56.4	44.3
Secondary	35.7	26.4	40.8
Higher	2.0	1.2	2.4
Gendered household type (percent of households)			
Adult Female no Adult Male	25.4	25.7	25.3
Adult Male no Adult Female	4.1	5.4	3.4
Male and Female Adults	70.2	68.5	71.1
Child No Adults	0.3	0.4	0.2
Number of responding households	5,006	2,483	2,523
Adult Female no Adult Male	1,278	639	639
Adult Male no Adult Female	222	131	91
Male and Female Adults	3,490	1,702	1,788
Child No Adults	16	11	5

4.2 Household Indicators

This section begins with the household survey findings for the household hunger scale (HHS), followed by the results for the household dietary diversity score (HDDS), the food consumption score (FCS) and the coping strategies index (CSI). The next section describes the results for the three poverty indicators followed by results for household WASH practices. Analysis of the qualitative data follows the presentation of each indicator to complement the household survey findings and provide clarity and enhancement to the interpretation of the survey's quantitative data.

A. Household Hunger Scale

Household hunger was measured using the HHS, a perception-based food deprivation scale. The scale consists of three components to measure inadequate household food access, with each component split into an occurrence question (whether the episode of food deprivation occurred at all in the past four weeks) and a frequency of occurrence question (how many times the episode had occurred in the past four weeks). The responses to the questions are coded and summed into a numerical score (with a minimum possible score of 0 and a maximum possible score of 6) representing three levels of hunger: (1) *Little to no hunger* (score = 0 to 1), (2) *Moderate hunger* (score = 2 to 3) and (3) *Severe hunger* (score = 4 to 6).

Table 4.2a shows the results for the HHS. Overall, 28 percent of households suffer from moderate or severe hunger and about 4 percent of households suffer from severe hunger. Households with an adult female and no adult male experienced higher rates of severe hunger compared to households with an adult male present. The HHS is based on perceptions of hunger in the past four weeks, and thus, may be

sensitive to the season in which the survey is conducted. The household survey data were collected during March and April, at the end of the lean season and beginning of the green harvest period.

Table 4.2a. Food for Peace Indicators - Household Hunger Score (HHS)
Household-level FFP indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
HHS (All Households)			
Prevalence of households with severe hunger	4.3	4.8	4.0
Adult Female no Adult Male	5.8	7.2	5.0
Adult Male no Adult Female	3.4	5.8	1.4
Male and Female Adults	3.8	3.8	3.7
Child No Adults	0.0	0.0	0.0
Prevalence of households with moderate or severe hunger	27.7	29.3	26.9
Adult Female no Adult Male	27.7	32.0	25.3
Adult Male no Adult Female	21.2	21.9	20.5
Male and Female Adults	28.1	28.9	27.7
Child No Adults	26.7	15.8	39.5
Number of responding households	4,916	2,426	2,490
Adult Female no Adult Male	1,258	627	631
Adult Male no Adult Female	214	125	89
Male and Female Adults	3,428	1,663	1,765
Child No Adults	16	11	5

The qualitative data, through inquiry on the number of meals eaten per day, illustrate similarities in food consumption patterns between the two program areas. Across both program areas, the number of meals eaten per day ranged from two to five, with most respondents indicating that children ate more frequently than adults did. Further, when respondents discussed their consumption patterns, definitions of what constitutes a meal differed; therefore, although the number of times they eat might be similar, the amount and type of food they are eating might vary greatly.

Respondents who described eating a higher frequency of meals per day stated when and which types of foods they frequently eat. For example, in a focus group discussion with pregnant women from Chivi, one woman described her household's eating patterns in the following way:

> We eat four times a day, in the morning when we get up we cook porridge, in the afternoon we prepare tea, after some time we boil even squashes, then I boil some nuts, and I once more cook *sadza* [cooked cornmeal] in the evening.

Participants in the qualitative study who ate less frequently generally described eating patterns in similar ways. A respondent from Bulimia stated, "I eat twice. I drink tea in the morning, *sadza* with vegetables in the afternoon and *sadza* with vegetables in the evening."

Meal frequency varied depending on several factors, such as the time of year, availability of condiments, agricultural production and food aid. A male migrant worker from Bikita described this variation in the following way:

> [I] can personally say [I eat] two times a day because of lack of adequate food. If you don't have sugar you have to wait until 12 o'clock to have some food. It was better during the time when we were getting some aid from CARE. The family could have porridge in the morning, then have some tea around 10 o'clock if there was sugar, then have some sadza in the afternoon around 1 o'clock and that makes them three meals a day.

Although some respondents discussed limiting the number of meals eaten due to availability, consistent with the survey data, few described instances of severe hunger, such as going to bed hungry or spending a whole day without food. In a focus group discussion with mothers of children under two years of age, one participant from Tsholotsho recalled, "although 2008 was a bad year for all of us, we never went for a day without food; instead we resorted to having one meal a day that is in the evening only." Further, several respondents stated that because the past year produced a bumper harvest they are able to eat more meals per day. As noted by a respondent from Gwanda, "These days we are eating quite well. We can eat even four times a day."

B. Household Dietary Diversity Score

The HDDS is based on the number of different food groups consumed by the head of household or any other household members in the past 24 hours. The set of 12 food groups is derived from FAO. The HDDS ranges from 0 to12, with lower numbers indicating less dietary diversity. Although the HDDS gives an indication of food groups consumed in the household, the HDDS should not be interpreted as a nutrition indicator that reflects diet quality, but rather as an indicator of food access; thus, it serves as a proxy for socioeconomic status.

Table 4.2b presents results for the HDDS. The overall score of 5.1 indicates that on average 5 of the 12 food groups are consumed in each household in the past 24 hours. In both program areas, over 98 percent of households consume cereals. Some differences between the two program areas were observed for other food groups, particularly roots and tubers, fruits, milk and milk products, oils and fats and sugar and honey.

Table 4.2b. Food for Peace Indicators - Household Dietary Diversity Score (HDDS)
Household-level FFP indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
HDDS (All Households)			
Average Household Dietary Diversity Score	5.1	5.3	5.0
Cereals	98.3	98.3	98.3
Root and tubers	8.2	3.3	11.1
Vegetables	77.1	73.5	79.2
Fruits	37.9	53.4	28.9
Meat, poultry, organ meat	22.7	21.3	23.6
Eggs	5.7	4.6	6.4
Fish and seafood	12.0	7.8	14.5
Pulses/legumes/nuts	39.0	41.6	37.5
Milk and milk products	21.3	31.6	15.3
Oil/fats	60.1	48.9	66.7
Sugar/honey	73.8	83.3	68.2
Miscellaneous (tea, coffee, condiments, etc.)	52.3	62.1	46.5
Number of responding households	4,633	2,385	2,248

Qualitative data indicate that the local availability of foods plays a role in the degree of diversity in diets. In both program areas, factors such as seasonality, agricultural production and income influence the types of foods consumed. Further, the two programs are operating in different regional locations characterized by various climactic and environmental conditions, which also affect the types of foods available. A male farmer from Chivi notes the seasonal changes in the availability and diversity of food:

> During the harvesting season like now, we have a variety of food. We have tea, a mixture of boiled maize, groundnuts, cow peas and round nuts and peanut butter in our relish or rice from our field which is seasonal and dependent on the availability of rainfall.

In addition to the increased diversity in food due to production, respondents also reported having more food because of increased income. A farmer from Chimanimani stated, "Sometimes in the season of harvesting we can find food that will be a bit more because at that time we produce tomatoes. It kind of pays us a bit…little money comes, so food will be abundant."

During the qualitative data collection, respondents in both program areas described consuming a variety of foods. The most common types of foods consumed were cereals (maize, rice, millet and sorghum), fresh and dried vegetables (including okra, cabbage and *rape* [collard greens]), meat and poultry (fish, chicken, mice, *kapenta* [small dried fish or sardines] and caterpillars) and pulses [pulses are legumes and are plants that have pods with tidy rows of seeds inside. This category includes beans, peas, lentils and peanuts], legumes and nuts (groundnuts, round nuts[42], peas, cow peas and beans). Respondents also commonly mentioned tea, sugar, oil and peanut butter as part of their diet. Few respondents discussed eating fruits regularly, but the most frequently mentioned were melons, pumpkins, tomatoes and indigenous fruits.

The high prevalence of cereals in the diet can be attributed to consumption of *sadza.* Participants in both program areas expressed a strong sentiment about *sadza* as the primary component of any meal. Several respondents stated that if they did not have *sadza,* then they had not truly eaten. Further, many participants described their meals as primarily consisting of *sadza* and vegetables, which indicates a potential reason for the low dietary diversity.

In line with the household survey, the qualitative data indicate that more respondents in the *Amalima* Program area reported having milk. Although the higher prevalence of livestock leads to more consumption of milk, it did not equate to more consumption of meat, poultry or organ meat. Respondents with livestock often stated that they sold or consumed their livestock only in emergencies or for special occasions. The majority of respondents viewed their livestock as an asset rather than a food source. In addition to locally available foods, *Amalima* Program area participants also discussed being able to access more diverse foods from their family members who were working in the bordering countries of South Africa and Botswana. Further, although respondents in both program areas reported eating *kapenta*, more respondents in the ENSURE Program area reported having access to fresh fish. As a male migrant worker from Bikita stated, "The relish changes during the rainy season when there would be a lot of fish."

C. Food Consumption Score

The FCS is a frequency-weighted diet diversity score, also referred to as a "food frequency indicator." The FCS is calculated using the frequency of consumption (number of days) of eight food groups consumed by a household during the seven days before the survey weighted by the nutrient density of

[42] Round nuts (***Vigna subterranea*** or more commonly known as Bambara groundnuts) ripen their pods underground, much like the peanut. They can be eaten fresh or boiled after drying. They are known as n*yimo* in the Shona language and *indlubu* in the Ndebele language.

the food group. The household food consumption classification is a standardized, objective and replicable tool for describing short-term food security.[43]

A team of analysts determined the food group weights based on nutrient density, a term used to subjectively describe a food group's quality of caloric density, macro- and micronutrient content, and actual quantities typically eaten. Although subjective, this weighting attempts to give greater importance to foods such as meat and fish, usually considered to have greater nutrient density and lesser importance to foods such as sugar.[44] Using standard thresholds, the FCS is recoded from a continuous score to a categorical variable with three levels of food consumption: poor, borderline and adequate.

The FCS differs from the HDDS in the following ways:

- The reference period is seven days compared to the past 24 hours for the HDDS,
- The main staple group is not disaggregated into two groups (cereals, and roots and tubers) as it is for the HDDS.
- The meat, fish and eggs group is not disaggregated into its three subgroups as it is for the HDDS.
- The FCS has no group for "other foods," such as condiments, coffee or tea.
- The FCS takes into consideration the frequency of food consumption for each group, but the HDDS does not.
- The FCS weights food groups according to nutrient density, but the HDDS does not.

As seen in Table 4.2c, analysis of the FCS indicates that 4 percent of households fall into the poor food consumption category, 32 percent of households have borderline food consumption and 64 percent of households are considered to have adequate food consumption.

Table 4.2c. Program-Specific Indicators - Food Consumption Score (FCS)
Household-level program-specific indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
FCS - Percent of Households			
Households with FCS ≤ 21 (Poor)	4.1	4.0	4.2
Households with FCS > 21 and FCS ≤ 35 (Borderline)	32.0	31.4	32.3
Households with FCS > 35 (Adequate)	63.9	64.6	63.5
Number of responding households	4,993	2,475	2,518

Although respondents said they desired to eat several foods, factors such as availability and costs made their consumption prohibitive. Respondents from both program areas are challenged in eating foods with high nutritional density. The following exchanges with respondents from Gwanda and Chimanimiani highlight the limited consumption of nutritionally dense foods:

> **Interviewer:** What types of food are you not accustomed to eating?
> **Respondent:** Meat, tinned fish and beans as well as fresh fish from the dam. We are not accustomed to eating those. This is because our dams have not water due to siltation.

[43] WFP, Vulnerability Analysis and Mapping Branch (ODAV). (2008). Food consumption analysis - Calculation and use of the food consumption score in food security analysis. Rome, Italy.

[44] Wiesman, D., Bassett, L., Benson, T., & Hoddinott, J. (2009).Validation of the World Food Programme's food consumption score and alternative indicators of household food security, IFPRI Discussion Paper.

Interviewer: Is there food that you rarely eat and why?
Respondent: Meat and fruits, some of them we rarely get, there aren't many fruits apart from when you have been able to grow sugar cane. Things like paw-paws and avocado pears you have to take from your wallet in order to get them. In terms of farming fruit trees do not really do well.

Findings from the household survey and respondents' accounts of food consumption indicated, especially during the period of data collection, an increased availability and access to food. Yet, in both program areas, financial constraints and unavailability limit consumption of foods with high nutritional density. Further, although individuals may have access to various forms of meat, as discussed in the section on household dietary diversity, cattle, goats and poultry are generally regarded as assets rather than food sources, and therefore are rarely consumed.

D. Coping Strategies Index

The CSI measures the extent that households use different consumption coping strategies when faced with food access challenges. This indicator is a proxy of household resilience to food security shocks and provides an estimate of absorptive capacity, which can be defined as the ability to minimize exposure to shocks and stresses (*ex ante*), where possible, and to recover quickly when exposed to them (*ex post*).[45] The CSI can be used as a measure of the impact of food aid programs, as an early warning indicator of impending food crisis and as a tool for assessing both food aid needs and whether food aid has been targeted to the most food-insecure households.[46]

To measure the CSI, the survey asked households if they used any of 12 different coping strategies when facing difficulties accessing enough food to eat over a 30-day recall period. Frequency of use is recorded on a scale of 1 to 5, where 1 is "never" and 5 is "daily." These frequency scores are then recoded as Never (1) = 0; Seldom (2) = 0.5; Sometimes (3) = 1.5; Often (4) = 3.5 and Daily (5) = 7. Responses for each coping strategy are scored and weighted based on the severity of the coping strategy used and then summed to produce the CSI. The CSI ranges from 0 to 350, but the raw score is not necessarily the best way to interpret the indicator because it is impossible for a household to achieve the maximum of 350 unless all 12 coping strategies are used daily. This indicator has more meaning when benchmarked with another time point or another country.

Table 4.2d shows the results for the CSI. The *Amalima* Program area CSI is 33.8, somewhat higher than the ENSURE Program area CSI of 28.5. The interpretation of these baseline values will be more powerful when compared to future CSI values. A decrease in the CSI over time indicates reduced frequency and severity of coping behaviors. As a reference point, the Zimbabwe Vulnerability Assessment Committee (ZimVAC) 2014 Rural Livelihoods Assessment reported CSIs of 32 and 22 in Matebeleland North and Matebeleland South (*Amalima* Program area) and CSIs of 10 and 12 in Masvingo and Manicaland (ENSURE Program area). Differences between the baseline study and the ZimVAC survey may result from differences in the population surveyed and survey timing; because the baseline study 30 day recall period overlapped in part with the peak hunger season.

The most frequently used coping strategies included limiting portion size at meals, relying on less expensive or less preferred foods and reducing the number of meals eaten per day. More dire coping strategies, such as going an entire day without eating, harvesting immature crops, sending family members to eat elsewhere or begging for food, were reported by few households and were used infrequently.

[45] Frankenberger, T. & Nelson, S. (2012). Background Paper for the Expert Consultation on Resilience Measurement for Food Security. Tango International.

[46] CARE. (2008). The Coping Strategies Index Field Methods Manual, Second Edition.

Table 4.2d. Program-Specific Indicators - Coping Strategies Index (CSI)
Household-level program-specific indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Coping Strategies Index (CSI)			
Average CSI	30.5	33.8	28.6
Number of responding households	5,006	2,483	2,523

Participants in the qualitative study discussed using several strategies when faced with limited or no food availability: sleeping hungry; eating less frequently or eating a smaller portion; receiving help from family members, friends or aid organizations; selling livestock; migrating out of the country to find food or work; performing casual labor to earn money to buy food; and planning or budgeting ahead. In addition to these strategies, respondents from the ENSURE program area also mentioned eating *baobab* fruit [a common fruit from the *baobab* tree found in the region] as a way to stifle hunger.

The following exchange is from a focus group discussion in Gwanda with potential male migrants.[47] It illustrates the various strategies individuals used when faced with a food crisis.

Interviewer: Is there a time when you have felt hungry but found nothing to eat?
Respondent: It is quite common, especially during the times when there were no rains. We had no food and no money to buy any, so we would just sleep hungry.
Respondent 2: During times of drought you really sleep without putting anything into the mouth.
Respondent 3: Especially if there is no money to buy food for your family. Sometimes you would just get the very little that you can afford with your little money.
Interviewer: If this has happened to you, what did you do at the time?
Respondent 1: You see this place of ours; it differed from people to people. You see, some of our children who were teachers or educated are the ones who ended up aiding us because they would go out of the country and send us this or that when they got something. But those with no such children had a really tough time.
Respondent 2: The other honest truth is that when I have slept hungry, what must come to mind next is to think where I can get something or who I can go to for assistance.
Respondent 3: We would go for panning so that we could get some gold to sell. We would also at times cross to other countries to find some goods to sell.
Interviewer: Where do you get most of the food that you eat?
Respondent: From the fields.
Respondent 2: If you go for gold panning and get some cash, you can come back and buy some.
Respondent 3: We get most of our food from these organizations that aid people, the NGOs.
Interviewer: But are you satisfied with the availability of this food?
Respondent: We are not satisfied because the food that we get from the NGOs is limited. And they give out to only a few people when in reality everyone would be hungry. This is what causes us to be unsatisfied in the end.

[47] Focus groups were digitally voice recorded. Before the session began, participants were assigned a number to identify them, but preserve their anonymity. They were asked to state their number when they began to speak so they could later be identified by number in a transcript of the session. However, respondents sometimes forgot to state their number prior to speaking.

Respondents to the qualitative study described doing whatever possible to help mitigate food challenges or food security shocks; however, participants rarely mentioned planning or having strategies in place to mitigate food security shocks. The few strategies mentioned included modification of food consumption practices and other household-level initiatives. Few participants mentioned other sustainable community-level or agricultural initiatives, although those strategies include cooperative farming, sharing of resources or relying on food aid and agricultural initiatives that include growing drought-resistant crops, livestock rearing and gardening.

E. Household Poverty Levels

Poverty indicators are based on household expenditures, which are used as a proxy for income. Income in most developing countries and rural areas is difficult to measure, and expenditure data typically are less prone to recall error and distributed more evenly over time than income data.

The three FFP poverty indicators are (1) prevalence of poverty: percentage of people living on less than USD $1.25 per day, (2) daily per capita expenditures and (3) mean depth of poverty. The lack of official purchasing power parity rates for Zimbabwe prevented the computation of the FFP indicator, "prevalence of poverty: percent of people living on less than USD $1.25 per day," using the standard approach. Instead, this indicator and the mean depth of poverty indicator are based on Zimbabwe's own TPCPDL and therefore do not align with these FFP poverty indicators which are based on a poverty line of USD$1.25 per day.[48] See Annex 5 for definitions of these indicators and the methodology used to compute them. The results for these indicators appear in Table 4.2e.

Ninety-seven percent of the population in the Title II program area currently lives in poverty (equivalent to less than the TPCPDL of USD $3.3547 per day), which is substantially higher than the 72.3 percent that was estimated in 2012 for Zimbabwe as a whole.[49] Poverty is slightly more prevalent in the *Amalima* Program area (98.2 percent) than the ENSURE Program area (96.1 percent). Although communities in the program areas are not representative of the population of Zimbabwe as a whole, or of any given province, this pattern is consistent with findings from the 2011-2012 PICES, which found higher rates of poverty in Matabeleland North and Matebeleland South (*Amalima* Program area) than in Manicaland or Masvingo (ENSURE Program area).

Daily per capita expenditures in 2014 as reported by households were on average equivalent to constant 2010 USD $0.50 and 2014 USD $1.22. Note that these two figures represent the same consumption estimate, simply expressed in different units.[50] Daily per capita expenditures again were lower in the *Amalima* Program area (USD $0.45) than in the ENSURE Program area (USD $0.53). On average, the overwhelming majority of household consumption is devoted to food, which represents 96 percent of the total average consumption. Of the 114 food groups included in the food consumption module, maize meal is clearly the most important item, with average per capita consumption of corn representing about 11 percent of total daily per capita consumption. Green mealie [ground maize] is also as important, representing 10 percent of daily per capita consumption. Other important food groups include round nuts, okra and indigenous fruits and groundnuts, each representing between 4 and 5 percent of daily per capita consumption.

The two program areas exhibit differences in the relative importance of different food groups. Maize meal represents 16 percent of daily per capita food consumption in the *Amalima* Program area, compared to 9 percent in the ENSURE Program area. Round nuts are, on the other hand, a more

[48] Note that results for the two indicators, prevalence of poverty and mean depth of poverty, cannot be compared with other countries that use the standard poverty prevalence definition of people living on less than USD $1.25 per day.
[49] According to the "Poverty and Poverty Datum Line Analysis in Zimbabwe 2011/12." Available at www.zimstat.co.zw/dmdocuments/Finance/Poverty2011.pdf
[50] The 2010 figures are adjusted down to account for purchasing power differences between the United States and Zimbabwe and for cumulative inflation between 2010 and 2014. Total inflation between 2010 and the survey months in 2014 was about 9 percent, according to ZIMSTAT. Besides inflation, the 2010 figures are adjusted to a pseudo-purchasing power parity rate derived from the ratio of the Zimbabwe poverty line to the international poverty line (see Annex 5).

important food group in the ENSURE Program area (6 percent of daily per capita food consumption) than in the *Amalima* Program area (2 percent of daily per capita food consumption).

The mean depth of poverty is defined as the average of the differences between total daily per capita consumption for the poor and the poverty line, expressed as a proportion of the poverty line, with 0 representing the shallowest possible poverty and 100 representing the deepest possible poverty. One way to interpret the mean depth of poverty is that it gives the per capita cost of ending poverty as a percentage of the poverty line, if money could be targeted perfectly. The mean depth of poverty in the survey areas was 65.2 percent of the poverty line, with significantly deeper poverty in the *Amalima* Program area (68.5 percent) than in the ENSURE Program area (63.2 percent).

Table 4.2e. Program-Specific Indicators - Poverty by Gendered Household Type
Household-level indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Poverty (Household Members)			
Percent of people living below the Total Per Capita Poverty Datum Line (TPCPDL) [1]	96.9	98.2	96.1
Adult Female no Adult Male	96.7	98.7	95.4
Adult Male no Adult Female	85.5	88.6	82.4
Male and Female Adults	97.1	98.3	96.5
Child No Adults	98.4	97.1	100.0
Daily per capita expenditures (Constant 2010 USD)	0.50	0.45	0.53
Adult Female no Adult Male	0.51	0.45	0.56
Adult Male no Adult Female	0.78	0.67	0.90
Male and Female Adults	0.49	0.44	0.52
Child No Adults	0.53	0.42	0.66
Daily per capita expenditures (As reported in 2014 USD)	1.22	1.09	1.29
Adult Female no Adult Male	1.25	1.09	1.34
Adult Male no Adult Female	1.90	1.61	2.18
Male and Female Adults	1.20	1.07	1.27
Child No Adults	1.28	1.01	1.59
Mean depth of poverty (using the TPCPDL) [2]	65.2	68.5	63.2
Adult Female no Adult Male	64.2	68.1	61.8
Adult Male no Adult Female	49.9	55.5	44.4
Male and Female Adults*	65.7	68.9	63.9
Child No Adults	62.0	69.9	52.5
Number of household members in responding households	26,426	13,556	12,870
Adult Female no Adult Male	5,208	2,743	2,465
Adult Male no Adult Female	475	295	180
Male and Female Adults	20,700	10,488	10,212
Child No Adults	43	30	13

[1] Based on Zimbabwe's Total Per Capita Poverty Datum Line (TPCPDL), equivalent to a daily per capita poverty line of 3.3547 USD

[2] Expressed as percent of TPCPDL

The household survey did not collect data on income sources; however, the qualitative study included several questions about livelihood options. Understanding how individuals are earning income and the challenges faced provides insights on some of the factors driving the poverty indicators. Across both program areas, livelihood options fell into the following three categories: (1) casual labor, (2) agriculture inclusive of farming and livestock rearing and (3) internal and external migration inclusive of remittances earned from family migration.

Forms of casual labor were similar between the two program areas, but more individuals in the ENSURE Program area reported casual labor as their main form of livelihood. Several of the casual labor jobs involved manual labor and molding bricks, cutting wood and trees, doing domestic work, building homes, thatching roofs and cultivating land. Other types of work included brewing beer, sewing clothes, braiding hair, making tools, running a scotch cart or maintaining a store. A female respondent from Chivi describes the advantages of her husband's participation in casual labor in the following way:

> I think that his going for piece jobs helps us as he brings money which we use for our children's school fees and clothing. Our produce has no market and does not generate a sound income which can sustain our family. But if he goes to look for piece job he brings money that we use to buy fertilizers, seeds and pay for fees.

In the quote above, the participant described the limited market access to sell produce as a challenge, and therefore to see casual labor as the primary way to earn cash to pay for household needs.

Respondents mentioned farming or gardening as a source of income, especially in cases where production exceeded household needs. Rearing livestock was another source of income either through the sale of the animal or, in the case of chickens, their eggs. Although the discussion of agriculture as a form of livelihood was common in both program areas, the extent to which individuals relied solely on agriculture or the level of success varied. Some farmers were able to diversify and increase their production which reduced their need to purchase food.

Across both program areas, respondents stated that their livelihood depended on the rains. When the rainy season produced enough rains, yields would be sufficient lessen reliance on purchased food. During these times, respondents described being able to use earned income for other household needs. Generally, respondents said that they preferred to produce rather than purchase food.

Respondents also discussed migration as a way to earn a living or as a source for increased income. In addition to migration within Zimbabwe, people living in the *Amalima* Program areas tend to migrate to South Africa and Botswana. The male household head or sons are the most likely to migrate and be responsible for sending income earned home. Although the reliance on migration is evident, the perceptions about its benefit varied. On one hand, participants felt that their lives are better off with someone in their family migrating. A respondent from Chivi put it this way:

> If we did not have a chance to go there [to South Africa], life would have been difficult because there are times when things get tough, to do gardening there would be no water, no money to start a project, so if we had not been going there life would have been hard.

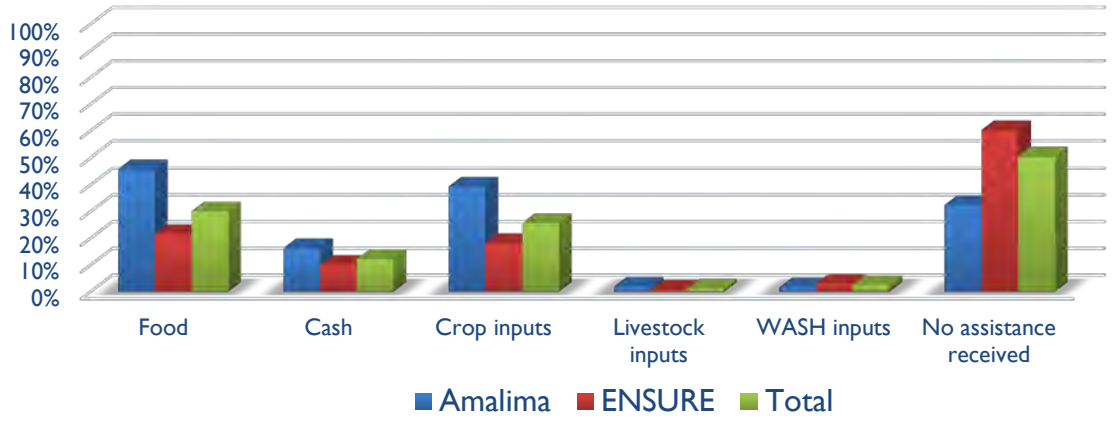
Conversely, several other respondents noted the negative consequences of migration. Migrants often have expense to meet at home and where they work thus, depending on how much they earn, face challenges providing for two households. Further, migrants are not able help with other household needs as a respondent from Tsholotsho states:

> I feel that had they [speaking about those that migrated] had been at home maybe we would be helping each other out. They would go to the field and could be farming right now. Now all of them and their spouses are all away. I think if they were here things would be better as they will spend time with their children and they will be farming and will be able to sell their crops.

Through the interpretation of the qualitative data, it is possible to surmise that the primary income sources, casual labor and agriculture, in the ENSURE Program area translates to more money for expenditures than in the *Amalima* Program areas, where the primary sources of income are agriculture and migrant labor and remittances. Although respondents reported using migration as a coping strategy and a form of livelihood, it does not come without challenges, and it may even hinder household-level agriculture productivity. The challenges associated with successful agriculture production, discussed in detail in the agriculture section, also deter individuals from relying on agriculture as a primary livelihood.

In addition to income, households may have received supplemental assistance in food, cash and agricultural or WASH inputs. The level of assistance households receive may affect consumption and expenditure patterns and poverty levels. Figure 4.2 illustrates that about half of households reported not receiving any assistance. About 30 percent of households reported receiving food aid, 25 percent reported receiving crop inputs and 12 percent reported receiving cash. Very few households received livestock or WASH inputs. Levels of assistance for food, cash and crop inputs were higher in the *Amalima* Program area than in the ENSURE Program area. Overall, 33 percent of households in the *Amalima* Program area reported receiving no assistance, compared to 60 percent in the ENSURE Program area who received no assistance.

Figure 4.2. Type of Assistance Received by Households in the Past Six Months



Participants in the qualitative study discussed receiving assistance from various donors, organizations, friends and relatives as one coping strategy in difficult times. Most common types of assistance discussed were food (oil, maize or corn meal and porridge), agricultural inputs (seeds, fertilizer and insecticide) and training or skills to help improve agricultural productivity. Although food assistance is generally targeted for specific household members, for example for pregnant or lactating women, respondents described using the items received to prepare meals for all members in the household.

F. Household WASH Practices

Household WASH practices were assessed based on three standard FFP indicators: (1) percentage of households using an improved drinking water source, (2) percentage of households using improved

sanitation facilities and (3) percentage of households with a cleansing agent and water available at a handwashing station. Table 4.2f shows the results for these indicators and Table A12.1 in Annex 12 provides a further breakdown of each indicator's components.

Poor WASH practices are associated with increased morbidity and mortality, particularly for diarrheal diseases. Worldwide, it is estimated that improved water sources reduce diarrhea morbidity by 21 percent, improved sanitation reduces diarrhea morbidity by 37.5 percent and the simple act of washing hands at critical times can reduce the number of diarrhea cases by as much as 35 percent.[51] Results for children's diarrhea indicators in the survey population appear in Section 4.5B.

Table 4.2f. Food for Peace Indicators - Water, Sanitation and Hygiene
Household-level FFP indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
WASH (All Households)			
Percentage using an improved drinking water source[1]	44.2	44.3	44.2
Percentage using improved sanitation facilities[2]	33.1	40.9	28.8
Number of responding households	5,003	2,482	2,521
Percentage with cleansing agent and water available at handwashing station	2.2	1.6	2.6
Number of responding households that gave permission to observe handwashing station	4,962	2,452	2,510

[1] Improved drinking water sources include piped water into the dwelling or yard, standpipe or public pipe, tube well or borehole, protected well, protected spring or rain water.
[2] Improved sanitation facilities are "non-shared" and include flush toilets to sewer system, septic tank or pit latrine, ventilated improved latrine, and pit latrine with a slab.

Data from the baseline survey indicate that 44 percent of households use an improved drinking water source. The definition of an improved drinking water source includes two components: (1) type of water source and (2) water availability at the source. Types of improved drinking water sources include water piped into the dwelling or yard, public tap water, tube wells or boreholes, protected wells or springs and rainwater collection. If participants reported water was unavailable from the source for a day or more during the past two weeks, then it was not considered as improved. Three quarters of all households reported using an improved type of water source, most often a tube well, borehole or a protected well; however, 22 percent of households reported that water was unavailable from the source for a day or more in the past two weeks and 34 percent of households reported that water is not available all year round.

About one-third of households reported using a non-shared improved sanitation facility, either a ventilated pit latrine or a pit latrine with a slab. Use of improved sanitation facilities is higher in the *Amalima* Program area (41 percent) than in the ENSURE Program area (29 percent). Interviewers from the household survey observed a type of shared or non-shared sanitation facility in 53 percent of survey households. A total of 44 percent of survey households do not use any type of sanitation facility.

Interviewers from the household survey observed the presence of water and soap, detergent or another cleansing agent at the place for handwashing in only 2.2 percent of households. A handwashing station was observed in 20 percent of all households.

[51] WHO. (2004). *Facts and Figures: Water, sanitation and hygiene links to health.* Available at http://www.who.int/water_sanitation_health/publications/factsfigures04/en/print.html.

In addition to data for the FFP indicators for WASH practices, the survey collected data on three additional program-specific indicators related to drinking water and handwashing practices. The results for these indicators appear in Table 4.2g.

Survey responses indicate that 11 percent of households practice correct use of recommended water treatment technologies. The most common treatments used were boiling water and adding bleach or chlorine. Participants also were asked about the use of safe storage practices for drinking water. These included a sealed bucket with a spigot, a narrow-necked jerry can or a covered container with a ladle. Approximately half of the households reported using one of these safe storage practices.

Having a handwashing station with soap and water near the household sanitation facility is a practice promoted by the programs to encourage handwashing after use of the sanitation facility. Interviewers observed a handwashing station with soap and water near a sanitation facility in 2.7 percent of all households with a sanitation facility present.

Table 4.2g. Program-Specific Indicators - Water, Sanitation and Hygiene
Household-level program-specific indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Water Treatment, Storage, and Handwashing (All Households)			
Percent of households practicing correct use of recommended household water treatment technologies	10.9	8.6	12.1
Percent of households practicing safe storage of drinking water	51.9	49.7	53.2
Number of responding households	5,002	2,481	2,521
Percent of households with a handwashing station with soap and water near a sanitation facility	2.7	2.6	2.7
Number of responding households with a sanitation facility	2,545	1,168	1,377

Drinking Water

Results of the qualitative interviews were largely in line with findings from the household survey. Although individuals reported having access to improved drinking water, the water from this source was not always available, which is reflected in the low percentage of households with access to an improved drinking water source. According to the qualitative data, many people shared the same sources, which meant additional time was needed to obtain water or that longer distances were traveled to find alternative sources. Broken, rusted or dried out boreholes also added to limited access and the need to travel farther for water. Several respondents felt that they did not receive any help from government or organizations to increase water availability. A village head from the *Amalima* Program area describes one of the challenges faced:

> **Respondent:** Water is life and so even if it's a stand, there should be a pipe with running water for one to use. Here water is a problem because we only see it if we go to the boreholes. In ward 2 we are more than 63 households that use the same water source.
> **Interviewer:** How often does it break?
> **Respondent:** It breaks often, especially if it's the cylinder or valve; it can stretch up to a year not working.

Further, specifically in the *Amalima* Program area, individuals reported using the same water source for all needs, collected mainly from boreholes and rivers. Many respondents reported that it takes them one hour to obtain water, and at times they need to travel more than 1 km. Two respondents reported traveling over 4 km and one reported traveling 8 km for water. Because water is scarce, many people also needed to obtain water for their livestock. Some participants reported that existing community funds, government support or water committees help maintain boreholes. A female lead farmer from Tsholotsho describes in how the community deals with water-related challenges:

> If the borehole is broken, we look for an alternative method, such as using some of the water we store at home, but this will only last for about a day. If it is something major like the cylinder, that is when the committee meets to see how best it can be fixed and we get water… if I was the one pumping water at the time when the borehole broke, I will have to go report to the water committee and tell them that it is broken. Fortunately, we have someone who knows how to fix boreholes that stays in our line [area]; he doesn't charge us as much as the other guys charged the last time.

In the ENSURE Program area, individuals used different water sources depending on the purpose of the water (cooking or washing cloths). A respondent from Chimanimani said, "We say that [the water] from the borehole it [is for] washing plates, cooking and drinking because [of] health reasons, that from the river we no longer use it to wash plates with as it is not hygienic." Several respondents reported needing 30 minutes to obtain water from boreholes or wells, and collection time varied based on how many others are collecting water from the source. Most respondents reported traveling 1 km or less, with the majority needing to go only 300 m for water. These respondents also indicated that they retrieved water two or more times per day. Water was also fetched from different sources for varying purposes. Many individuals reported that organizations help increase availability of water sources. Water committees and community members also repair boreholes when needed. Increasing the functionality of existing water sources in addition to improving access to water is a primary need to improve drinking water sources.

Although several respondents from both program areas were satisfied with water quality and did not feel the need to take steps to reduce contamination, some expressed dissatisfaction. Dissatisfied respondents in the *Amalima* Program area said their dissatisfaction is due to visible black particles, chemicals from nearby mines and insects in the water. Some respondents also reported a salty or bitter taste, which contributes to their dissatisfaction. Several respondents reported using contamination prevention practices, such as boiling water, water purification tablets and digging deep to reach insect-free water.

In the ENSURE Program areas, dissatisfaction was a result of sewage, dirt and rust in the water and boreholes. Respondents in the area also said they felt that children tended to dirty water sources through unclean practices, such as washing hands and dishes upstream. Water contamination prevention practices used in the ENSURE Program areas included boiling water, using water purification tablets or Water Guard [a water purification product], keeping water storage containers closed, using surface water to wash dishes and collecting flowing river water. Some respondents indicated they do not boil water or use purification tablets because of the effect on water taste. Individuals were less likely to take extra precautions to treat their water, especially if they perceived the water source is safe or if they believe that treating the water adversely affects the taste.

Sanitation Facilities

Participants in the qualitative study in both program areas reported using a number of non-improved sanitation facilities in addition to their own or using a neighbor's Blair or ventilated improved pit latrine. Individuals described several reasons for using improved sanitation facilities, such as added privacy, increasing cleanliness, preventing diseases and flies and having a means for providing for large numbers in

a household without a flush toilet system. Several respondents reported going in the bush (digging and covering holes with a hoe following defecation, going in the open or going deeper in the bush without digging any holes). Respondents said that the bush lacks privacy, it is dangerous to go to at night and leads to diseases when water washes away to where livestock or people drink, but they also reported a lack of feasible alternative options. A respondent from Bikita provided suggestions for improving the availability of toilets:

> **Interviewer:** What are your suggestions on what to be done for you to be able to have toilets?
> **Respondent:** Digging up the holes and moulding bricks.
> **Interviewer:** What is really preventing you from having toilets?
> **Respondent:** The lack of knowledge. When one does not have the knowledge of the use of a toilet they will not understand its use.
> **Interviewer:** So you are suggesting that if people get educated about toilets they will start building?
> **Respondent:** Yes they will start to build because they will understand the implications of not having one on their health.

Although respondents indicated a high desirability in having a latrine, households were often unable to construct their own latrines due to a lack of materials, labor and funds. Very few individuals reported support from community programs or funds or other organizations, although some respondents reported receiving support and advice in improvement of sanitation practices from donors, international aid organizations and health care workers. As a male farmer from Chivi noted, "Red Cross built toilets for those that did not have any. We now have toilets with vents that trap flies and these are different from the ones we used to have because we had no building material." Assistance in the construction of latrines resulted in some common latrine construction practices that include using cement, making sure latrines were downwind and south facing, incorporating vents to trap flies and ensuring the presence of separate doors for men and women.

A few respondents also indicated that they ensure the environment is kept clean by building new latrines when existing ones fill up, washing toilets with water, adding ash, keeping latrines closed and adding handwashing stations, such as tippy taps or buckets with water, and equipping with soap or washing powder. Several respondents also reported challenges with sanitation facilities such as no clear responsibility assigned for cleaning toilets shared among neighbors, latrine holes that collapse without cement, a shortage of communal facilities and latrines that are inaccessible for elderly who are unable to squat easily. Qualitative data indicate that although participants want latrines, knowledge is limited about the relationship between health and the proper use and maintenance of latrines. Although participants indicated a desire for a latrine, health concerns are not necessarily the reason.

Handwashing

Qualitative interviews with individuals in the *Amalima* and ENSURE Program areas provided further insight into decision-making and the drivers behind handwashing. In both areas, some respondents reported maintaining a handwashing station outside the toilet and a few participants in each area reported they keep handwashing facilities in the house, kitchen or another place outside the house. In the *Amalima* Program area, most people reported using a bowl to wash their hands, having a child or someone else bring water to them or using a water container. In the ENSURE Program area, most respondents reported using a tippy tap or container to wash their hands, followed by using a bucket in the house or receiving help from another person to wash. One participant reported receiving education from a health care worker in proper handwashing techniques.

Participants in both program areas said that they always wash their hands before eating and after using the latrine or going to the bush. Other handwashing motivation includes before cooking, before

preparing food for a baby or breastfeeding, after changing diapers and every morning after waking up. Driving factors for handwashing across both program areas included disease prevention and elimination of germs, a need to stay clean and the desire for a healthy life.

The importance of using cleansing agents was reported as prevalent in both program areas, and respondents who reported having access also commonly reported using a cleansing agent. Knowledge about the importance of soap seemed commonplace, and participants cited non-governmental organizations (NGOs), village health workers and other health care professionals as likely sources of information. When soap is unavailable, respondents reported using alternatives, such as in the *Amalima* Program area, Sunlight® liquid detergent, ash, and, in one case, soil. Alternatives in the ENSURE Program area mentioned most often were ash, Surf® detergent, green bar laundry soap, fruit from the *muhumbangu* tree (used traditionally to wash clothes) and tomatoes. In both program areas, some respondents reported using soap because water does not clean well enough alone to control germs and disease, which is important. The following exchange with a male farmer from Bikita highlights perceptions about the importance of cleansing agents:

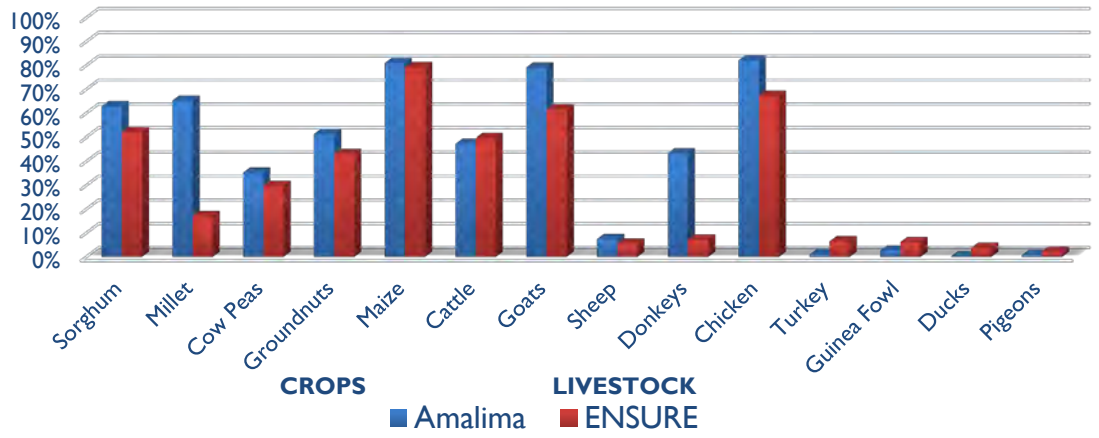
> **Interviewer:** What do you usually use to wash your hands?
> **Respondent:** Soap.
> **Interviewer:** Why do you use soap?
> **Respondent:** Because it is the one that's important.
> **Interviewer:** Why is it important?
> **Respondent:** Because it washes away diseases.
> **Interviewer:** If there is no soap what do you use?
> **Respondent:** Ash.

Although most respondents could not always buy soap, its importance in households was widely acknowledged. In both program areas, respondents reported seeking work to earn money to afford soap. A few respondents reported they are never able to afford soap; on the other hand, a few respondents placed high priority on soap and stated that it was so important they would sell livestock to buy soap.

4.3 Agricultural Indicators

The agricultural component of the household survey was completed by 6,321 farmers—3,036 in the *Amalima* Program area and 3,285 in the ENSURE Program area. Of these farmers, 58 percent are female and 42 percent are male. The most commonly planted crops are maize, sorghum, millet, groundnuts and cow peas, while the most commonly raised animals are chicken, goats, cattle and donkey (Figure 4.3a).

Figure 4.3a. Percentage of Farmers Raising Crops or Livestock



Participants in the qualitative study reported planting similar crops and raising the same animals reported in the survey findings. Across both program areas, respondents reported growing maize, *tsweda* [sorghum], millet, tomatoes, beans, round nuts, peanuts, groundnuts, pumpkin, cow peas, peas and sweet potatoes. Specific to the *Amalima* Program area, respondents mentioned melons, sweet reed and butternut, and for the ENSURE Program area, additional crops mentioned included cabbage and wheat. Participants also described growing crops such as maize and sorghum in the fields and others such as vegetables in their gardens. Respondents in both program areas commonly mentioned growing small grains such as millet and sorghum, like this lead farmer in Gwanda, who explained the reason for this tendency:

> What makes me say small grains is that if the rains are few they will survive and get ripen. Once maize doesn't get sufficient rain it will wilt quickly but small grains can withstand long dry spells, such that when the rain eventually comes they will recover; so small grains are the ones that are able to survive.

Respondents in the qualitative study also mentioned keeping cattle, chickens and goats. Some respondents also mentioned keeping sheep and turkey. In addition, respondents in the *Amalima* Program area mentioned donkeys, pigeons and bees. Respondents in the ENSURE Program area mentioned having a few guinea fowl. Respondents reported using cattle for plowing and donkeys for both plowing and transportation.

The household survey data were used to calculate FFP agricultural indicators for financial services, value chain activities and use of agricultural and storage practices. Increased use of financial services can help farmers access inputs and other resources to improve agricultural productivity. Strong agricultural value chains create livelihoods, increase incomes and promote economic growth. Use of sustainable agricultural practices and improved storage practices also help farmers increase agricultural production and provide better protection for crops that are harvested. All of these practices are expected to directly benefit households and lead to increased food security.

A. Financial Services

As shown in Table 4.3a, about 11 percent of farmers reported accessing financial services in the past 12 months, either through agricultural credit or saving cash through formal institutions or insurance. Agricultural credit includes agro-dealers, contract farming, village savings groups, farmers associations, micro-finance institutions, government or private institutions and non-cash loans (i.e., saved seeds). Fewer farmers in the *Amalima* Program area (5.4 percent) reported accessing financial services than in the ENSURE Program (14.2 percent). In the *Amalima* Program area, 3.8 percent of farmers reported taking agricultural credit (mainly from farmers associations), 1.8 percent of farmers reported saving cash (mainly with village savings groups and cooperatives or by using "EcoCash Save"[52]) and 0.1 percent reported having agricultural insurance. In the ENSURE Program area, 9.4 percent of farmers reported taking agricultural credit (mainly through contract farming, agro-dealers and input from buyers), 6.7 percent of farmers reported saving cash (mainly using EcoCash Save or through village savings groups), and 0.1 percent reported having agricultural insurance.

[52] EcoCash Save is a paperless banking service that enables subscribers to operate a savings account through their mobile phones.

Table 4.3a. Food for Peace Indicators - Financial Services
FFP agricultural indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Percentage using at least one financial service (past 12 months) [1]	11.2	5.4	14.2
Male farmers	12.9	5.3	16.3
Female farmers	10.0	5.5	12.5
Number of responding farmers	6,321	3,036	3,285
Male farmers	2,650	1,194	1,456
Female farmers	3,671	1,842	1,829

[1] Financial services include saving cash through formal institutions, credit, and insurance.

In line with the survey findings, reports about financial services were more common in the ENSURE Program area, although most participants in the qualitative study reported not having formal savings. Rather, some respondents reported participation in clusters or savings societies. A female lead farmer from Chivi stated that clusters are "a way of income generation; we do not keep the money, it is just that when you borrow the money, you use it to generate income and then return it with interest."

Similar to the process described above, female focus group participants from Buhera described a rotating credit process that women in the community participate in:

> **Interviewer**: As ladies, do you have any clubs that you do to help you with money?
> **Respondent**: We take turns to give each other money in groups every month.
> **Interviewer**: What about others?
> **Respondent**: They have clubs here, but I am not part of them. There is one where all the ladies select one person whom they give money to every month. When they have collected a huge amount of money, they decide on what to buy for each other. It can either be household equipment or livestock.

Respondents stated that with their limited finances, they did not see the value in placing money in formal savings or financial systems. Further, few participants exhibited knowledge of where to access financial services.

B. Value Chain Activities

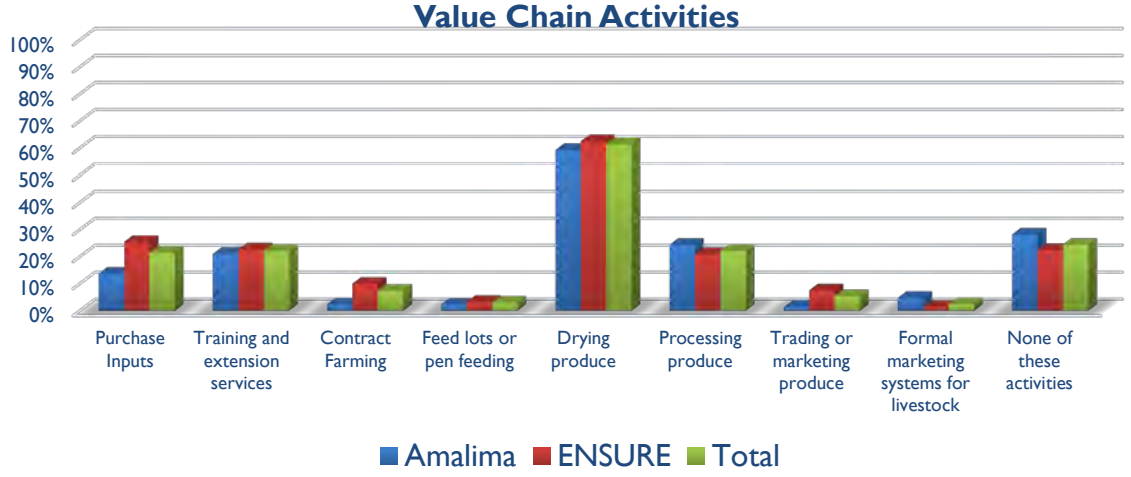
When asked about value chain activities used during the past 12 months, 75.6 percent of farmers reported practicing at least one value chain activity (Table 4.3b). In the *Amalima* Program area, 71.8 percent of farmers reported practicing at least one value chain activity, while 77.5 percent of farmers in the ENSURE Program reported practicing at least one value chain activity. The most common value chain activities practiced are drying and processing produce, using training and extension services and purchasing inputs (Figure 4.3b).

Table 4.3b. Food for Peace Indicators - Value Chain Activities
FFP agricultural indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Percentage practicing at least one value chain activity (past 12 months) [1]	75.6	71.8	77.5
Male farmers	74.5	67.8	77.5
Female farmers	76.4	74.4	77.5
Number of responding farmers	6,321	3,036	3,285
Male farmers	2,650	1,194	1,456
Female farmers	3,671	1,842	1,829

[1] Value chain activities include purchase of inputs through agri-dealers and/or community associations, use of mobile financial services, use of financial services other than mobile, training and extension services, contract farming, use of feedlots or pen feeding, drying and/or processing produce, trading or marketing through agri-dealers and/or community associations, and use of formal marketing systems for livestock.

Figure 4.3b. Percentage of Farmers Practicing Value Chain Activities



Farmers interviewed for the qualitative study described drying produce as a primary step in harvesting crops. Participants in the qualitative study also reported few sources of information on implementing sustainable agricultural practices. When asked where they receive information, farmers mentioned that the Agricultural Research Extension (AGRITEX) officers are helpful and teach farmers techniques that help improve their productivity. A farmer from Chivi described one of the processes commonly taught:

> … if you have fertilizer you put in it just a teaspoon and mix with manure and then we plant our maize. We put three seeds in a hole, then we remove one of the seedlings when they grow. This is better than putting fertilizers on the whole field.

The sale of produce also depended on the type of crop harvested. Several participants stated that they tend to sell tomatoes because of their perishability. Although some farmers are taking measures to improve their agricultural productivity, farmers from the ENSURE Program area identified how market

access poses challenges. They reported that although they have excess produce, they either are not able to sell it or cannot make a profit from selling it due to unviable markets. A male farmer from Chimanimani described his market access challenges in the following exchange:

> **Respondent:** What hinders us from getting the items? It's the farming; that you do not have somewhere to send our produce, markets are no longer available. You can farm tomatoes. Then they get finished in that very field or your money is taken not being able to purchase anything.
> **Interviewer:** So?
> **Respondent:** So we are able to grow maize but there is nowhere to sell. It may be there but being bought for very little amount of money.
> **Interviewer:** So its low prices or it's the unavailability of market?
> **Respondent:** Not being able to find the markets or the market is found but having low prices.

C. Sustainable Agricultural Practices

As shown in Table 4.3c, 64 percent of farmers reported using at least five sustainable agricultural practices in the past 12 months. Sustainable agricultural practices were divided into three subcategories: (1) crop practices, (2) livestock practices or (3) natural resource management (NRM) practices. In the *Amalima* Program area, 28 percent of farmers reported using at least five sustainable crop practices compared to 41 percent in the ENSURE Program area. The most common crop practice reported is weed control, followed by intercropping, crop rotation, use of manure and early planting or planting before the first rains (see Table A12.4 in Annex 12). About 26 percent of farmers reported using at least three sustainable livestock practices. Vaccinations, homemade animal feeds, improved animal shelters and deworming are the most common sustainable livestock practices reported. About 15 percent of farmers reported using at least three sustainable NRM practices. Sustainable harvesting of forest products, management of forest plantation and agro-forestry are the most frequently reported NRM practices (see Figure 4.3c).

Table 4.3c. Food for Peace Indicators - Sustainable Agricultural Practices

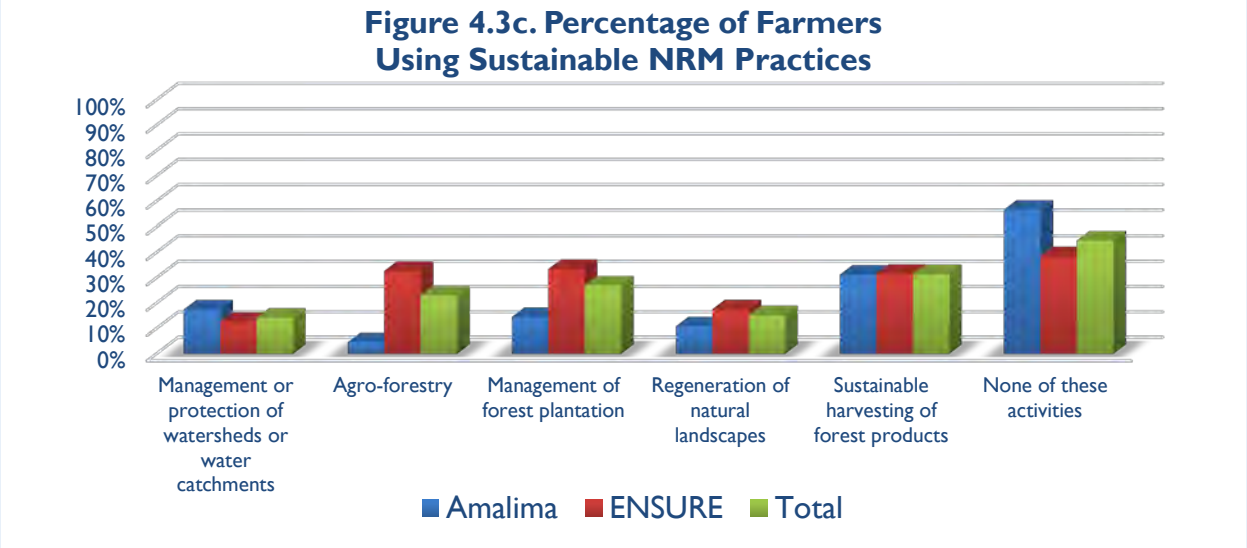
FFP agricultural indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Percentage using at least **five** sustainable agricultural practices (past 12 months)	63.8	56.8	67.5
Male farmers	68.2	58.8	72.6
Female farmers	60.6	55.4	63.4
Percentage using at least **five** sustainable agricultural (crop) practices (past 12 months) [1]	36.5	28.2	40.7
Percentage using at least **three** sustainable agricultural (livestock) practices (past 12 months) [2]	25.6	28.2	24.3
Percentage using at least **three** sustainable natural resource management (NRM) practices (past 12 months) [3]	15.0	8.7	18.2
Number of responding farmers	6,321	3,036	3,285
Male farmers	2,650	1,194	1,456
Female farmers	3,671	1,842	1,829

[1] Sustainable agricultural practices for crops include micro dosing, manure, compost, planting basins, mulching, weed control, dry planting, ripping into residues, clean ripping, tied ridges, pot-holing, crop rotations, intercropping, integrated pest management, early planting or planting with the first rains, use of improved crop varieties, dead level contours, and ridging. This subindicator is based on all farmers, not just those that reported raising crops.

[2] Sustainable livestock practices include improved animal shelters, vaccinations, deworming, castration, dehorning, homemade animal feed made of locally available products, animal feed supplied by stock feed manufacturer, artificial insemination, pen feeding, fodder production and/ or veld reinforcement with legumes, and used the services of community animal health workers/paravets. This subindicator is based on all farmers, not just those that reported raising livestock.

[3] Sustainable NRM practices include management or protection of watersheds or water catchments, agro-forestry, management of forest plantation, regeneration of natural landscapes, and sustainable harvesting of forest products.



Participants in the qualitative study cited several challenges to agricultural production. Respondents cited AGRITEX as important sources of information and technical support; however, across both program areas respondents reported that lack of equipment, fertilizer, inputs and water and fuel for a water pump are challenges that affect crops. For livestock, the difficulties encountered were diseases, limited access to vaccines and preventive services. A male framer from Bikita describes the challenges associated with livestock in the following exchange:

> **Interviewer:** What challenges do you face in livestock keeping?
> **Respondent:** Failure to secure vaccines and they die. Drought is also a challenge.
> **Interviewer:** When this happens, what measure do you take?
> **Respondent:** If you have money you go to the veterinary.
> **Interviewer:** So are there people who help there?
> **Respondent:** The veterinary help us by prescribing the proper vaccines for the animals and we go and buy.
> **Interviewer**: Are there organizations that help you when the animals are sick?
> **Respondent:** AGRITEX sometimes provides us with prevention vaccines.

D. Improved Storage Practices

Farmers were asked about use of improved storage practices in the past 12 months for sorghum and groundnuts. Improved storage practices include hermetic storage, improved granaries, warehousing or cereal banks, use of traps and use of grain bags treated with pesticides. A total of 17.2 percent of all farmers reported using at least one of these improved storage methods for either sorghum or groundnuts (Table 4.3d). It is important to note that not all farmers grew the crops of interest (sorghum groundnuts); this contributes to the low percentage of farmers that use improved storage specific to those crops.

Table 4.3d. Food for Peace Indicators - Improved Storage Practices
FFP agricultural indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Percentage using improved storage practices (past 12 months) [1]	17.2	15.0	18.3
Male farmers	18.3	16.5	19.1
Female farmers	16.4	14.0	17.7
Number of responding farmers	6,321	3,036	3,285
Male farmers	2,650	1,194	1,456
Female farmers	3,671	1,842	1,829

[1] This indicator refers to the use of one or more improved storage practices. Improved storage practices include hermetic storage, improved granaries, w arehousing or cereal banks, use of traps, and grain bags w ith pesticides. This indicator is based on improved storage practices used for sorghum or groundnuts and is based on all farmers, not just those grow ing sorghum or groundnuts.

Storage of Sorghum

In both program areas, about 69 percent of farmers reported not storing sorghum. Of those farmers that reported storing sorghum in the *Amalima* Program area, 52 percent do not use improved storage practices, 25 percent use improved granaries, 17 percent use grain bags treated with pesticides and 6 percent use hermetic storage. In the ENSURE Program area, 43 percent of farmers who reported storing sorghum do not use improved storage methods, 45 percent use grain bags treated with pesticides and 10 percent use hermetic storage.

Storage of Groundnuts

About three-quarters of farmers in both program areas reported not storing groundnuts. Of those farmers that reported storing groundnuts in the *Amalima* Program area, 56 percent do not use improved storage practices, 22 percent use improved granaries, 13 percent use grain bags treated with pesticides and 8 percent use hermetic storage. In the ENSURE Program area, 63 percent of farmers who reported storing groundnuts do not use improved storage methods, 24 percent use grain bags treated with pesticides and 9 percent used hermetic storage.

From the qualitative study, respondents in the *Amalima* Program area mainly described granaries as the form of storage for their crops. Others described storing crops in grain bags placed in their homes. Few respondents in the qualitative study reported storing their crops in pesticide-treated drums. Respondents in the *Amalima* Program area described slightly different storage methods than those in the ENSURE Program area. More respondents described storing their crops in grain bags treated with pesticides and fewer described storing their crops in granaries.

Challenges associated with using improved storage practices are limited finances and, in the case of granaries, the fear of theft. In interviews with five male and three female farmers from Chimaminmani, the respondents described their reasons for the limited use of granaries:

> **Respondent:** We put it all in one place and bag it up in sacks.
> **Interviewer:** Why do you use sacks?
> **Respondent**: Because there are not granaries in the rural areas anymore…granaries are for the old school, people of this generation now use sacks to store their produce.
> **Interviewer**: Where do you store your agricultural produce?
> **Respondent 8**: We no longer have granaries so we store the harvest in our bedrooms.
> **Interviewer**: What happened to the granaries?
> **Respondent 7**: The issue is that there was an increase of cases of theft; they could even gain access into the room you would be sleeping.
> **Respondent 1**: It was mainly because of droughts. They are no longer relevant because of the harvest that we have been getting over the years.

Farmers discussed various techniques and practices to store and help preserve their crops, and yet they still face several challenges. Commonly noted challenges are theft, destruction of crops by birds or animals and cost of pesticides and storage materials. Famers also stated that they can do little to help mitigate these challenges.

4.4 Women's Health and Nutrition Indicators

A. Women's Nutritional Status

The women's module of the household survey was administered in each household to one woman 15-49 years of age. A total of 3,473 women were interviewed—1,627 in the *Amalima* Program area and 1,846 in the ENSURE Program area. Valid anthropometry measurements were taken for 3,046 women who were not pregnant or had not given birth in the past two months (postpartum).

The nutritional status of women was assessed using the body mass index (BMI). To derive BMI, height and weight measurements were taken for women between 15 and 49 years of age who were not pregnant or two months postpartum. BMI, expressed as the ratio of weight in kilograms to the square of height in meters (kg/m^2), was used to measure the prevalence of underweight women. A BMI below 18.5 indicates underweight or acute malnutrition and is associated with increased mortality.

As shown in Table 4.4a, 8.6 percent of women 15-49 years of age in the *Amalima* and ENSURE Program areas are underweight (BMI < 18.5) and 2 percent are in the moderately to severely underweight range

(BMI < 17). The *Amalima* Program area has a higher percentage of underweight women (13.9 percent) than the ENSURE Program area (5.9 percent). About two-thirds (65 percent) of women 15-49 in the *Amalima* Program area have a BMI in the normal range (18.5-24.9) compared to 62 percent in the ENSURE Program area. About 21 percent of women 15-49 year of age are overweight or obese (BMI ≥25) in the *Amalima* Program area, compared to 32 percent in the ENSURE Program area.

Table 4.4a. Food for Peace Indicators - Women's Nutritional Status
Women-level FFP indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Prevalence of underweight women [1]	8.6	13.9	5.9
Number of eligible women (15-49 years) with valid measurements	3,046	1,430	1,616

[1] Excludes pregnant and postpartum (birth in the preceding 2 months) women.

B. Women's Dietary Diversity

The women's dietary diversity score (WDDS) is computed based on nine critical food groups. This indicator measures the micronutrient adequacy of the diet and reports the mean number of food groups consumed in the previous day by women of reproductive age (15-49 years of age). The indicator is tabulated by averaging the number of food groups consumed out of the nine food groups for all women.

The survey results indicate that women 15-49 years of age consume, on average, 3.1 of the nine basic food groups. In the *Amalima* Program area, the WDDS is 2.8, slightly lower than the WDDS of 3.3 for the ENSURE Program area. As shown in Table 4.4b, grains, roots and tubers (98 percent) and vitamin A dark green leafy vegetables (68 percent) are the most frequently consumed basic food groups, while organ meat (3.5 percent) and eggs (5 percent) are consumed least often. This dietary composition indicates nutrient deficient diets for most women because they consume only three of the nine critical food groups necessary for a nutrient-rich diet.

The findings for the women's health and nutrition indicators indicate that although women have a low dietary diversity score, the majority are maintaining a normal weight, with more women being overweight than underweight. The improvement of women's dietary diversity and the maintenance of a healthy weight contribute to several other factors, including improved child health and nutrition outcomes. The qualitative study explored the relationship between gender and food. This included the examination of what women usually eat, the role of gender in food allocation and food choices and beliefs or taboos about certain foods during pregnancy.

Table 4.4b. Food for Peace Indicators - Women's Dietary Diversity
Women-level FFP indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Women's Dietary Diversity Score	3.1	2.8	3.3
Percentage of women consuming food groups:			
Grains, roots and tubers	97.8	97.8	97.7
Legumes and nuts	28.0	27.1	28.5
Dairy products (milk, yogurt, cheese)	17.5	23.7	14.3
Organ meat	3.5	1.5	4.6
Eggs	5.2	4.1	5.7
Flesh foods and other misc. small animal protein	31.3	23.0	35.7
Vitamin A dark green leafy vegetables	68.2	57.1	74.0
Other Vitamin A rich vegetables and fruits	29.8	23.1	33.3
Other fruits and vegetables	32.9	24.3	37.5
Number of responding women (15-49 years)	3,473	1,627	1,846

The grain consumption patterns of women are similar to those of the household; almost all women consume grains. This is not surprising with *sadza* as the staple food. The high consumption of *sadza*, which has little nutritional value, may be contributing to the number of overweight women. Participants in the qualitative study described challenging times in which they eat *sadza* without anything else. For example, a lead mother from Tsholotsho states, "Sometimes we can afford to have breakfast. So you will be forced to cook say *sadza* in the morning but with no relish." This high-starch diet of *sadza* may contribute to the prevalence of overweight women indicated in the household survey results.

Across both program areas, respondents noted that the choice of what not to eat depends on different preferences. Although respondents stated that parents sometimes eat less to allow children to have more food, most responses did not indicate a gender bias. That is, both male and females reported sacrificing so that children can eat. Further, women have the primary responsibility for food preparation. Although women reported trying to diversify food, availability is the primary driver of food choices; and therefore, as with the HDDS, the differences between the two program areas in food availability and access and factors such as income and agricultural productivity affect what women eat.

Respondents in both program areas were attentive to the food intake of pregnant women. They were aware of the importance of eating nutritious, healthy foods during pregnancy, although they face challenges in accessing those foods. A woman from Chimanimani explained the challenge:

> When we are pregnant, when we go to the clinic, they write for us the food that we should eat, but now to then tell your husband that when I went to the clinic they said such and such is needed, you then find that he doesn't have the money to buy it.

Participants in both program areas hold beliefs or taboos about which foods pregnant women are not to eat. The food taboos during pregnancy are widespread across both program areas. Foods with associated taboos for pregnant women include eggs, leftover *sadza*, offal, spicy foods, sweet foods, nuts and *matohwe* fruits [edible indigenous fruit]. The series of responses that follows exemplifies some of the food beliefs and taboos that respondents expressed:

Respondent (Bulilima): ...you will be told that you should not eat boiled dried maize it will affect the baby. You should not drink whilst you are standing, the child will get chocked…I shouldn't eat fish because I was told that my child will have fish scales.
Respondent (Gwanda): ...she must not eat groundnuts and round nuts….the elders say that the white stuff will block the nose of the unborn baby.
Respondent (Tsholotsho): Offals should not be eaten by pregnant women because people believe that she will give birth to a baby whose skin resembles the offal texture. Also, pregnant women should not eat chilies as she will give birth to a baby with no eye lashes.
Respondent (Bikita): According to health practitioners it [chili pepper] affects the unborn, cause it to be born with problem of poor sight, inviting other medical problems in the process. That is what those who would have visited hospitals say.
Respondent (Buhera): They say that if you eat eggs the child will come out without any hair. If you eat sugarcane, the child will get cut.
Respondent (Chimanimani): Some say not to eat leftover *sadza* from the previous night. They say this would cause a delay in giving birth.
Respondent (Chivi): They say not to eat *matohwe* fruits because if you eat too much of *matohwe* fruits, when the baby comes out it will be strangled by the gluey extract from the *matohwe* fruits.

Although some women stated they change their behaviors based on these beliefs and taboos, others said the consequences of the taboo were not significant enough and therefore they did not follow them. Paradoxically, some women named foods that should be eaten during pregnancy, and other women report the same foods as taboo for pregnant women. Overall, results indicate an increase in knowledge about the importance of certain foods, and health care professionals seem to play an important role in highlighting the importance of nutrient-dense foods. Participants brought up cost and availability as limitations to consuming nutrient-rich food. Although some respondents have access to livestock and poultry, they do not see these animals as sources of food, but rather as assets, and therefore do not eat the meat.

C. Women's Antenatal Care

Additional data were collected during the household survey to explore the antenatal care (ANC) practices of women who gave birth in the past two years. A total of 979 women were interviewed—419 in the *Amalima* Program area and 560 in the ENSURE Program area.

As shown in Table 4.4c, the average number of ANC visits for women who gave birth in the past two years in the *Amalima* and ENSURE Program areas was 4.7. This result is in line with WHO guidelines that all pregnant women should have at least four ANC visits.

Of the 979 mothers of children under two years of age, 5.6 percent reported not receiving any ANC during their pregnancy and 21 percent reported having their first ANC visit in the first trimester of pregnancy. Almost one-third of women (32.7 percent) did not have their first ANC visit until after their fifth month of pregnancy.

Table 4.4c. Program-Specific Indicators - Women's Antenatal Care (ANC)
Program-specific indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Antenatal Care (Women 15-49 with pregnancy in the past 2 years)			
Average number of antenatal care visits by pregnant women	4.7	4.7	4.7
Number of months pregnant at time of first ANC visit			
Percent < 4 months pregnant	20.8	23.2	19.7
Percent 4-5 months pregnant	40.8	42.4	40.1
Percent 6-7 months pregnant	25.8	21.3	27.9
Percent 8 or more months pregnant	6.9	9.1	5.9
Percent with no antenatal care	5.6	4.0	6.4
Number of responding women 15-49 with pregnancy in the past 2 years	979	419	560

Findings from the qualitative data indicate that respondents were aware of the importance of seeking ANC during pregnancy and respondents said that village health workers and other health professionals are primary sources of information. In response to the focus group and household-level interview questions on what a woman should do to take care of herself and her unborn child when she is pregnant, many women mentioned the need to go to the clinic or hospital to see the nurses.

Women mentioned receiving recommendations from nurses and doctors on what foods to eat and which duties, such as working in the fields, they should not perform. In addition to the advice given, some women stated that doctors gave them tablets (that is, medication) and checked to make sure that the pregnancy was progressing well and that the baby was sitting well in the womb. Many respondents stated that they went to ANC to be tested for HIV/AIDS. They also wanted to be able to receive medicine and advice on how to prevent passing infections or diseases to their unborn child. A woman from Chivi explained ANC attendance in the following exchange:

> **Respondent:** If you look back, when people were not tested, babies could get diseases from their mothers, unlike nowadays when the baby can be free from any disease carried by the mother.
> **Interviewer**: I need to understand what you mean when you say diseases. Which are those diseases?
> **Respondent**: I mean HIV and BP [blood pressure], which can also affect the baby.

Several women discussed going to both the clinic and visiting the local traditional birth attendant for ANC. This is particularly true if the traditional birth attendant was perceived to have assisted in the conception by providing traditional medicines. Following is part of a discussion from a focus group in Buhera:

Interviewer: What about pregnant women, where do they get help?
Respondent: She can visit both. Some are also attended to by the traditional birth attendants.
Respondent: Maybe these traditional birth attendants are the ones who would have helped with their traditional medicines for one to conceive. So they will say that for you not to get a miscarriage, they will tie it up with the medicine [a reference to tying a string with traditional medicine around a woman's stomach]. Some say they use honey.
Interviewer: How do they tie the pregnancy?
Respondent: They use traditional medicine. The pregnancy can become painful at two months and the medical professionals will not be able to help you, but these traditional women will heal it.
Interviewer: Normally where do you go to get tied?
Respondent: We go to these traditional birth attendants from the village, but they encourage us to go and register at the clinic as well and get a card.
Interviewer: So you only get registered at the clinic as back up?
Respondent: I always get checked at the clinic.

Distance was the most common reason women gave for making limited visits to the clinic, as explained by this focus group participant from Chimanimani:

There is another problem that our hospitals are far away. Some cannot get the money so that their wives can go and see the nurses in time. It then becomes a problem that a woman walks like from Odzi all the way to Chako on foot whilst pregnant.

An officer in the ENSURE Program area commented that although much has been invested in promoting health-seeking behavior, it can be difficult to convince women to access care when the clinic or hospital is far away, a problem that is especially difficult with members of the Apostolic sect, some of whom do not approve of using medical facilities. The officer mentioned that parts of Buhera, Chimanimani and Chivi have high concentrations of Apostolic sect members.

4.5 Children's Health and Nutrition Indicators

A. Stunting and Underweight

Anthropometric indicators for children under five years of age provide outcome measures of nutritional status. Height (length) and weight measurements are taken using standardized procedures and compared with the 2006 WHO child growth standards, which are based on an international sample of ethnically, culturally and genetically diverse healthy children living under optimum conditions that are conducive to achieving a child's full genetic growth potential.[53] Use of the 2006 WHO child growth standards is based on the finding that well-nourished children of all population groups for which data exist follow similar growth patterns before puberty.

Weight-for-age takes into account both chronic and acute malnutrition and is often used to monitor nutritional status longitudinally. Children who are less than two standard deviations (SDs) below the median of the WHO child growth standards population for weight-for-age are considered underweight.

[53] WHO Multicentre Growth Reference Study Group. (2006). WHO Child Growth Standards: Length/height-for-age, weight-for-age, weight-for-length, weight-for-height and body mass index-for-age: Methods and development. Geneva: World Health Organization.

The height-for-age index provides an indicator of linear growth retardation (stunting) among children. Children who are less than two SDs below the median of the WHO child growth standards population for height-for-age may be considered short for their age (stunted) or chronically malnourished. Severe linear growth retardation (stunting) reflects the outcome of a failure to receive adequate nutrition over a number of years and the effect of recurrent and chronic illness. Height-for-age, therefore, represents a measure of the long-term effects of malnutrition in a population and does not vary appreciably according to the season of data collection.

Age, height and weight measurements were obtained for 3,115 children under five years of age—1,609 in the *Amalima* Program area and 1,506 in the ENSURE Program area. These measurements were used to calculate two indicators:

- Prevalence of underweight children under five years of age (weight-for-age)
- Prevalence of stunted children under five years of age (height-for-age)

Table 4.5a summarizes these anthropometric indicators.

A total of 10.8 percent of children under five years of age show signs of being moderately or severely underweight (less than two SDs below the median). Children in the *Amalima* Program area have a higher rate for underweight (14.6 percent) than children in the ENSURE Program area (8.6 percent). These results are higher than those reported in the 2010-2011 DHS for underweight children in all rural households in Zimbabwe (3.2 percent).

Table 4.5a. Food for Peace Indicators - Children's Nutritional Status
Child-level FFP indicators by program area and sex [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Children's Nutritional Status (Children under 5 years)			
Prevalence of underweight children	10.8	14.6	8.6
Male	10.9	15.4	8.2
Female	10.6	13.7	8.9
Number of children (under 5 years)	3,115	1,609	1,506
Prevalence of stunted children	29.4	31.7	28.1
Male	32.3	34.6	31.0
Female	26.4	28.6	25.1
Number of children (under 5 years)	3,115	1,609	1,506

In the survey population, 29.4 percent of children under five years of age shows signs of being stunted (less than two SDs below the median). The prevalence of stunting is higher in the *Amalima* Program area (31.7 percent) than in the ENSURE Program area (28.1 percent). These results are similar to those reported in the DHS for stunted children (33.4 percent) in all rural households in Zimbabwe.

To better understand the practices and beliefs that are potential factors in stunting rates, qualitative interviewers asked a series of questions about how respondents feel about their children's height, weight, development, food intake and overall health. Respondents commonly spoke of Kwashiorkor, a form of malnutrition, when discussing challenges that children face. Participants from the *Amalima* Program area were also familiar with the concept of stunting. The following series of responses, one from each of the seven districts visited, are representative of the similar ways respondents identified malnutrition among children as a problem:

Respondent (Bulilima): A child does not grow well if they do not eat well or lacking essential food which might lead to growth especially [for] a small baby.
Respondent (Gwanda): I could say for their weight, I see how it is when I take them to the clinic. For now they are quite wasted, I'm told their weight is too low. [They are] not getting enough food.
Respondent (Tsholotsho): In order for the child to grow up well they need to eat. In some instances, they may end up not growing well because they are not eating enough and they have kwashiorkor.
Respondent (Bikita): (in reference to kwashiorkor) the legs become thinner, the head becomes bigger and the stomach as well.
Respondent (Buhera): I can tell from their health that they have kwashiorkor…I can tell from the signs like peeling off of the skin.
Respondent (Chinanimani): If you are eating well, you will have your own body which is well, if you do not eat properly you will be slim it will end up causing kwashiorkor.
Respondent (Chivi): It's not good to starve young and old people, the baby can get kwashiorkor.

Responses across the qualitative data demonstrate some understanding of the drivers of malnutrition. One respondent from Chimanimani explained how her child's "body may deteriorate," meaning that the child is not getting the proper nutrition. Many respondents spoke to the ways childhood malnutrition is the result of the limited availability of food or the lack of financial resources to buy food. At the same time, other respondents voiced concern about developmental delays related to malnutrition.

Despite an awareness of causes for malnutrition among respondents, several respondents from the *Amalima* Program area voiced the concern that they did not know how to help their children who were not thriving. One focus group participant from Tsholotsho explained: "There is nothing you can do; you only wish your child grows healthy." Thus, awareness and understanding of malnutrition does not improve availability of resources or access to nutritious foods.

Several respondents from both programs mentioned receiving food assistance from local hospitals and the private volunteer organizations as a means to help improve child nutrition. As an example, a female lead farmer from Gwanda explained help that children receive, "children are well [cared] for because there are times when they are given food handouts by health officers … when a child is underweight they can take her to the hospital where they are assisted with food."

Predictors of Stunting

Multivariate analyses were performed to broaden the understanding of the causes of malnutrition in children using the HAZ in children under 24 months of age, a measure of stunting and a critical malnutrition indicator. An ordinary least squares regression model was attempted, although it showed counterintuitive results and low explanatory power ($R^2 = 0.18$).

This relatively low explanatory power is not surprising, considering that the model includes only a limited subset of the predictors that the literature identifies as relevant. Important child-level predictors that were not collected as part of the Title II baseline study include birth weight, breastfeeding duration and initiation, immunization status and iron, zinc or vitamin A supplementation. Important maternal-level predictors of child HAZ were omitted as well, including maternal BMI and height and maternal health or maternal supplementation with zinc, iron folate or micronutrients during pregnancy.

Due to the low explanatory power and counterintuitive results, the multivariate models are of limited usefulness and are discussed only in Annex 7. Future food security surveys may attempt to obtain better fitting models by incorporating some of the child and maternal-level predictors discussed above.

B. Diarrhea and Oral Rehydration Therapy

Dehydration caused by severe diarrhea is a major cause of morbidity and mortality among young children, although the condition can be easily treated with oral rehydration therapy (ORT). Exposure to diarrhea-causing agents is frequently related to the use of contaminated water and unhygienic practices in food preparation and disposal of excreta. Caregivers were asked whether any children under five years of age had diarrhea at any time during the two-week period preceding the survey. If the child had diarrhea, the caregiver was asked about feeding practices during the diarrheal episode, whether they sought advice or treatment, and whether ORT was given to the child. Types of ORT included oral rehydration solution (ORS), homemade sugar-salt water solution or increased fluids. Caregivers were also asked whether blood appeared in the child's stools. Diarrhea with blood in the stools indicates other more serious conditions, such as cholera or dysentery that require treatment in addition to ORT.

Table 4.5b shows the results for the two FFP indicators—the percentage of children with diarrhea in the past two weeks and the percentage of children with diarrhea who were treated with ORT. Overall, about 21.6 percent of all children under five years of age had diarrhea in the two weeks preceding the survey. Fewer children in the *Amalima* Program area (15.8 percent) had diarrhea than in the ENSURE Program area (24.7 percent). Of the children with diarrhea, 14 percent had blood in their stools.

About 58 percent of caregivers reported seeking advice or treatment for children with diarrhea and 77 percent of these children were treated with ORT. ORT with ORS was used for 31 percent of children with diarrhea and a homemade sugar-salt solution was used for 56 percent of children with diarrhea. Caregivers reported increasing fluids for 33 percent of children with diarrhea.

A bivariate analysis of the relationship between children with diarrhea and WASH practices (see Table A12.8 in Annex 12) indicates that children in households using improved WASH practices tend to experience lower rates of diarrhea than those in households not using them.

Table 4.5b. Food for Peace Indicators - Children's Diarrhea and Oral Rehydration Therapy (ORT)
Child-level FFP indicators by program area and sex [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Children's Diarrhea and ORT (Children under 5 years)			
Percentage of children who had diarrhea in the last two weeks	21.6	15.8	24.7
Male	22.2	16.5	25.5
Female	20.9	15.1	23.9
Number of children (under 5 years)	3,785	1,881	1,904
Percentage of children with diarrhea treated with ORT [1]	76.9	71.3	78.8
Male	74.8	67.3	77.6
Female	79.1	76.2	80.1
Number of children (under 5 years) with diarrhea	758	290	468

[1] Includes oral rehydration solution, home-made sugar-salt water solution or increased fluids.

The qualitative data indicate that forms of treatment for diarrhea were similar between the two program areas. Respondents reported either seeking treatment at a health care facility or giving children an ORS of clean water, sugar and salt. Although treatment practices were similar, analysis of the qualitative data indicate varying levels of understanding about prevention between the two program areas. Respondents from the *Amalima* Program area reported receiving information from health care professionals on treatment and care practices for diarrhea. For example, a respondent from Bulilima explained that to prevent diarrhea they were taught that,"[since] we get drinking water from unclean sources, we had pills that we were being given and you were to put one in a 20-liter bucket of water or

boil the water." Some awareness of diarrhea prevention strategies in the community is indicated because most participants reported treating their children with ORT.

Although several participants were knowledgeable about the causes and potential prevention measures for diarrhea, several misconceptions, specifically from the ENSURE Program area, emerged. Misconceptions were that diarrhea is "caused by high environmental temperature" or that "when the sun gets too hot and the child gets too hot they have diarrhea" and "even over-eating you will cause the child to have diarrhea."

Poor hygiene, exposure to untreated water and poor handwashing behavior all allow bacteria, viruses and parasites to be ingested, frequently leading to onset of diarrhea and other illnesses. Many respondents reported that their children had experienced occasional episodes of diarrhea, and several respondents associated these incidences with teething in young children or seasonality. Some causes for childhood diarrhea that emerged from both program areas included eating dirty food, exposure to dirty living conditions, flies getting into the food and drinking untreated water.

C. Minimum Acceptable Diet

Adequate nutrition during the period from birth to two years of age is critical for a child's optimal growth, health and development. This period is one marked for growth faltering, micronutrient deficiencies and common childhood illnesses, such as diarrhea and acute respiratory infection. Adequate nutrition requires a minimum dietary diversity, which is measured in seven key food groups. In addition to dietary diversity, feeding frequency (i.e., the number of times the child is fed) and consumption of breast milk or other types of milk or milk products needs to be considered. All three dimensions are aggregated in the MAD indicator. This indicator measures the percentage of children 6-23 months of age who receive a MAD, apart from breast milk. The MAD indicator measures both the minimum feeding frequency and minimum dietary diversity, as appropriate for various age groups. If a child meets the minimum feeding frequency and minimum dietary diversity for his or her age group and breastfeeding status, the child is considered to be receiving a MAD. The MAD indicator minimum requirements for feeding frequency and dietary diversity are set separately for three groups: breastfed children 6-8 months, breastfed children 9-23 months and non-breastfed children 6-23 months.

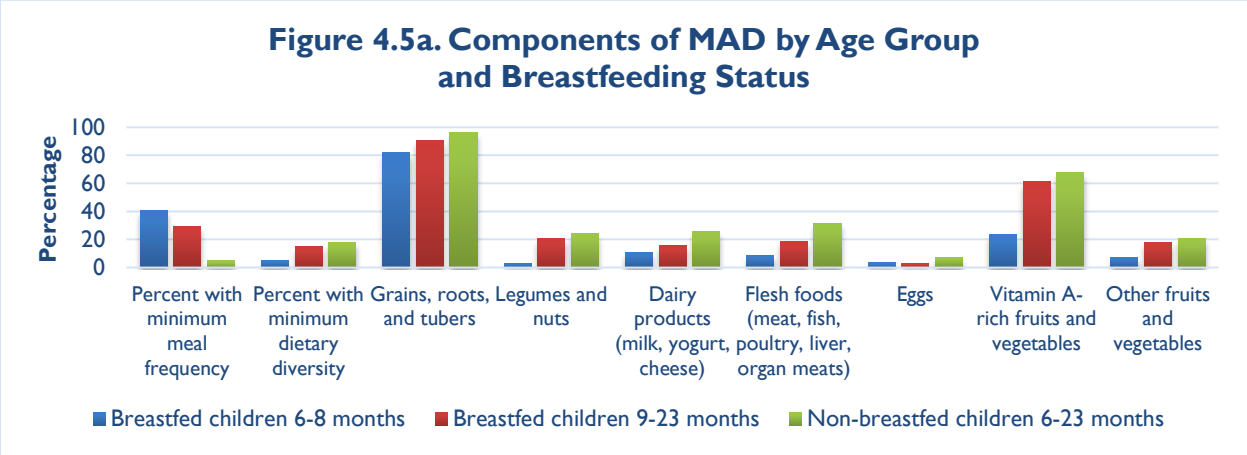
Table 4.5c shows the results for the MAD indicator. A total of 1,073 children 6-23 months of age were included in the survey. Overall, only 4.7 percent of these children are receiving a MAD. Fewer children in the *Amalima* Program area (3.4 percent) receive a MAD than in the ENSURE Program area (5.4 percent). Fewer non-breastfed children (0.4 percent) receive a MAD, compared to breastfed children (7.3 percent).

As Figure 4.5a shows, the proportion of children 6-23 months of age with a minimum dietary diversity of four or more food groups is low: 5 percent for breastfed children 6-8 months of age, 15 percent for breastfed children 9-23 months of age and 18 percent for non-breastfed children 6-23 months of age. The percentage of children meeting the minimum meal frequency requirements is higher for breastfed children 6-8 months of age (41 percent) and breastfed children 9-23 months of age (30 percent), compared to non-breastfed children 6-23 months of age (5 percent). The food groups consumed follow patterns similar to those consumed by women 15-49 years of age; they generally lack nutrient-rich foods.

Table 4.5c. Food for Peace Indicators - Minimum Acceptable Diet

Child-level FFP indicators by program area, sex, and breastfeeding status [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Minimum Acceptable Diet (Children 6-23 months)			
All Children			
Male	4.2	4.0	4.4
Female	5.2	2.8	6.4
Total	4.7	3.4	5.4
Number of children (6-23 months)	1,073	510	563
Breastfed Children			
Male	6.4	6.9	6.2
Female	8.2	4.7	9.7
Total	7.3	5.8	8.0
Number of breastfed children (6-23 months)	661	301	360
Non-breastfed Children			
Male	0.4	0.0	0.7
Female	0.4	0.0	0.6
Total	0.4	0.0	0.6
Number of non-breastfed children (6-23 months)	412	209	203



Generally, children tend to eat at the same time and the same meals that their parents eat; and therefore, their dietary diversity and meal frequency mirror that of their parents. Across both program areas respondents identified complementary foods such as mealie-meal [used in a porridge made from ground maize or pumpkin] with peanut butter and *Sadza*. A few other respondents said ideally, they would like to feed their children vegetables (including pumpkin, carrots, peas and avocado), fruit (including oranges and bananas), milk, yogurt, beans, soup and *mazoe* juice [a common dilatable flavoured drink]; however, these foods are rarely available. A few respondents mentioned eating eggs and meat. Some participants also served their children sorghum malt drink or a fermented milk drink, primarily to fill empty stomachs. Respondents from the *Amalima* Program area also mentioned serving groundnuts, potatoes, goat milk, *maheu* or *mahae* [thick drink made from maize meal], powdered milk called Nan® and cow peas.

When asked what foods babies should eat, one respondent from Gwanda emphasized the lack of available food choices by saying: "We may be stating all these [foods] but in reality we don't have it." Another respondent from Tsholotsho mentioned how rarely people in their area even see fruit: "Since we are in the rural areas, we don't have it [nutritious foods], foods such as fruits. Many children don't know fruits. They see them when they grow up." These two focus group respondents from Tsholotsho explained how availability of nutritious food, water and poverty are inextricably linked to one another:

> **Respondent 8:** We don't get nutritional food because we also have water shortages, hence we can't grow vegetables for us to eat nutritional foods.
> **Respondent 3:** Here in Tsholotsho we don't have fruit-bearing trees for us to eat. We only buy fruits from those who order from the city. The problem is we don't always have the money to buy fruits from them.

D. Breastfeeding

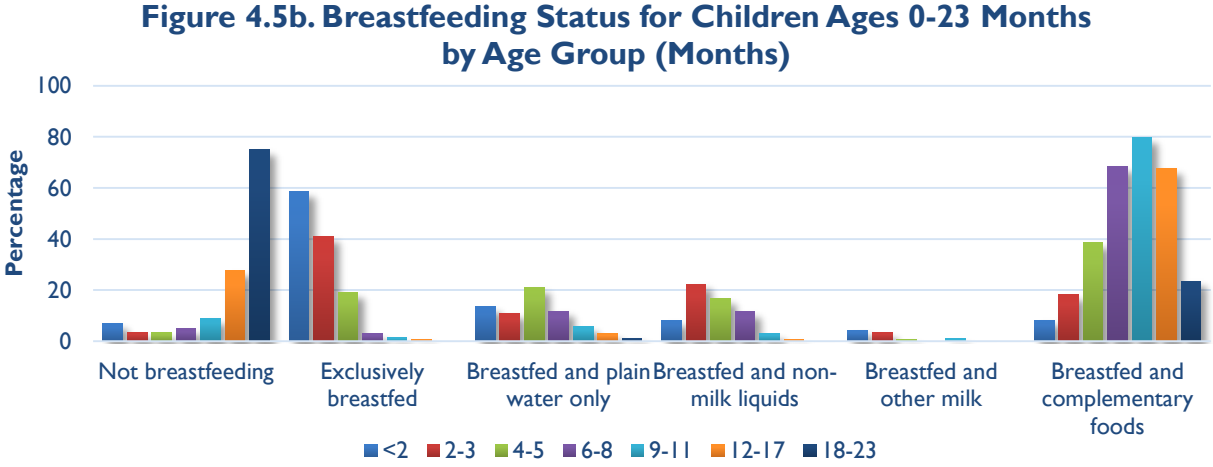
Breastfeeding is an important factor in predicting the future health of children. Research indicates a strong link between breastfeeding and the development of a child's immune system.[54] The United Nations Children's Fund (UNICEF) and WHO recommend that children be exclusively breastfed (no other liquid or solid food or plain water) during the first six months of life and that children be given solid or semi-solid complementary food, in addition to continued breastfeeding beginning when the child is six months of age and continuing to two years of age and beyond. Introducing breast milk substitutes to infants before six months of age can contribute to limiting breastfeeding, which has negative implications for a child's health and development. Substitutes, such as formula, other kinds of milk and porridge, are often watered down, easily contaminated during preparation and provide too few calories. The lack of appropriate complementary feeding may lead to malnutrition, frequent illnesses and possibly death.

Table 4.5d shows the results of the household survey for the prevalence of exclusive breastfeeding in the last 24 hours. Breastfeeding in the past 24 hours serves as a proxy for long-term breastfeeding behavior, which is difficult to measure due to recall issues. Of the 320 children under six months of age in the survey households, 39 percent are exclusively breastfed. More children in the *Amalima* Program area are exclusively breastfed (45 percent) than in the ENSURE Program area (36 percent). As Figure 4.5b shows, the prevalence of exclusive breastfeeding is highest in the 0-2 months old range (57 percent) and gradually decreases with each age group thereafter. About 76 percent of children 18-23 months of age are no longer breastfeeding. The addition of complementary foods along with breastfeeding begins early; about 40 percent of children 2-3 months of age are receiving complementary foods and over 90 percent of children 9-11 months of age are receiving complementary foods.

[54] Additional information on breast milk and the immune system is available in Slade, H. B., & Schwartz, S. A. (1987). Mucosal immunity: The immunology of breast milk. *J Allergy Clin Immunol,* 80(3 Pt 1):348-58; Cunningham, A. S., Jelliffe, D. B., & Jelliffe, E. F. (1991). Breast-feeding and health in the 1980s: A global epidemiologic review. *J Pediatr,* 118(5):659-66; and Goldman, A. S. (1993). The immune system of human milk: Antimicrobial, anti-inflammatory and immunomodulating properties. *Pediatr Infect Dis J,* 12(8):664-71.

Table 4.5d. Food for Peace Indicators - Exclusive Breastfeeding
Child-level FFP indicators by program area and sex [Zimbabwe, 2014]

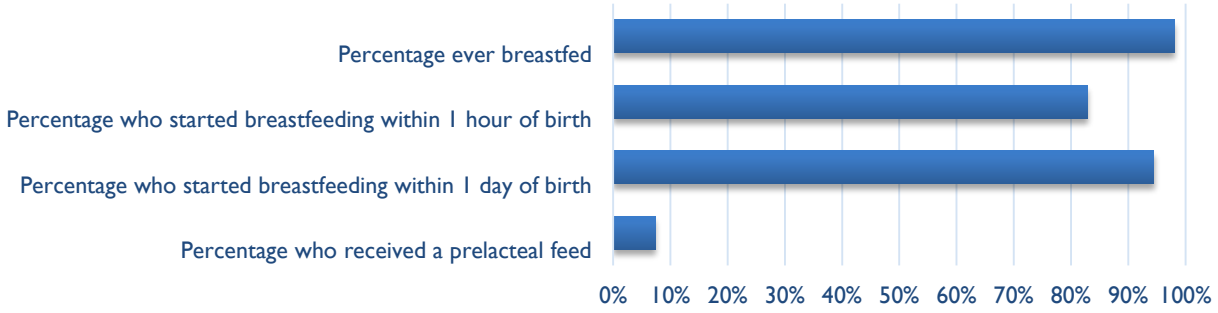
	Total	Amalima	ENSURE
Exclusive Breastfeeding (Children under 6 months)			
Prevalence of exclusive breastfeeding	39.2	44.9	35.6
Male	37.2	45.1	31.8
Female	41.3	44.7	39.4
Number of children (under 6 months)	320	167	153



The survey collected information on children who were ever breastfed, who were breastfed in the first hour and the first day after birth and children who were fed anything other than breast milk before breast milk was regularly given, also known as "prelacteal feeding." Provision of mother's breast milk to infants within one hour of birth is referred to as "early initiation of breastfeeding" and ensures that the infant receives the colostrum, or "first milk," which is rich in protective factors. The practice of giving prelacteal feeds is discouraged because it limits the infant's frequency of suckling and exposes the baby to the risk of infection.

As shown in Figure 4.5c, almost all children born in the past two years are ever breastfed (98 percent), 83 percent started breastfeeding within one hour of birth and 94 percent started within the first day. Overall, 7 percent are given prelacteal feeds within the first three days of life.

Figure 4.5c. Initial Breastfeeding and Prelacteal Feeding for Last Birth Within the Past Two Years



The qualitative study participants in both program areas noted the importance of exclusive breastfeeding. They stated that breast milk is what will help the baby grow, be healthy, and stay strong. Several respondents stated that breast milk contains the vitamins and the right nutrients needed to help the baby grow. Others mentioned that it helps the baby grow up without being prone to diseases. One mentioned that breast milk is all that babies should be given because their digestive systems are not yet strong enough to take in other foods.

Further advantages of breast milk that respondents mentioned are that it is cheap and always available. Breast milk does not need to be purchased, and when no other food is available, a baby can still breastfeed. Breast milk is always ready, always warm and hygienic and does not require cups to be washed. Several respondents mentioned that breastfeeding can create a bond between the baby and mother.

Respondents mentioned receiving encouragement to exclusively breastfeed from several sources, most notably from nurses. Other sources of information and encouragement include the hospital and clinics, doctors and village health workers. Several respondents in the ENSURE Program area stated that information about exclusive breastfeeding is written on the baby's clinic card. A woman in Chimanimani implied that the social pressure against early feeding is high: "The child is given the mother's milk. Is that not what you are encouraged by doctors in hospitals? If you are caught cooking porridge for it [the child], you will be rebuked."

Despite the knowledge about the importance of exclusive breastfeeding, respondents noted several challenges in accomplishing it. A commonly cited reason for stopping exclusive breastfeeding before six months was a perceived lack of milk. Participants explained that if a baby is crying a lot, it is generally assumed that he or she is not getting enough to eat. A woman from Chivi explained it this way: "It will have cried and kept on crying, then you say let us test and you see the baby then eating and you keep on giving it."

Another frequently mentioned reason women stop breastfeeding exclusively is that they go to work. This male focus group discussion participant provides an example of how the need to return to work plays a role in women's breastfeeding practices.

> I know that mothers should breastfeed for six months. The reasons why other mothers don't breastfeed for six months is that it is now common at our homes that when a child gets pregnant even if she is in South Africa or in Bulawayo she comes back and gives birth at home. When she gives birth she leaves the child with her grandmother and she goes back to work without breastfeeding for six months…due [to] the fact that she would be going back to work she would be forced to go back before six months.

The third frequently mentioned reason for stopping exclusive breastfeeding is that the mother is ill or has been diagnosed as HIV-positive. This could result in her death (in which case, the care for the baby would pass to a grandparent or another person) or her being advised by the clinic to either not breastfeed or to breastfeed for a limited amount of time, as explained by a female respondent from Chivi:

> There are various diseases. Some have diseases, but also want a child. If they go to the clinic, they are told we will give you a pill and you can have your child but you can no longer breastfeed like one who hasn't got the disease. You have to look for milk for the baby so that the baby does not get the disease from you.

Culture and decision-making roles also come into play. One respondent mentioned that it may be a tribal decision to give the child porridge right from birth. It may not matter if a woman is taught to exclusively breastfeed for six months if she is not in the position to make the final decision in these matters. A nutrition expert interviewed in the *Amalima* Program area explained the dynamic this way:

> …all the young girls when they give birth they [stay] with their mother-in-law or grandmother…because the mother-in-law would have told her to give the child porridge [after] two weeks...Whilst the young mothers may have the knowledge and desire to do certain things, but there are cultural barriers that come into play, and that decision making is taken away…

The point at which a woman introduces food other than breast milk varies greatly, from immediately after birth to nine months of age. Most participants who mentioned specific ages said they introduced complementary foods between three and six months of age. Some of those interviewed mentioned milestones, such as when the baby is able to raise a hand or hold a spoon, rather than specific ages.

The most common food introduced is a very weak porridge made with water, mealie-meal [ground maize], salt and sugar. A number of respondents stated that porridge is given if the mother cannot afford to buy milk or formula from the store. Other foods mentioned include milk from an unspecified source, boiled goat milk, fermented malt drink, *sadza*, bananas, water and juice.

4.6 Gender Equality

The household survey included a series of questions adapted from the Access to Resources Module of the WEAI. The questions in this module concern ownership of assets and access to and decision-making power about productive resources, such as land, livestock, agricultural equipment, consumer durables and credit. These questions were asked of the self-identified primary male and female decisionmakers in each household. Indices were calculated to determine the percentage of male and female decisionmakers that achieved adequacy (see Table 4.6a) in three areas:

1. Ownership of assets
2. Purchase, sale or transfer of assets
3. Access to and decisions on credit

Table 4.6a. Criteria to Establish Adequacy for Each Gender Equality Index

Index	Question asked	Screener for achievement*	Criteria to establish adequacy*
Ownership of assets	Who would you say owns most of the [*item*]? Agricultural land, large livestock, small livestock, chicks, etc.; farm equipment (non-mechanized); farm equipment (mechanized); non-farm business equipment; house; large durables; small durables; cell phone; transport	Achievement in any, if not only one, small asset (chickens, non-mechanized equipment and no small consumer durables)	Inadequate if household does not own any asset or if household owns the type of asset *but* she or he does not own most of it alone
Purchase, sale or transfer of assets	Who would you say can decide whether to sell, give away, rent or mortgage [*item*] most of the time? Who contributes most to decisions regarding a new purchases of [*item*]? Agricultural land, large livestock, small livestock, chicks, etc.; farm equipment (non-mechanized); farm equipment (mechanized); non-farm business equipment; house; large durables; small durables; cell phone; transport	Achievement in any, if not only chickens and farming equipment (non-mechanized)	Inadequate if household does not own any asset or household owns the type of asset *but* she or he does not participate in the decisions (exchange or buy) about it
Access to and decisions on credit	Who made the decision to borrow, what to do with money, item borrowed from [*which source*]? NGO, informal lender, formal lender (bank), friends or relatives, savings or credit group	Achievement in any	Inadequate if household has no credit *or* used a source of credit *but* she or he did not participate in *any* decisions about it

*For a more detailed explanation of these achievement and adequacy criteria see: Alkire, S., Meinzen-Dick, R., Peterman, A., Quisumbing, A. R., Seymour, G. and A. Vaz. 2012. "The Women's Empowerment in Agriculture Index," Poverty, Health & Nutrition Division, International Food Policy Research Institute, IFPRI Discussion Paper No. 01240, December 2012. http://www.ifpri.org/publication/women-s-empowerment-agriculture-index

The results for the three indices are shown in Table 4.6b disaggregated by sex and gendered household type. A total of 4,499 primary female decisionmakers and 2,591 primary male decisionmakers were included in the analysis.

Males scored higher in adequacy (94 percent) for ownership of assets and decision-making in the purchase, sale or ownership of assets (84 percent), compared to females (86 percent and 72 percent, respectively). More females in the *Amalima* Program area (37 percent) achieved adequacy for access and decisions on credit compared to males (31 percent). In the ENSURE Program area, males and females achieved the same level of adequacy for access to and decisions on credit (30 percent).

Table 4.6b. Program-Specific Indicators - Gender Equality

Program-specific indicators by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Gender Indicators – WEAI Access to Resources			
Percentage achieving adequacy by sex			
Female			
Adequacy in Ownership of Assets	86.3	89.9	84.5
Adequacy in Decisions for Purchase, Sale or Ownership of Assets	72.3	80.8	67.9
Adequacy in Access to and Decisions on Credit	32.2	37.3	29.6
Male			
Adequacy in Ownership of Assets	93.7	91.6	94.7
Adequacy in Decisions for Purchase, Sale or Ownership of Assets	83.9	82.9	84.4
Adequacy in Access to and Decisions on Credit	30.0	30.6	29.7
Number of responding primary male decision makers	2,591	1,141	1,450
Number of responding primary female decision makers	4,499	2,165	2,334
Percentage achieving adequacy by gendered household type and sex			
Male only Households			
Male			
Adequacy in Ownership of Assets	88.7	90.0	87.6
Adequacy in Decisions for Purchase, Sale or Ownership of Assets	67.3	77.6	58.7
Adequacy in Access to and Decisions on Credit	40.7	35.4	45.2
Number of responding primary male decision makers	202	119	83
Female only Households			
Female			
Adequacy in Ownership of Assets	94.0	94.7	93.7
Adequacy in Decisions for Purchase, Sale or Ownership of Assets	83.8	86.1	82.5
Adequacy in Access to and Decisions on Credit	38.5	44.2	35.4
Number of responding primary female decision makers	1,236	608	628
Male and Female Households			
Female			
Adequacy in Ownership of Assets	83.7	88.3	81.3
Adequacy in Decisions for Purchase, Sale or Ownership of Assets	68.3	79.1	62.9
Adequacy in Access to and Decisions on Credit	29.8	34.7	27.3
Male			
Adequacy in Ownership of Assets	94.7	92.9	95.4
Adequacy in Decisions for Purchase, Sale or Ownership of Assets	85.9	85.5	86.1
Adequacy in Access to and Decisions on Credit	29.3	30.1	28.9
Number of responding primary male decision makers	2,343	991	1,352
Number of responding primary female decision makers	3,229	1,540	1,689

In the program areas, it is common for male decisionmakers to migrate and be away from the household for extended periods, typically beyond the six-month threshold needed to be included as part of the household roster. In these cases, by definition, the gendered household type is considered female-only because no adult male is included in the roster. In many of these cases, the male still has ownership of assets and contributes to decision-making in the household, even when he is not physically present. The results by gendered-household type indicate that females in female-only households achieve higher rates of adequacy for all three indices compared to females in households with an adult male and female present. Males in male-only households achieve lower rates of adequacy for ownership of assets and decision-making on the purchase, sales or ownership of assets than males in dual male and female

households, but score higher in adequacy for access to and decisions on credit. One possible explanation for this result is that males in male-only households do not have as many assets as males in dual adult households, and therefore are more likely to try to obtain credit to purchase assets.

The qualitative study integrated questions concerning gender equality, perceptions about equality and decision-making between men and women. Although participants indicated that most decisions were made jointly, respondents in both program areas still generally expressed the view that men and women are not equal. Reasons given for the inequality included physical strength, gendered roles and responsibilities, religious and traditional beliefs or designations, cultural practices and perceived differences in mental capabilities. The following exchange from a focus group discussion highlights some of the reasons behind this perceived inequality:

> **Interviewer:** I am saying, do you see men and women as equal?
> **Respondent:** As I was growing up I saw them as not equal and up until today, they are not equal.
> **Respondent:** We might be mentally equal but in terms of physical powers we were created differently. A woman has some things that she ends up saying are for men. Us as men there are issues that are feminine, like we can't fall pregnant. That is for women. It's just the way they were created.
> **Interviewer:** In your community, what are the barriers or hindrances to men and women being equal? What causes them not to be equal?
> **Respondent:** We can say when it comes to assets we cannot be equal because I could then find my phone lent out when I'm not there, saying it needs to be used by so and so [someone else].
> **Respondent:** The other thing that I see that was messed up a long time ago which causes men and women not to be equal, maybe I am the one that fails to see it right, that the man is the one that pays dowry for the woman so that she comes into his home, that really greatly reduced women.

As illustrated in the exchange above, several of the reasons for inequalities between men and women are rooted in beliefs and practices outside of the individual's control. According to a lead farmer: "Men use the Bible to dominate women. They will tell you that it is written in the Bible that women should be under men."

As noted, the *Amalima* Program area has a higher frequency of external migration for extended periods. This may contribute to the lower number of male respondents in this program area. As the survey respondents illustrate, women have slightly lower adequacy in decision-making. The qualitative data provide nuanced understanding of these differences. Across both program areas, both men and women stated that joint decision-making in households was common, and yet, further probing revealed that the extent of a woman's say in decision-making was often contingent on the value of the asset being decided. Women were more likely to make decisions over smaller assets, as illustrated in this exchange:

> **Interviewer:** Who makes the decision of how things are done and planned in the home?
> **Respondent:** The father.
> **Interviewer:** So you are responsible for deciding on when and what to sell?
> **Respondent:** Yes.
> **Interviewer:** Ok, but doesn't it depend on what that thing is?
> **Respondent:** It depends on whether it's a cow or goat. If it's a chicken, my wife can decide to sell in my absence and inform me later.
> **Interviewer:** So if it's a chicken your wife doesn't need to consult you?
> **Respondent:** She can do it after she has already sold.

The survey findings indicate that women achieved adequacy in some aspects of decision-making. Yet the qualitative data indicate that factors, such as the type of asset, who owns the asset and the presence of a male partner, all contribute to the decision-making process; therefore, these factors should be considered in asserting if adequacy in decision-making by women can translate to tangible benefits.

5. Summary of Key Findings

The data for the baseline study for Title II development food assistance programs in Zimbabwe were collected through a household survey (March and April 2014) and a qualitative study (July 2014), and is publicly available in USAID's Development Data Library (DDL).[55]

The final section of this report includes a brief analytic summary of the key findings. Table 5 presents the values for the indicators that were collected for the 2014 Title II baseline study in Zimbabwe for each program area along with comparable indicators for rural households collected from the 2010-2011 DHS, when available. This overview and comparison of food security, agriculture, health and nutrition can serve to promote discussion among the *Amalima* and ENSURE teams and relevant stakeholders and identify areas for further investigation. Differences in indicator values between the DHS and the Title II baseline study may reflect differences in the underlying populations that were sampled and the three-year difference in timing between the two surveys. The DHS results represent all rural populations in Zimbabwe; the baseline survey results represent the rural populations in the four provinces where the Title II programs are operating.

Food Security

Despite the FEWSNET report for Zimbabwe for April through September 2014 that shows households across the country are experiencing minimal food insecurity,[56] the household survey and qualitative data indicate that households in both program areas are still facing food security challenges. Food security indicators show a moderate level of food insecurity for both program areas in availability, access and utilization of food. Although 2014 appeared to be a good year due to abundant and well-distributed rains, the HHS still shows about 30 percent of households are experiencing moderate or severe hunger, and 4 percent of households are experiencing severe hunger. The FCS is consistent with the HHS in showing that about 70 percent of households report adequate food consumption. Participants in the qualitative study discussed using several coping strategies when faced with limited or no food availability. These strategies include sleeping hungry; eating less frequently or eating a smaller portion; receiving help from family members, friends or aid organizations; selling livestock; migrating out of the country to find food or work; performing casual labor to earn money to buy food; and planning or budgeting ahead.

Over 95 percent of people in both program areas are living on less than USD $3.35 per day (Zimbabwe TPDPDL), which limits their ability to purchase and access food. Given daily per capita expenditures of 2014 USD $1.22 and a mean depth of poverty of about 65 percent, most households are well below the Zimbabwe poverty line and spend almost all available income on food. Analysis of consumption patterns indicates that food accounted for 96 percent of household consumption. Poverty levels are higher in the *Amalima* Program and more households receive some type of assistance compared to the ENSURE Program area.

[55] The Development Data Library (DDL) is USAID's public repository of Agency-funded, machine readable data. The DDL is part of USAID's commitment to evidence-based programming and rigorous evaluation, while supporting the principles of the President's Open Government Initiative. The DDL can be found at www.usaid.gov/data.

[56] FEWSNET. (2014). Zimbabwe: Food security outlook: April 2014 to September 2014. op. cit.

Table 5: Summary and Comparison of Indicators

	Title II *Amalima* 2014	Title II ENSURE 2014	2010-2011 DHS (Rural Households)
FOOD SECURITY INDICATORS			
Prevalence of households with moderate or severe hunger (HHS)	29.3	26.9	--
Average household dietary diversity score (HDDS)	5.3	5.0	--
Food consumption score (FCS)			
Households with FCS = ≤21 (poor)	4.0	4.2	--
Households with FCS > 21 and FCS ≤35 (moderate)	31.4	32.3	--
Households with FCS >35 (adequate)	64.6	63.5	--
Coping Strategies Index (CSI)	33.8	28.6	--
POVERTY INDICATORS			
Percent of people living below the Total Per Capita Poverty Datum Line (TPCPDL)*	98.2	96.1	--
Mean depth of poverty (using the TPCPDL)	68.5	63.2	--
Per capita expenditures (as a proxy for income) of USG targeted beneficiaries	0.45	0.53	--
WATER, SANITATION AND HYGIENE INDICATORS			
Percentage of households using improved drinking water source	44.5	44.2	70.4
Percentage of households using improved sanitation facilities	40.6	28.9	30.8
Percentage of households with soap and water at a handwashing station commonly used by family members	1.6	2.6	--
Percent of households practicing correct use of recommended household water treatment technologies	8.6	12.1	9.6
Percent of households practicing safe storage of drinking water	49.7	53.2	--
Percent of households with a handwashing station near a sanitation facility	2.6	2.7	--
AGRICULTURAL INDICATORS			
Percentage of farmers who used financial service in the past 12 months	5.4	14.2	--
Percentage of farmers who practiced value chain activities promoted by the project in the past 12 months	71.8	77.5	--
Percentage of farmers who used at least five sustainable agriculture (crop, livestock, natural resource management) practices and/or technologies in the past 12 months	56.8	67.6	--
Percentage of farmers who used improved storage practices in the past 12 months	15.0	18.3	--
WOMEN'S HEALTH AND NUTRITION INDICATORS			
Prevalence of underweight women	13.9	5.9	9.7
Women's dietary diversity score (WDDS)	2.8	3.3	3.6
Average number of antenatal care (ANC) visits by pregnant women	4.7	4.7	--
Timing of ANC visit by pregnant women (percentage with visit in first trimester)	23.2	19.7	19.6
CHILDREN'S HEALTH AND NUTRITION INDICATORS			
Prevalence of underweight children under 5 years of age	14.6	8.6	3.2
Prevalence of stunted children under 5 years of age	31.7	28.1	33.4
Percentage of children under age 5 with diarrhea in last two weeks	15.8	24.7	12.5
Percentage of children under age 5 with diarrhea treated with ORT	71.3	78.8	70.8
Prevalence of exclusive breastfeeding of children under six months of age	44.9	35.6	31.4
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD)	3.4	5.4	8.3
GENDER EQUALITY			
Percentage who achieve adequacy in ownership of assets - MALE	91.6	94.7	
Percentage who achieve adequacy in ownership of assets - FEMALE	89.9	84.5	
Percentage who achieve adequacy in in decision-making for purchase, sale or ownership of assets - MALE	82.9	84.4	
Percentage who achieve adequacy in in decision-making for purchase, sale or ownership of assets - FEMALE	80.8	67.9	
Percentage who achieve adequacy in decisions on credit - MALE	30.6	29.7	
Percentage who achieve adequacy in decisions on credit - FEMALE	37.3	29.6	

*Based on Zimbabwe's Total Per Capita Poverty Datum Line, equivalent to a daily per capita poverty line of USD $3.3547
NOTE: Yellow highlighting shows indicators with statistically significant differences between programs

Access to and consumption of food does not guarantee a diverse diet or that the diet will include nutrient rich foods. The HDDS, although not an indicator used to measure the nutritional quality of a diet, indicates that 98 percent of households consume cereals and 78 percent consume vegetables. Thirty-eight percent reported consuming fruit, 23 percent meat or poultry and 39 percent pulses or nuts. Qualitative data indicate that the local availability of foods plays a role in the degree of diversity in diets. In both program areas, factors such as seasonality, agricultural productivity and income influence the types of foods consumed. Although respondents expressed a desire to eat more diverse foods, factors such as availability and costs made the consumption of these foods prohibitive.

Agriculture

Because a small percentage of farmers access credit in both program areas, existing sources need to be more accessible to farmers, a change that is critical for sustained improvements in agricultural productivity. It is important to note that most farmers are smallholders that farm less than two hectares of land, and most consume what they produce. These farmers make purchases to tide them over in periods of food insecurity and resort to other livelihood options during the lean season. For these smallholder farmers, consuming what they produce and, when needed, complementing it with local market purchases is the norm. Value chain activities consist mainly of drying and processing crops, primary steps needed to prepare food for consumption but that do not necessarily guarantee that foods will be taken to market. Very few farmers market their produce locally or in formal marketing systems, and very few farmers undertake contract farming or use feed lots for cattle.

Health, Nutrition and WASH

The WDDS indicates that women of reproductive age consumed slightly over three of nine critical food groups the previous day. While consumption of grains was high, consumption of legumes and nuts, meats and eggs were low. Food taboos for pregnant women, particularly consumption of eggs, play a role in limiting consumption of some foods.

Also significant is the low level of early ANC visits for pregnant women, with only 21 percent making an ANC visit within the first trimester. Thirty-two percent of pregnant women did not make their first ANC visit until after the fifth month of pregnancy, representing a lost opportunity to maximize and protect fetal growth and development, particularly if iron folic acid supplements and good nutrition counseling is made available during ANC visits. Traditional birth attendants appear to play an important role in program areas, and therefore are candidates for social and behavior change communication strengthening for ANC attendance and timely referrals. Qualitative data indicate an understanding of the importance of ANC visits and proper maternal nutrition during pregnancy.

Infant and young child feeding practices in the program areas are in need of improvement. Only 4.7 percent of children 6-23 months of age are receiving a MAD. Minimum meal frequency requirements were met by only 30 percent of breastfed children 9-23 months of age and an alarmingly low 5 percent of non-breastfed children 6 -23 months of age met the minimum requirement. Consistent with dietary patterns for women of reproductive age, consumption of grains and vitamin A rich vegetables and fruits was common, but consumption of legumes and nuts, meat, eggs and dairy products was low.

The data show that 39 percent of children under six months of age were exclusively breastfed in the last 24 hours. Weaning foods are introduced too early, with 40 percent of children 2 to 3 months of age already receiving complementary foods. Most children are weaned (no longer breastfeeding) by 18 months of age.

The WASH-related indicators for the program areas show significant room for improvement: 67 percent of households do not use an improved sanitation facility, 44 percent report having no sanitation facility and only 2 percent of households had a handwashing station with soap and water available. These percentages indicate a strong likelihood for a fecal-contaminated environment that can contribute to increased illness episodes, helminthes infestation and, ultimately, poor food utilization outcomes for infants, children and adults. Less than half of households (44 percent) have access to an

improved drinking water source, and the majority of households (89 percent) do nothing to make the water safer to drink. WASH practices need to be improved to protect and improve the growth of infants and children and fetal development in the program areas. Qualitative findings are encouraging; participants indicated in their references to tippy taps that they are aware of the importance of handwashing at critical moments.

Results show that one in five children under five years of age had diarrhea in the past two weeks. Although 77 percent of children whose caregivers sought care were given ORT, 33 percent of caregivers reported increasing fluids during the diarrhea episode. Lower rates of diarrhea were observed in households that used improved sanitation practices compared to those that did not, further emphasizing the need for improvement in WASH-related practices.

The household survey and qualitative data identify several areas that the Title II programs might consider targeting. Dietary diversity for all household members appears to be lacking, particularly for women 15-49 years of age and children under five years of age. Diets that lack essential nutrients can significantly affect the health of the survey population, as shown in the survey rates of stunting and underweight for children under five years of age and the rates of overweight and obesity in women 15-49 years of age. Poor hygiene practices are another area for programs to target since these practices also significantly contribute to morbidity and mortality in the survey population. High poverty levels that result from a lack of employment opportunities and the inability of households to generate income from farming affect all of these areas. Community-level constraints, such as poor irrigation systems, roads and market access and limited availability of agricultural extension services and input suppliers also exacerbate food security challenges.

ANNEXES

ANNEX I
Statement of Work
Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

Statement of Work for Baseline Study:

Title II Development Food Assistance Programs in Haiti and Zimbabwe

I. Introduction

A. Overview

In FY 2013, USAID's Office of Food for Peace (FFP) plans to enter into new awards for Title II development food assistance programs in Haiti and Zimbabwe. Subject to the availability of funds and commodities, FFP anticipates the following funding levels:

- in Haiti, up to one award totaling approximately $20 million for the first year and $80 million over a four-year life-of-activity and
- in Zimbabwe, up to two awards totaling approximately $20 million for the first year and $100 million over a five-year life-of-activity.

FFP is currently reviewing applications from private voluntary organizations and cooperatives submitted in response to a Request for Applications (RFA) for Title II Development Food Assistance Programs.[1] The RFA provided information on funding opportunities for multi-year, development food assistance programs that are integrated with USAID strategies to address the underlying causes of chronic food insecurity. FFP's goal for multi-year development programming is to reduce risks and vulnerabilities to food insecurity and increase food availability, access, and utilization. FFP anticipates issuing awards for programs in Zimbabwe by July 1, 2013, and in Haiti by August 1, 2013.

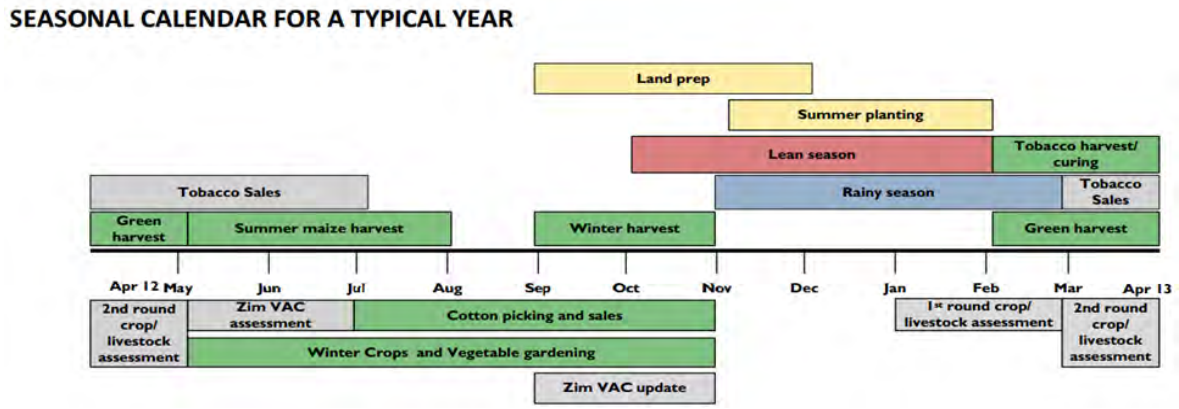
Through this solicitation, FFP seeks a firm (referred to in this document as "the Contractor") to conduct a baseline study to determine conditions in targeted areas of Haiti and Zimbabwe prior to the start of new Title II programs. FFP requires a representative population-based household survey focused on the collection of data for the required impact and outcome indicators for Title II program intervention areas. The study will also include a qualitative component that will add depth, richness, and context and serve to triangulate information from survey findings and analysis.

The Contractor should strive to conduct the baseline study during the first year of the program cycle, prior to the start of program implementation, and, in the case of Zimbabwe, during the country's lean season if possible. The Famine Early Warning System Network (FEWSNET) graphs below show the seasonal calendar and critical events timelines for Zimbabwe. Note that although these graphs correspond to the country in general, the specific zones in which the Title II programs will be working may have a seasonal calendar that varies slightly from this graph. After contract issuance, the

[1] The FY 2013 RFA for Title II Development Food Aid Programs can be found at www.usaid.gov/what-we-do/agriculture-and-food-security/food-assistance/programs/development-programs.

Contractor should confirm with FFP and the USAID Missions in Haiti and Zimbabwe when data collection will take place.

FEWSNET Seasonal Calendar and Critical Events Timeline for Zimbabwe [2]



B. Program Background

While specific information on the Title II programs in each country is not yet available, the Country-Specific Information documents for Haiti[3] and Zimbabwe[4] provide information on the food security situation and programming priorities for FFP and USAID Missions in each country.

In Haiti, the Title II program will be implemented in the following communes:

- **Artibonite Department**: Gonaives (urban), Gonaives (rural), Anse Rouge, Terre Neuve, and Ennery;
- **Centre (Central) Department**: Thomassique, Cerca Carvajal, Cerca La Source, Thomonde, Hinche, Boucan Carre, Saut d'Eau, Maissade, and Lascahobas;
- **Nord-Est (Northeast) Department:** Baie de Henne, Bombardopolis, Mole Saint Nicholas, Jean Rabel, Bassin Bleu, Port de Paix (Rural), Port de Paix (Urban), and Chansolme;
- **Ouest (West) Department:** Pointe-à-Raquette and Anse-à-Galets ; and
- **Sud-Est (Southeast) Department**: Anse-à-Pitres, Belle Anse, Grand Gosier, La Vallée de Jacmel, Bainet, Côtes de Fer, Thiotte, and Marigot.

Please refer to the FY 2013 Country-Specific Information documents for additional detail. Program-specific information will be available to the Contractor when FFP awards cooperative agreements for the Title II development food assistance programs.

[2] FEWSNET's Zimbabwe Food Security Outlook – January to June 2013 is available at: http://www.fews.net/docs/Publications/Zimbabwe_OL_2013_01_final.pdf.
[3] The FY 2013 Country-Specific Information for Haiti document can be found at http://pdf.usaid.gov/pdf_docs/PDACU468.pdf.
[4] The FY 2013 Country-Specific Information for Zimbabwe document can be found at http://pdf.usaid.gov/pdf_docs/PDACU301.pdf.

C. Purpose and Objectives of the Baseline Study

The purpose of the baseline study is twofold:

1. Provide a baseline for impact and outcome indicators to serve as a point of comparison for a final evaluation and

2. Inform program targeting and, where possible, program design.

The baseline study is designed as the first step in a two-part evaluation process, with the final evaluation at program end as the second step. Both steps should be conducted at approximately the same time of the year. Ideally, data collection associated with the baseline study will be conducted during the lean season. Given that the lean season coincides with the rainy season, the Contractor should be aware that certain areas where data collection will occur may be difficult to access. FFP expects to conduct the final evaluation as close as possible to the end of the program four or five years later, depending on prevailing conditions at that time.

The specific objectives of the baseline study are the following:

1. Determine the baseline values of key impact and outcome level indicators—disaggregated by awardee, age, and sex as appropriate— in addition to baseline values of demographics in target areas and appropriate independent variables;

2. Conduct bivariate and multivariate analyses of impact and outcome indicators with independent variables identified for inclusion in survey as appropriate, with results provided by awardee and the overall Title II country program area;

3. Use qualitative data to ground-truth survey data and provide contextual information on the overall food insecurity and malnutrition situation; and

4. Help awardees establish end-of-program targets for impact and outcome indicators and, where possible, refine program design.

While the baseline study will be externally designed, led, and reported on by the Contractor, staff from FFP, USAID Missions in Haiti and Zimbabwe, and FANTA[5] will provide input and be involved during all stages. The Contractor will consult with Title II awardees to understand the program description and theory of change, obtain inputs for the quantitative survey instrument and qualitative study, and receive contextual information to properly develop a sampling and logistics plan. In discussion and coordination with FFP, the Contractor will provide draft and final versions of specific deliverables to the awardees for review and information.

[5] The Food and Nutrition Technical Assistance III Project (FANTA) provides technical support to FFP on monitoring and evaluation.

II. Indicators for Collection and Baseline Evaluation Questions

A. Indicators for Collection

The Contractor will be responsible for collecting data on all applicable indicators listed below, plus a limited number of additional indicators for each Title II development food aid program awardee, including women's status and empowerment indicators. The final list of indicators to be collected will be discussed and agreed upon in consultation with FFP, the USAID Missions in Haiti and Zimbabwe, and each of the FY 2013 Title II awardees.

The FFP Indicators for the baseline and final evaluation surveys are:

1. Prevalence of underweight children under five years of age

2. Prevalence of Poverty: Percent of people living on less than $1.25/day

3. Mean depth of poverty

4. Per capita expenditures (as a proxy for income) of USG targeted beneficiaries

5. Prevalence of stunted children under five years of age

6. Prevalence of underweight women (of reproductive age)

7. Percentage of farmers who used at least [a project-defined minimum number of] sustainable agriculture (crop/livestock and/or NRM) practices and/or technologies in the past 12 months

8. Percentage of farmers who used at least [a project-defined minimum number of] improved storage techniques in the past 12 months

9. Percentage of farmers who used financial services (savings, agricultural credit, and/or agricultural insurance) in the past 12 months

10. Percentage of farmers who practiced the value chain activities promoted by the project in the past 12 months

11. Household Hunger Scale (HHS): Prevalence of households with moderate or severe hunger

12. Average Household Dietary Diversity Score (HDDS)

13. Percentage of children 6-23 months of age receiving a minimum acceptable diet

14. Women's Dietary Diversity Score (WDDS): Mean number of food groups consumed by women of reproductive age

15. Prevalence of exclusive breastfeeding of children under six months of age

16. Percentage of children under age five who had diarrhea in the prior two weeks

17. Percent of children under five years old with diarrhea treated with Oral Rehydration Therapy (ORT)

18. Percentage of households using an improved drinking water source

19. Percentage of households with access to an improved sanitation facility

20. Percent of households with soap and water at a handwashing station commonly used by family members

21. Women's status and empowerment indicator(s) and/or awardee gender objectives as identified in the results frameworks[6]

The Contractor will closely follow the guidance on the FFP Standard Indicators Handbook for Baseline and Final Evaluation for indicator definition, collection, and analysis for the indicators listed above.[7] In several instances, the Contractor will have to refer to the source documents used to develop the FFP Standard Indicators Handbook for Baseline and Final Evaluation for instructions on adapting questionnaires to the local context, as well as other important details on data collection and tabulation. The Contractor will also work closely with FFP, USAID Missions in Haiti and Zimbabwe, and Title II awardees to develop questionnaires and tabulation instructions for the agriculture indicators (#7-10), gender indicator(s), and any additional program-specific indicators not specified in the Handbook.

For the poverty prevalence indicator, the Contractor will closely follow FTF guidance for indicator definition, collection, and analysis.[8] To derive the mean depth of poverty indicator, the Contractor will use the same per capita expenditure data used for the poverty prevalence indicator. The Contractor will work closely with FFP to develop tabulation and analysis instructions for this indicator.

The Contractor will ensure that rigorous practices are used to collect, tabulate, and analyze the indicator data. Refer to Section III of this SOW for further information on the required quantitative methodology.

B. Evaluation Questions

FFP has identified preliminary evaluation questions that will guide the design and development of baseline study. Although the evaluation questions will be answered during the final evaluation at the end of the Title II programs, the Contractor will be responsible for ensuring that all necessary quantitative and qualitative data will be collected and reported in the baseline study to serve as a basis for comparison during the programs' final evaluation. In concert with the Title II program awardees, the

[6] Indicators on women's status and empowerment from the Women's Empowerment in Agriculture Index (http://feedthefuture.gov/article/release-womens-empowerment-agriculture-index) and the Demographic and Health Survey (DHS) (http://www.measuredhs.com/topics/Womens-Status-and-Empowerment.cfm) can be used as reference.

[7] The FFP Standard Indicators Handbook for Baseline and Final Evaluation can be found at http://www.usaid.gov/what-we-do/agriculture-and-food-security/food-assistance/guidance/food-peace-information-bulletins.

[8] For information and guidance on FTF indicators, visit http://feedthefuture.gov/progress.

Contractor is expected to assess the technical viability of the evaluation questions and incorporate specific elements in the design and methodology of the baseline study (both the quantitative and qualitative components) to ensure that the study will provide valid and reliable data to serve as comparison to respond to the evaluation questions during final evaluation. This might involve incorporating additional variables or strata in the design of the household survey and the qualitative component.

The following table lists the primary evaluation questions:

Criteria	Main evaluation questions	Sub-questions
Impact	1. To what extent did the programs achieve the intended goal, objectives and results as defined by their Results Framework? 2. How did program activities improve the ability of beneficiary households and communities able to mitigate, adapt to, and recover from food security shocks and stresses?	1.1. Were there any important unintended outcomes, either positive or negative? 1.2. What were the main reasons that determined whether intended outcomes were or were not achieved, and whether there were positive or negative unintended outcomes? Which reasons were under control of the programs and which were not?
Beneficiary satisfaction	3. How satisfied were beneficiaries with the programs?	3.1. What issues were most important to beneficiaries forming their perceptions of the programs? What were the key successes and challenges of the programs?
Relevance	4. How relevant were program activities and beneficiary targeting, considering the needs of the target population?	4.1. Were beneficiary targeting criteria and processes appropriate, transparent, and properly implemented? 4.2. Were the scale, type, and timing of the program activities appropriate to the needs of the target population?

Criteria	Main evaluation questions	Sub-questions
Effectiveness	5. How well were program activities planned and implemented?	5.1. What were the main factors that contributed to whether activities resulted in intended outputs and outcomes? 5.2. What quality standards were defined? How did the programs develop those standards?
Coordination	6. To what extent did the programs coordinate with other food security and humanitarian programming, the host country government, and the donor? 7. In Haiti, how well did the Title II program meet the Government of Haiti's expectations?	
Sustainability and Replicability	8. How sustainable are programs' outcomes? 9. In Haiti, how replicable are the program's outcomes?	8.1. What exit strategies were incorporated into program design? Were such strategies implemented, how were they perceived by the beneficiary population, and what were the strengths and weaknesses of the exit strategies adopted?
Cross-cutting issues	10. How well were gender and environmental considerations integrated into program design and implementation?	10.1. Were they successful in meeting their stated objectives? How?
Lessons learned	11. What lessons can be learned to inform future FFP and USAID Title II programming in Haiti and Zimbabwe?	

III. Baseline Study Design and Methodology

The Baseline study will consist of the following data collection activities:

1. Representative population-based household survey
2. Qualitative data collection activities

A. Representative Population-based Household Survey

The Contractor is expected to take responsibility for the design and execution of all aspects of a representative, population-based household survey, including sampling plan; questionnaire instrument development; field procedure manuals for enumerators and supervisors; training of enumerators, supervisors, and anthropometrists; piloting of the questionnaire instrument; organization of field work; pre-testing of the survey rollout; data collection, cleaning, manipulation, and analysis.

1. Sampling Design: Before embarking on designing the sample survey, the Contractor should become familiar with the FANTA Sampling Guide (1997)[9] and Addendum (2012)[10]. The former provides an overview of the recommended design features for Title II baseline and final evaluation surveys. The 2012 Addendum provides important corrections to the guide, which should be followed closely. The survey population should be limited to those living in geographic areas where program implementation is intended to take place and the sampling frame should reflect this constraint.

The Contractor should plan to conduct one survey, with each awardee area representing one stratum in the survey design. A multi-stage cluster sampling design should be used. FFP requires that the final evaluation for the program—which will be implemented four-to-five years after the baseline study— be a performance evaluation (rather than an impact evaluation). This implies that a simple pre-post design without control groups will be used at both baseline and final evaluation.

The Contractor should provide initial indication of the sampling design for the baseline survey in a Sampling Plan document in advance of field implementation. This document should include all of the following elements:

- The base sample size at both the awardee and overall combined levels.. The equation used to drive the calculation of the sample size should also be indicated, where the basis of the calculation should be a test of differences of proportions over two time points. The parameters used in the equation, including the design effect, confidence level, and statistical power assumed should be given. The Contractor should provide a table showing a comparison of sample sizes across "candidate indicators" under consideration for taking on the role of "principal indicator to drive the overall sample size". The Contractor should carry out sample size calculations separately for each awardee and then sum them to obtain the total sample size for the country survey.
- The final choice of principal indicator that will drive the sample size calculation for the entire survey (and associated target group) along with a rationale for the choice of indicator. In terms of associated target group, if stunting is the principal indicator, the target group will be children 0-59 months, for example.
- The number of households to be sampled in order to achieve the desired sample size for the target group (assuming that households may contain more than one or no eligible members from the target group). The Contractor should give an indication of how the base sample size will be

[9] Although the FANTA Sampling Guide presents random walk as an acceptable sampling method, it is no longer considered acceptable and will not be accepted as a proposed second stage method.

[10] The FANTA Sampling Guide and Addendum can be found at http://www.fantaproject.org/publications/sampling.shtml.

adjusted to account for the number of households that need to be visited. See the FANTA 2012 Addendum for more details.

- The number of households to be sampled to account for anticipated household non-response. The Contractor should indicate by how much the number of households to be sampled will be pre-inflated to account for household non-response.
- Geographic or other stratification along with the associated sample allocation scheme (optional). Note that at a minimum, the sample will be stratified by awardee if two awards are made. Additional strata are not required but may be considered. Note that estimates must be produced at both the awardee and combined Title II country program level. Also note, while additional stratification can be considered in the design, estimates do not have to be produced at the level of the lower strata and are likely not feasible given limited survey resources.
- The number of stages of sampling to be used.
- Explanation of how the number of clusters and of households per cluster in the sample will be determined.
- Explanation on the source of the information for the sampling frame, e.g. census lists or other national or internationally-sponsored surveys, such as the Demographic Health Surveys (DHS). The Contractor should indicate how reliable and recent the frame information is.
- A Probability Proportionate to Size (PPS) sampling mechanism should be used to randomly select the clusters. The Contractor should use the number of households per cluster as the size measure and include a table of size measures and another table showing the final list of selected clusters along with their probabilities of selection.
- Indication that the Contractor will use systematic sampling (or some other probability-based sampling technique such as Simple Random Sampling) to select dwellings within clusters. This implies that for the sampled clusters, a list of all households, with household identification and location indicated, must be obtained through either a mapping and listing operation in the cluster prior to interviewing (preferred), or through other existing reliable sources.
- The Contractor should collect geographic information system (GIS) information using GPS equipment to locate dwellings during the listing process. GPS units should be used to capture the precise longitude and latitude of each household to be surveyed. These values may then be randomly displaced by a given distance or aggregated up to a higher administrative unit as needed.
- Explanation of how households are defined by the Census office in the country in question. In cases where there are multiple households per dwelling, the Contractor should adopt a "take-all-households" approach. The Contractor should specify how polygamous households will be treated as polygamy is prevalent in Zimbabwe.
- Indication that the Contractor will adopt a "take-all-individuals" approach to select individuals within households from whom to collect data for each target group, particularly for target groups that are more rare in the population, such as children aged 0-5 months in the case of the exclusive breastfeeding indicator, for example.

2. Questionnaire Instrument: FFP expects the Contractor to develop a questionnaire instrument in English and the local languages, Ndebele and Shona in Zimbabwe and Haitian Creole (Kreyol) in Haiti,

in which the survey will be conducted, incorporating modules specified in the FFP Standard Indicators Handbook for Baseline and Final Evaluation (referenced above) to respond to the data collection needs of the Title II development food aid programs and USAID. Some of the modules associated with various FFP Indicators, such as HDDS, will require country-specific adaptation which should be done in consultation with FFP and the Title II awardees.[11] Given the limited time and resources for development, it is recommended that the Contractor limit the instrument to a paper and pencil version. The questionnaire should include an informed consent statement for each respondent and commence with a set of questions to establish a household roster. The questions within the questionnaire should be organized by respondent type[12] and questions should follow international standard format, e.g. DHS, wherever possible. In general, the Contractor should ensure that questions are written following established questionnaire design principles and that rigorous practices are used to collect, tabulate, and analyze indicator data. These practices should include adding identifiers, such as cluster number, household number, and respondent identification number (line number from household roster) to each page of the questionnaire(s). This helps to ensure that pages can be correctly associated with a given household and respondent if separated, and enable the derivation of household-level sampling weights and a household non-response adjustment to be incorporated into the sampling weights for use in all data analyses. The Contractor should ensure that the questionnaire is piloted and validated in communities not included in the sample frame prior to commencement of data collection.

3. Field Procedure Manuals for Enumerators and Supervisors: FFP expects that the Contractor will develop two field manuals to be used as part of the training materials and serve as reference material for staff in the field conducting the survey: one for enumerators and one for supervisors of enumerators. The field manual for enumerators should give recommended best practices for conducting interviews and dealing with specific challenging situations, e.g. households that refuse to participate, and provide a household and individual respondent non-response follow-up strategy. It should also contain a detailed explanation of how to properly administer each question in the questionnaire. The field manual for supervisors can contain some of the same material as the field manual for enumerators, The supervisor field procedure manual should also describe the roles and responsibilities of the field staff and outline the chronology of field work, including training, piloting the questionnaire, pre-testing the survey, data collection, etc. It should also include instructions on mapping and listing clusters, use of GPS equipment, enumerator quality assurance monitoring, questionnaire editing procedures, re-interviewing procedures, and procedures for sampling dwellings within clusters, households within dwellings, and individuals within households

[11] Note that questionnaire instruments, field procedure manuals, and training materials from baseline studies and final evaluations recently conducted in Guatemala, Haiti, Niger, and Uganda will be available as reference for the Contractor.

[12] Note that a respondent is an individual or set of individual(s) identified as most appropriate to respond to a set of questions on behalf of a specific target group. Such respondents can be the actual sampled members of the target group themselves (e.g., adults providing direct responses on behalf of themselves) or can be individuals not part of the target group providing proxy responses on behalf of sampled individuals in the target group (e.g., caregivers on behalf of young children).

4. Anthropometry Training Materials: The Contractor will provide a short guide and/or other materials to support the training of anthropometrists in the measurements required for the stunting and underweight indicators. This will include instructions on how to take measurements on height and weight for both women and children under five years of age, citing a reference for the methodology that will be used. It will also include a section on methods (event calendars, e.g.) that will be used to ascertain the age of the individuals whose measurements are being taken. Finally, the training materials should include a section on standardization testing of the anthropometrists, which should cover anthropometrical measurement taking and testing of precision and validity of measurements taken by each anthropometrist.

5. Data Treatment and Analysis Plan: The Contractor will prepare a data treatment and analysis plan to address the following elements:

- Indication of how and when data will be entered into the database, as well as the software to be used for data entry. Double-data entry is required;
- Data quality checks and edits (data cleaning) planned to ensure logical consistency and coherence across records, as well as an indication of the software to be used;
- Sampling weights to be included on the data file. The formulae used to calculate the sampling weights should be included as part of a data dictionary document. Different sampling weights will need to be calculated for separate analysis of each awardee area and of the aggregate Title II program data for the country. Note that a household non-response adjustment should be made to the sampling weights as part of the final weighting system;
- Indicator tabulation plan. Estimates should be produced for each awardee stratum and for the overall level;
- Sub-groups (e.g., age, sex or other geographic breakdowns), if any, for which the Contractor will produce estimators (provided the associated precision levels are sufficient);
- Any other planned data analyses. The Contractor should specify all intended bivariate and multivariate analyses here;
- Confidence intervals associated with the indicators that will be produced alongside the indicator estimates, and assurance that that these will take into account the design effect associated with the complex sampling design; and
- Software to be used for data analysis and for conversion of anthropometric data into Z-scores (WHO's Anthro is recommended but not mandatory).
- Upon completion of the survey, location information and associated data collected as part of this award will be delivered to FFP. The Contractor should specify how location data will be adjusted to protect personally identifiable information in accordance with the research protocol submitted to the Institutional Review Board (IRB). Note that the Contractor will be responsible for adhering to and obtaining all necessary US and host country IRB approvals.

The Contractor will ensure that the labeling and architecture of all datasets is consistent to help facilitate meta-analyses of datasets across Title II development programs and countries at a later date.

FFP will discuss with the Contractor specific details with respect to the requested architecture of the datasets. The meta-analysis of data is not part of this SOW.

B. Qualitative Data Collection

The Contractor will undertake qualitative data collection as part of the baseline study. The main objective of the qualitative study is to provide a deeper understanding of the overall food security situation in the program implementation area as perceived by communities and potential beneficiaries. Qualitative information adds depth, richness, and context and will serve to triangulate and interpret information from the household survey. Quantitative and qualitative results should be combined to provide a more complete picture of the overall food security situation. The qualitative study described in this SOW is not expected to replace any in-depth qualitative assessments or formative research that implementing partners may conduct at the beginning of a program to inform specific aspects of their program design.

The Contractor is expected to take responsibility for the design and execution of all aspects of the qualitative study. The Contractor should submit a proposed methodology for the qualitative study that clearly shows how it will complement the quantitative survey and includes the following elements:

1. Purpose and objectives of the qualitative study;
2. Research questions the qualitative study will answer;
3. Conceptual framework presenting the themes that are thought to be relevant to answer the research questions;
4. Detailed methodology presenting data collection methods to be used, e.g., rapid appraisal/participatory rural appraisal, focus groups, key informant interviews, structured/semi-structured interviews, anecdotal evidence, organizational capacity assessments, observations, or seasonal calendars;
5. Description of the instruments that will be developed and the type of questions to be asked, e.g., key informant interview guides, focus group guides, or organizational capacity assessment questionnaires;
6. Sampling design and approach for selecting sites, key informants, focus group discussion participants, and/or direct observation sites for the qualitative component;
7. Timeline and overall approach to data collection, i.e. will it take place prior, in parallel, or subsequent to the household survey, and any potential timeline constraints. (Note that it is highly recommended to conduct the qualitative data collection after the quantitative data collection has been completed and at least partially analyzed to better inform the questions that the qualitative component will set out to answer); and
8. Plan for data management, coding, and analysis specifying how collected data will be translated, transcribed, coded, and analyzed, the time required for each, and the specific software to be used.

IV. Baseline Study Deliverables and Report Outline

A. Deliverables

The Contractor is responsible for the following deliverables:

	Details	Deliverables	Deadline
1) Pertinent permissions, insurance, and other required permits	a. Obtain all necessary permissions for implementing the baseline data collection. b. Adhere to Governments of the U.S., Haiti, and Zimbabwe national and local formalities. Obtain all required permits related to data collection from human subjects and logistics of survey implementation, including necessary IRB approvals, health and accident insurance, salary and taxes for all enumerators, supervisors and anthropometrists.	Evidence of permits, approvals, and insurance for implementing survey and other data collection activities	Evidence submitted and approved prior to FFP granting permission to Contractor to commence pre-data collection activities, including training of enumerators, supervisors and anthropometrists.
2) Inception report and project management tool	a. Inception report: specify details for critical tasks, anticipated outputs, date-bound timelines, resource needs, and responsible person(s). Composition of a standard field survey team, including expected tasks and responsibilities of each team member, should also be described. b. Project management tool: an online project management tool should be set up and accessible by FFP, FANTA, and the Contractor. The tool should include a breakdown of key tasks and activities with agreed-upon deadlines, as well as a Gantt/flow chart of activities over the lifetime of the study.	Inception report and project management tool approved by FFP	Draft of inception report submitted four weeks after contract issuance. Draft reviewed, revised, finalized, and approved within eight weeks of signing contract. Launch of project management tool four weeks after contract issuance.

	Details	Deliverables	Deadline
3) In-country baseline workshop	a. Organize, develop materials for, and conduct a three- to four-day in-country workshop in English that brings together the Contractor, Title II awardees, FFP, USAID Missions in Haiti and Zimbabwe, and FANTA. b. Purpose is to glean information on program implementation and country-specific ground realities in relation to survey sampling and fieldwork logistics planning; define questions for qualitative component, and vet quantitative instrument and qualitative methodology plan. c. Contractor staff who must attend include those responsible for developing the sampling plan, quantitative instrument, and qualitative methodology, and responsible for overseeing fieldwork. Staff from sub-contractor firms must also attend the workshop. d. Participants from FFP, USAID, FANTA, and Title II awardees will fund their attendance at the workshop. However, the Contractor will bear the costs of travel and attendance, in addition to the costs of venue rental, catering, simultaneous translation for the Haiti workshop, etc.	Workshop conducted in line with requirements	Two months after the conclusion of the M&E in-country workshop, which is organized by FANTA on behalf of FFP. The M&E workshop in Zimbabwe is scheduled for late September 2013; therefore, the baseline workshop should take place in the November – December timeframe. The M&E workshop in Haiti has yet to be scheduled. Additional information on the workshop will be provided after contract issuance.

	Details	Deliverables	Deadline
4) Quantitative survey questionnaire instrument	a. Draft a questionnaire instrument in English adapted to the Haiti and Zimbabwe contexts that responds to the elements specified in Section III A above. b. Translate the approved questionnaire instrument from English into the local languages, Ndebele and Shona in Zimbabwe and Haitian Creole (Kreyol) in Haiti, in which the survey will be administered. If oral (non-written) languages are needed, a phonetic translation will be required and additional training of enumerators will be necessary. c. Back-translate the questionnaire from the local language(s) to English with a second translator to ensure accurate translation. d. Pilot the survey instrument in all the languages in which the survey will take place. (More details under deliverable #9).	Final English, corresponding local language, and back-translated questionnaires approved by FFP	Draft English version of instrument submitted two weeks after conclusion of in-country workshop conducted by Contractor (see Deliverable 3). Local language versions of questionnaire instrument to be submitted after English version approved. Date TBD. Draft versions reviewed, revised, finalized, and approved by FFP prior to granting permission to Contractor to commence pre-data collection activities, including training of enumerators, supervisors and anthropometrists.
5) Qualitative data collection methodology	a. Draft a detailed qualitative data collection methodology that responds to the elements specified in Section III B.	Qualitative data collection materials approved by FFP	Draft materials to be submitted to FFP three weeks after conclusion of in-country workshop conducted by Contractor (see Deliverable 3). Draft version of materials reviewed, revised, and approved by FFP prior to granting permission to the Contractor to commence qualitative data collection.

	Details	Deliverables	Deadline
6) Sampling plan	a. Draft sampling plan for the household survey that responds to the elements specified in Section III A.	Sampling plan approved by FFP	Draft to be submitted two weeks after in-country workshop. List of sampled and replacement villages may follow as a separate appendix but to be submitted and approved prior to FFP granting permission to Contractor to commence pre-data collection activities, including training of enumerators, supervisors, and anthropometrists.
7) Field procedure manuals for a) enumerators and b) supervisors	a. Draft two field procedure manuals for the quantitative population-based household survey that respond to the elements specified in Section III A.	Two field procedure manuals—one for enumerators and another for supervisors—approved by FFP	Drafts of both manuals submitted three weeks after conclusion of in-country workshop.
8) Data treatment and analysis plan	a. Detailed data treatment and analysis plan that responds to the elements specified in Section III A.	Data treatment and analysis plan approved by FFP	Draft submitted two weeks after conclusion of in-country workshop conducted by Contractor (see Deliverable 3). Draft reviewed, revised, finalized and approved prior to FFP granting permission to the Contractor to commence pre-data collection, including training of enumerators, supervisors and anthropometrists.

	Details	Deliverables	Deadline
9) Training curriculum and pre-data collection activities	a. Develop training materials to address the household survey and the qualitative components, including anthropometry training and standardization testing materials, as outlined in Section III A. b. Pilot test the survey instrument in each of the local languages following enumerator and supervisor training with a small number of non-sampled households. This will serve as an opportunity to verify that skip patterns, flow, wording, and translation of the questionnaire instrument are working well. Each enumerator team should interview at least two households during the pilot test. c. Pre-test the survey procedures using the finalized survey instrument in all languages in which the questionnaire will be administered in a small number of households in non-sampled communities, prior to starting data collection. This will serve as an opportunity to verify that enumerators and supervisors have understood their roles and responsibilities as well as all of the survey procedures, prior to "going live". Each enumerator team should interview at least two households during the pre-test. d. Develop field movement plan indicating clear intended chronology of interviewing through list of sampled villages, as well as associated assignments of enumerator teams to sampled villages.	Training materials approved by FFP	Draft training materials submitted at least four weeks prior to commencement of pre-data collection activities, including training of enumerators, supervisors and anthropometrists. Draft training materials reviewed, revised, finalized, and approved prior to FFP granting permission to the Contractor to commence pre-data collection activities, including training of enumerators, supervisors and anthropometrists.

	Details	Deliverables	Deadline
10) Sampling frame, data sets and data files	a. Sampling frame b. Raw data set c. Edit rules for cleaning data d. Data dictionary/codebook e. Syntax and output for all analyses and variable transformations f. Final data set including cleaned data, sampling weights at each stage, final sampling weights, and all derived indicators Programming specifications for data cleaning to be submitted and approved prior to commencement of programming. Final submission of the data sets must be in the format required by FFP Information Bulletin 11-02 (August 11, 2011).	a. Sampling frame b. Raw data set c. Edit rules d. Data dictionary / codebook e. Syntax f. Final data set	All files submitted six weeks after completing survey data collection.

	Details	Deliverables	Deadline
11) Briefings	a. Weekly phone briefings with FFP and other stakeholders identified by FFP, such as FANTA, to include a progress report and discussion on any difficulties related to the baseline study. During data collection period, electronic material accompanying briefings should include short field progress reports with number of clusters completed, non-response rates, re-interview rates, enumerator drop-out rates, etc. Template for field progress reports to be determined jointly by FFP and Contractor. b. Monthly phone briefings with the USAID Missions in Haiti and Zimbabwe and FFP. These briefings should follow the same format as the weekly briefings. c. Formal, final in-country briefing to USAID Missions in Haiti and Zimbabwe, FFP, and Title II awardees to include a PowerPoint presentation and cover the contents of the baseline study report, including findings, conclusions, lessons learned, and recommendations.	Weekly phone briefings with FFP and other stakeholders. Monthly phone briefing and final in-country briefings with USAID Missions in Haiti and Zimbabwe, FFP, and Title II awardees.	Schedule of briefings to be determined jointly by Contractor and FFP.
12) Draft baseline study report	a. Draft final report, not to exceed 50 pages, excluding appendices and attachments. The report must be presented in English and must include the results of both the quantitative and qualitative components of the study. b. Must follow the report outline in this Scope of Work.	Draft report reviewed by FFP	Submitted 14 weeks after completing data collection in the field (and eight weeks after submission of data set as per Deliverable 10). Contractor should allocate sufficient time to allow for several rounds of review by FFP, USAID Missions in Haiti and Zimbabwe, and awardees prior to issuing a final report.

	Details	Deliverables	Deadline
13) Final baseline study report	a. A revised version of the draft report that incorporates the comments of FFP and USAID Missions in Haiti and Zimbabwe. b. The final report must be presented in English and follow the reporting format given in Section IV B of this SOW. c. FFP expects that the final report will adhere to the USAID Evaluation Policy's criteria to ensure the quality of the evaluation report (refer to USAID Evaluation Policy, page 11, Appendix 1). d. The approved final report must be submitted to USAID's Development Experience Clearinghouse (DEC) and a cover sheet attached indicating the type of evaluative work conducted and design. e. The completed baseline study report must include a three- to five- page summary of the purpose, background of the project, methods, findings, and, if applicable recommendations.	Final report reviewed and approved by FFP and submitted to the DEC	Submitted two weeks after receiving comments from FFP and USAID Missions in Haiti and Zimbabwe on draft final report (see Deliverable 12).
14) Lessons Learned and Best Practices Document	a. Draft a lessons learned and best practices document, not to exceed five pages, related to the Contractor's overall experience in conducting the baseline study as an independent third-party to FFP and the Title II awardees. The document should include recommendations for FFP on areas of improvement for future baseline studies and final evaluations.	A five-page lessons learned and best practices document	Submitted one week after FFP approval of the final evaluation report.

B. Outline of Baseline Study Report

The recommended outline for each country's baseline study report is the following:

1. **Cover page, Table of Contents, List of Acronyms**;

2. **Executive Summary** should be a clear and concise stand-alone document that states the most salient findings, conclusions, and recommendations of the study and gives readers the essential contents of the baseline report in three to five pages. The Executive Summary helps readers to build a mental framework for organizing and understanding the detailed information within the report;

3. **Introduction** should include purpose, audience, and synopsis of task;

4. **Methodology and Study Design** should describe the methodology and design of the household survey and qualitative component, constraints and limitations to the study process and rigor, and issues in carrying out the study;

5. **Overview of the Current Food Security Situation** should provide a brief overview of the current food security situation in Haiti and Zimbabwe related to food availability, access, and utilization; current and anticipated programming; and stakeholders. A desk review of information already available will suffice;

6. **Tabular summary of quantitative survey results** should present findings of the household survey in table form for all the indicators by awardee and for the aggregate Title II program area in Haiti and Zimbabwe;

7. **Findings** should present results from the household quantitative survey and qualitative study. Results from the quantitative survey should be analyzed and discussed, using findings from the qualitative study to complement and help triangulate them. The qualitative study findings should also provide a deeper understanding of the overall food security situation in the program implementation area. Any bivariate and multivariate analysis undertaken should also be included;

8. **Conclusions and Recommendations** should provide high-level conclusions from the baseline study and recommendations for the design and implementation of future mid-term and final evaluation surveys and studies in Haiti and Zimbabwe. Recommendations must be relevant to program and context and include concrete and realistic steps for implementing or applying the recommendation;

9. **Issues** should provide a list of key technical and/or administrative issues, if any, that the Title II programs for which the baseline study was conducted should consider; and

10. **Annexes** should document the following and be succinct, pertinent, and readable:

    a. References, including bibliographical documentation;
    b. List of meetings, including key informant interviews and focus group discussions, with number, type, and date of interactions;
    c. Quantitative survey instruments in English and applicable local languages, Ndebele and Shona in Zimbabwe and Haitian Creole (Kreyol) in Haiti;
    d. Sampling Plan for the quantitative survey;
    e. Qualitative study methodology and instruments developed and used;
    f. Quantitative data sets and qualitative data transcripts in electronic format;
    g. Data dictionary and program files used to process the data in electronic format;
    h. Baseline study SOW; and
    i. Other special documentation identified as necessary or useful.

V. Contractor Qualifications

The selected firm/consortium shall possess the following qualifications:

a. Legal status recognized to work in the country, enabling the organization to perform the above-mentioned tasks;
b. Demonstrated experience and strong internal capacity in designing, organizing, and managing the implementation of large-scale population-based household surveys in developing countries within the past five years;
c. Demonstrated experience and strong internal capacity in designing, organizing, and conducting qualitative research, data collection, and analysis in developing countries within the past five years;
d. Demonstrated experience and strong internal capacity in the statistical analysis of complex survey data and in analyzing data from mixed-method studies;
e. Good network of experienced enumerators, supervisors, anthropometrists, and data entry clerks in Haiti and Zimbabwe, or demonstrated ability to effectively recruit skilled enumerators, supervisors, and data entry clerks in developing countries
f. Experience engaging and managing statistical or evaluation firms and/or institutions in Haiti, Zimbabwe or other developing countries; and
g. Ability to deliver high-quality written and oral products.

VI. Team Composition and Qualifications

For planning purposes, the team for this study will consist of key personnel with defined technical expertise, a mix of consultants that will provide varying technical and subject matter expertise, and support staff. The team should include local consultants with expertise, knowledge, and experience in Haiti and Zimbabwe. Offerors may propose an alternative personnel configuration to implement the study based on the approach provided in their proposals.

The required areas of technical and subject matter expertise represented on the team should reflect the multi-sectoral nature of Title II food assistance and the expertise required to conduct qualitative research and quantitative population-based household surveys:

- Expertise in food security programming;
- Expertise in agriculture;
- Expertise in maternal and child health and nutrition;
- Expertise in gender integration;
- Expertise in qualitative data collection methods and analysis; and
- Expertise in the design and execution of population-based household surveys, and in the analysis of complex survey data.

Key Personnel:

1. **Baseline Study Team Leader** – This individual will serve as team leader in a full-time position for the duration of the study. S/he will be the primary point of contact between USAID and the baseline study team and have responsibility for the overall compilation of the final baseline study report. The incumbent must meet the following criteria:
   - At least 10 years of food security programming in senior management positions;
   - Master's or PhD degree in development studies, management, program evaluation, or other relevant field of study;

- Directly managed the design and implementation of at least two food security-related, large-scale, population-based household surveys with complex designs;
- Broad range of subject matter expertise and demonstrated experience in the areas of food security, agriculture development, nutrition, and health;
- Excellent organization and writing skills and a demonstrated ability to deliver a quality written product (Evaluation Report and PowerPoint)
- Excellent oral communication, presentation, and inter-personal skills;
- Technical and management skills to manage budget resources (dollars and staff) for the evaluation, as well as assist and support the team with field logistics (e.g., coordinating with USAID and/or a government ministry to set up initial appointments for interviews); and
- Experience on past Title II baseline surveys or final evaluations would be a plus.

2. **Senior Survey Specialist** – This individual will be responsible for designing, managing, and coordinating the population-based household survey and analysis of the survey data. The incumbent must meet the following criteria:
   - At least eight years of experience designing, managing, leading, and coordinating representative population-based household surveys in developing countries;
   - Master's degree or PhD in statistics, survey methodology, epidemiology or other relevant field of study;
   - Extensive knowledge of and experience in sample design for complex surveys and complex survey data analysis;
   - Extensive experience with the design and development of quantitative survey questionnaire instruments;
   - Extensive experience with data management and database organization, including developing data entry programs and supervising data entry, cleaning, and quality control;
   - Strong working knowledge of SPSS, STATA, SAS or other statistical package;
   - Excellent writing and organization skills and a demonstrated ability to deliver a high-quality written product ; and
   - Experience on past Title II baseline surveys or final evaluations would be a plus.

3. **Qualitative Research Specialist** – This individual will be responsible for designing, managing, and supervising qualitative data collection and analysis. The incumbent must meet the following criteria:
   - At least eight years of experience designing and implementing qualitative research studies in developing countries;
   - Experience with a diverse range of qualitative methodologies, such as rapid appraisal/participatory rural appraisal, focus groups, key informant interviews, structured/semi-structured interviews, anecdotal evidence, organizational capacity assessments, observations, and seasonal calendars;
   - Excellent writing and organization skills and a demonstrated ability to deliver a high-quality written product;
   - Familiarity with a broad range of subject matter in the areas of food security, agriculture development, nutrition, and health; and
   - Experience on past Title II baseline surveys or final evaluations would be a plus

4. **Field Operation Manager** – This individual will be responsible for planning, managing, and supervising the household survey data collection in-country. The incumbent must meet the following criteria:
    - Undergraduate degree inone of the social science disciplines;
    - Eight years of experience supervising large-scale survey field work in developing countries, preferably involving anthropometric data collection;
    - Experience hiring, training, and overseeing field supervisors and enumerators; coordinating field logistics, schedules, and equipment; and managing data quality control in the field; and
    - Fluency in relevant national language required.

As per the criteria presented above and given the multi-sectoral approach of Title II programs, the Contractor will be expected to involve sectoral experts in the areas of agriculture, livelihoods, health, and nutrition, as needed. These experts can either be external consultants engaged on a full- or part-time basis or members of the selected firm with the necessary skills. The required skills of the agriculture and health and nutrition experts are outlined below; however, additional sectoral experts may be needed based on the country context and Title II program activities:

Agriculture Expert – This expert will provide technical guidance related to agriculture and agribusiness during the study. The incumbent must meet the following criteria:

- At least five years of food security implementation experience in developing countries;
- Master's or PhD degree in agriculture-related field of study;
- Strong knowledge of agriculture indicators, agriculture extension, conservation agriculture, input management, post-harvest handling, livestock management, and agricultural marketing;
- Excellent writing and organization skills;
- Excellent oral communication, presentation, and inter-personal skills;
- Excellent analytical and technical skills; and
- Strong knowledge of Title II programming, experience on past Title II baseline surveys or final evaluations would be a plus.

Health and Nutrition Expert – This expert will provide technical guidance related to maternal and child health and nutrition during the study. The incumbent must meet the following criteria:

- At least five years of maternal and child health and nutrition expertise in developing countries;
- Master's or PhD degree in international public health, international nutrition or other relevant field of study;
- At least three years of emergency or development food security implementation experience;
- Strong knowledge of health and nutrition indicators, supplementary and vulnerable group feeding practices, positive deviance, care group, and community healthcare methodologies;
- Excellent writing and organization skills;
- Excellent oral communication, presentation, and inter-personal skills;
- Excellent analytical and technical skills; and
- Strong knowledge of Title II programming, experience on past Title II baseline surveys or final evaluations would be a plus.

Other team members:
The Offeror will need to consider and budget accordingly to what extent the team will require junior or mid-level support (e.g., to assist in collecting, analyzing, and cleaning data, and preparing tabular or graphic materials).

As per the USAID Evaluation Policy, all baseline study team members will provide a signed statement attesting to a lack of conflict of interest or describing an existing conflict of interest relative to the program for which the baseline study is being conducted.

VII. Baseline Study Management

A. Logistics

FFP will provide overall direction to the Contractor, identify key documents, and assist in facilitating a work plan. FFP staff in Washington and USAID Missions in Haiti and Zimbabwe will assist in arranging meetings with key stakeholders as identified by USAID prior to the initiation of field work. The Contractor is responsible for arranging other meetings as identified during the course of this study and advising FFP prior to each of those meetings. The Contractor is also responsible for arranging vehicle rental and drivers as needed for site visits and field work. The Contractor will be responsible for making hotel arrangements, procuring its own work/office space, computers, internet access, printing, and photocopying. The Contractor will be required to make its own payments. Staff from FFP and USAID Missions in Haiti and Zimbabwe will be made available to the team for consultations regarding sampling, geographical targeting, sources, and technical issues before and during the evaluation process.

B. Schedule/ Timeline

Offerors must submit a timeline of activities as part of their proposals, which should follow the timeline set forth in Section IV A of this Scope of Work.

C. Budget

A firm bidding on this activity must, in addition to a technical proposal, submit a Budget in Excel showing the projected Level of Effort (LOE) for each proposed full-time and/or short-time member of the Team, including subject matter expertise and administrative (logistical) support. Other costs that should be included are international travel and per diem, in-country costs for data collection and interviewing, communications, report preparation and reproduction, and other costs as appropriate. A six-day work week is authorized when working in-country.

D. Evaluation Criteria for Proposals

Offeror proposals will be evaluated on the merit of the proposed approach including the following criteria:

30% Technical Approach as illustrated in the description of proposed methodology.
25% Timeline reflecting proposed activities, which emphasizes the ability to meet the proposed deadlines.

25% Key personnel and composition of the technical team, including CVs and commitment of availability. FFP will also consider the offeror's ability to engage and use local firms.

20% Past performance, including a sample document (preferably of a baseline or final evaluation with quantitative and qualitative methodologies) provided as a writing sample to evaluate this criteria. The offeror should also include in the submission a list of references, preferably in USAID, related to the completion of a baseline study or final evaluation for a Title II or food security project.

VIII. Intellectual Property

USAID shall, solely and exclusively, own all rights in and to any work created in connection with this agreement, including all data, documents, information, copyrights, patents, trademarks, trade secrets or other proprietary rights in and to the work. The Contractor is not allowed to withhold any information related to this agreement, as this will become public information.

ANNEX 2
Sampling Plan
Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

Background

In accordance with the U.S. Agency for International Development (USAID) Evaluation Policy, the Office of Food for Peace (FFP) contracted with ICF International to conduct baseline studies for 2013 Title II program awards in Haiti (one award) and Zimbabwe (two awards). The baseline household surveys will be standardized across the participating countries to permit comparative analysis and will collect data for FFP indicators as described in the USAID FFP *Standard Indicator Handbook*. These indicators are related to food access; children's nutritional status and feeding practices; women's nutritional status and dietary diversity; water, sanitation, and hygiene; agricultural practices (in Zimbabwe only) and measurements of poverty. In addition to the required FFP indicators, the baseline household surveys will also include program-specific indicators identified by the Title II awardees as key measures for their individual programs. The sampling plan for the baseline household surveys for both countries will be described in detail in this report.

Survey Research Design

This baseline survey is the first phase of a pre-post evaluation for each Title II program. The second phase will include a final evaluation survey to be conducted when the Title II program is completed. Thus, the primary objective of the baseline household surveys will be to assess the status of the FFP and program-specific indicators prior to program implementation. The baseline measurements will then be used to calculate change in these indicators (and to undertake a statistical test of differences in the indicators) at completion of the Title II program when the same survey will be conducted again in the program areas. This pre-post design will allow for the determination of statistically significant change in indicators between the baseline and final evaluation; but will not allow statements about attribution or causation relating to program impact to be made.

The baseline survey will be designed as a population-based survey with a sample that will be statistically representative of all households within each of the two Title II program areas.

Sampling Frame

The sampling frame for each Title II program in Zimbabwe will be constructed from the geographic areas of implementation defined by the program and will be complemented with census-level household and population information. The last available census level information for the geographic regions in each country at the lowest enumeration level will be used.

In Zimbabwe, the last census was completed in 2012 and this up-to-date census information will be used. The administrative levels for the Zimbabwe census are as follows:

- Province
- District
- Ward
- Enumeration Area (EA)

The two Title II programs will be operating in 4 provinces – Masvingo, Manicaland, and North and South Matabeleland. The Title II *Amalima* program will be implemented in rural areas in 52 wards in four districts within the provinces of North and South Matabeleland. The Title II ENSURE program will be

implemented in rural areas in 60 wards in six districts within the provinces of Manicaland and Masvingo. The sampling frame for each program will consist of the EAs in these wards. The wards included in the sampling frame for each program are shown in Appendix A.

Sample Design

Multi-stage cluster sampling will be used to select census enumeration areas for each of the two Title II programs. Stunting will be used as the primary indicator for deriving the sample size calculation since it is one of several key measure for food insecurity.

Assumptions used for calculating the sample size for each Title II program are as follows:

- design effect of 2,
- confidence level of 95 percent,
- power level of 80 percent,
- expected change in stunting over the life of the program of 6.5 percentage points,
- use of the Stukel/Deitchler Inflation and Deflation Factors to determine the appropriate number of households (with children aged 0-59 months) to select, as described in the FANTA Sampling Guide Addendum (March 2012)[1], and
- inflation of the sample size of households by 10 percent to account for anticipated household nonresponse.

The formula used for deriving sample size is based on a statistical test of the difference of proportions (or prevalences) for an indicator (e.g., from baseline to final evaluation), controlling for inferential error as described in Appendix I of the Addendum to FANTA Sampling Guide. Table 1 provides the target sample size for each Title II program in Zimbabwe based on currently available estimates from the DHS for the prevalence of stunting in rural households, proportion of children aged 0–59 months in rural households, and average rural household size in each country.

Table 1. Target sample size for Zimbabwe

Target Population for Stunting	Estimated Proportion of Population (A)*	Average HH size (B)*	Individuals per HH (A*B/100)	Estimated Prevalence of Stunting*	Detectable Change |P2-P1|	Individual Sample Size Needed	HH Sample Size Needed**	HHs Needed including 10% Non-response	Number of Clusters of 30 Needed
Children 0-59 months	15.5	4.3	0.67	0.33	0.065	1,227	2,329	2,588	87

*Source: Zimbabwe 2010-2011 DHS; HH=household

** Includes Stukel/Dietchler inflation and deflation adjustment

Based on the target sample size calculated above, ICF will sample 87 clusters with 30 households per cluster for each Title II program in Zimbabwe resulting in an overall household sample size of 5,220 in Zimbabwe.

[1] FANTA III Sampling Guide (1999) and Addendum (2012). Retrieved from http://www.fantaproject.org/monitoring-and-evaluation/sampling

Sample Selection

The sample will be selected using multi-stage cluster sampling with four stages of sampling: 1) selection of enumeration areas, 2) selection of dwellings, 3) selection of households within dwellings, and 3) selection of individuals within households.

First stage sampling of enumeration areas

One consideration for the first stage of sampling is to ensure that some sampled EAs fall within each of the districts in which each program will be implemented. In order to ensure representation in each of the districts, the "universe" of EAs will be stratified by district. A fraction of the total EAs for each Title II program will be proportionately allocated to each stratum for sampling based on the overall distribution of EAs in the sampling frame. Then the "universe" of EAs within each stratum will be sampled as described in the following paragraph. Two replacement EAs will be selected for each stratum. Tables 2a and 2b provides summary counts for the EAs and households within each stratum for each program.

Table 2a. Number of EAs and households in the sampling frame and sample for the ENSURE Program

PROVINCE/District	Number of EAs in Program Area	Number of EAs Sampled	Number of Households in Program Area	Number of Households Sampled
MASVINGO				
Chivi	141	13	13,834	390
Zaka	145	13	13,743	390
Bikita	132	12	13,097	360
MANICALAND				
Chipinge	317	28	33,912	840
Buhera	103	9	11,526	270
Chimanimani	131	12	11,400	360
Total	**969**	**87**	**97,512**	**2,610**

Table 2b. Number of EAs and households in the sampling frame and sample for the *Amalima* Program

PROVINCE/District	Number of EAs in Program Area	Number of EAs Sampled	Number of Households in Program Area	Number of Households Sampled
MATABELELAND SOUTH				
Bulilima	137	22	13,120	660
Mangwe	103	17	10,095	510
Gwanda	126	21	12,189	630
MATABELELAND NORTH				
Tsholotsho	163	27	16,488	810
Total	**529**	**87**	**51,892**	**2,610**

Although surveys often use probability proportional to size (PPS) sampling at the first stage of sampling so that larger villages/communities (which are often used as first stage sampling units) have an increased probability of selection, this approach is not always necessary when using census enumeration areas (EAs) since variation in the size of EAs is often minimal due to the conscious effort of census planners to maintain a consistent number of households in each EA. A review of the sampling frame for Zimbabwe indicates that enumeration areas are relatively uniform in size; therefore enumeration areas will be selected using Simple Random Sampling (SRS), rather than PPS. Appendices B1 and B2 provide a list of the sampled EAs for each Title II program in Zimbabwe.

Second stage sampling of dwellings

The second stage sampling will entail selection of 30 dwellings within each EA using a systematic sampling method. The sampling interval will be calculated based on the number of dwellings in the EA divided by 30. In cases where the sampling interval is not an even integer, the sampling interval will be rounded down to the nearest integer. In Zimbabwe, the census counts of dwellings are reasonably up-to-date since the most recent census was conducted in 2012, but an initial walk through will be undertaken in each EA to confirm the number of dwelling units (group of huts) or "compounds".

Polygamy is fairly prevalent in the four provinces in which *Amalima* and ENSURE will be operating. In these areas, extended polygamous families often live in "compounds" which consist of one or more related huts that are located in close proximity to each other within the compound and that are circumscribed by a physical boundary such as a fence. In such cases where multiple wives of one husband live within these compounds, most often (but not always) wives live in their own huts with their own offspring (and possibly other members of the extended family) while the husband may rotate the hut in which he lives and eats over time. In most instances (but not always), wives within a compound cook separately for their own offspring or other extended family members using different pots than the other wives within the compound. For the second stage of sampling, ICF is adopting the strategy of sampling compounds rather than the individual huts within the compounds since individual huts may or may not represent households units (which are discussed later in this document) and it is only possible to determine household composition upon interviewing. More details on sampling within compounds will be given in the next section.

The systematic sampling of dwellings entails: 1) randomly choosing a starting point between 1 and n (the sampling interval) where the dwelling labeling 1, 2, …., n commences at one end of the EA; 2) conducting an interview in the first dwelling represented by the random starting point; and 3) choosing every n^{th} dwelling from the previous one thereafter for an interview (where n is the sampling interval and equals the total number of dwellings in the EA divided by 30), until the entire EA has been covered and the target number of interviews has been obtained. Specific instructions on implementing the systematic sampling will be provided to supervisors during training and in the field procedures manual.

Third stage of sampling: Multiple households within dwellings

The third stage of sampling involves selection of one household in the cases where there are multiple households in one dwelling unit (or compound). This can happen in various situations including polygamous situations in Zimbabwe (men with more than one wife) or more generally, other multi-

household dwelling arrangements.

For the purposes of the household survey a household will be defined as follows:

A person or group of people who live together and share meals ("eating from the same pot").

This is not the same as a family. A family includes only people who are related, but a household includes any people who live together, whether or not they are related. For example, three unrelated men who live and cook meals together would not be considered one family, but they would be considered one household.

For men with more than one wife (polygamous situations), households will be treated in accordance with the above definition as follows:

If the wives live in the same homestead and also share the same eating arrangements, they should be treated as the same household. But if the wives live independently and do not share the same eating arrangements they should be treated as separate households.

In all cases (polygamous or otherwise) where the interviewers determine that there is more than one household in a dwelling (or compound); one household will be randomly selected from amongst them using a Kish Grid (see Appendix C). Note that this case implies an additional stage of sampling with an associated additional sampling weight.

Fourth stage of sampling: Selection of individuals within households

The household survey is broken into several modules with different individuals eligible to be interviewed, depending on the target groups relevant to the various FFP indicators. This means that, depending on the composition of a sampled household, it may or may not contain children under 6 months (relevant to exclusive breastfeeding indicator), children aged 0-23 months (relevant to minimum acceptable diet indicator), children aged 0-59 months (relevant to the diarrhea, oral rehydration therapy, stunting and underweight indicators), women of reproductive age (relevant to the WDDS or woman's dietary diversity score), non-pregnant/ non-post-partum women of reproductive age (relevant to the BMI indicator), farmers (relevant to agricultural indicators), or heads of households/responsible adults (relevant to the household dietary diversity scale and expenditures indicators).

The household roster will be completed at the beginning of the interview, thus identifying all members of the selected household. Individuals are considered household members if they have lived in the household for six of the past twelve months. The protocol for sampling of individuals is as follows:

- For the children's module, *all* children 0-59 months will be selected.
- For the woman's module (WDDS indicator), one woman between the ages of 15-49 years will be selected. If there are multiple women eligible to be interviewed within a sampled household, a Kish Grid (see Appendix D) will be used to select only one.
- For woman's anthropometry (BMI indicator), one woman between the ages of 15-49 who is not pregnant or post-partum (birth in the preceding two months) will be selected. If there are multiple women eligible to be interviewed within a sampled household, a Kish Grid will be used to select only one.

- For the farmer's module, *all* eligible farmers will be selected.
- For the gender module, the primary adult male and female decision-makers will be selected.

Based on discussions during the baseline planning workshops held in each country, the protocol for selection of respondents to be interviewed on behalf of sampled individuals within households is defined as follows:

- For the modules requiring data about the household, the head of household or any responsible adult will be interviewed.
- For the children's module, the mother or caregiver of each child under age five years will be interviewed. Note that there may be more than one mother or caregiver. There should be no substitute respondents for mothers or caregivers.
- For the woman's module, the selected woman will be interviewed. If the selected woman is not available after three visits she will NOT be replaced.
- For woman's anthropometry, the selected woman will be measured for height and weight. If the selected woman is not available after three visits she will NOT be replaced.
- For the farmer's module, all farmers will be interviewed. A responsible adult who is knowledgeable of the farming practices can be interviewed in cases where a farmer is not available or when the farmer has migrated for an extended period and cannot be interviewed.
- For the gender module, if the primary male and female adult decision-makers are not available, no other individuals should be interviewed to take their place.

Sampling Weights

Sample weights will be computed and used in the data analyses. This will involve computing an overall sampling weight for each indicator corresponding to a unique sampling scheme. The sampling weight will consist of the inverse of the product of the probabilities of selection from each of the stages of sampling (EA selection, dwelling selection, household selection and, when relevant, individual selection). Because of the last stage of sampling (individual selection), a series of different weights are required for data analysis. Separate weights will be calculated for:

1) Households (used for indicators derived from Modules C, F, H and J)
2) Children 0-59 months (Module D)
3) Women 15-49 years (Module E)
4) Women 15-49 years who are not pregnant or post-partum (Anthropometry)
5) Farmers (Module F) – for Zimbabwe only

Different sampling weights will be calculated for separate analyses of each Title II program area and for the aggregate Title II program data. Weights will also be adjusted to compensate for household and individual level non-response where appropriate. Given that all eligible individuals will be selected for Modules D and F, the sampling weights for these modules will differ from those for households (used in Modules C, F, H and J) by an individual non-response adjustment only. Single questionnaire items that are missing responses will not be imputed for and will not be included in the calculations for relevant indicators.

APPENDIX A
WARDS INCLUDED IN THE SAMPLING FRAME FOR ZIMBABWE

ENSURE Program

Province/District	Wards Included in Program Area																Totals
Masvingo																	
Chivi	12	13	14	15	17	18	20	21	24	25	26						11
Zaka	2	13	14	15	18	19	20	21	24	25							10
Bikita	1	2	3	4	5	6	7	8	14	26							10
Manicaland																	
Chipinge	1	3	4	16	20	22	24	25	26	27	28	29	30				13
Buhera	11	17	19	25	26	27	29										7
Chimanimani	2	3	4	5	6	8	9	19	20								9
Total																	**60**

Amalima Program

Province/District	Wards Included in Program Area																Totals
South Matabeleland																	
Bulilima	1	5	6	7	8	9	11	12	13	14	15	20	21				13
Gwanda	7	8	9	13	14	15	17	18	19	20	24						11
Mangwe	1	3	5	6	7	8	9	10	13	15	16	17					12
North Matabeleland																	
Tsholotsho	1	2	3	4	5	6	7	9	10	11	13	14	15	16	17	18	16
Total																	**52**

APPENDIX B1
SAMPLED ENUMERATION AREAS FOR HOUSEHOLD SURVEY IN ENSURE PROGRAM AREA

Program	EA Code	Province	District	Ward	Households
ENSURE	201	Manicaland	Buhera	17	78
ENSURE	202	Manicaland	Buhera	25	90
ENSURE	203	Manicaland	Buhera	17	79
ENSURE	204	Manicaland	Buhera	26	119
ENSURE	205	Manicaland	Buhera	29	125
ENSURE	206	Manicaland	Buhera	11	93
ENSURE	207	Manicaland	Buhera	19	105
ENSURE	208	Manicaland	Buhera	19	107
ENSURE	209	Manicaland	Buhera	29	159
ENSURE	210	Manicaland	Chimanimani	4	79
ENSURE	211	Manicaland	Chimanimani	20	76
ENSURE	212	Manicaland	Chimanimani	5	102
ENSURE	213	Manicaland	Chimanimani	8	100
ENSURE	214	Manicaland	Chimanimani	5	115
ENSURE	215	Manicaland	Chimanimani	6	83
ENSURE	216	Manicaland	Chimanimani	4	70
ENSURE	217	Manicaland	Chimanimani	8	109
ENSURE	218	Manicaland	Chimanimani	19	71
ENSURE	219	Manicaland	Chimanimani	8	115
ENSURE	220	Manicaland	Chimanimani	5	82
ENSURE	221	Manicaland	Chimanimani	4	93
ENSURE	222	Manicaland	Chipinge	3	88
ENSURE	223	Manicaland	Chipinge	20	108
ENSURE	224	Manicaland	Chipinge	25	75
ENSURE	225	Manicaland	Chipinge	26	111
ENSURE	226	Manicaland	Chipinge	26	68
ENSURE	227	Manicaland	Chipinge	29	115
ENSURE	228	Manicaland	Chipinge	26	86
ENSURE	229	Manicaland	Chipinge	16	100
ENSURE	230	Manicaland	Chipinge	25	94
ENSURE	231	Manicaland	Chipinge	28	100
ENSURE	232	Manicaland	Chipinge	20	135
ENSURE	233	Manicaland	Chipinge	28	112
ENSURE	234	Manicaland	Chipinge	20	107
ENSURE	235	Manicaland	Chipinge	20	65
ENSURE	236	Manicaland	Chipinge	26	101
ENSURE	237	Manicaland	Chipinge	26	80
ENSURE	238	Manicaland	Chipinge	28	116
ENSURE	239	Manicaland	Chipinge	27	54
ENSURE	240	Manicaland	Chipinge	29	98
ENSURE	241	Manicaland	Chipinge	25	84
ENSURE	242	Manicaland	Chipinge	24	119
ENSURE	243	Manicaland	Chipinge	16	183
ENSURE	244	Manicaland	Chipinge	22	96

APPENDIX B1
SAMPLED ENUMERATION AREAS FOR HOUSEHOLD SURVEY IN ENSURE PROGRAM AREA

Program	EA Code	Province	District	Ward	Households
ENSURE	245	Manicaland	Chipinge	3	169
ENSURE	246	Manicaland	Chipinge	26	95
ENSURE	247	Manicaland	Chipinge	22	103
ENSURE	248	Manicaland	Chipinge	26	57
ENSURE	249	Manicaland	Chipinge	28	83
ENSURE	250	Masvingo	Bikita	5	72
ENSURE	251	Masvingo	Bikita	4	134
ENSURE	252	Masvingo	Bikita	6	89
ENSURE	253	Masvingo	Bikita	5	104
ENSURE	254	Masvingo	Bikita	2	115
ENSURE	255	Masvingo	Bikita	3	92
ENSURE	256	Masvingo	Bikita	1	90
ENSURE	257	Masvingo	Bikita	2	96
ENSURE	258	Masvingo	Bikita	2	122
ENSURE	259	Masvingo	Bikita	2	92
ENSURE	260	Masvingo	Bikita	1	102
ENSURE	261	Masvingo	Bikita	26	74
ENSURE	262	Masvingo	Chivi	14	111
ENSURE	263	Masvingo	Chivi	24	74
ENSURE	264	Masvingo	Chivi	25	93
ENSURE	265	Masvingo	Chivi	20	119
ENSURE	266	Masvingo	Chivi	14	74
ENSURE	267	Masvingo	Chivi	17	105
ENSURE	268	Masvingo	Chivi	20	72
ENSURE	269	Masvingo	Chivi	26	139
ENSURE	270	Masvingo	Chivi	25	98
ENSURE	271	Masvingo	Chivi	20	108
ENSURE	272	Masvingo	Chivi	18	92
ENSURE	273	Masvingo	Chivi	26	116
ENSURE	274	Masvingo	Chivi	25	65
ENSURE	275	Masvingo	Zaka	15	93
ENSURE	276	Masvingo	Zaka	18	110
ENSURE	277	Masvingo	Zaka	14	97
ENSURE	278	Masvingo	Zaka	19	108
ENSURE	279	Masvingo	Zaka	15	99
ENSURE	280	Masvingo	Zaka	19	147
ENSURE	281	Masvingo	Zaka	15	81
ENSURE	282	Masvingo	Zaka	15	100
ENSURE	283	Masvingo	Zaka	15	101
ENSURE	284	Masvingo	Zaka	21	75
ENSURE	285	Masvingo	Zaka	24	97
ENSURE	286	Masvingo	Zaka	13	109
ENSURE	287	Masvingo	Zaka	18	92

APPENDIX B2
SAMPLED ENUMERATION AREAS FOR HOUSEHOLD SURVEY IN *AMALIMA* PROGRAM AREA

Program	EA Code	Province	District	Ward	Households
Amalima	101	Matebeleland North	Tsholotsho	2	99
Amalima	102	Matebeleland North	Tsholotsho	2	85
Amalima	103	Matebeleland North	Tsholotsho	2	97
Amalima	104	Matebeleland North	Tsholotsho	3	99
Amalima	105	Matebeleland North	Tsholotsho	5	82
Amalima	106	Matebeleland North	Tsholotsho	6	105
Amalima	107	Matebeleland North	Tsholotsho	6	123
Amalima	108	Matebeleland North	Tsholotsho	9	81
Amalima	109	Matebeleland North	Tsholotsho	9	111
Amalima	110	Matebeleland North	Tsholotsho	10	73
Amalima	111	Matebeleland North	Tsholotsho	11	97
Amalima	112	Matebeleland North	Tsholotsho	11	52
Amalima	113	Matebeleland North	Tsholotsho	11	108
Amalima	114	Matebeleland North	Tsholotsho	13	110
Amalima	115	Matebeleland North	Tsholotsho	13	80
Amalima	116	Matebeleland North	Tsholotsho	13	98
Amalima	117	Matebeleland North	Tsholotsho	13	123
Amalima	118	Matebeleland North	Tsholotsho	14	108
Amalima	119	Matebeleland North	Tsholotsho	14	120
Amalima	120	Matebeleland North	Tsholotsho	14	127
Amalima	121	Matebeleland North	Tsholotsho	15	99
Amalima	122	Matebeleland North	Tsholotsho	15	111
Amalima	123	Matebeleland North	Tsholotsho	15	107
Amalima	124	Matebeleland North	Tsholotsho	16	104
Amalima	125	Matebeleland North	Tsholotsho	16	71
Amalima	126	Matebeleland North	Tsholotsho	17	77
Amalima	127	Matebeleland North	Tsholotsho	17	70
Amalima	128	Matebeleland South	Bulilima	1	70
Amalima	129	Matebeleland South	Bulilima	1	116
Amalima	130	Matebeleland South	Bulilima	1	110
Amalima	131	Matebeleland South	Bulilima	1	112
Amalima	132	Matebeleland South	Bulilima	5	112
Amalima	133	Matebeleland South	Bulilima	5	90
Amalima	134	Matebeleland South	Bulilima	5	89
Amalima	135	Matebeleland South	Bulilima	6	111
Amalima	136	Matebeleland South	Bulilima	6	85
Amalima	137	Matebeleland South	Bulilima	7	108
Amalima	138	Matebeleland South	Bulilima	7	86
Amalima	139	Matebeleland South	Bulilima	7	127
Amalima	140	Matebeleland South	Bulilima	7	107
Amalima	141	Matebeleland South	Bulilima	8	75
Amalima	142	Matebeleland South	Bulilima	9	95
Amalima	143	Matebeleland South	Bulilima	9	83
Amalima	144	Matebeleland South	Bulilima	11	84

APPENDIX B2
SAMPLED ENUMERATION AREAS FOR HOUSEHOLD SURVEY IN *AMALIMA* PROGRAM AREA

Program	EA Code	Province	District	Ward	Households
Amalima	145	Matebeleland South	Bulilima	12	107
Amalima	146	Matebeleland South	Bulilima	12	102
Amalima	147	Matebeleland South	Bulilima	13	98
Amalima	148	Matebeleland South	Bulilima	14	119
Amalima	149	Matebeleland South	Bulilima	21	66
Amalima	150	Matebeleland South	Gwanda	8	135
Amalima	151	Matebeleland South	Gwanda	8	105
Amalima	152	Matebeleland South	Gwanda	8	131
Amalima	153	Matebeleland South	Gwanda	13	82
Amalima	154	Matebeleland South	Gwanda	13	92
Amalima	155	Matebeleland South	Gwanda	14	77
Amalima	156	Matebeleland South	Gwanda	14	58
Amalima	157	Matebeleland South	Gwanda	15	83
Amalima	158	Matebeleland South	Gwanda	17	77
Amalima	159	Matebeleland South	Gwanda	17	96
Amalima	160	Matebeleland South	Gwanda	17	93
Amalima	161	Matebeleland South	Gwanda	17	106
Amalima	162	Matebeleland South	Gwanda	18	91
Amalima	163	Matebeleland South	Gwanda	18	120
Amalima	164	Matebeleland South	Gwanda	18	121
Amalima	165	Matebeleland South	Gwanda	18	86
Amalima	166	Matebeleland South	Gwanda	18	87
Amalima	167	Matebeleland South	Gwanda	19	152
Amalima	168	Matebeleland South	Gwanda	19	75
Amalima	169	Matebeleland South	Gwanda	24	102
Amalima	170	Matebeleland South	Gwanda	24	102
Amalima	171	Matebeleland South	Mangwe	3	90
Amalima	172	Matebeleland South	Mangwe	3	110
Amalima	173	Matebeleland South	Mangwe	3	106
Amalima	174	Matebeleland South	Mangwe	5	105
Amalima	175	Matebeleland South	Mangwe	6	119
Amalima	176	Matebeleland South	Mangwe	6	59
Amalima	177	Matebeleland South	Mangwe	7	129
Amalima	178	Matebeleland South	Mangwe	7	93
Amalima	179	Matebeleland South	Mangwe	8	99
Amalima	180	Matebeleland South	Mangwe	10	121
Amalima	181	Matebeleland South	Mangwe	13	112
Amalima	182	Matebeleland South	Mangwe	15	131
Amalima	183	Matebeleland South	Mangwe	16	77
Amalima	184	Matebeleland South	Mangwe	16	67
Amalima	185	Matebeleland South	Mangwe	16	129
Amalima	186	Matebeleland South	Mangwe	16	54
Amalima	187	Matebeleland South	Mangwe	17	85

APPENDIX C
KISH GRID FOR SELECTION OF HOUSEHOLDS

KISH GRID for Random Selection of Households in Multi-household Dwellings

INSTRUCTIONS

1. List all households in the dwelling, writing the name of the head of household (in alphabetical order) in Column D.
2. Look up the last digit of the HH number in column (1) of the field control sheet , and circle the corresponding column number below
3. Look up where last digit of the household (columns) crosses the number of households in the dwelling (rows)
4. The digit in the cell where the column and row meet is the household to interview

EXAMPLE: If No of households= 3 & last digit = 5, select the 2nd household listed.

No of Households	Name of Head of Household	Last digit of the household number. See Field Control Sheet, Column (1)									
		1	2	3	4	5	6	7	8	9	0
1		1	1	1	1	1	1	1	1	1	1
2		1	2	1	2	1	2	1	2	1	2
3		1	2	3	1	2	3	1	2	3	3
4		1	2	3	4	1	2	3	4	1	4
5		1	2	3	4	5	1	2	3	4	5
6		1	2	3	4	5	6	4	2	6	1
7		1	2	3	4	5	6	7	1	4	7
8		1	2	3	4	5	6	7	8	4	3
9		1	2	3	4	5	6	7	8	9	2
10		1	2	3	4	5	6	7	8	9	10

APPENDIX D
KISH GRIDS FOR SELECTION OF WOMEN

KISH GRID for random selection of women ages 15-49 for Module E

INSTRUCTIONS

1. Check Column 9 in the household roster. If there is more than one woman 15-49 then select one using the procedure below.
2. List the name and line number of all women ages 15-49 in the household, in descending order by age (oldest first).
3. Look up the last digit of the household number from Module A and circle the corresponding column number below.
4. Look up where the last digit of the household number (columns) crosses the number of women 15-49 (rows).
5. The digit in the cell where the column and row meet is the number of the woman to interview for Module E.

EXAMPLE: If number of women 15-49 = 3 & last digit of household = 5, select the 2nd woman listed.

Number of Woman 15-49	Line Number from HH Roster	Name	Age	Last digit of the household number (See Module A, A01)									
				1	2	3	4	5	6	7	8	9	0
1				1	1	1	1	1	1	1	1	1	1
2				1	2	1	2	1	2	1	2	1	2
3				1	2	3	1	2	3	1	2	3	3
4				1	2	3	4	1	2	3	4	1	4
5				1	2	3	4	5	1	2	3	4	5
6				1	2	3	4	5	6	4	2	6	1
7				1	2	3	4	5	6	7	1	4	7
8				1	2	3	4	5	6	7	8	4	3
9				1	2	3	4	5	6	7	8	9	2
10				1	2	3	4	5	6	7	8	9	10

KISH GRID for random selection of women for Anthropometry

INSTRUCTIONS

1. Check the answer to Question E38 in Module E. If the answer is Yes, then check the names of the women listed in Question E39 and cross them off the Kish Grid above. If there is more than one woman left then select one using the procedure below.
2. List all women that have not been crossed off the Kish Grid above in descending order by age (oldest first).
3. Look up the last digit of the household number from Module A and circle the corresponding column number below.
4. Look up where the last digit of the household number (columns) crosses the number of women 15-49 (rows).
5. The digit in the cell where the column and row meet is the number of the woman to interview for Module E.

EXAMPLE: If number of women 15-49 = 3 & last digit of household = 5, select the 2nd woman listed.

Number of Woman 15-49	Line Number from HH Roster	Name	Age	Last digit of the household number (See Module A, A01)									
				1	2	3	4	5	6	7	8	9	0
1				1	1	1	1	1	1	1	1	1	1
2				1	2	1	2	1	2	1	2	1	2
3				1	2	3	1	2	3	1	2	3	3
4				1	2	3	4	1	2	3	4	1	4
5				1	2	3	4	5	1	2	3	4	5
6				1	2	3	4	5	6	4	2	6	1
7				1	2	3	4	5	6	7	1	4	7
8				1	2	3	4	5	6	7	8	4	3
9				1	2	3	4	5	6	7	8	9	2
10				1	2	3	4	5	6	7	8	9	10

ANNEX 3
Household Survey Questionnaire
Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

Module A. Identification and Informed Consent (Head of HH or Responsible Adult)

IDENTIFICATION (1)

A01 **HOUSEHOLD NUMBER (HH)** .....

A02 **ENUMERATION AREA (EA) CODE** .....

A03 **PROVINCE AND DISTRICT CODE** .....

Province	Manicaland		Masvingo		Matebeleland South		Matebeleland North	
District	BUHERA	101	BIKITA	801	BULILIMA	602	TSHOLOTSHO	506
	CHIMANIMANI	102	CHIVI	803	MANGWE	603		
	CHIPINGE	103	ZAKA	807	GWANDA	604		

INTERVIEWER VISITS

	FIRST VISIT	SECOND VISIT	THIRD VISIT	FINAL VISIT
A05 **DATE**				A09 DAY
A06 **ENUMERATOR**				A10 MONTH
A07 **DAY OF VISIT**				A11 YEAR
A08 **RESULT** (USE CODES)				A12 INT. NUMBER
NEXT VISIT: DATE				A13 TOTAL NUMBER OF VISITS
TIME				

A14 **FINAL OUTCOME OF INTERVIEW (CIRCLE ONE)**

1 COMPLETED
2 NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME AT TIME OF VISIT
3 ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME
4 POSTPONED
5 REFUSED
9 OTHER _____ (SPECIFY)

A17 TOTAL ELIGIBLE WOMEN 15-49 YRS

A18 TOTAL CHILDREN UNDER FIVE

A18A TOTAL FARMERS

A19 LINE NO. OF RESPONDENT TO HOUSEHOLD ROSTER

A15 **PRIMARY MALE DECISION-MAKER* NAME & ID** _____

A16 **PRIMARY FEMALE DECISION-MAKER* NAME & ID** _____

A20 **SUPERVISOR**	A21 **FIELD EDITOR**	A22 **OFFICE EDITOR**	A23 **DATA ENTRY**
NAME _____	NAME _____	NAME _____	OPERATOR _____
CODE	CODE	CODE	DAY MONTH YEAR

*THE PRIMARY MALE AND FEMALIE DECISION MAKERS ARE THOSE WHO SELF-IDENTIFY AS THE PRIMARY MALE AND FEMALE (OR FEMALE ONLY) MEMBERS RESPONSIBLE FOR DECISION MAKING, BOTH SOCIAL AND ECONOMIC, WITHIN THE HOUSEHOLD. IN MALE AND FEMALE ADULT HOUSEHOLDS, THEY ARE USUALLY THE HUSBAND AND WIFE; HOWEVER THEY CAN ALSO BE OTHER HOUSEHOLD MEMBERS AS LONG AS THEY ARE AGED 15 AND OVER.

INFORMED CONSENT

START TIME ☐☐ : ☐☐ (Hour Minute)

IT IS NECESSARY TO INTRODUCE THE HOUSEHOLD TO THE SURVEY AND OBTAIN THE CONSENT OF ALL RESPONDENTS. FIRST IDENTIFY THE PRIMARY MALE AND FEMALE DECISION MAKERS AND CONDUCT THE INFORMED CONSENT WITH THEM. THEN BEGIN THE INTERVIEW. AS YOU IDENTIFY NEW RESPONDENTS FOR SUBSEQUENT MODULES, RETURN TO THIS PAGE AND OBTAIN THEIR CONSENT BEFORE INTERVIEWING THEM.

Hello. My name is _____. I am working with ICF/PROBE. We are conducting a survey to learn about food security, food consumption, nutrition and wellbeing of households in Zimbabwe. Your household was selected for the survey. I would like to ask you some questions about your household. The questions usually take about 2 hours. We can return tomorrow if you don't have time to finish all the questions today. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. If i ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time.

Do you have any questions about the study or about your participation?

You or othere respondents can ask any questions you may have about the study at any time.

AS APPLICABLE, CHECK AND SIGN THE CONSENT BOX BELOW.

1. Who is the main male adult (15 years or older) decision-maker in the household?
   [NAME], do you agree to participate in the survey?
   NAME: _____ RESPONDENT AGREED ____ RESPONDENT DID NOT AGREE ____
2. Who is the main female adult (15 years or older) decision-maker in the household?
   [NAME], do you agree to participate in the survey?
   NAME: _____ RESPONDENT AGREED ____ RESPONDENT DID NOT AGREE ____
3. PRIMARY CAREGIVERS FOR CHILDREN UNDER FIVE YEARS OF AGE
   [NAME], do you agree to participate in the survey and allow your child to be weighed and measured?
   NAME: _____ RESPONDENT AGREED ____ RESPONDENT DID NOT AGREE ____
   NAME: _____ RESPONDENT AGREED ____ RESPONDENT DID NOT AGREE ____
   NAME: _____ RESPONDENT AGREED ____ RESPONDENT DID NOT AGREE ____
   NO CHILDREN UNDER FIVE IN THE HOUSEHOLD _____

ADDITIONAL ELIGIBLE HOUSEHOLD MEMBERS		RESPONDENT AGREED	RESPONDENT DID NOT AGREE
4.	NAME_____ Do you agree to participate in the survey?	___	___
5.	NAME_____ Do you agree to participate in the survey?	___	___
6.	NAME_____ Do you agree to participate in the survey?	___	___

My signature affirms that I have read the verbal informed consent statement to the respondent(s), and I have answered any questions asked about the study.

INTERVIEWER'S NAME AND CODE _____ ☐☐☐

SIGNATURE AND DATE _____ DAY ☐☐ . MONTH ☐☐ . YEAR ☐☐☐☐

INTERVIEWER'S NAME AND CODE _____ ☐☐☐

SIGNATURE AND DATE _____ DAY ☐☐ . MONTH ☐☐ . YEAR ☐☐☐☐

INTERVIEWER'S NAME AND CODE _____ ☐☐☐

SIGNATURE AND DATE _____ DAY ☐☐ . MONTH ☐☐ . YEAR ☐☐☐☐

END TIME ☐☐ : ☐☐ (Hour Minute)

MODULE B. HOUSEHOLD ROSTER (HEAD OF HH OR RESPONSIBLE ADULT) **START TIME: HOUR** ☐☐ **MINUTE** ☐☐

							IF AGE IS UNDER 5 YEARS				IF AGE 15 OR OLDER	IF AGE 0-17 YEARS				IF AGE 5 YEARS OR OLDER		IF AGE 5-24 YEARS	
LINE NO.	USUAL RESIDENTS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	AGE	ELIGIBILITY						MARITAL STATUS	SURVIVORSHIP AND RESIDENCE OF BIOLOGICAL PARENTS				EVER ATTENDED SCHOOL		CURRENT/RECENT SCHOOL ATTENDANCE	
					MODULE C, H1	MODULE D	PRIMARY CAREGIVER	MODULE E	MODULE F, H2-H5	MODULE G									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	Please tell me the name and sex of each person who lives here, starting with the head of the household. For our purposes today, members of a household are adults or children that live together and eat from the "same pot". It should include anyone who has lived in your house for 6 of the last 12 months, but it does not include anyone who lives here but eats separately. AFTER LISTING NAMES, RELATIONSHIP, AND SEX FOR EACH PERSON, ASK QUESTIONS 2A-2C TO BE SURE THAT THE LISTING IS COMPLETE. THEN ASK APPROPRIATE QUESTIONS IN COLUMNS 5-20 FOR EACH PERSON.	What is the relationship of (NAME) to the head of the household? SEE CODES BELOW.	Is (NAME) male or female?	How old is (NAME)? IF 95 OR MORE, RECORD '95'. '98'=DON'T KNOW. USE ONLY FOR PERSONS WHO ARE ≥ 50. USE '00' IF CHILD IS LESS THAN 1 YEAR	Was [NAME] in charge of the food preparation during the past 7 days?	IS THIS A CHILD UNDER 5 YEARS OF AGE?	Who is the primary caregiver of [NAME]? *SEE DEFINITION BELOW ENTER LINE NUMBER OF PRIMARY CAREGIVER	IS THIS A WOMAN 15-49 YEARS OF AGE?	IS THIS PERSON THE HEAD OF THE HH; OR A RESPON-SIBLE ADULT IF HEAD OF HH IS ABSENT?	Is (NAME) a farmer? **READ DEFINITION OF FARMER BELOW TO RESPON-DENT	What is (NAME)'s current marital status? 1 = MARRIED OR LIVING TOGETHER 2 = DIVORCED/ SEPARATED 3 = WIDOWED 4 = NEVER-MARRIED AND NEVER LIVED TOGETHER	Is (NAME)'s natural mother alive?	Does (NAME)'s natural mother usually live in this household? IF "YES": What is her name? RECORD MOTHER'S LINE NUMBER. IF "NO", RECORD '00'.	Is (NAME)'s natural father alive?	Does (NAME)'s natural father usually live in this household? IF YES: What is his name? RECORD FATHER'S LINE NUMBER. IF NO, RECORD '00'.	Has (NAME) ever attended school?	What is the highest level of school (NAME) has attended? SEE CODES BELOW. What is the highest grade (NAME) completed at that level? SEE CODES BELOW.	Did (NAME) attend school at any time during the 2014 school year?	During this school year, what level and grade was (NAME) attending? SEE CODES BELOW.
			M F	IN YEARS	Y N	Y N		Y N	Y N	Y N		Y N DK		Y N DK		Y N	LEVEL GRADE	Y N	LEVEL GRADE
01		0 1	1 2	☐☐	1 2	1 2	☐☐	1 2	1 2	1 2	☐	1 2 8 → GO TO 15	☐☐	1 2 8 → GO TO 17	☐☐	1 2 → NEXT LINE	☐☐☐	1 2 → NEXT LINE	☐☐☐
02		☐☐	1 2	☐☐	1 2	1 2	☐☐	1 2	1 2	1 2	☐	1 2 8 → GO TO 15	☐☐	1 2 8 → GO TO 17	☐☐	1 2 → NEXT LINE	☐☐☐	1 2 → NEXT LINE	☐☐☐
03		☐☐	1 2	☐☐	1 2	1 2	☐☐	1 2	1 2	1 2	☐	1 2 8 → GO TO 15	☐☐	1 2 8 → GO TO 17	☐☐	1 2 → NEXT LINE	☐☐☐	1 2 → NEXT LINE	☐☐☐
04		☐☐	1 2	☐☐	1 2	1 2	☐☐	1 2	1 2	1 2	☐	1 2 8 → GO TO 15	☐☐	1 2 8 → GO TO 17	☐☐	1 2 → NEXT LINE	☐☐☐	1 2 → NEXT LINE	☐☐☐
05		☐☐	1 2	☐☐	1 2	1 2	☐☐	1 2	1 2	1 2	☐	1 2 8 → GO TO 15	☐☐	1 2 8 → GO TO 17	☐☐	1 2 → NEXT LINE	☐☐☐	1 2 → NEXT LINE	☐☐☐
06		☐☐	1 2	☐☐	1 2	1 2	☐☐	1 2	1 2	1 2	☐	1 2 8 → GO TO 15	☐☐	1 2 8 → GO TO 17	☐☐	1 2 → NEXT LINE	☐☐☐	1 2 → NEXT LINE	☐☐☐
07		☐☐	1 2	☐☐	1 2	1 2	☐☐	1 2	1 2	1 2	☐	1 2 8 → GO TO 15	☐☐	1 2 8 → GO TO 17	☐☐	1 2 → NEXT LINE	☐☐☐	1 2 → NEXT LINE	☐☐☐
08		☐☐	1 2	☐☐	1 2	1 2	☐☐	1 2	1 2	1 2	☐	1 2 8 → GO TO 15	☐☐	1 2 8 → GO TO 17	☐☐	1 2 → NEXT LINE	☐☐☐	Y N 1 2 → NEXT LINE	☐☐☐

2A) Just to make sure that I have a complete listing: are there any other persons such as small children or infants that we have not listed? YES → ADD TO TABLE, NO

2B) Are there any other people who may not be members of your family, such as domestic servants, lodgers, or friends who usually live here? YES → ADD TO TABLE, NO

2C) Does anyone else live here even if they are not at home now? INCLUDE CHILDREN IN SCHOOL OR HOUSEHOLD MEMBERS AT WORK OR MIGRATED. YES → ADD TO TABLE, NO

END TIME:

HOUR ☐☐

MINUTE ☐☐

CODES FOR Q. 3: RELATIONSHIP TO HEAD OF HOUSEHOLD

01 = HEAD OF HOUSEHOLD
02 = WIFE OR HUSBAND
03 = SON OR DAUGHTER
04 = SON-IN-LAW OR DAUGHTER-IN-LAW
05 = GRANDCHILD
06 = PARENT
07 = PARENT-IN-LAW
08 = BROTHER OR SISTER
09 = OTHER RELATIVE
10 = ADOPTED/FOSTER/ STEPCHILD
11 = NOT RELATED
98 = DON'T KNOW

DEFINITIONS

*The primary caregiver is the person who knows the most about how and what the child is fed. Usually, but not always, this will be the child"s mother.

**Farmers, including herders and fishers, are: 1) men and women who have access to a plot of land (even if very small) over which they make decisions about what will be grown, how it will be grown, and how to dispose of the harvest; AND/OR 2) men and women who have animals and/or aquaculture products over which they have decision-making power. Farmers produce food, feed, and fiber, where "food" includes agronomic crops(crops grown in large scale, such as grains), horticulture crops (vegetables, fruit, nuts, berries, and herbs), animal and aquaculture products, as well as natural products (e.g., non-timber forest products, wild fisheries). These farmers may engage in processing and marketing of food, feed, and fiber and may reside in settled communities, mobile pastoralist communities, or refugee/internally displaced person camps. An adult member of the household who does farm work but does not have decision-making responsibility over the plot OR animals would not be considered a "farmer." For instance, a woman working on her husband's land who does not control a plot of her own would not be interviewed.

CODES FOR Qs. 18 AND 20: EDUCATION

LEVEL
1 = PRIMARY
2 = SECONDARY
3 = HIGHER
6 = PRE-PRIMARY
8 = DON'T KNOW

GRADE
00 = LESS THAN 1 YEAR COMPLETED. (USE '00' FOR Q. 18 ONLY. THIS CODE IS NOT ALLOWED FOR Q. 20)
98 = DON'T KNOW

							IF AGE IS UNDER 5 YEARS				IF AGE 15 OR OLDER	IF AGE 0-17 YEARS				IF AGE 5 YEARS OR OLDER		IF AGE 5-24 YEARS	
LINE NO.	USUAL RESIDENTS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	AGE	ELIGIBILITY						MARITAL STATUS	SURVIVORSHIP AND RESIDENCE OF BIOLOGICAL PARENTS				EVER ATTENDED SCHOOL		CURRENT/RECENT SCHOOL ATTENDANCE	
					MODULE C, H1	MODULE D	PRIMARY CAREGIVER	MODULE E	MODULE F, H2-H5	MODULE G									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	Please tell me the name and sex of each person who lives here, starting with the head of the household. For our purposes today, members of a household are adults or children that live together and eat from the "same pot". It should include anyone who has lived in your house for 6 of the last 12 months, but it does not include anyone who lives here but eats separately. AFTER LISTING NAMES, RELATIONSHIP, AND SEX FOR EACH PERSON, ASK QUESTIONS 2A-2C TO BE SURE THAT THE LISTING IS COMPLETE. THEN ASK APPROPRIATE QUESTIONS IN COLUMNS 5-20 FOR EACH PERSON.	What is the relationship of (NAME) to the head of the household? SEE CODES BELOW.	Is (NAME) male or female?	How old is (NAME)? IF 95 OR MORE, RECORD '95'. '98'=DON'T KNOW. USE ONLY FOR PERSONS WHO ARE ≥ 50. USE '00' IF CHILD IS LESS THAN 1 YEAR	Was [NAME] in charge of the food preparation during the past 7 days?	IS THIS A CHILD UNDER 5 YEARS OF AGE?	Who is the primary caregiver of [NAME]? *SEE DEFINITION BELOW ENTER LINE NUMBER OF PRIMARY CAREGIVER	IS THIS A WOMAN 15-49 YEARS OF AGE?	IS THIS PERSON THE HEAD OF THE HH; OR A RESPON-SIBLE ADULT IF HEAD OF HH IS ABSENT?	Is (NAME) a farmer? **READ DEFINITION OF FARMER BELOW TO RESPON-DENT	What is (NAME)'s current marital status? 1 = MARRIED OR LIVING TOGETHER 2 = DIVORCED/ SEPARATED 3 = WIDOWED 4 = NEVER-MARRIED AND NEVER LIVED TOGETHER	Is (NAME)'s natural mother alive?	Does (NAME)'s natural mother usually live in this household? IF "YES": What is her name? RECORD MOTHER'S LINE NUMBER. IF "NO", RECORD '00'.	Is (NAME)'s natural father alive?	Does (NAME)'s natural father usually live in this household? IF YES: What is his name? RECORD FATHER'S LINE NUMBER. IF NO, RECORD '00'.	Has (NAME) ever attended school?	What is the highest level of school (NAME) has attended? SEE CODES BELOW. What is the highest grade (NAME) completed at that level? SEE CODES BELOW.	Did (NAME) attend school at any time during the 2014 school year?	During this school year, what level and grade was (NAME) attending? SEE CODES BELOW.
09			M F 1 2	IN YEARS	Y N 1 2	Y N 1 2		Y N 1 2	Y N 1 2	Y N 1 2		Y N DK 1 2 8 GO TO 15		Y N DK 1 2 8 GO TO 17		Y N 1 2 NEXT LINE	LEVEL GRADE	Y N 1 2 NEXT LINE	LEVEL GRADE
10			1 2		1 2	1 2		1 2	1 2	1 2		1 2 8 GO TO 15		1 2 8 GO TO 17		1 2 NEXT LINE		1 2 NEXT LINE	
11			1 2		1 2	1 2		1 2	1 2	1 2		1 2 8 GO TO 15		1 2 8 GO TO 17		1 2 NEXT LINE		1 2 NEXT LINE	
12			1 2		1 2	1 2		1 2	1 2	1 2		1 2 8 GO TO 15		1 2 8 GO TO 17		1 2 NEXT LINE		1 2 NEXT LINE	
13			1 2		1 2	1 2		1 2	1 2	1 2		1 2 8 GO TO 15		1 2 8 GO TO 17		1 2 NEXT LINE		1 2 NEXT LINE	
14			1 2		1 2	1 2		1 2	1 2	1 2		1 2 8 GO TO 15		1 2 8 GO TO 17		1 2 NEXT LINE		1 2 NEXT LINE	
15			1 2		1 2	1 2		1 2	1 2	1 2		1 2 8 GO TO 15		1 2 8 GO TO 17		1 2 NEXT LINE		1 2 NEXT LINE	
16			1 2		1 2	1 2		1 2	1 2	1 2		1 2 8 GO TO 15		1 2 8 GO TO 17		1 2 NEXT LINE		1 2 NEXT LINE	
17			1 2		1 2	1 2		1 2	1 2	1 2		1 2 8 GO TO 15		1 2 8 GO TO 17		1 2 NEXT LINE		1 2 NEXT LINE	

CODES FOR Q. 3: RELATIONSHIP TO HEAD OF HOUSEHOLD

01 = HEAD
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04 = SON-IN-LAW OR DAUGHTER-IN-LAW
05 = GRANDCHILD
06 = PARENT
07 = PARENT-IN-LAW
08 = BROTHER OR SISTER
09 = OTHER RELATIVE
10 = ADOPTED/FOSTER/ STEPCHILD
11 = NOT RELATED
98 = DON'T KNOW

DEFINITIONS

*The primary caregiver is the person who knows the most about how and what the child is fed. Usually, but not always, this will be the child"s mother.

**Farmers, including herders and fishers, are: 1) men and women who have access to a plot of land (even if very small) over which they make decisions about what will be grown, how it will be grown, and how to dispose of the harvest; AND/OR 2) men and women who have animals and/or aquaculture products over which they have decision-making power. Farmers produce food, feed, and fiber, where "food" includes agronomic crops(crops grown in large scale, such as grains), horticulture crops (vegetables, fruit, nuts, berries, and herbs), animal and aquaculture products, as well as natural products (e.g., non-timber forest products, wild fisheries). These farmers may engage in processing and marketing of food, feed, and fiber and may reside in settled communities, mobile pastoralist communities, or refugee/internally displaced person camps. An adult member of the household who does farm work but does not have decision-making responsibility over the plot OR animals would not be considered a "farmer." For instance, a woman working on her husband's land who does not control a plot of her own would not be interviewed.

CODES FOR Qs. 18 AND 20: EDUCATION

LEVEL
1 = PRIMARY
2 = SECONDARY
3 = HIGHER
6 = PRE-PRIMARY
8 = DON'T KNOW

GRADE
00 = LESS THAN 1 YEAR COMPLETED. (USE '00' FOR Q. 18 ONLY. THIS CODE IS NOT ALLOWED FOR Q. 20)
98 = DON'T KNOW

TICK HERE IF CONTINUATION SHEET USED ☐

Module F. Water, Sanitation and Hygiene (Head of HH or Responsible Adult)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
F00	INSERT TIME MODULE STARTED	HOUR ☐☐ MINUTE ☐☐	
F01	HOUSEHOLD NUMBER AND EA CODE	HH ☐☐ EA ☐☐☐	
F02	HEAD OF THE HOUSEHOLD OR RESPONSIBLE ADULT FROM COLUMN 10 ON HOUSEHOLD ROSTER	LINE NUMBER ☐☐	
DRINKING WATER			
F04	What is currently the main source of drinking water for members of your household?	**PIPED WATER** PIPED INTO HOME ..... 11 PIPED TO YARD/PLOT ..... 12 PUBLIC TAP/STANDPIPE ..... 13 TUBEWELL OR BOREHOLE ..... 21 DUG WELL PROTECTED WELL ..... 31 UNPROTECTED WELL ..... 32 WATER FROM SPRING PROTECTED SPRING ..... 41 UNPROTECTED SPRING ..... 42 RAINWATER ..... 51 TANKER TRUCK ..... 61 CART WITH SMALL TANK ..... 71 SURFACE WATER (RIVER/DAM/ LAKE/POND/STREAM/CANAL/IRRIGATION CHANNEL) . 81 DIGGING INTO A DRY RIVER BED 82 BOTTLED WATER ..... 91 OTHER _____ 96 (SPECIFY)	→ F07 → F07
F05	Where is that water source located?	IN OWN DWELLING ..... 1 IN OWN YARD/PLOT ..... 2 ELSEWHERE 3	→ F07
F06	How long does it take to go there, get water, and come back?	MINUTES ..... ☐☐☐ DON'T KNOW 998	
F07	Is water available from this source all year round?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
F08	In the last two weeks, was water unavailable from this source for a day or longer?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
F09	Do you do anything to the water to make it safer to drink?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ F10A
F10	What do you usually do to make the water safer to drink? Anything else? RECORD ALL MENTIONED.	BOIL (Until the water comes to a boil) 01 ADD BLEACH/CHLORINE (Water Guard, Jik, Aquatabs) 02 STRAIN THROUGH A CLOTH ..... 03 USE WATER FILTER (CERAMIC/SAND/COMPOSITE/ETC.) 04 SOLAR DISINFECTION ..... 05 LET IT STAND AND SETTLE ..... 06 [BIO] SAND FILTRATION ..... 07 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	
	Do you store your drinking water in any of the following types of containters?	YES NO DK	
F10A	a) Sealed bucket with spigot	Sealed buckets with spigot 1 2 8	
F10B	b) Narrow-necked jerry can	Narrow-necked jerry can 1 2 8	
F10C	c) Covered container with a ladle	Covered container with a ladle 1 2 8	

Module F. Water, Sanitation and Hygiene (Head of HH or Responsible Adult)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SANITATION			
F11	What kind of toilet facility do members of your household usually use ?	**FLUSH OR POUR FLUSH TOILET** FLUSH TO PIPED SEWER SYTEM ..... 11 FLUSH TO SEPTIC TANK ..... 12 FLUSH TO PIT LATRINE ..... 13 FLUSH TO SOMEWHERE ELSE ..... 14 FLUSH, DON'T KNOW WHERE ..... 15 **PIT LATRINE** VENTILATED IMPROVED PIT LITRINE ..... 21 PIT LATRINE WITH SLAB ..... 22 PIT LATRINE WITHOUT SLAB/OPEN PIT ..... 23 BUCKET TOILET ..... 41 NO FACILITY/BUSH/FIELD ..... 61 HANGING LATRINE (PILE) ..... 71 OTHER _____ 96 (SPECIFY)	→ F14
F12	Does your household share the toilet facility with other households?	YES ..... 1 NO 2	→ F14
F13	How many households share that toilet facility?	NUMBER OF HOUSEHOLDS IF LESS THAN 10 ..... 0 [ ] 10 OR MORE HOUSEHOLDS ..... 95 DON'T KNOW 98	
HANDWASHING			
F14	Please show me where members of your household most often wash their hands.	OBSERVED ..... 1 NOT OBSERVED, NOT IN DWELLING/YARD/PLOT ..... 2 NOT OBSERVED, NO PERMISSION TO SEE ..... 3 NOT OBSERVED, OTHER REASON ..... 4 (SKIP TO F17)	
F15	OBSERVATION ONLY: OBSERVE PRESENCE OF WATER AT THE PLACE FOR HANDWASHING.	WATER IS AVAILABLE ..... 1 WATER IS NOT AVAILABLE 2	
F16	OBSERVATION ONLY: OBSERVE PRESENCE OF SOAP, DETERGENT, OR OTHER CLEANSING AGENT AT THE PLACE FOR HANDWASHING.	SOAP OR DETERGENT (BAR, LIQUID, POWDER, PASTE) ..... 1 ASH, MUD, SAND ..... 2 NONE 3	
F17	OBSERVATION ONLY: OBSERVE PRESENCE OF TOILET FACILITY THAT HOUSEHOLD SAID THEY USED.	TOILET FACILITY IS AVAILABLE ..... 1 TOILET FACILITY IS NOT AVAILABLE ..... 2 (SKIP TO F18)	
F17A	OBSERVATION ONLY: CHECK TO SEE IF THERE IS A HANDWASHING STATION AT THE TOILET FACILITY.	YES, HANDWASHING STATION OBSERVED AT FACILITY 1 NO, HANDWASHING STATION NOT OBSERVED AT FACILITY 2 (SKIP TO F18)	
F17B	OBSERVATION ONLY: OBSERVE PRESENCE OF WATER AT THE HANDWASHING STATION AT THE TOILET FACILITY.	WATER IS AVAILABLE ..... 1 WATER IS NOT AVAILABLE 2	
F17C	OBSERVATION ONLY: OBSERVE PRESENCE OF SOAP, DETERGENT, OR OTHER CLEANSING AGENT AT THE HANDWASHING STATION AT THE TOILET FACILITY.	SOAP OR DETERGENT (BAR, LIQUID, POWDER, PASTE) ..... 1 ASH, MUD, SAND ..... 2 NONE 3	
F18	INSERT TIME MODULE FINISHED	HOUR [ ] MINUTE [ ]	→ **GO TO MODULE G**

Module G. Agriculture (All Farmers)

NO.	QUESTIONS AND FILTERS	FIRST FARMER NAME ________	SECOND FARMER NAME ________	THIRD FARMER NAME ________
G00	INSERT TIME MODULE STARTED	HOUR [ ][ ]	MINUTE [ ][ ]	
G01	HOUSEHOLD NUMBER AND EA CODE	HH [ ][ ]	EA [ ][ ][ ]	
	REGISTER NAME, SEX AND LINE NUMBER FROM THE HOUSEHOLD ROSTER FOR THE FIRST FARMER. START WITH QUESTION G04 FOR THE FIRST FARMER. IF THERE IS MORE THAN ONE FARMER IN THE HOUSEHOLD THEN ADD ADDITIONAL FARMERS AS NEEDED. QUESTIONS G03B-G03D ARE ONLY USED IF THE FARMER IS ABSENT AFTER THREE TRIES AND THERE IS SOMEONE IN THE HOUSEHOLD THAT IS KNOWLEDGABLE ABOUT THE FARMING ACTIVITIES THAT CAN BE SUBSTITUTED.			
G02	FARMER'S SEX FROM THE ROSTER	MALE .... 1 FEMALE 2	MALE .... 1 FEMALE 2	MALE .... 1 FEMALE 2
G03	LINE NUMBER FORM THE HOUSEHOLD ROSTER	LINE NUMBER..... [ ][ ]	LINE NUMBER..... [ ][ ]	LINE NUMBER..... [ ][ ]
G03A	IS THIS RESPONDENT A RESPONSIBLE ADULT WHO IS BEING INTERVIEWED ABOUT A FARMER	YES .... 1 NO .... 2 (SKIP TO **G04**)	YES .... 1 NO . ... 2 (SKIP TO **G04**)	YES .... 1 NO .... 2 (SKIP TO **G04**)
G03B	RESPONDENT'S LINE NUMBER FROM THE HOUSEHOLD ROSTER	LINE NUMBER..... [ ][ ]	LINE NUMBER..... [ ][ ]	LINE NUMBER..... [ ][ ]
G03C	RESPONDENT'S SEX FROM THE ROSTER	MALE .... 1 FEMALE 2	MALE .... 1 FEMALE 2	MALE .... 1 FEMALE 2
G03D	**INSTRUCTION TO RESPONDENT WHEN THE FARMER IS ABSENT:** I want to know about all farming activities in this household. Because [NAME OF ABSENT FARMER] is absent, please answer these questions about [HIS/HER] farming.			
G04	Do you have access to a plot of land (even if very small) over which you make decisions about what will be grown, OR how it will be grown, OR how to dispose of the harvest? INCLUDES PLOTS OF LAND ALLOCATED TO FARMERS FOR GROWING CROPS BUT NOT OWNED.	YES .... 1 NO .... 2 DON'T KNOW 8	YES .... 1 NO . ... 2 DON'T KNOW 8	YES .... 1 NO .... 2 DON'T KNOW 8
G05	Do you have animals and/or aquaculture products over which you make decisions about their management OR how to dispose of the production?	YES .... 1 NO .... 2 DON'T KNOW 8	YES .... 1 NO . ... 2 DON'T KNOW 8	YES .... 1 NO .... 2 DON'T KNOW 8
G06	CHECK ANSWERS TO QUESTIONS **G04** AND **G05.** DO THE ANSWERS TO QUESTIONS G04 AND G05 INCLUDE AT LEAST ONE "YES"?	YES .... 1 NO .... 2 (SKIP TO G02 FOR NEXT FARMER OR GO TO G25 IF NO MORE FARMERS)	YES .... 1 NO . ... 2 (SKIP TO G02 FOR NEXT FARMER OR GO TO G25 IF NO MORE FARMERS)	YES .... 1 NO .... 2 (SKIP TO G02 FOR NEXT FARMER OR GO TO G25 IF NO MORE FARMERS)
	FINANCIAL SERVICES			
G07	Did you take any agricultural credit, in cash or in kind, in the [PAST 12 MONTHS] from any of the following? READ LIST. CIRCLE ALL THAT APPLY MFI=MICRO FINANCE INSTITUTION IF NO AGRICULTURAL CREDIT TAKEN THEN CIRCLY 97	Agro-dealers 1 Contract farming 2 Village savings groups 3 Farmers associations 4 MFI 5 Private institution 6 Government institution 7 Non-cash loans 8 Input from buyers 9 Other ________ 96 Specify Did not take any agricultural credit 97	Agro-dealers 1 Contract farming 2 Village savings groups 3 Farmers associations 4 MFI 5 Private institution 6 Government institution 7 Non-cash loans 8 Input from buyers 9 Other ________ 96 Specify Did not take any agricultural credit 97	Agro-dealers 1 Contract farming 2 Village savings groups 3 Farmers associations 4 MFI 5 Private institution 6 Government institution 7 Non-cash loans 8 Input from buyers 9 Other ________ 96 Specify Did not take any agricultural credit 97

Module G. Agriculture (All Farmers)

NO.	QUESTIONS AND FILTERS	FIRST FARMER NAME _____	SECOND FARMER NAME _____	THIRD FARMER NAME _____
G08	Did you save any cash through any of the following formal institutions in the [PAST 12 MONTHS]? READ LIST. CIRCLE ALL THAT APPLY. IF NO SAVINGS THEN CIRCLY 97	Village savings and loan 1 MFI . . . . . 2 Cooperative . . . . . 3 ECO CASH/SAVE 4 Mobile banking 5 Other _____ 96 Specify Did not save any cash 97	Village savings and loan 1 MFI . . . . . 2 Cooperative . . . . . 3 ECO CASH/SAVE 4 Mobile banking 5 Other _____ 96 Specify Did not save any cash 97	Village savings and loan 1 MFI . . . . . 2 Cooperative . . . . . 3 ECO CASH/SAVE 4 Mobile banking 5 Other _____ 96 Specify Did not save any cash 97
G09	Some people insure their agricultural production against negative unexpected circumstances, such as drought, floods, and pests. Did you have agricultural insurance in the [PAST 12 MONTHS] from any of the following insurance companies?	ECO farmer 1 Hale . . . . . 2 ZIMNAT . . . . . 3 TRISTAR 4 Other _____ 96 Specify Did not have insurance 97	ECO farmer 1 Hale . . . . . 2 ZIMNAT . . . . . 3 TRISTAR 4 Other _____ 96 Specify Did not have insurance 97	ECO farmer 1 Hale . . . . . 2 ZIMNAT . . . . . 3 TRISTAR 4 Other _____ 96 Specify Did not have insurance 97
	Now I want to ask you about farming and livestock practices about which you make decisions. This includes practices about crops, animals and aquaculture products.			
G10	Which of the following activities related to farming and animal husbandry have you practiced or received services for during [PAST 12 MONTHS]? READ EACH ACTIVITY. RECORD RESPONSES IN THE CELL BELOW THE RESPONSE LIST FOR EACH FARMER. IF NONE OF THESE ACTIVITIES WERE PRACTICED, THEN CIRCLE 97.	1 Purchase inputs through agro-dealers and/or community associations 2 Use of mobile financial services 3 Use of financial services other than mobile 4 Use of training and extension services 5 Contract farming 6 Use of feed lots or pen feeding 7 Drying produce 8 Processing produce 9 Trading or marketing produce through agro-dealers and/or community associations 10 Use of formal marketing systems for livestock 97 DID NOT PRACTICE ANY OF THESE ACTIVITIES IN PAST 12 MONTHS		
	CIRCLE ALL ACTIVITIES STATED.	1 2 3 4 5 6 7 8 9 10 97	1 2 3 4 5 6 7 8 9 10 97	1 2 3 4 5 6 7 8 9 10 97
G11	REFER TO G04 TO DETERMINE WHETHER THE RESPONDENT HAS ACCESS TO A PLOT OF LAND OVER WHICH HE/SHE MAKES DECISIONS.	"YES" CIRCLED / NO CIRCLED (SKIP TO **G14**)	"YES" CIRCLED / NO CIRCLED (SKIP TO **G14**)	"YES" CIRCLED / NO CIRCLED (SKIP TO **G14**)
G12	In the past 12 months, did you plant any crops in the plot(s) over which you make decisions?	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G14**) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G14**) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G14**) DON'T KNOW 8
G13	What crops did you plant during the [PAST 12 MONTHS] in the plot(s) over which you make decisions. REGISTER ALL CROPS NAMED BY	SORGHUM ..... 1 MILLET ... . 2 COW PEAS ..... 3 GROUNDNUTS ..... 4 MAIZE . . . . . 5 WHEAT . . . . . 6 OTHER _____ 7 (SPECIFY) OTHER _____ 8 (SPECIFY)	SORGHUM ..... 1 MILLET ... . 2 COW PEAS ..... 3 GROUNDNUTS ..... 4 MAIZE . . . . . 5 WHEAT . . . . . 6 OTHER 1 _____ 7 (SPECIFY) OTHER 2 _____ 8 (SPECIFY)	SORGHUM ..... 1 MILLET ... . 2 COW PEAS ..... 3 GROUNDNUTS ..... 4 MAIZE . . . . . 5 WHEAT . . . . . 6 OTHER 1 _____ 7 (SPECIFY) OTHER 2 _____ 8 (SPECIFY)

Module G. Agriculture (All Farmers)

NO.	QUESTIONS AND FILTERS	FIRST FARMER NAME _____	SECOND FARMER NAME _____	THIRD FARMER NAME _____
G13A	For the crops (including vegetables) that you planted, did you use any of these practices in the [PAST 12 MONTHS]? READ EACH PRACTICE. RECORD RESPONSES IN THE CELL BELOW THE RESPONSE LIST FOR EACH FARMER. DO NOT CIRCLE THE CODE IN THE RESPONSE LIST. IF NONE OF THESE PRACTICES WERE USED, THEN CIRCLE 97.	1. Micro dosing 2. Manure 3. Compost 4. Planting basins 5. Mulching 6. Weed control 7. Dry planting 8. Ripping into residues 9. Clean ripping 10. Tied ridges 11. Pot-holing 12. Crop rotations 13. Intercropping 14. Integrated Pest Management (IPM) 15. Early planting or planting with first rains 16. Use of improved crop varieties 17. Dead level contours 18. Ridging 97. DID NOT USE ANY OF THESE PRACTICES IN PAST 12 MONTHS		
	CIRCLE ALL PRACTICES STATED.	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 97	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 97	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 97
G13B1	Did you plant sorghum during the [PAST 12 MONTHS]?	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G13B3**) ←	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G13B3**) ←	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G13B3**) ←
G13B2	What was the origin of the sorghum seeds that you planted during the [PAST 12 MONTHS]? MULTIPLE ANSWERS ARE POSSIBLE. CIRCLE ALL THAT APPLY.	BOUGHT AT MARKET.... 01 FROM NGO..... 02 FROM GOVERNMENT..... 03 AGRI-DEALER..... 04 SAVED FROM LAST HARVEST..... 05 BORROWED FROM FRIENDS/FAMILY.....06 OTHER _____ 96 SPECIFY DON'T KNOW..... 98	BOUGHT AT MARKET.... 01 FROM NGO..... 02 FROM GOVERNMENT..... 03 AGRI-DEALER..... 04 SAVED FROM LAST HARVEST..... 05 BORROWED FROM FRIENDS/FAMILY.....06 OTHER _____ 96 SPECIFY DON'T KNOW..... 98	BOUGHT AT MARKET... 01 FROM NGO.....02 FROM GOVERNMENT....03 AGRI-DEALER..... 04 SAVED FROM LAST HARVEST..... 05 BORROWED FROM FRIENDS/FAMILY..... 06 OTHER _____ 96 SPECIFY DON'T KNOW..... 98
G13B3	Did you harvest sorghum during the [PAST 12 MONTHS]?	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G13C1**) ←	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G13C1**) ←	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G13C1**) ←
G13B4	What portion of the sorghum that you harvested was consumed? RECORD WHOLE NUMBERS	☐☐☐ PERCENT DON'T KNOW.....999	☐☐☐ PERCENT DON'T KNOW.....999	☐☐☐ PERCENT DON'T KNOW.....999
G13B5	What portion of the sorghum that you harvested was used for livestock feed? RECORD WHOLE NUMBERS	☐☐☐ PERCENT DON'T KNOW.....999	☐☐☐ PERCENT DON'T KNOW.....999	☐☐☐ PERCENT DON'T KNOW.....999
G13B6	What portion of the sorghum that you harvested was sold? RECORD WHOLE NUMBERS	☐☐☐ PERCENT DON'T KNOW.....999	☐☐☐ PERCENT DON'T KNOW.....999	☐☐☐ PERCENT DON'T KNOW.....999
G13B7	To whom did you sell the sorghum? RECORD THE TYPES OF BUYERS	1. _____ 2._____ DON'T KNOW.....8	1. _____ 2._____ DON'T KNOW.....8	1. _____ 2._____ DON'T KNOW.....8
G13C1	Did you plant groundnuts during the [PAST 12 MONTHS]??	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G13C3**) ←	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G13C3**) ←	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G13C3**) ←

Module G. Agriculture (All Farmers)

NO.	QUESTIONS AND FILTERS	FIRST FARMER NAME _____	SECOND FARMER NAME _____	THIRD FARMER NAME _____
G13C2	What was the origin of the groundnut seeds that you planted during the [PAST 12 MONTHS]? MULTIPLE ANSWERS ARE POSSIBLE. CIRCLE ALL THAT APPLY.	BOUGHT AT MARKET.... 01 FROM NGO..... 02 FROM GOVERNMENT..... 03 AGRI-DEALER..... 04 SAVED FROM LAST HARVEST..... 05 BORROWED FROM FRIENDS/FAMILY.....06 OTHER _____ 96 SPECIFY DON'T KNOW..... 98	BOUGHT AT MARKET.... 01 FROM NGO..... 02 FROM GOVERNMENT..... 03 AGRI-DEALER..... 04 SAVED FROM LAST HARVEST..... 05 BORROWED FROM FRIENDS/FAMILY.....06 OTHER _____ 96 SPECIFY DON'T KNOW..... 98	BOUGHT AT MARKET... 01 FROM NGO.....02 FROM GOVERNMENT....03 AGRI-DEALER..... 04 SAVED FROM LAST HARVEST..... 05 BORROWED FROM FRIENDS/FAMILY..... 06 OTHER _____ 96 SPECIFY DON'T KNOW..... 98
G13C3	Did you harvest the groundnuts during the [PAST 12 MONTHS]?	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G14**)	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G14**)	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G14**)
G13C4	What portion of the groundnuts that you harvested was consumed? RECORD WHOLE NUMBERS	☐☐☐ PERCENT DON'T KNOW.....999	☐☐☐ PERCENT DON'T KNOW.....999	☐☐☐ PERCENT DON'T KNOW.....999
G13C5	What portion of the groundnuts that you harvested was sold? RECORD WHOLE NUMBERS	☐☐☐ PERCENT DON'T KNOW.....999	☐☐☐ PERCENT DON'T KNOW.....999	☐☐☐ PERCENT DON'T KNOW.....999
G13C6	To whom did you sell the groundnuts? RECORD THE TYPES OF BUYERS	1. _____ 2._____ DON'T KNOW.....8	1. _____ 2._____ DON'T KNOW.....8	1. _____ 2._____ DON'T KNOW.....8
G14	**CHECK G05:** DETERMINE WHETHER THE RESPONDENT HAS ANY ANIMALS OR AQUACULTURAL PRODUCTS OVER WHICH HE/SHE MAKES DECISIONS	☐ CODE "YES" CIRCLED CODE "NO" CIRCLED ☐ (SKIP TO **G18**)	☐ CODE "YES" CIRCLED CODE "NO" CIRCLED ☐ (SKIP TO **G18**)	☐ CODE "YES" CIRCLED CODE "NO" CIRCLED ☐ (SKIP TO **G18**)
G15	What livestock did you raise/care for and make decisions about during the [PAST 12 MONTHS]? REGISTER THE NAME OF ALL ANIMAL SPECIES (INCLUDING FISH) LISTED BY THE RESPONDENT	CATTLE . . . . . 1 GOATS . . . . . 2 SHEEP . . . . . 3 DONKEYS . . . . . 4 PIGS . . . . . 5 CHICKEN . . . . . 6 RABBITS . . . . . 7 TURKEYS . . . . . 8 GUINEA FOWL . . . . . 9 DUCKS . . . . . 10 FISH . . . . . 11 PIGEONS ..... 12 OTHER 1 _____ 13 (SPECIFY) OTHER 2 _____ 14 (SPECIFY)	CATTLE . . . . . 1 GOATS . . . . . 2 SHEEP . . . . . 3 DONKEYS . . . . . 4 PIGS . . . . . 5 CHICKEN . . . . . 6 RABBITS . . . . . 7 TURKEYS . . . . . 8 GUINEA FOWL . . . 9 DUCKS . . . . . 10 FISH . . . . . 11 PIGEONS ..... 12 OTHER 1 _____ 13 (SPECIFY) OTHER 2 _____ 14 (SPECIFY)	CATTLE . . . . . 1 GOATS . . . . . 2 SHEEP . . . . . 3 DONKEYS . . . . . 4 PIGS . . . . . 5 CHICKEN . . . . . 6 RABBITS . . . . . 7 TURKEYS . . . . . 8 GUINEA FOWL . . . 9 DUCKS . . . . . 10 FISH . . . . . 11 PIGEONS ..... 12 OTHER 1 _____ 13 (SPECIFY) OTHER 2 _____ 14 (SPECIFY)

Module G. Agriculture (All Farmers)

NO.	QUESTIONS AND FILTERS	FIRST FARMER NAME ________	SECOND FARMER NAME ________	THIRD FARMER NAME ________
G16	Did you use any of the following practices when you cared for the livestock during the [PAST 12 MONTHS]? READ EACH PRACTICE. RECORD RESPONSES IN THE CELL BELOW THE RESPONSE LIST FOR EACH FARMER. DO NOT CIRCLE THE CODE IN THE RESPONSE LIST. IF NONE OF THESE PRACTICES WERE USED, THEN CIRCLE 97.	1. Improved Animal shelters 2. Vaccinations 3. Deworming 4. Castration 5. Dehorning 6. Homemade animal feeds made of locally available products 7. Animal feed supplied by stockfeed manufacturer 8. Artificial insemination 9. Pen feeding 10. Fodder production and/or veld reinforcement with legumes 11.Used the services of community animal health workers/paravets 97. DID NOT PRACTICE ANY OF THESE ACTIVITIES IN PAST 12 MONTHS		
	CIRCLE ALL PRACTICES STATED.	1 2 3 4 5 6 7 8 9 10 11 97	1 2 3 4 5 6 7 8 9 10 11 97	1 2 3 4 5 6 7 8 9 10 11 97
G17	If you purchased drugs or medicines to give to livestock during the past 12 months, where did you primarily purchase the drugs? IF DRUGS OR MEDICINES WERE NOT PURCHASED, THEN CIRCLE 9. CIRCLE ONLY ONE RESPONSE	VETERINARIAN . . . . 1 COMMUNITY ANIMAL HEALTH WORKER. . 2 AGRI-DEALER. . . . . . 3 OTHER ________ 8 SPECIFY DID NOT PURCHASE DRUGS/MEDICINES 9	VETERINARIAN . . . . 1 COMMUNITY ANIMAL HEALTH WORKER. . 2 AGRI-DEALER. . . . . . 3 OTHER ________ 8 SPECIFY DID NOT PURCHASE DRUGS/MEDICINES 9	VETERINARIAN . . . . 1 COMMUNITY ANIMAL HEALTH WORKER. . 2 AGRI-DEALER. . . . . . 3 OTHER ________ 8 SPECIFY DID NOT PURCHASE DRUGS/MEDICINES 9
G18	Did you use any of the following natural resources management practices or techniques that were not related directly to your on-farm production during the [PAST 12 MONTHS]? READ EACH PRACTICE. RECORD RESPONSES IN THE CELL BELOW THE RESPONSE LIST FOR EACH FARMER. IF NONE OF THESE PRACTICES WERE USED, THEN CIRCLE 97.	1. Management or protection of watersheds or water catchments 2. Agro-forestry 3. Management of forest plantation 4. Regeneration of natural landscapes 5. Sustainable harvesting of forest products 97. DID NOT PRACTICE ANY OF THESE ACTIVITIES FOR THE PAST 12 MONTHS		
	CIRCLE ALL PRACTICES STATED.	1 2 3 4 5 97	1 2 3 4 5 97	1 2 3 4 5 97
G19	CHECK **G04:** DETERMINE WHETHER THE RESPONDENT HAS ACCESS TO A PLOT OF LAND OVER WHICH HE/SHE MAKES DECISIONS.	CODE "YES" CIRCLED ☐ CODE "NO" CIRCLED ☐ (SKIP TO G24)	CODE "YES" CIRCLED ☐ CODE "NO" CIRCLED ☐ (SKIP TO G24)	CODE "YES" CIRCLED ☐ CODE "NO" CIRCLED ☐ (SKIP TO G24)
G20	During [THE LAST 12 MONTHS], did you store sorghum from the plot(s) over which you make decisions?	YES . . . . 1 NO . . . . 2 (SKIP TO **G22)** DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO **G22)** DON'T KNOW 8	YES . . . . 1 NO . . . . 2 (SKIP TO **G22)** DON'T KNOW 8
G21	Did you use any of the following methods to store the sorghum? MULTIPLE RESPONSES POSSIBLE. READ EACH METHOD AND CIRCLE ALL THAT APPLY. IF NONE OF THESE METHODS WERE USED, THEN CIRCLE 97.	Hermetic storage… 01 Improved granary 02 Warehousing or cereal banks 03 Use of traps 04 Grain bag with pesticides 05 Did not use any of These methods 97	Hermetic storage… 01 Improved granary 02 Warehousing or cereal banks 03 Use of traps 04 Grain bag with pesticides 5 Did not use any of These methods 97	Hermetic storage… 01 Improved granary 02 Warehousing or cereal banks 03 Use of traps 04 Grain bag with pesticides 5 Did not use any of These methods 97

Module G. Agriculture (All Farmers)

NO.	QUESTIONS AND FILTERS	FIRST FARMER NAME _____	SECOND FARMER NAME _____	THIRD FARMER NAME _____
G22	During [THE LAST 12 MONTHS], did you store groundnuts from the plot(s) over which you make decisions?	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G24)** ← DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G24)** ← DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO **G24)** ← DON'T KNOW 8
G23	Did you use any of the following methods to store the groundnuts? MULTIPLE RESPONSES POSSIBLE. READ EACH METHOD AND CIRCLE ALL THAT APPLY. IF NONE OF THESE METHODS WERE USED, THEN CIRCLE 97.	Hermetic storage… 01 Improved granary 02 Warehousing or cereal banks 03 Use of traps 04 Grain bag with pesticides 05 Did not use any of These methods 97	Hermetic storage… 01 Improved granary 02 Warehousing or cereal banks 03 Use of traps 04 Grain bag with pesticides 05 Did not use any of These methods 97	Hermetic storage… 01 Improved granary 02 Warehousing or cereal banks 03 Use of traps 04 Grain bag with pesticides 05 Did not use any of These methods 97
G24	THERE ARE NO MORE QUESTIONS FOR THIS FARMER.	GO TO **G02** FOR ANOTHER FARMER. IF THERE ARE NO MORE FARMERS, GO TO G25.	GO TO **G02** FOR ANOTHER FARMER. IF THERE ARE NO MORE FARMERS, GO TO G25.	GO TO **G02** FOR ANOTHER FARMER. IF THERE ARE NO MORE FARMERS, GO TO G25.
G25	INSERT TIME MODULE ENDED	HOUR ☐☐	MINUTE ☐☐	→ **GO TO MODULE C**

Module C. Food Access

(Person in charge of food preparation in last 7 days, or adult who ate in the household in last 7 days)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
C00	INSERT TIME MODULE STARTED	HOUR ☐☐ MINUTE ☐☐
C01	HOUSEHOLD NUMBER AND EA CODE	HH ☐☐ EA ☐☐☐
C02	LINE NUMBER FROM MODULE B (COLUMN 6) OF THE PERSON IN CHARGE OF FOOD PREPARATION IN THE PAST 7 DAYS OR A RESPONSIBLE ADULT WHO WAS PRESENT AND ATE IN THE HOUSEHOLD DURING THE PAST 7 DAYS	LINE NUMBER ☐☐

FCS and HDDS QUESTIONS

Now I would like to ask you about the types of foods that you or the majority of household members ate during the past 7 days. I will read each of the food items and then ask you a few questions about each item.

READ EACH QUESTION INSERTING THE NAME OF THE FOOD ITEM LISTED IN QUESTIONS C03 TO C25 AND RECORD THE RESPONSE IN THE BOXES PROVIDED. NOTE THAT FOR COLUMN 3, WE ARE ASKING IF THE FOOD WAS EATEN ***INSIDE THE HOME YESTERDAY***.

1. How many days did you or members of your household eat ….. during the past 7 days both inside and outside your home?

1= 1 day
2= 2 days
3= 3 days
4= 4 days
5= 5 days
6= 6 days
7= 7 days
9= Not consumed

2. What was the primary source from which ….. was obtained?

1= Own Production
2= Purchases (cash or barter)
3= Remittance from **outside** Zim
4= Remittances from **within** Zim
5= Government Food Assistance (In kind, cash, or vouchers)
6= Grain loan Scheme
7= Non State Agencies Food Assistance (In cash or kind)
8= Gifts(non-relative well wishers)
9= Labour exchange
10= Borrowed
11= Hunting and gathering from wild
12=Gleaning
13 = Not consumed

3. Did you or a member of your household eat ….. inside your home yesterday?

1= YES
2= NO

		1. How many days did you or members of your household eat ….. during the past 7 days both inside and outside your home?	2. What was the primary source from which ….. was obtained?	3. Did you or a member of your household eat ….. inside your home yesterday? (Y=1, N=2)
C03	Sadza, maize or mealie-meal porridge (mahewu) or gruel, samp, bread, rice, sorghum, millet, finger millet (Zviyo, Uphoko), barley, bulgar wheat, pasta, noodles or other foods made from cereals/grains?	C03.1 ☐	C03.2 ☐☐	C03.3 ☐
C04	Cassava, potatoes,sweet potatoes, yams, tsenza or any other foods made from roots, plantains?	C04.1 ☐	C04.2 ☐☐	C04.3 ☐
C05	Any vegetables (leaves, root)? Such as carrots, pumpkin leaves, traditional/indigenous vegetables, okra, pumpkin, squash, gordes (Mapudzi/Amakhomane), mushrooms	C05.1 ☐	C05.2 ☐☐	C05.3 ☐
C06	Any fruits? Including traditional/indigenous fruits, watermelon, baobaba	C06.1 ☐	C06.2 ☐☐	C06.3 ☐
C07	Any meat? Beef, pork, lamb, goat, rabbit, wild game, chicken, duck, or other birds, liver, kidney, heart, or other organ meats or blood, edible insects (mopane worms), mice, harurwa, mandera, frog (dzetse), lizard (mpurwa/hukurutombo)?	C07.1 ☐	C07.2 ☐☐	C07.3 ☐
C08	Any eggs? (chicken, turkey, fowl, duck)	C08.1 ☐	C08.2 ☐☐	C08.3 ☐
C09	Any fresh or dried fish/Kapenta, dried shellfish, crabs?	C09.1 ☐	C09.2 ☐☐	C09.3 ☐
C10	Any foods made from beans, peas, lentils, cowpeas, pigeon peas, groundnuts, cashew nuts?	C10.1 ☐	C10.2 ☐☐	C10.3 ☐
C11	Any cheese, yogurt, milk, sour milk or other dairy products?	C11.1 ☐	C11.2 ☐☐	C11.3 ☐
C12	Any foods made with oil, fat, animal fat, lard or butter, peanut butter?	C12.1 ☐	C12.2 ☐☐	C12.3 ☐
C13	Any sugar or honey, sugar cane, sweet reed?	C13.1 ☐	C13.2 ☐☐	C13.3 ☐
C14	Any other foods, such as tomato sauce or condiments, spices, coffee, or tea?	C14.1 ☐	C14.2 ☐☐	C14.3 ☐
C15	Was yesterday an unusual or special day (Festival, Funeral, etc.) or were most household members absent?	YES . . . . . 1 NO 2		

Module C. Food Access

(Person in charge of food preparation in last 7 days, or adult who ate in the household in last 7 days)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	
C16	In the past **[4 WEEKS/30DAYS]** was there ever no food to eat of any kind in your house because of lack of resources to get food?	YES . . . . . 1 NO 2	→ C18
C17	How often did this happen in the past **[4 WEEKS/30 DAYS]**? READ OPTIONS.	RARELY (1-2 TIMES)……..1 SOMETIMES (3-10 TIMES)……..2 OFTEN (MORE THAN 10)……3	
C18	In the past **[4 WEEKS/30 DAYS]** did you or any household member go to sleep at night hungry because there was not enough food?	YES . . . . . 1 NO 2	→ C20
C19	How often did this happen in the past **[4 WEEKS/30 DAYS]**?	RARELY (1-2 TIMES)……..1 SOMETIMES (3-10 TIMES)……..2 OFTEN (MORE THAN 10)……3	
C20	In the past **[4 WEEKS/30 DAYS]** did you or any household member go a whole day and night without eating anything at all because there was not enough food?	YES . . . . . 1 NO 2	→ C22
C21	How often did this happen in the past **[4 WEEKS/30 DAYS]**?	RARELY (1-2 TIMES)……..1 SOMETIMES (3-10 TIMES)……..2 OFTEN (MORE THAN 10)……3	
C22	Now I am going to ask you about strategies that your household may have used to deal with difficulties accessing food in the past 30 days. I will read the strategy that you may have used to deal with problems accessing food and then ask you to tell me how many times you may have used the strategy during the past 30 days.		
C23	Skip entire days without eating?	NEVER ..... 1 SELDOM (1-3 DAYS PER MONTH) ... 2 SOMETIMES (1-2 DAYS PER WEEK) ... 3 OFTEN (3-6 DAYS PER WEEK) .... 4 DAILY 5	
C24	Limit portion size at mealtimes?	NEVER ..... 1 SELDOM (1-3 DAYS PER MONTH) ... 2 SOMETIMES (1-2 DAYS PER WEEK) ... 3 OFTEN (3-6 DAYS PER WEEK) .... 4 DAILY 5	
C25	Reduce number of meals eaten per day?	NEVER ..... 1 SELDOM (1-3 DAYS PER MONTH) ... 2 SOMETIMES (1-2 DAYS PER WEEK) ... 3 OFTEN (3-6 DAYS PER WEEK) .... 4 DAILY 5	
C26	Borrow food or rely on help from friends or relatives?	NEVER ..... 1 SELDOM (1-3 DAYS PER MONTH) ... 2 SOMETIMES (1-2 DAYS PER WEEK) ... 3 OFTEN (3-6 DAYS PER WEEK) .... 4 DAILY 5	
C27	Rely on less expensive or less preferred foods?	NEVER ..... 1 SELDOM (1-3 DAYS PER MONTH) ... 2 SOMETIMES (1-2 DAYS PER WEEK) ... 3 OFTEN (3-6 DAYS PER WEEK) .... 4 DAILY 5	
C28	Purchase/borrow food on credit?	NEVER ..... 1 SELDOM (1-3 DAYS PER MONTH) ... 2 SOMETIMES (1-2 DAYS PER WEEK) ... 3 OFTEN (3-6 DAYS PER WEEK) .... 4 DAILY 5	
C29	Harvest immature crops?	NEVER ..... 1 SELDOM (1-3 DAYS PER MONTH) ... 2 SOMETIMES (1-2 DAYS PER WEEK) ... 3 OFTEN (3-6 DAYS PER WEEK) .... 4 DAILY 5	
C30	Send household members to eat elsewhere?	NEVER ..... 1 SELDOM (1-3 DAYS PER MONTH) ... 2 SOMETIMES (1-2 DAYS PER WEEK) ... 3 OFTEN (3-6 DAYS PER WEEK) .... 4 DAILY 5	

Module C. Food Access

(Person in charge of food preparation in last 7 days, or adult who ate in the household in last 7 days)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	
C31	Send household members to beg?	NEVER ..... 1 SELDOM (1-3 DAYS PER MONTH) ... 2 SOMETIMES (1-2 DAYS PER WEEK) ... 3 OFTEN (3-6 DAYS PER WEEK) .... 4 DAILY 5	
C32	Reduce adult consumption so children can eat?	NEVER ..... 1 SELDOM (1-3 DAYS PER MONTH) ... 2 SOMETIMES (1-2 DAYS PER WEEK) ... 3 OFTEN (3-6 DAYS PER WEEK) .... 4 DAILY 5	
C33	Rely on casual labor for food?	NEVER ..... 1 SELDOM (1-3 DAYS PER MONTH) ... 2 SOMETIMES (1-2 DAYS PER WEEK) ... 3 OFTEN (3-6 DAYS PER WEEK) .... 4 DAILY 5	
C35	**INSERT TIME MODULE ENDED**	HOUR ☐☐ MINUTE ☐☐	→ **GO TO MODULE D**

Module D1. Children's Nutritional Status and Feeding Practices (Primary Caregivers)

NO.	QUESTIONS AND FILTERS	FIRST ELIGIBLE CHILD FROM ROSTER NAME _____	SECOND ELIGIBLE CHILD FROM ROSTER NAME _____	THIRD ELIBIBLE CHILD FROM ROSTER NAME _____
D00	INSERT TIME MODULE STARTED	HOUR [ ][ ]	MINUTE [ ][ ]	
D01	HOUSEHOLD NUMBER AND EA CODE	HH [ ][ ]	EA [ ][ ][ ]	
D02	CAREGIVER'S LINE NUMBER FROM THE HOUSEHOLD ROSTER (COLUMN 8)	LINE NO. CAREGIVER [ ][ ]	LINE NO. CAREGIVER [ ][ ]	LINE NO. CAREGIVER [ ][ ]
D03	CHILD'S LINE NUMBER FROM THE HOUSEHOLD ROSTER (COLUMN 1)	LINE NO. CHILD [ ][ ]	LINE NO. CHILD [ ][ ]	LINE NO. CHILD [ ][ ]
D04	What is [CHILD NAME]'s sex?	MALE . . . . . 1 FEMALE 2	MALE . . . . . 1 FEMALE 2	MALE . . . . . 1 FEMALE 2
D05	I would like to ask you some questions about [CHILD'S NAME]. Does [CHILD'S NAME] have a health/vaccination card or other document with the birth date recorded? IF A DOCUMENT WITH THE BIRTHDATE IS SHOWN AND THE RESPONDENT CONFIRMS THE INFORMATION IS CORRECT, RECORD THE DATE AS DOCUMENTED AND USE THE BIRTH CONVERSION TABLE TO FILL IN THE AGE IN MONTHS IN D07. THEN SKIP TO QUESTION D14. IF A DOCUMENT WITH THE BIRTHDATE IS NOT SHOWN THEN ASK: In what month and year was [CHILD'S NAME] born? What is [HIS/HER] birthday? RECORD BIRTH DAY, MONTH AND YEAR	DAY . . . . . [ ][ ] MONTH . . . [ ][ ] YEAR [ ][ ][ ][ ]	DAY . . . . . [ ][ ] MONTH . . . [ ][ ] YEAR [ ][ ][ ][ ]	DAY . . . . . [ ][ ] MONTH . . . [ ][ ] YEAR [ ][ ][ ][ ]
D06	How old was [CHILD'S NAME] at [HIS/HER] last birthday? RECORD AGE IN COMPLETED YEARS	YEARS [ ][ ]	YEARS [ ][ ]	YEARS [ ][ ]
D07	How many months old is [CHILD'S NAME]? RECORD AGE IN COMPLETED MONTHS	MONTHS [ ][ ]	MONTHS [ ][ ]	MONTHS [ ][ ]
D08	CHECK D05, D06, AND D07 TO VERIFY CONSISTENCY. A) IS THE YEAR RECORDED IN D05 CONSISTENT WITH THE AGE IN YEARS RECORDED IN D06? B) ARE YEAR AND MONTH OF BIRTH RECORDED IN D05 CONSISTENT WITH AGE IN MONTHS RECORDED IN D07? USE BIRTHDATE CONVERSION TABLE TO CHECK. IF THE ANSWER TO A OR B IS "NO" RESOLVE ANY INCONSISTENCIES.			

Module D1. Children's Nutritional Status and Feeding Practices (Primary Caregivers)

NO.	QUESTIONS AND FILTERS	FIRST ELIGIBLE CHILD FROM ROSTER	SECOND ELIGIBLE CHILD FROM ROSTER	THIRD ELIBIBLE CHILD FROM ROSTER
		NAME _____	NAME _____	NAME _____

Birth Date - 2014	Study Date 2014		
	Mar.	Apr.	May
Jan.	2	3	4
Feb.	1	2	3
Mar.	0	1	2
Apr.	--	0	1
May	--	--	0
June	--	--	--
July	--	--	--
Aug.	--	--	--
Sept.	--	--	--
Oct.	--	--	--
Nov.	--	--	--
Dec.	--	--	--

Birth Date - 2013	Study Date 2014		
	Mar.	Apr.	May
Jan.	14	15	16
Feb.	13	14	15
Mar.	12	13	14
Apr.	11	12	13
May	10	11	12
June	9	10	11
July	8	9	10
Aug.	7	8	9
Sept.	6	7	8
Oct.	5	6	7
Nov.	4	5	6
Dec.	3	4	5

Birth Date - 2012	Study Date 2014		
	Feb.	Mar.	May
Jan.	26	27	28
Feb.	25	26	27
Mar.	24	25	26
Apr.	23	24	25
May	22	23	24
June	21	22	23
July	20	21	22
Aug.	19	20	21
Sept.	18	19	20
Oct.	17	18	19
Nov.	16	17	18
Dec.	15	16	17

Birth Date - 2011	Study Date 2014		
	Mar.	Apr.	May
Jan.	38	39	40
Feb.	37	38	39
Mar.	36	37	38
Apr.	35	36	37
May	34	35	36
June	33	34	35
July	32	33	34
Aug.	31	32	33
Sept.	30	31	32
Oct.	29	30	31
Nov.	28	29	30
Dec.	27	28	29

Birth Date - 2010	Study Date 2014		
	Mar.	Apr.	May
Jan.	50	51	52
Feb.	49	50	51
Mar.	48	49	50
Apr.	47	48	49
May	46	47	48
June	45	46	47
July	44	45	46
Aug.	43	44	45
Sept.	42	43	44
Oct.	41	42	43
Nov.	40	41	42
Dec.	39	40	41

Birth Date - 2009	Study Date 2014		
	Mar.	Apr.	Apr.
Jan.	--	--	--
Feb.	--	--	--
Mar.	**60**	--	--
Apr.	59	**60**	--
May	58	59	**60**
June	57	58	59
July	56	57	58
Aug.	55	56	57
Sept.	54	55	56
Oct.	53	54	55
Nov.	52	53	54
Dec.	51	52	53

INSTRUCTIONS:

1. Check the child's birth year in Question D05 and go to the appropriate table as labeled on the side of each table "Birth Date". Example: If the child is born in 2012, use the table with "Birth Date – 2012" on the side.
2. Using the current month, select the appropriate "Study Date" column. Example: If it is March 2014, use the middle column labeled Mar.
3. Check the child's birth month in Question D05 and cross the appropriate "Study Date" month column with the row of the child's birth month. Example: Today is March 11, 2014 and the child is born on September 27, 2012. Cross the middle column "Mar." with the row "Sept." in the table "Birth Date – 2012".
4. The digit in the cell where the column of the study month and the birth month of the child meet is the child's age in months. For the example above, the child is 18 months old.
5. In converting the child's age in month, subtract 1 when the actual birth DATE (the day of the month) hasn't passed yet. For example, if the child was born on February 27, 2013 and the date of interview is March 17, 2014, the age in month will be 12 months after subtracting 1 from the 13 months shown in the conversion table.

Module D1. Children's Nutritional Status and Feeding Practices (Primary Caregivers)

NO.	QUESTIONS AND FILTERS	FIRST ELIGIBLE CHILD FROM ROSTER NAME _____	SECOND ELIGIBLE CHILD FROM ROSTER NAME _____	THIRD ELIBIBLE CHILD FROM ROSTER NAME _____
D14	CHECK **D07:** IS THE CHILD UNDER 60 MONTHS (5 YEARS)?	YES . . . . . 1 NO . . . . . 2 (GO TO D01 FOR NEXT CHILD OR TO D66 IF NO MORE CHILDREN) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (GO TO D01 FOR NEXT CHILD OR TO D66 IF NO MORE CHILDREN) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (GO TO D01 ON NEW PAGE FOR NEXT CHILD OR TO D66 IF NO MORE CHILDREN) DON'T KNOW 8
D15	CHECK **D07:** IS THE CHILD UNDER 24 MONTHS (2 YEARS)?	YES . . . . . 1 NO . . . . . 2 (SKIP TO D54) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO D54) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO D54) DON'T KNOW 8
D16	Has [CHILD'S NAME] ever been breastfed?	YES . . . . . 1 NO . . . . . 2 (SKIP TO D18) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO D18) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO D18) DON'T KNOW 8
D17	Was [CHILD'S NAME] breastfed yesterday during the day or at night?	YES . . . . . 1 (SKIP TO D19) NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 (SKIP TO D19) NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 (SKIP TO D19) NO . . . . . 2 DON'T KNOW 8
D18	Sometimes babies are breastfed by another woman or given breast milk from another woman by spoon, cup, bottle, or some other way. This can happen if a mother cannot breastfeed her own baby for various reasons, such as the mother is sick or away, mastitis, etc. Did [CHILD'S NAME] consume breast milk in any of these ways yesterday during the day or at night?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D19	Now I would like to ask you about some medicines and vitamins that are sometimes given to infants. Was [CHILD'S NAME] given any vitamin drops or other medicines as drops yesterday during the day or at night?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D20	Was [CHILD'S NAME] given oral rehydration solution yesterday during the day or at night?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
	Next I would like to ask you about some liquids that [CHILD'S NAME] may have had yesterday during the day or at night. Did [CHILD'S NAME] have:			
D21	Plain water?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D22	Any kind of Infant formula? IF THE RESPONDENT IS UNSURE OF WHAT IS MEANT BY "INFANT FORMULA" THEN PROBE WITH BRAND NAMES SUCH AS NANI, SMA, NESTLE, ENFAMIL, ISOMIL, LACTOGEN?	YES . . . . . 1 NO . . . . . 2 (SKIP TO D24) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO D24) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO D24) DON'T KNOW 8
D23	How many times yesterday during the day or at night did [CHILD'S NAME] consume any formula?	TIMES	TIMES	TIMES . . . .

Module D1. Children's Nutritional Status and Feeding Practices (Primary Caregivers)

NO.	QUESTIONS AND FILTERS	FIRST ELIGIBLE CHILD FROM ROSTER NAME _____	SECOND ELIGIBLE CHILD FROM ROSTER NAME _____	THIRD ELIBIBLE CHILD FROM ROSTER NAME _____
D24	Did [CHILD'S NAME] have any milk such as tinned, powdered, or fresh animal milk?	YES . . . . . 1 NO . . . . . 2 (SKIP TO D26) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO D26) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO D26) DON'T KNOW 8
D25	How many times yesterday during the day or at night did [CHILD'S NAME] consume any milk?	TIMES	TIMES	TIMES . . . .
D26	Did [CHILD'S NAME] have any juice or juice drinks, including sodas, cream sodas, Mazoe etc ?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D27	Clear broth?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D28	Yogurt?	YES . . . . . 1 NO . . . . . 2 (SKIP TO D30) DON'T KNOW 8	NO . . . . . 2 (SKIP TO D30) DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 (SKIP TO D30) DON'T KNOW 8
D29	How many times yesterday during the day or at night did [CHILD'S NAME] consume any yogurt?	TIMES	TIMES	TIMES . . . .
D30	Did [CHILD'S NAME] have any thin porridge? PROBES: mahewu, gruel, Gerber, Cerelac, Ace, Nestum, Cerevita, Purity	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D31	Any other liquids? PROBES: Gripe water, glucose water, sugar water?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D32	Next I would like to ask you about foods that [CHILD'S NAME] may have eaten yesterday during the day or at night. Yesterday, during the day and night, did [CHILD'S NAME] eat any (ASK QUESTIONS D33-D48)?			
D33	Bread, biscuits, pastries, doughnut, pasta, noodles, rice, crackersor other foods made from grains such as corn, wheat, millet (Zviyo, Uphoko), sadza, mahewu, mealie-meal, sorghum, bulgar wheat, barley?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D34	Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D35	White potatoes, white yams, cassava, plantains or any other foods made from roots?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D36	Any dark green leafy vegetables such as spinach, pumpkin leaves, ulude/nyevhe, kale, or okra?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D37	Ripe mangoes, ripe papaya, apricots, cantaloupe melons or other fruits that are yellow or orange inside?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D38	Other fruits or vegetables, like bananas, tomatoes, green beans, avocado, etc?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D39	Liver, kidney, heart, or other organ meats?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D40	Any meat, such as beef, pork, lamb, goat, chicken, duck, game meat, birds, mice, frog (dzetse), lizard (mpurwa/hukurutombo)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8

Module D1. Children's Nutritional Status and Feeding Practices (Primary Caregivers)

NO.	QUESTIONS AND FILTERS	FIRST ELIGIBLE CHILD FROM ROSTER NAME _____	SECOND ELIGIBLE CHILD FROM ROSTER NAME _____	THIRD ELIBIBLE CHILD FROM ROSTER NAME _____
D41	Eggs? (chicken, turkey, fowl, duck)	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D42	Fresh or dried fish, shellfish, crabs or seafood?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D43	Any foods made from beans, peas, lentils, walnuts, or other nuts and seeds?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D44	Cheese, yogurt, sour milk or other milk products?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D45	Other oils, fats, butter, peanut butter, or foods made with any of of those products?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D46	Any sugary foods such as chocolates, sweets, sugar cane, sweet reed, candies, pastries, cakes, or biscuits?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D47	Condiments for flavor, such as chilies, spices, herbs, or fish powder?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
D48	Grubs, snails, edible insects, mopane worms?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
	CHECK QUESTIONS **D33-D48**:	"NO" TO ALL → D50 AT LEAST ONE "YES" OR "DK" TO ALL → D51	"NO" TO ALL → D50 AT LEAST ONE "YES" OR "DK" TO ALL → D51	"NO" TO ALL → D50 AT LEAST ONE "YES" OR "DK" TO ALL → D51
D50	Did [CHILD'S NAME] eat any solid, semi-solid, or or soft foods yesterday during the day or at night? IF **"YES"** PROBE: What kind of solid, semi-solid, or soft foods did [CHILD'S NAME] eat?	YES . . . . . 1 GO BACK TO D33-D48 AND RECORD FOODS EATEN. THEN CONTINUE WITH **D51**. NO . . . . . 2 GO TO D52 ← DON'T KNOW 8	YES . . . . . 1 GO BACK TO D33-D48 AND RECORD FOODS EATEN. THEN CONTINUE WITH **D51**. NO . . . . . 2 GO TO D52 ← DON'T KNOW 8	YES . . . . . 1 GO BACK TO D33-D48 AND RECORD FOODS EATEN. THEN CONTINUE WITH **D51**. NO . . . . . 2 GO TO D52 ← DON'T KNOW 8
D51	How many times did [CHILD'S NAME] eat solid, semi-solid, or soft foods other than liquids yesterday during the day or at night?	TIMES . . . . [ ][ ] DON'T KNOW 98	TIMES . . . . [ ][ ] DON'T KNOW 98	TIMES . . . . [ ][ ] DON'T KNOW 98
D52	Did [CHILD'S NAME] drink anything from a bottle with a nipple yesterday during the day or night?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8

Module D2. Children's Diarrhea and Oral Rehydration Therapy (Primary Caregivers)

NO.	QUESTIONS AND FILTERS	FIRST ELIGIBLE CHILD FROM ROSTER NAME ________	SECOND ELIGIBLE CHILD FROM ROSTER NAME ________	THIRD ELIGIBLE CHILD FROM ROSTER NAME ________
D54	Has [CHILD'S NAME] had diarrhea in the last 2 weeks? **(1)** DIARRHEA IS DEFINED AS 3 OR MORE WATERY STOOLS IN A DAY.	YES . . . . 1 NO . . . . 2 **(GO TO D01 FOR NEXT CHILD OR TO D66 IF NO MORE CHILDREN)** DON'T KNOW 8	YES . . . . 1 NO . . . . 2 **(GO TO D01 FOR NEXT CHILD OR TO D66 IF NO MORE CHILDREN)** DON'T KNOW 8	YES . . . . 1 NO . . . . 2 **(GO TO D01 ON NEW PAGE FOR NEXT CHILD OR TO D66 IF NO MORE CHILDREN)** DON'T KNOW 8
D55	Was there any blood in the stools?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	YES . . . . 1 NO . . . . 2 DON'T KNOW 8
D56	Now I would like to know how much [CHILD'S NAME] was given to drink during the period that [HE/SHE] had diarrhea (including breastmilk). Was he/she given less than usual to drink, about the same amount, or more than usual to drink? IF LESS, PROBE: Was he/she given much less than usual to drink or somewhat less?	MUCH LESS . . . . . . 1 SOMEWHAT LESS...... 2 ABOUT THE SAME .... 3 MORE . . . . 4 NOTHING TO DRINK..... 5 DON'T KNOW 8	MUCH LESS . . . . . . 1 SOMEWHAT LESS...... 2 ABOUT THE SAME .... 3 MORE . . . . 4 NOTHING TO DRINK..... 5 DON'T KNOW 8	MUCH LESS . . . . . . 1 SOMEWHAT LESS...... 2 ABOUT THE SAME .... 3 MORE . . . . 4 NOTHING TO DRINK..... 5 DON'T KNOW 8
D57	When [CHILD'S NAME] had diarrhea, was he/she given less than usual to eat, about the same amount, more than usual, or nothing to eat? IF LESS, PROBE: Was he/she given much less than usual to eat or somewhat less?	MUCH LESS . . . . . . 1 SOMEWHAT LESS....... 2 ABOUT THE SAME...... 3 MORE . . . . 4 STOPPED FOOD......... 5 NEVER GAVE FOOD.... 6 DON'T KNOW 8	MUCH LESS . . . . . . 1 SOMEWHAT LESS....... 2 ABOUT THE SAME...... 3 MORE . . . . 4 STOPPED FOOD......... 5 NEVER GAVE FOOD.... 6 DON'T KNOW 8	MUCH LESS . . . . . . 1 SOMEWHAT LESS....... 2 ABOUT THE SAME...... 3 MORE . . . . 4 STOPPED FOOD......... 5 NEVER GAVE FOOD.... 6 DON'T KNOW 8
D58	Did you seek advice or treatment for the diarrhea from any source?	YES . . . . 1 NO . . . . 2 (SKIP TO D62)	YES . . . . 1 NO . . . . 2 (SKIP TO D62)	YES . . . . 1 NO . . . . 2 (SKIP TO D62)

Module D2. Children's Diarrhea and Oral Rehydration Therapy (Primary Caregivers)

NO.	QUESTIONS AND FILTERS	FIRST ELIGIBLE CHILD FROM ROSTER NAME _____	SECOND ELIGIBLE CHILD FROM ROSTER NAME _____	THIRD ELIGIBLE CHILD FROM ROSTER NAME _____
D59	Where did you seek advice or treatment? Anywhere else? PROBE TO IDENTIFY EACH TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF THE PLACE)	**PUBLIC SECTOR** CENTRAL HOSP 01 PROVINCIAL HOSP 02 DISTRICT HOSP 03 RURAL HOSP 04 RURAL HEALTH CENTER 05 URB MUNCPL CLIN 06 COMMUN/VILLAGE HEALTH WORKER 07 OTHER PUBLIC SECTOR _____ 08 (SPECIFY) **MISSION HOSPITAL** 09 **PRIVATE MEDICAL SECTOR** PVT. HOSPITAL/ CLINIC . . . . . 10 PHARMACY . . . 11 PVT. DOCTOR 12 OTHER PRIVATE MED. SECTOR _____ 13 (SPECIFY) **OTHER SOURCE** SHOP . . . . . 14 TRADITIONAL PRACTITIONER 15 MARKET . . . . . 16 **OTHER** _____ 17 (SPECIFY)	**PUBLIC SECTOR** CENTRAL HOSP 01 PROVINCIAL HOSP 02 DISTRICT HOSP 03 RURAL HOSP 04 RURAL HEALTH CENTER 05 URB MUNCPL CLIN 06 COMMUN/VILLAGE HEALTH WORKER 07 OTHER PUBLIC SECTOR _____ 08 (SPECIFY) **MISSION HOSPITAL** 09 **PRIVATE MEDICAL SECTOR** PVT. HOSPITAL/ CLINIC . . . . . 10 PHARMACY . . . 11 PVT. DOCTOR 12 OTHER PRIVATE MED. SECTOR _____ 13 (SPECIFY) **OTHER SOURCE** SHOP . . . . . 14 TRADITIONAL PRACTITIONER 15 MARKET . . . . . 16 **OTHER** _____ 17 (SPECIFY)	**PUBLIC SECTOR** CENTRAL HOSP 01 PROVINCIAL HOSP 02 DISTRICT HOSP 03 RURAL HOSP 04 RURAL HEALTH CENTER 05 URB MUNCPL CLIN 06 COMMUN/VILLAGE HEALTH WORKER 07 OTHER PUBLIC SECTOR _____ 08 (SPECIFY) **MISSION HOSPITAL** 09 **PRIVATE MEDICAL SECTOR** PVT. HOSPITAL/ CLINIC . . . . . 10 PHARMACY . . . . 11 PVT. DOCTOR 12 OTHER PRIVATE MED. SECTOR _____ 13 (SPECIFY) **OTHER SOURCE** SHOP . . . . . 14 TRADITIONAL PRACTITIONER 15 MARKET . . . . . 16 **OTHER** _____ 17 (SPECIFY)
D60	CHECK **D59**: NUMBER OF CODES CIRCLED.	☐ TWO OR MORE CODES CIRCLED ☐ ONLY ONE CODE CIRCLED (SKIP TO **D62**)	☐ TWO OR MORE CODES CIRCLED ☐ ONLY ONE CODE CIRCLED (SKIP TO **D62**)	☐ TWO OR MORE CODES CIRCLED ☐ ONLY ONE CODE CIRCLED (SKIP TO **D62**)
D61	Where did you first seek advice or treatment? USE NUMBER CODE FROM **D59**.	FIRST PLACE . . . ☐☐	FIRST PLACE . . . ☐☐	FIRST PLACE . . . . ☐☐
D62	Was he/she given any of the following to drink at any time since he/she started having the diarrhea:	YES NO DK	YES NO DK	YES NO DK
	a) An fluid made from a special packet called an ORS sachet ?	FLUID FROM ORS PKT 1 2 8	FLUID FROM ORS PKT 1 2 8	FLUID FROM ORS PKT 1 2 8
	b) A home-made sugar-salt water solution (SSS)?	SSS . . 1 2 8	SSS . . 1 2 8	SSS . . 1 2 8

Module D2. Children's Diarrhea and Oral Rehydration Therapy (Primary Caregivers)

NO.	QUESTIONS AND FILTERS	FIRST ELIGIBLE CHILD FROM ROSTER NAME _____	SECOND ELIGIBLE CHILD FROM ROSTER NAME _____	THIRD ELIGIBLE CHILD FROM ROSTER NAME _____
D63	Was anything (else) given to treat the diarrhea?	YES . . . . . 1 NO . . . . . 2 **(GO TO D01 FOR NEXT CHILD OR TO D66 IF NO MORE CHILDREN)** DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 **(GO TO D01 FOR NEXT CHILD OR TO D66 IF NO MORE CHILDREN)** DON'T KNOW 8	YES . . . . . 1 NO . . . . . 2 **(GO TO D01 ON NEW PAGE FOR NEXT CHILD OR TO D66 IF NO MORE CHILDREN)** DON'T KNOW 8
D64	What (else) was given to treat the diarrhea? Anything else? RECORD ALL TREATMENTS GIVEN.	**PILL OR SYRUP** ANTIBIOTIC . . . . . 01 ANTIMOTILITY . . . . . 02 ZINC . . . . . 03 OTHER (NOT ANTIBIOTIC, ANTIMOTILITY, OR ZINC) . . . . . 04 UNKNOWN PILL OR SYRUP . . . . . 05 **INJECTION** ANTIBIOTIC . . . . . 06 NON-ANTIBIOTIC . . . 07 UNKNOWN INJECTION . . . . . 08 (IV) INTRAVENOUS (DRIPS) . . . . . 09 HOME REMEDY/ HERBAL MEDICINE . 10 OTHER _____ 96 (SPECIFY)	**PILL OR SYRUP** ANTIBIOTIC . . . . . 01 ANTIMOTILITY . . . . . 02 ZINC . . . . . 03 OTHER (NOT ANTIBIOTIC, ANTIMOTILITY, OR ZINC) . . . . . 04 UNKNOWN PILL OR SYRUP . . . . . 05 **INJECTION** ANTIBIOTIC . . . . . 06 NON-ANTIBIOTIC . . . 07 UNKNOWN INJECTION . . . . . 08 (IV) INTRAVENOUS (DRIPS) . . . . . 09 HOME REMEDY/ HERBAL MEDICINE . 10 OTHER _____ 96 (SPECIFY)	**PILL OR SYRUP** ANTIBIOTIC . . . . . 01 ANTIMOTILITY . . . . . 02 ZINC . . . . . 03 OTHER (NOT ANTIBIOTIC, ANTIMOTILITY, OR ZINC) . . . . . 04 UNKNOWN PILL OR SYRUP . . . . . 05 **INJECTION** ANTIBIOTIC . . . . . 06 NON-ANTIBIOTIC . . . . 07 UNKNOWN INJECTION . . . . . 08 (IV) INTRAVENOUS (DRIPS) . . . . . 09 HOME REMEDY/ HERBAL MEDICINE . 10 OTHER _____ 96 (SPECIFY)
D65		GO TO **D01** FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO D66	GO TO **D01** FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO D66	GO TO **D01 ON NEW PAGE** FOR NEXT CHILD OR, IF NO MORE CHILDREN, GO TO D66
D66	INSERT TIME MODULE ENDED	HOUR ☐☐ MINUTE ☐☐ → **GO TO WOMEN'S KISH GRID #1**		

(1) The term(s) used for diarrhea should encompass the expressions used for all forms of diarrhea, including bloody stools (consistent with dysentery), watery stools, etc.

1. KISH GRID for random selection of women ages 15-49 for Module E

INSTRUCTIONS

1. Check Column 9 in the household roster. If there is more than one woman 15-49 then select one using the procedure below.
2. List the name and line number of all women ages 15-49 in the household, in descending order by age (oldest first).
3. Look up the last digit of the household number from Module A and circle the corresponding column number below.
4. Look up where the last digit of the household number (columns) crosses the number of women 15-49 (rows).
5. The digit in the cell where the column and row meet is the number of the woman to interview for Module E.

EXAMPLE: If number of women 15-49 = 3 & last digit of household = 5, select the 2nd woman listed.

Number of Woman 15-49	Line Number from HH	Name	Age	Last digit of the household number (See Module A, A01)									
				1	2	3	4	5	6	7	8	9	0
1				1	1	1	1	1	1	1	1	1	1
2				1	2	1	2	1	2	1	2	1	2
3				1	2	3	1	2	3	1	2	3	3
4				1	2	3	4	1	2	3	4	1	4
5				1	2	3	4	5	1	2	3	4	5
6				1	2	3	4	5	6	4	2	6	1
7				1	2	3	4	5	6	7	1	4	7
8				1	2	3	4	5	6	7	8	4	3
9				1	2	3	4	5	6	7	8	9	2
10				1	2	3	4	5	6	7	8	9	10

"NOTE THAT THE SECOND KISH GRID WILL ONLY BE IMPLEMENTED AFTER MODULE E (E38-E40) AND BEFORE WOMEN'S ANTHROPOMETRY."

2. KISH GRID for random selection of women for Anthropometry

INSTRUCTIONS

1. Check the answer to Question E43 in Module E. If the answer is Yes, then check the names of the women listed in Question E44 and cross them off the Kish Grid above. If there is only one woman left then select that woman. If there is more than one woman left then select one using the procedure below.
2. List all women that have not been crossed off the Kish Grid above in descending order by age (oldest first).
3. Look up the last digit of the household number from Module A and circle the corresponding column number below.
4. Look up where the last digit of the household number (columns) crosses the number of women 15-49 (rows).
5. The digit in the cell where the column and row meet is the number of the woman to interview for Anthropometry.

EXAMPLE: If number of women 15-49 = 3 & last digit of household = 5, select the 2nd woman listed.

Number of Woman 15-49	Line Number from HH	Name	Age	Last digit of the household number (See Module A, A01)									
				1	2	3	4	5	6	7	8	9	0
1				1	1	1	1	1	1	1	1	1	1
2				1	2	1	2	1	2	1	2	1	2
3				1	2	3	1	2	3	1	2	3	3
4				1	2	3	4	1	2	3	4	1	4
5				1	2	3	4	5	1	2	3	4	5
6				1	2	3	4	5	6	4	2	6	1
7				1	2	3	4	5	6	7	1	4	7
8				1	2	3	4	5	6	7	8	4	3
9				1	2	3	4	5	6	7	8	9	2
10				1	2	3	4	5	6	7	8	9	10

Module E. Women's Nutrition, Breastfeeding and Antenatal Care (Women 15-49)

NO.	QUESTIONS AND FILTERS	WOMAN'S NAME _____
E00	INSERT TIME MODULE STARTED	HOUR [ ][ ] MINUTE [ ][ ]
E01	HOUSEHOLD NUMBER AND EA CODE	HH [ ][ ] EA [ ][ ][ ]
E02	WOMAN'S LINE NUMBER FROM THE HOUSEHOLD ROSTER	LINE NUMBER [ ][ ]
E03	In what month and year were you born? IF DON'T KNOW MONTH RECORD "98" IF DON'T KNOW YEAR RECORD "9998"	MONTH . . . . . [ ][ ] YEAR [ ][ ][ ][ ]
E04	Please tell me how old you are. What was your age at your last birthday? RECORD AGE IN COMPLETED YEARS AND SKIP TO E06. IF RESPONDENT CANNOT REMEMBER HOW OLD SHE IS, CIRCLE 98 AND ASK QUESTION E05.	AGE IN YEARS [ ][ ] (SKIP TO E06) ★ DON'T KNOW 98
E05	Are you between the ages of 15 and 49 years old?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E06	CHECK E03, E04 AND E05 (IF APPLICABLE): IS THE RESPONDENT BETWEEN THE AGES OF 15 AND 49 YEARS? IF THE INFORMATION IN E03, E04 AND E05 CONFLICTS, DETERMINE WHICH IS MOST ACCURATE. IF ANSWER IS 'NO' AND ANOTHER WOMAN IS SELECTED, THAN QUESTIONS E02-E05 MUST BE REPEATED FOR THE NEW WOMAN.	YES . . . . . 1 NO . . . . . 2 GO BACK TO WOMEN'S KISH GRID #1 AND SELECT ANOTHER WOMAN
	WOMAN'S DIETERY DIVERSITY	
	Yesterday during the day or night did you drink/eat any [ASK QUESTIONS E11 to E26]?	
E11	Bread, biscuits, pastries, doughnut, pasta, noodles, rice, crackers or other foods made from grains such as corn, wheat, millet (Zviyo, Uphoko), rice, sadza, mahewu, mealie-meal, sorghum, bulgar wheat, barley?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E12	Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E13	White potatoes, white yams, cassava, plantains or any other foods made from roots?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E14	Any dark green leafy vegetables such as spinach, pumpkin leaves, ulude/nyevhe, kale, or okra?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E15	Ripe mangoes, ripe papaya, apricots, cantaloupe melons or other fruits that are yellow or orange inside?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E16	Other fruits or vegetables, like bananas, green beans, avocado, tomatoes, etc?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8

Module E. Women's Nutrition, Breastfeeding and Antenatal Care (Women 15-49)

NO.	QUESTIONS AND FILTERS	WOMAN'S NAME _____
E17	Liver, kidney, heart, or other organ meats?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E18	Any meat, such as beef, pork, lamb, goat, chicken, duck, game meat, birds, mice, frog (dzetse), lizard (mpurwa/hukurutombo)?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
		NO . . . . . 2 DON'T KNOW 8
E20	Fresh or dried fish, shellfish, crabs or seafood?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E21	Any foods made from beans, peas, lentils, walnuts or other nuts and seeds?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E22	Cheese, yogurt, sour milk or other milk products?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E23	Any other oils, fats, butter, peanut butter, or foods made with any of of those products?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E24	Any sugary foods such as chocolates, sweets, sugar cane, sweet reed, candies, pastries, cakes, or biscuits?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E25	Condiments for flavor, such as chilies, spices, herbs, or fish powder?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E26	Grubs, snails, edible insects, mopane worms?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
E28	Now I would like to ask you about pregnancies and births you may have had. Are you currently pregnant?	YES . . . . . 1 (SKIP TO E30) ↵ NO . . . . . 2 DON'T KNOW 8
E29	Have you ever been pregnant?	YES . . . . . 1 NO . . . . . 2 (SKIP TO E43) ↵
E30	Have you ever given birth?	YES . . . . . 1 NO . . . . . 2 (SKIP TO E43) ↵
E31	When was the last time you gave birth ? IF THE RESPONDENT DOES NOT KNOW THE BIRTHDATE ASK: Do you have a health/vaccination card for that child with the birthdate recorded? IF THE HEALTH/VACCINATION CARD IS SHOWN, RECORD THE DATE OF BIRTH AS DOCUMENTED ON THE CARD	Date of Last Birth DAY..... |___|___| If day is not known, enter '98' above MONTH..... |___|___| YEAR..... |___|___| |___|___|

Module E. Women's Nutrition, Breastfeeding and Antenatal Care (Women 15-49)

NO.	QUESTIONS AND FILTERS	WOMAN'S NAME _____
	CHECK ANSWER TO QUESTION E31. DID THE RESPONDENT'S LAST BIRTH OCCUR WITHIN THE LAST TWO YEARS, THAT IS, SINCE *(INSERT MONTH OF INTERVIEW)* 2012?	YES . . . . . 1 NO . . . . . 2 (SKIP TO E43) ↵
E32	What is the name of your child who was born on (DATE INDICATED IN E31)?	NAME _____
E33	Is [CHILD'S NAME] a male or female?	MALE . . . . . 1 FEMALE 2
E34	Did you ever breastfeed [CHILD'S NAME]?	YES . . . . . 1 NO . . . . . 2 (SKIP TO E38) ↵
E35	How long after birth did you first put [CHILD'S NAME] to the breast? IF THE RESPONDENT REPORTS SHE PUT THE INFANT TO THE BREAST IMMEDIATELY AFTER BIRTH, CIRCLE '000' IF LESS THAN 1 HOUR, CIRCLE '1' FOR HOURS AND RECORD '00' HOURS IF LESS THAN 24 HOURS, CIRCLE '1' FOR HOURS AND RECORD NUMBER OF COMPLETED HOURS FROM 01 TO 23 OTHERWISE, CIRCLE '2' AND RECORD NUMBER OF COMPLETED DAYS	IMMEDIATELY..... 0 0 0 ***OR*** HOURS..... 1 |___|___| ***OR*** DAYS..... 2 |___|___|
E36	In the first three days after delivery, was [CHILD'S NAME] given anything to drink other than breast milk?	YES . . . . . 1 NO . . . . . 2 (SKIP TO E38) ↵
E37	What was [CHILD'S NAME] given to drink? Anything else? PROBE TO IDENTIFY EACH TYPE OF DRINK AND RECORD ALL MENTIONED.	MILK (OTHER THAN BREAST MILK) . . . . . 01 PLAIN WATER . . . . . 02 SUGAR OR GLUCOSE WATER 03 GRIPE WATER . . . . . 04 SUGAR-SALT-WATER SOLUTION 05 FRUIT JUICE . . . . . 06 INFANT FORMULA . . . . . 07 TEA/INFUSIONS. . . . . 08 COFFEE . . . . . 09 HONEY . . . . . 10 OTHER _____ 96 (SPECIFY)
E38	Did you see anyone for antenatal care during the pregnancy?	YES . . . . . 1 NO . . . . . 2 (SKIP TO E43) ↵
E39	Whom did you see? Anyone else? PROBE TO IDENTIFY EACH TYPE OF CAREGIVER AND RECORD ALL MENTIONED.	DOCTORS . . . . . 01 NURSE/MIDWIFE . . . . . 02 NURSE AID ..... 03 TRADITIONAL BIRTH ATTENDANT 04 VILLAGE HEALTH WORKER 05 .OTHER _____ 96 (SPECIFY)

Module E. Women's Nutrition, Breastfeeding and Antenatal Care (Women 15-49)

NO.	QUESTIONS AND FILTERS	WOMAN'S NAME _____
E40	Where did you receive antenatal care for this pregnancy? Anywhere else? PROBE TO IDENTIFY EACH TYPE OF FACILITY AND RECORD ALL MENTIONED.	GOVERNMENT HOSPITAL . . . . . 01 GOVERNMENT CLINIC/ GOVERNMENT FACILITY . . . . . 02 PRIVATE HOSPITAL . . . . . 03 PRIVATE MATERNITY . . . . . 04 HOME OF TRADITIONAL BIRTH ATTENDANT . . . . . 05 YOUR HOME . . . . . 06 OTHER _____ 96 (SPECIFY)
E41	How many months pregnant were you when you first received antenatal care during this pregnancy?	MONTHS ☐☐
E42	How many times did you receive antenatal care during this pregnancy?	NUMBER OF TIMES ☐☐
E43	Are there any other women ages 15-49 in the household who are currently pregnant or who gave birth to a child within the past two months?	YES . . . . . 1 NO . . . . . 2 (SKIP TO E45) ↵
E44A	What are the names of the women that are currently pregnant or who gave birth to a child within the past two months?	A. NAME _____ LINE NUMBER FROM ROSTER |___|___|
E44B	WRITE THE NAMES AND LINE NUMBERS FROM THE HOUSEHOLD ROSTER OF ALL WOMEN THAT ARE MENTIONED.	B. NAME _____ LINE NUMBER FROM ROSTER |___|___|
E44C		C. NAME _____ LINE NUMBER FROM ROSTER |___|___|
E45	**INSERT TIME MODULE ENDED** HOUR ☐☐ MINUTE ☐☐	→ GO TO WOMEN'S KISH GRID #2 FOR ANTHROPOMETRY

ANTHROPOMETRY (Children under 5 years of age and non-pregnant women 15-49)

HOUSEHOLD NUMBER ☐☐ **EA CODE** ☐☐☐ **START TIME** **HOUR:** ☐☐ **MINUTE:** ☐☐

CHILDREN LESS THAN 5 YEARS OF AGE (0-59 Months)						WEIGHT AND HEIGHT OF CHILDREN LESS THAN 5 YEARS OF AGE (0-59 MONTHS)				
D67	D68	D69	D70	D71	D72	D73	D74	D75	D76	D77
LINE NO. FROM HH ROSTER	NAME	SEX MALE: 1 FEMALE: 2	AGE IN MONTHS	CHILD'S BIRTH DATE	SOURCE BIRTH DATE	WEIGHT (KG)	HEIGHT (CM)	HEIGHT MEASURED 1. LAYING DOWN 2.STANDING UP	RESULT 1.MEASURED 2. NOT PRESENT 3. REFUSED 6. OTHER (explain in comments #1)	EDEMA 1. YES 2. NO
				DAY MONTH YEAR						
☐☐	________	☐	☐☐	☐☐ ☐☐ ☐☐	☐	☐☐.☐☐ KG	☐☐☐.☐ CM	☐	☐	☐
☐☐	________	☐	☐☐	☐☐ ☐☐ ☐☐	☐	☐☐.☐☐ KG	☐☐☐.☐ CM	☐	☐	☐
☐☐	________	☐	☐☐	☐☐ ☐☐ ☐☐	☐	☐☐.☐☐ KG	☐☐☐.☐ CM	☐	☐	☐
☐☐	________	☐	☐☐	☐☐ ☐☐ ☐☐	☐	☐☐.☐☐ KG	☐☐☐.☐ CM	☐	☐	☐
☐☐	________	☐	☐☐	☐☐ ☐☐ ☐☐	☐	☐☐.☐☐ KG	☐☐☐.☐ CM	☐	☐	☐

COMMENTS #1:

SOURCE OF BIRTH DATE
1. BIRTH CERTIFICATE
2. BAPTISMAL/CHURCH RECORD
3. HEALTH REGISTRATION CARD
4. HOME RECORD
5. PARENT STATEMENT
6. OTHER ____________________

SELECTED WOMAN'S (15-49) INFORMATION			WEIGHT AND HEIGHT OF SELECTED WOMAN (15-49)		
E50	E51	E52	E53	E54	E55
LINE NO. FROM HH ROSTER	NAME	AGE IN YEARS	WEIGHT (KG)	HEIGHT (CM)	RESULT 1. MEASURED 2. NOT PRESENT 3. REFUSED 6. OTHER (explain in comments #2)
☐☐		☐☐	☐☐☐ . ☐☐ KG	☐☐☐ . ☐ CM	☐

COMMENTS #2:

END TIME

HOUR: ☐☐

MINUTE: ☐☐

GO TO MODULE J

ANTHROPOMETRIST PRINT NAME: ____________________ SIGNATURE: ____________________ ☐☐☐ ID # ☐☐ DAY ☐☐ MONTH ☐☐ YEAR

SUPERVISOR PRINT NAME: ____________________ SIGNATURE: ____________________ ☐☐☐ ID # ☐☐ DAY ☐☐ MONTH ☐☐ YEAR

MODULE H. POVERTY MEASUREMENT (Person in charge of food preparation in last 7 days, or adult who ate in the household in last 7 days)

HOUSEHOLD NUMBER FROM MODULE A ..... | | |

EA CODE FROM MODULE A ..... | | | |

RESPONDENT'S LINE NUMBER FROM HOUSEHOLD ROSTER (COLUMN 6) ..... | |

INSERT TIME MODULE STARTED

HOUR | |

MINUTES | |

MODULE H1. FOOD, BEVERAGES AND TOBACCO CONSUMPTION OVER PAST 7 DAYS

ITEM CODE	PRODUCT	YES = 1 NO = 2	FOOD CONSUMPTION OVER PAST 7 DAYS		FROM PURCHASES		TOTAL SPENT	FROM AGRICULTURAL PRODUCTION		FROM GIFTS AND OTHER SOURCES	
	Over the past 7 days, did you or others in your household consume any [ITEM]? INCLUDE FOOD BOTH EATEN COMMUNALLY IN THE HOUSEHOLD AND SEPARATELY BY INDIVIDUAL HOUSEHOLD MEMBERS. DO NOT INCLUDE FOOD OR DRINKS EATEN IN RESTAURANTS, WHICH ARE MEASURED SEPARATELY	IF "NO" SKIP TO NEXT ITEM	How much in total did your household consume in the past 7 days?		How much of the amount consumed in the last 7 days came from purchases?		How much did you spend on the amount consumed in the past 7 days? IF THE FAMILY ATE PART BUT NOT ALL OF SOMETHING THEY PURCHASED, ESTIMATE ONLY COST OF WHAT WAS CONSUMED.	How much came from your own production?		How much came from gifts and other sources?	
H1.01		**H1.02** Yes	**H1.03A QUANTITY**	**H1.03B UNIT**	**H1.04A QUANTITY**	**H1.04B UNIT**	**H1.05 US DOLLARS**	**H1.06A QUANTITY**	**H1.06B UNIT**	**H1.07A QUANTITY**	**H1.07B UNIT**
101	Biscuits (gr)	1 2						NOT APPLICABLE			
102	Bread (units = loaves)	1 2						NOT APPLICABLE			
103	Breakfast cereals (gr)	1 2						NOT APPLICABLE			
104	Broken maize/mealie rice/samp (kg)	1 2									
105	Wheat flour (kg)	1 2									
106	Buns (units)	1 2						NOT APPLICABLE			
107	Maize grain (kg, bucket)	1 2									
108	Maize meal (kg)	1 2									
109	Sorghum (kg)	1 2									
110	Millet (kg)	1 2									
111	Soya chunks (kg)	1 2									
112	Rice (kg)	1 2									
113	Macaroni/spaghetti/noodles (gr)	1 2						NOT APPLICABLE			
114	Rapoko/Rukweza/Uphoko grain (bucket, kg)	1 2									
115	Wheat (bucket, kg)	1 2									
116	Beef (kg)	1 2									
117	Chicken (kg)	1 2									
118	Other poultry e.g. duck, guinea fowl (kg)	1 2									
119	Game (kg)	1 2									
120	Goat meat (kg)	1 2									
121	Macimbi/Madora (kg)	1 2									
122	Mutton (kg)	1 2									

UNIT CODES

Kg…….. 1	Cups…….5	Plates ……..9
Gr……..2	Buckets……6	Small units…..10
Liters……..3	Units……..7	Medium units..11
Milliliters……..4	Bundles…….8	Large units….12

MODULE H1. FOOD, BEVERAGES AND TOBACCO CONSUMPTION OVER PAST 7 DAYS

ITEM CODE	PRODUCT	YES = 1 NO = 2	FOOD CONSUMPTION OVER PAST 7 DAYS		FROM PURCHASES		TOTAL SPENT	FROM AGRICULTURAL PRODUCTION		FROM GIFTS AND OTHER SOURCES	
	Over the past 7 days, did you or others in your household consume any [ITEM]? INCLUDE FOOD BOTH EATEN COMMUNALLY IN THE HOUSEHOLD AND SEPARATELY BY INDIVIDUAL HOUSEHOLD MEMBERS. DO NOT INCLUDE FOOD OR DRINKS EATEN IN RESTAURANTS, WHICH ARE MEASURED SEPARATELY	IF "NO" SKIP TO NEXT ITEM	How much in total did your household consume in the past 7 days?		How much of the amount consumed in the last 7 days came from purchases?		How much did you spend on the amount consumed in the past 7 days? IF THE FAMILY ATE PART BUT NOT ALL OF SOMETHING THEY PURCHASED, ESTIMATE ONLY COST OF WHAT WAS CONSUMED.	How much came from your own production?		How much came from gifts and other sources?	
H1.01		**H1.02** Yes No	**H1.03A QUANTITY**	**H1.03B UNIT**	**H1.04A QUANTITY**	**H1.04B UNIT**	**H1.05 US DOLLARS**	**H1.06A QUANTITY**	**H1.06B UNIT**	**H1.07A QUANTITY**	**H1.07B UNIT**
124	Pork (kg)	1 2									
126	Tinned meat (kg, gr)	1 2									
128	Bream, Mackerel or other fresh/frozon fish (kg, unit)	1 2									
130	Sour milk (liters, cups)	1 2									
136	Cream (kg, gr)	1 2									
138	Yogurt (liters)	1 2									
140	Butter/Margarine (gr)	1 2									
142	Cooking oil (liters, milliliters)	1 2									
144	Apples (small/medium/large units)	1 2									
146	Avocados (small/medium/large units)	1 2									

UNIT CODES

Kg…….. 1	Cups…….5	Plates ……..9
Gr……..2	Buckets……6	Small units…..10
Liters……..3	Units……....7	Medium units..11
Milliliters……..4	Bundles…….8	Large units....12

MODULE H1. FOOD, BEVERAGES AND TOBACCO CONSUMPTION OVER PAST 7 DAYS

ITEM CODE	PRODUCT	YES = 1 NO = 2	FOOD CONSUMPTION OVER PAST 7 DAYS		FROM PURCHASES		TOTAL SPENT	FROM AGRICULTURAL PRODUCTION		FROM GIFTS AND OTHER SOURCES	
	Over the past 7 days, did you or others in your household consume any [ITEM]? INCLUDE FOOD BOTH EATEN COMMUNALLY IN THE HOUSEHOLD AND SEPARATELY BY INDIVIDUAL HOUSEHOLD MEMBERS. DO NOT INCLUDE FOOD OR DRINKS EATEN IN RESTAURANTS, WHICH ARE MEASURED SEPARATELY	IF "NO" SKIP TO NEXT ITEM	How much in total did your household consume in the past 7 days?		How much of the amount consumed in the last 7 days came from purchases?		How much did you spend on the amount consumed in the past 7 days? IF THE FAMILY ATE PART BUT NOT ALL OF SOMETHING THEY PURCHASED, ESTIMATE ONLY COST OF WHAT WAS CONSUMED.	How much came from your own production?		How much came from gifts and other sources?	
H1.01		H1.02 Yes No	H1.03A QUANTITY	H1.03B UNIT	H1.04A QUANTITY	H1.04B UNIT	H1.05 US DOLLARS	H1.06A QUANTITY	H1.06B UNIT	H1.07A QUANTITY	H1.07B UNIT
147	Bananas (small/medium/large units)	1 2									
149	Lemon/Lime (small/medium/large units)	1 2									
151	Indigenous Fruits (cups, buckets, kg)	1 2									
153	Mulberries (kg, cups)	1 2									
155	Paw paws (small/medium/large units)	1 2									
157	Pears (small/medium/large units)	1 2									
159	Plums (units)	1 2									
161	Green beans (bundles, kg)	1 2									
163	Cabbage (units = heads)	1 2									
165	Cauliflower (units = heads)	1 2									
167	Garlic (units = heads)	1 2									
169	Green pepper (units)	1 2									
	Lettuce (bundles)	1 2									
172	Okra (bundles)	1 2									

UNIT CODES

Kg…….. 1	Cups…….5	Plates ……..9
Gr……...2	Buckets……6	Small units.….10
Liters……..3	Units……....7	Medium units..11
Milliters……..4	Bundles…….8	Large units....12

MODULE H1. FOOD, BEVERAGES AND TOBACCO CONSUMPTION OVER PAST 7 DAYS

ITEM CODE	PRODUCT	YES = 1 NO = 2	FOOD CONSUMPTION OVER PAST 7 DAYS		FROM PURCHASES		TOTAL SPENT	FROM AGRICULTURAL PRODUCTION		FROM GIFTS AND OTHER SOURCES	
	Over the past 7 days, did you or others in your household consume any [ITEM]? INCLUDE FOOD BOTH EATEN COMMUNALLY IN THE HOUSEHOLD AND SEPARATELY BY INDIVIDUAL HOUSEHOLD MEMBERS. DO NOT INCLUDE FOOD OR DRINKS EATEN IN RESTAURANTS, WHICH ARE MEASURED SEPARATELY	IF "NO" SKIP TO NEXT ITEM	How much in total did your household consume in the past 7 days?		How much of the amount consumed in the last 7 days came from purchases?		How much did you spend on the amount consumed in the past 7 days? IF THE FAMILY ATE PART BUT NOT ALL OF SOMETHING THEY PURCHASED, ESTIMATE ONLY COST OF WHAT WAS CONSUMED.	How much came from your own production?		How much came from gifts and other sources?	
H1.01		**H1.02** Yes No	**H1.03A QUANTITY**	**H1.03B UNIT**	**H1.04A QUANTITY**	**H1.04B UNIT**	**H1.05 US DOLLARS**	**H1.06A QUANTITY**	**H1.06B UNIT**	**H1.07A QUANTITY**	**H1.07B UNIT**
174	Peas (incl. cow peas) (kg)	1 2									
176	Pumpkins/squashes (small/medium/large units)	1 2									
178	Rape/Covo/Chomoulier (bundle)	1 2									
180	Tomatoes (plates, kg)	1 2									
182	Indigenous vegetables (bundles)	1 2									
185	Groundnuts (kg)	1 2									
187	Potatoes (kg)	1 2									
189	White Sugar (kg)	1 2									
191	Sweets (kg)	1 2									
193	Tea (gr)	1 2									
195	Baking powder (gr)	1 2									
400	Chocolate (excl. drinks) (gr)	1 2									

UNIT CODES

Kg…….. 1	Cups…….5	Plates ……..9
Gr……..2	Buckets……6	Small units…..10
Liters…….3	Units……....7	Medium units..11
Milliliters……..4	Bundles…….8	Large units....12

MODULE H1. FOOD, BEVERAGES AND TOBACCO CONSUMPTION OVER PAST 7 DAYS

ITEM CODE	PRODUCT	YES = 1 NO = 2	FOOD CONSUMPTION OVER PAST 7 DAYS		FROM PURCHASES		TOTAL SPENT	FROM AGRICULTURAL PRODUCTION		FROM GIFTS AND OTHER SOURCES	
	Over the past 7 days, did you or others in your household consume any [ITEM]? INCLUDE FOOD BOTH EATEN COMMUNALLY IN THE HOUSEHOLD AND SEPARATELY BY INDIVIDUAL HOUSEHOLD MEMBERS. DO NOT INCLUDE FOOD OR DRINKS EATEN IN RESTAURANTS, WHICH ARE MEASURED SEPARATELY	IF "NO" SKIP TO NEXT ITEM	How much in total did your household consume in the past 7 days?		How much of the amount consumed in the last 7 days came from purchases?		How much did you spend on the amount consumed in the past 7 days? IF THE FAMILY ATE PART BUT NOT ALL OF SOMETHING THEY PURCHASED, ESTIMATE ONLY COST OF WHAT WAS CONSUMED.	How much came from your own production?		How much came from gifts and other sources?	
H1.01		H1.02 Yes No	H1.03A QUANTITY	H1.03B UNIT	H1.04A QUANTITY	H1.04B UNIT	H1.05 US DOLLARS	H1.06A QUANTITY	H1.06B UNIT	H1.07A QUANTITY	H1.07B UNIT
403	Mixed condiments e.g Royco, or Spices and seasoning (gr)	1 2									
405	Sauces (milliliters)	1 2									
408	Yeast (gr)	1 2									
410	Restaurant meals (units)	1 2									
415	Minerals, maheo (liters)	1 2									
417	Beer (liters)	1 2									
422	Liquors (Brandy, cane, gin etc.) (liters)	1 2									
424	Pipe tobacco (gr)	1 2									
426	OTHER FOOD (specify) _____	1 2									
428	OTHER FOOD (specify) _____	1 2									

UNIT CODES

Kg…….. 1	Cups…….5	Plates ……..9
Gr……..2	Buckets……6	Small units…..10
Liters……..3	Units……..7	Medium units..11
Milliters……..4	Bundles…….8	Large units....12

MODULE H2. NON-DURABLE GOODS AND FREQUENTLY PURCHASED SERVICES OVER PAST 30 DAYS (Head of HH or Responsible Adult)

H2.01	HOUSEHOLD NUMBER AND EA CODE	HH..... ☐☐	EA. . . . . ☐☐☐
H2.02	LINE NUMBER IN THE HOUSEHOLD LISTING (COLUMN 10) OF HEAD OF HOUSEHOLD OR RESPONSIBLE ADULT	. . . . . ☐☐	

ITEM NO.	QUESTIONS FOR A REFERENCE PERIOD OF 30 DAYS	CODING CATEGORIES		COST IN US DOLLARS
	Over the past 30 DAYS, did your household use or buy any [ITEM]:	Yes	No	How much did you pay (how much did they cost) in total?
UTILITIES/FUEL/POWER				
201	Water charges	1	2	
202	Electricity charges	1	2	
203	Gas	1	2	
204	Gel	1	2	
205	Paraffin (Kerosene)?	1	2	
206	Spirit	1	2	
207	Charcoal, Coal, Coke and Briquette	1	2	
208	Firewood	1	2	
209	Peat	1	2	
210	Waterpoint committee fees	1	2	
211	Diesel	1	2	
VEHICLE-RELATED EXPENSES				
212	Tyres	1	2	
213	Tubes	1	2	
214	Parts and accessories including car batteries	1	2	
215	Repair charges	1	2	
216	Petrol	1	2	
218	Engine oil, Brake fluid, gear and crown oil or other greases	1	2	
219	Servicing	1	2	
220	Parking fees	1	2	
221	Toll-gate fees	1	2	
222	Vehicle licenses (incl. cost of obtaining number plates)	1	2	
223	Driving lessons (incl. other costs of obtaining driving licence)	1	2	
224	Insurance of personal transport vehicle and equipment	1	2	
TRANSPORT AND COMMUNICATIONS				
225	Public Transportation, includiig railways, buses, taxis or lorries	1	2	
230	Passport, Visa and ETD fees	1	2	
231	Postal service charges	1	2	
232	Telephone charges	1	2	
233	Cell phone charges / Airtime	1	2	
234	Internet charges	1	2	
234a	Rental vehicles, including Oxen Carts, cars, etc.	1	2	
235	Envelopes, stamps	1	2	
HEALTH CARE				
236	Medicines	1	2	
237	Vitamins	1	2	
238	Medical aid subscription	1	2	
239	Other medical goods (specify)_____	1	2	
PERSONAL CARE AND EFFECTS				
240	Services of barber shops/hair dresser (men's)	1	2	
241	Services of barber shops/hair dresser (women's)	1	2	
242	Services of beauty shops/massage parlour	1	2	
243	Hair dressing related items e.g. braids, weave, wig etc	1	2	

MODULE H2. NON-DURABLE GOODS AND FREQUENTLY PURCHASED SERVICES OVER PAST 30 DAYS				
ITEM NO.	QUESTIONS FOR A REFERENCE PERIOD OF 30 DAYS	CODING CATEGORIES		COST IN US DOLLARS
	Over the past 30 DAYS, did your household use or buy any [ITEM]:	Yes	No	How much did you pay (how much did they cost) in total?
244	Bath soap	1	2	
245	Toilet paper	1	2	
246	Shaving blades and cream	1	2	
247	Skin cream	1	2	
248	Tooth brush	1	2	
249	Tooth paste	1	2	
250	Powder	1	2	
251	Petroleum jelly	1	2	
252	Perfume/deodorant	1	2	
253	Cotton wool	1	2	
254	Sanitary-ware	1	2	
HOUSEHOLD OPERATIONS				
255	Bulbs	1	2	
256	Laundry and dry cleaning charges	1	2	
257	Candles	1	2	
258	Torches	1	2	
259	Matches	1	2	
260	Torch and radio batteries	1	2	
261	Soap for laundry	1	2	
262	Washing powder	1	2	
263	Disinfectants	1	2	
264	Garden and other tools	1	2	
265	Mops, brooms and brushes including floor brushes	1	2	
266	Needles and pins	1	2	
267	Polish (furniture, floor, metal)	1	2	
268	Shoe brush and other brushes	1	2	
269	Shoe polish	1	2	
270	Umbrellas	1	2	
271	Travel goods	1	2	
RECREATION AND ENTERTAINMENT				
272	Audio-visual accessories eg. DVD, cassette, CD	1	2	
273	Expenditure on sport	1	2	
274	Expenditure on clubs,unions, and burial societies	1	2	
275	Gambling e.g. Casino	1	2	
276	License fees for radio and TV	1	2	
277	Photographic films and developing films, etc.	1	2	
278	Other equipment	1	2	
279	Sports equipment	1	2	
280	Parts and accessories of recreational goods	1	2	
281	Repair of recreational goods	1	2	
282	Hire of wedding clothes (gown, suit, etc)	1	2	
283	Expenditure on wedding in cash (excluding hiring clothes)	1	2	
284	Expenditure on wedding in kind	1	2	
285	Novels (not for educational purposes)	1	2	
286	Drawing, writing equipment and supplies (not for school)	1	2	
287	Magazines and journals	1	2	
288	Newspapers	1	2	
OTHER EXPENDITURES				
289	Expenditure in hotels (other than food)	1	2	
290	Other expenditure in hotels e.g. laundry, tips etc	1	2	
291	Jewellery, watches, rings and precious stones	1	2	

MODULE H3. NON-FOOD EXPENDITURES OVER PAST 12 MONTHS (Head of HH or Responsible Adult)

ITEM NO.	QUESTIONS AND FILTERS (ONE YEAR REFERENCE)	CODING CATEGORIES		TOTAL COST IN US DOLLARS
	Over the past twelve months, did your household use or buy any [ITEM]:	Yes	No	How much did you pay (how much did they cost) in total?
MEN'S CLOTHING AND FOOTWEAR				
301	Trousers	1	2	
302	Shirts	1	2	
303	T-shirts	1	2	
304	Jackets	1	2	
305	Suits	1	2	
306	Socks	1	2	
307	Underwear	1	2	
308	Jerseys	1	2	
309	Religious robes	1	2	
310	Men's footwear	1	2	
311	Repair of men's footwear	1	2	
312	Other men´s clothing – hats, belts, pyjamas etc (specify):_____	1	2	
WOMEN'S CLOTHING AND FOOTWEAR				
313	Dresses	1	2	
314	Suits (jacket and skirt/trousers)	1	2	
315	Skirts	1	2	
316	Blouses	1	2	
317	Trousers	1	2	
318	T–shirts	1	2	
319	Lady's underwear, eg panti–hoses, brassiere, etc	1	2	
322	Jerseys	1	2	
323	Religious robes	1	2	
324	Women's footwear	1	2	
325	Repair of women's footwear	1	2	
326	Other women´s clothing (specify):_____	1	2	
CHILDREN'S CLOTHING AND FOOTWEAR				
327	Shorts	1	2	
328	Trousers	1	2	
329	T–shirts	1	2	
330	Shirts	1	2	
331	Dresses	1	2	
332	Blouses	1	2	
333	Skirt	1	2	
334	Socks	1	2	
335	Underwear	1	2	
336	Napkins	1	2	
337	Disposable nappies e.g. pampers, huggies	1	2	
338	Rompers	1	2	
339	Children's footwear (excluding school shoes)	1	2	
340	Repair of children's footwear	1	2	
341	Other children´s clothing (specify):_____	1	2	
OTHER CLOTHING EXPENSES				
342	Dressing materials (e.g. fabric, yarn, buttons etc.)	1	2	
343	Tailoring charges (including clothing repairs)	1	2	

MODULE H3. NON-FOOD EXPENDITURES OVER PAST 12 MONTHS (Head of HH or Responsible Adult)

ITEM NO.	QUESTIONS AND FILTERS (ONE YEAR REFERENCE)	CODING CATEGORIES	TOTAL COST IN US DOLLARS
	Over the past twelve months, did your household use or buy any [ITEM]:	Yes No	How much did you pay (how much did they cost) in total?
344	Bedsheets	1 2	
346	Towels	1 2	
348	Table clothes/Table napkins/serviettes	1 2	
350	Flower pots, plant boxes	1 2	
352	Cutlery (knives, spoons, forks, etc.)	1 2	
354	Plates and cups	1 2	
356	Tea pots (enamel)	1 2	
358	Pots (enamel)	1 2	
360	Girl's uniform	1 2	
362	School shoes (pair)	1 2	
364	Exercise books	1 2	
366	Educational books (textbooks and novels)	1 2	
368	Pre-school fees	1 2	
370	School/College/University tuition fees (excl. payments for food, beverage & shelter)	1 2	
372	Parents and Teachers' association fee or levy or building fund	1 2	
374	Fees paid to doctors	1 2	
376	Fees paid to clinics	1 2	
378	Fees paid for medical or laboratory tests	1 2	
380	Traditional/Spiritual healers	1 2	
382	Repairs of medical equipment and prosthetics	1 2	

MODULE H5. VALUE OF ASSETS (Head of HH or Responsible Adult)

ITEM CODE	PRODUCT OWNERSHIP		NUMBER OF UNITS OF EACH ITEM	AGE OF ITEMS	PRICE IF SOLD	PRICE NEW
	Does your household own a [ITEM]? CIRCLE 1 (YES) OR 2 (NO) IN THE FOLLOWING COLUMN. IF THE ANSWER IS "NO" ASK THE QUESTIONS FOR THE FOLLOWING ITEM.		How many [ITEMS] do you own?	What is the age of these [ITEM]s? IF MORE THAN ONE ITEM, AVERAGE AGE	If you wanted to sell these [ITEM]s today, how much would you receive? IF MORE THAN ONE ITEM, AVERAGE VALUE	How much were these [ITEM]s worth when you acquired them? PUT "0" IF IT WAS A GIFT GIVE AVERAGE VALUE IF MORE THAN ONE ITEM
H5.1	H5.2		H5.3 NUMBER OF ITEMS	H5.4 NUMBER OF YEARS	H5.5 US DOLLARS	H5.6 US DOLLARS
	ITEM	Yes No				
501	Television	1 2				
502	Computer	1 2				
503	Refrigerator/Deep–freezer	1 2				
504	Motor Vehicle	1 2				
505	Motor Cycle/Scooter	1 2				
506	Bicycle	1 2				
507	Satellite Dish	1 2				
508	Radio (Shortwave, FM)	1 2				
509	Cell-phone	1 2				
510	Stove (gas, electric, charcoal or wood)	1 2				
511	Sewing/knitting machine	1 2				
512	Peanut Butter / Candle Making /Oil-pressing machine	1 2				
513	Grinding mill	1 2				
514	Generator	1 2				
515	Solar Panel	1 2				
516	Lounge suite	1 2				
517	Bedroom suite	1 2				
518	Dining room suite	1 2				
519	Carpets	1 2				
520	DVD Player/ Video Tape Recorder	1 2				
521	Hoover	1 2				
522	Desks, sideboards, stools and benches	1 2				
523	Irons	1 2				
524	Heating appliances e.g. heater	1 2				
525	Electric fans	1 2				
526	Other household appliances (specify)_____	1 2				
H5.7	**INSERT TIME MODULE ENDED**	**HOUR**		**MINUTE**		

MODULE J – GENDER (for MALE)

EA Code |___|___|___| Household Number |___|___|

1. **NAME OF PRIMARY *MALE* DECISION-MAKER FROM MODULE A _____ Leave blank if there is no primary male-decision maker.**
2. **LINE NO. OF PRIMARY *MALE* DECISION-MAKER FROM MODULE B |___|___| Record 00 if there is no primary male-decision maker and go to female form.**

Start Time: Hour |___|___| Minute |___|___|

	Productive Capital	Does anyone in your household currently have any [ITEM]? Yes ..... 1 No ..... 2 → next item	How many of [ITEM] does your household currently have?	Who would you say owns most of the [ITEM]?	Who would you say can decide whether to sell [ITEM] most of the time?	Who would you say can decide whether to give away [ITEM] most of the time?	Who would you say can decide to mortgage or rent out [ITEM] most of the time?	Who contributes most to decisions regarding a new purchase of [ITEM]?
	Productive Capital	3.01a	3.01b	3.02	3.03	3.04	3.05	3.06
A	Agricultural land (pieces/plots)	1 / 2		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
B	Large livestock (oxen, cattle)	1 / 2		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
C	Small livestock (goats, pigs, sheep)	1 / 2		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
D	Chickens, Ducks, Turkeys, Pigeons	1 / 2		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
F	Farm equipment (non-mechanized)	1 / 2		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
G	Farm equipment (mechanized)	1 / 2		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
H	Nonfarm business equipment	1 / 2		1 2 3 4 5 6 7 8 9 10				
J	Large consumer durables (fridge, TV, sofa)	1 / 2		1 2 3 4 5 6 7 8 9 10				
K	Small consumer durables (radio, cookware)	1 / 2		1 2 3 4 5 6 7 8 9 10				
L	Cell phone	1 / 2		1 2 3 4 5 6 7 8 9 10				
N	Means of transportation (bicycle, motorcycle, car)	1 / 2		1 2 3 4 5 6 7 8 9 10				

GO TO 3.07

3.02-3.06: Decision-making and control over productive capital

Self.....1
Partner/Spouse.....2
Self and partner/spouse jointly.....3
Other household member 4
Self and other household member(s).....5
Partner/Spouse and other household member(s).....6
Someone (or group of people) outside the household.....7
Self and other outside people.....8
Partner/Spouse and other outside people.....9
Self, partner/spouse and other outside people.....10

MODULE J – GENDER (for MALE)

EA Code |___|___|___| Household Number |___|___|

1. **NAME OF PRIMARY *MALE* DECISION-MAKER FROM MODULE A _____ Leave blank if there is no primary male-decision maker.**
2. **LINE NO. OF PRIMARY *MALE* DECISION-MAKER FROM MODULE B |___|___| Record 00 if there is no primary male-decision maker and go to female form.**

Lending sources		Has anyone in your household taken any loans or borrowed cash/in-kind from [SOURCE] in the past 12 months? Yes, cash……...1 Yes, in-kind……..2 Yes, cash and in-kind…..3 No……4 } Next source Don't know……5 } Next source	Who made the decision to borrow from [SOURCE]?	Who makes the decision about what to do with the money or item borrowed from [SOURCE]?
Lending source names		**3.07**	**3.08**	**3.09**
A	Non-governmental organization (NGO)	1 2 3 4 5	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
B	Informal lender	1 2 3 4 5	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
C	Formal lender (bank/financial institution)	1 2 3 4 5	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
D	Friends or relatives	1 2 3 4 5	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
E	Group based micro-finance or lending including VSLAs / SACCOs/ merry-go-rounds	1 2 3 4 5	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
	RECORD END TIME		**3.08/3.09: Decision-making and control over credit** Self……1 Partner/Spouse……2 Self and partner/spouse jointly……3 Other household member……4 Self and other household member(s)……5 Partner/Spouse and other household member(s)……6 Someone (or group of people) outside the household…7 Self and other outside people……8 Partner/Spouse and other outside people……9 Self, partner/spouse and other outside people……10	

End Time: Hour |___|___| Minute |___|___| GO TO FEMALE FORM

MODULE J – GENDER (for FEMALE)

EA Code |___|___|___| **Household Number** |___|___|

1. **NAME OF PRIMARY *FEMALE* DECISION-MAKER FROM MODULE A** _____ **Leave blank if there is no primary female-decision maker.**
2. **LINE NO. OF PRIMARY *FEMALE* DECISION-MAKER FROM MODULE B** |___|___| **Record 00 if there is no primary female-decision maker and go to Module H.**

	Productive Capital	Does anyone in your household currently have any [ITEM]? Yes ..... 1 No ..... 2 → next item	How many of [ITEM] does your household currently have?	Who would you say owns most of the [ITEM]?	Who would you say can decide whether to sell [ITEM] most of the time?	Who would you say can decide whether to give away [ITEM] most of the time?	Who would you say can decide to mortgage or rent out [ITEM] most of the time?	Who contributes most to decisions regarding a new purchase of [ITEM]?
	Productive Capital	**3.01a**	**3.01b**	**3.02**	**3.03**	**3.04**	**3.05**	**3.06**
A	Agricultural land (pieces/plots)	1 2		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
B	Large livestock (oxen, cattle)	1 2		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
C	Small livestock (goats, pigs, sheep)	1 2		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
D	Chickens, Ducks, Turkeys, Pigeons	1 2		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
F	Farm equipment (non-mechanized)	1 2		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
G	Farm equipment (mechanized)	1 2		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
H	Nonfarm business equipment	1 2		1 2 3 4 5 6 7 8 9 10				
J	Large consumer durables (fridge, TV, sofa)	1 2		1 2 3 4 5 6 7 8 9 10				
K	Small consumer durables (radio, cookware)	1 2		1 2 3 4 5 6 7 8 9 10				
L	Cell phone	1 2		1 2 3 4 5 6 7 8 9 10				
N	Means of transportation (bicycle, motorcycle, car)	1 2		1 2 3 4 5 6 7 8 9 10				

GO TO 3.07

3.02-3.06: Decision-making and control over productive capital

1 Self
2 Partner/Spouse
3 Self and partner/spouse jointly
4 Other household member
5 Self and other household member(s)
6 Partner/Spouse and other household member(s)
7 Someone (or group of people) outside the household
8 Self and other outside people
9 Partner/Spouse and other outside people
10 Self, partner/spouse and other outside people

MODULE J – GENDER (for FEMALE)

EA Code |___|___|___| **Household Number** |___|___|

1. **NAME OF PRIMARY *FEMALE* DECISION-MAKER FROM MODULE A** _____ **Leave blank if there is no primary female-decision maker.**
2. **LINE NO. OF PRIMARY *FEMALE* DECISION-MAKER FROM MODULE B** |___|___| **Record 00 if there is no primary female-decision maker and go to Module H.**

Lending sources		Has anyone in your household taken any loans or borrowed cash/in-kind from [SOURCE] in the past 12 months? Yes, cash……...1 Yes, in-kind……...2 Yes, cash and in-kind…..3 No……4 } Next source Don't know……5 } Next source	Who made the decision to borrow from [SOURCE]?	Who makes the decision about what to do with the money or item borrowed from [SOURCE]?
Lending source names		**3.07**	**3.08**	**3.09**
A	Non-governmental organization (NGO)	1 2 3 4 5	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
B	Informal lender	1 2 3 4 5	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
C	Formal lender (bank/financial institution)	1 2 3 4 5	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
D	Friends or relatives	1 2 3 4 5	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
E	Group based micro-finance or lending including VSLAs / SACCOs/ merry-go-rounds	1 2 3 4 5	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
	RECORD END TIME		**3.08/3.09: Decision-making and control over credit** Self……1 Partner/Spouse ……2 Self and partner/spouse jointly…… ……3 Other household member ……4 Self and other household member(s)……5 Partner/Spouse and other household member(s)……6 Someone (or group of people) outside the household…7 Self and other outside people……8 Partner/Spouse and other outside people……9 Self, partner/spouse and other outside people……10	

End Time: Hour |___|___| **Minute** |___|___|

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF TEAM LEADER: _____ DATE: _____

EDITOR'S OBSERVATIONS

NAME OF EDITOR: _____ DATE: _____

ANNEX 4
Household Survey Indicator Definitions
Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

Indicator	Disaggregation Level	Data Points
1. Average Household Dietary Diversity Score (HDDS)[1]	None	Indicator, CI, # households in target area
2. Prevalence of households with moderate or severe hunger -Household Hunger Scale (HHS)[2]	Gendered Household Type	Indicator, CI, # households in target area
3. Prevalence of poverty: Percent of people living on less than $1.25/day	Gendered Household Type	Indicator, CI, # individuals in target area
4. Mean depth of poverty	Gendered Household Type	Indicator, CI, # individuals in target area
5. Per capita expenditures (as a proxy for income) of USG targeted beneficiaries	Gendered Household Type	Indicator, CI, # individuals in target area
6. Prevalence of underweight children under five years of age[3]	Sex	Indicator, CI, # children 0–59 months in target area
7. Prevalence of stunted children under five years of age[4]	Sex	Indicator, CI, # children 0–59 months in target area
8. Percentage of children under age five who had diarrhea in the last two weeks[4]	Sex	Indicator, CI, # children 0–59 months in target area
9. Percentage of children under age five with diarrhea treated with Oral Rehydration Therapy (ORT)[5]	Sex	Indicator, CI, # children 0–59 months in target area who had diarrhea in the last two weeks
10. Prevalence of exclusive breastfeeding of children under six months of age[5]	Sex	Indicator, CI, # children < 6 months in target area
11. Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD)[6]	Sex	Indicator, CI, # children 6-23 months in target area
12. Prevalence of underweight women of reproductive age[4]	None	Indicator, CI, # women 15-49 years in target area (excluding pregnant or post-partum women)
13. Women's Dietary Diversity Score[6]	None	Indicator, CI, # women 15-49 years in target area
14. Percentage of households using an improved drinking water source[5]	None	Indicator, CI, # households in target area
15. Percentage of households using improved sanitation facilities[5]	None	Indicator, CI, # households in target area
16. Percentage of households with soap and water at a handwashing station commonly used by family members[5]	None	Indicator, CI, # households in target area
17. Percentage of farmers who used financial services in the past 12 months	Sex	Indicator, CI, # farmers in target area
18. Percentage of farmers who practiced the value chain activities promoted by the project in the past 12 months	Sex	Indicator, CI, # farmers in target area
19. Percentage of farmers who used a minimum number of sustainable agricultural practices in the past 12 months	Sex	Indicator, CI, # farmers in target area
20. Percentage of farmers who used improved storage practices in the past 12 months	Sex	Indicator, CI, # farmers in target area

[1]Anne Swindale and Paula Bilinski. 2006. *Household Dietary Diversity Score (HDDS) for Measurement of Household Food Access: Indicator Guide,* Version 2. Available at http://www.fantaproject.org/publications/hdds_mahfp.shtml.

[2]Terri Ballard, Jennifer Coats, Anne Swindale, and Megan Deitchler. 2011. *Household Hunger Scale: Indicator Definition and Measurement Guide*. Available at http://www.fantaproject.org/publications/hhs_2011.shtml.

[3]Bruce Cogill. 2003. *Anthropometric Indicators Measurement Guide*. Revised Edition. Available at http://www.fantaproject.org/publications/anthropom.shtml.

[4]Demographic Household Survey (DHS). Phase 6 (2008-2013). Available at http://www.measuredhs.com/

[5]WHO. 2008. *Indicators for assessing infant and young child feeding practices – Part 1: Definitions*. Available at http://www.who.int/nutrition/publications/infantfeeding/9789241596664/en/index.html.

WHO. 2010. *Indicators for assessing infant and young child feeding practices – Part 2: Measurement*. Available at http://www.who.int/nutrition/publications/infantfeeding/9789241599290/en/index.html

[6]Mary Arimond et al. 2010. 'Developing Simple Measures of Women's Diet Quality in Developing Countries: Methods and Findings.' *Journal of Nutrition* 140(11): Supplement. Available at http://www.fantaproject.org/publications/JofN_Oct2010.shtml.

Program-specific indicators for Zimbabwe	
21.	% of households in target areas practicing correct use of recommended household water treatment technologies • Numerator: F09 = 1 and (F10 = 1, 2, 3, 4, 5, 6 or 7) • Denominator: Total number of households
22.	% of households in target areas practicing safe storage of drinking water • Numerator: F10A = 1 or F10B = 1 or F10C = 1 • Denominator: Total number of households
23.	% of household with a handwashing station near a sanitation facility • Numerator:F17A = 1 and F17B = 1 and (F17C = 1 or F17C = 2) • Denominator: Total number of households with a toilet facility available (F17 = 1)
24.	Average number of antenatal care visits by pregnant women • Numerator: Number of antenatal care visits (E36). If E33 = "No", Visits = 0. • Denominator: Women 15-49 years with pregnancy in the past 2 years.
25.	Timing of first antenatal care visit by pregnant women This indicator is reported for multiple brackets, including (1) No Antenatal Care, (2) <4 months, (3) 4-5 months, (4) 6-7 months and (5) 8 or more months. • Numerator (1): Women with no ANC (E33 = 2) • Numerator (2): Women with first ANC visit before 4 months (E36 < 4) • Numerator (3): Women with first ANC visit between 4 and 5 months (E36=4 or E36=5) • Numerator (4): Women with first ANC visit between 6 and 7 months (E36=6 or E36=7) • Numerator (5): Women with first ANC visit after 8 or more months (E36>7) • Denominator: Women 15-49 years with pregnancy in the past 5 years
26.	Average Food Consumption Score (FCS) All values of '9' in variables C03_1 to C13_1 are recoded to '0' before computing the indicator. Then the following 8 food groups are computed as a sum of the days that individual items were consumed: • Staples = sum (C03_1, C04_1). • Pulses = C10_1. • Vegetables = C05_1. • Fruits = C06_1. • Animal Protein = sum (C07_1, C08_1, C09_1). • Milk = C11_1. • Sugar = C13_1. • Oil = C12_1. These food groups are then capped to a maximum of 7. That is, even if a household consumed both cereals and grains (C03_1) and roots and tubers (C04_1) for all 7 days of the week, the total score for the "Staples" category would not be the sum of the two items (14), but would be capped at 7. The final FCS is computed as a weighted sum of the eight food groups: FCS = (Staples*2)+(Pulses*3)+(Vegetables*1)+(Fruits*1)+(AnimalProtein*4)+(Milk*4)+(Sugar*0.5)+(Oil*0.5) The FCS is reported in 3 brackets: (1) Poor: 0-21 (2) Borderline: 21.5 to 35, and (3) Adequate: >35 • Numerator (1): Households with FCS =<21 • Numerator (2): Households with FCS > 21 and FCS =<35 • Numerator (3): Households with FCS >35 • Denominator: Total number of households

Program-specific indicators for Zimbabwe	
27	Coping strategies index (CSI) Frequency scores for items C23 thru C33 are first recoded into C23r thru C33r as: Never (1) = 0; Seldom (2) = 0.5; Sometimes (3) = 1.5; Often (4) = 3.5 and Daily (5) = 7. Using these recoded scores, the CSI is calculated as a weighted average (see below). CSI = C23r*8 + C24r*2 + C25r*2 + C26r*4 + C27r*2 + C28r*4 + C29r*8 + C30r*4 + C31r*8 + C32r*2 + C33r*6 • Numerator: Sum of CSI for all households • Denominator: Total number of households
28	Gender indicator – WEAI Access to Resources Module (G3) – Disaggregate by sex and gendered household type Separate indicators are calculated for 3 domains: 1. Ownership of Assets 2. Purchase, sale, or transfer of assets 3. Access to and decisions on credit Indicator for each domain is: Percent who achieve adequacy • Numerator: Number of male or female decision-makers who achieve adequacy • Denominator: Total number of male or female decision-makers See definitions below for achievement of adequacy in each domain

Ownership of assets	Who would you say owns most of the [ITEM]? Agricultural land,Large livestock, Small livestock, Chicks etc; Fish pond/equip; Farm equip (non-mech); arm equip (mechanized) Nonfarm business equipment House; Large durables; Small durables; Cell phone; Non-ag land (any); Transport	G3.02 A-N	Achievement in any if not only one small asset (chickens, non-mechanized equipment and no small consumer durables)	Inadequate if household does not own any asset or if household owns the type of asset BUT she/he does not own most of it alone	G3.01a==1 & (G3.02=1, 3, 5, 8, 10)
Purchase, sale, or transfer of assets	Who would you say can decide whether to sell, give away, rent/mortgate [ITEM] most of the time? Who contributes most to decisions regarding a new purchase of [ITEM]? Ag land; Lg livestock, Sm livestock; Chicks etc; Fish pond; Farm equip (non); Farm equip (mech)	G3.03-G3.05 A-G G3.06 A-G	Achievement in any if not only chickens and farming equipment non-mechanized	Inadequate if household does not own any asset or household owns the type of asset BUT she/he does not participate in the decisions (exchange or buy) about it	G3.01a==1 & (G3.03=1,3, 5,8.10) & (G3.04=1,3, 5,8.10) & (G3.05=1,3, 5,8.10)& (G3.06=1,3, 5,8.10)
Access to and decisions on credit	Who made the decision to borrow/what to do with money/item borrowed from [SOURCE]? Non-governmental organization (NGO); Informal lender; Formal lender (bank); Friends or relatives; ROSCA (savings/credit group)	G3.08-G3.09 A-E	Achievement in any	Inadequate if household has no credit OR used a source of credit BUT she/he did not participate in ANY decisions about it	G3.07<=3 & (G3.08=1, 3, 5, 8.10) & (G3.09=1, 3, 5, 8.10)

ANNEX 5
Methods for Derivation of Poverty Indicators
Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

Introduction

The World Bank defines poverty as whether households or individuals have enough resources or abilities today to meet their needs. Poverty is usually measured based on consumption levels rather than other measures such as income. Actual consumption is more closely related to a person's well-being in the sense of having enough to meet current basic needs. Also, in poor agrarian economies and in urban economies with large informal sectors, income may be difficult to estimate. It may be seasonal and erratic, and it may be difficult to estimate particularly for agricultural households whose income may not be monetized.

The prevalence of household poverty was measured using information on household expenditures to compute a household consumption aggregate. The consumption aggregates was constructed following guidelines from Deaton & Zaidi (2002)[1] and Grosh & Muñoz (1996)[2] by adding together the various goods and services consumed by each household during a period of 12 months. The various components of consumption were grouped together into 4 main categories, including food, occasional expenses (expenses in the last 30 days), unusual expenses (expenses in the last 12 months), and durable assets. Housing expenses are excluded for Zimbabwe given the estimation difficulties due to the lack of a developed real estate market in rural areas.

In general consumption was calculated by adding the value in local currency units (LCU) of the items consumed by the household, as reported by household informants. These items were collected according to different time horizons, but were then transformed into daily per capita consumption.

Whenever a household missed data on the value consumed for a given item, that value was imputed using the closest local median value for that item. That is, if a household is missing consumption information on a given item, it was assigned the median value reported by other households in the vicinity. Whenever the item is reported frequently enough, this imputation was done at the district level. However some items may be consumed by few households. In those cases the level of imputation would be at the total level, depending on how rare the item is.

The reported values for each item and each consumption component were checked for outliers to detect possible coding errors or extreme values. Values that are 5 standard deviations (SD) above the average, or 2 SD below, were flagged and checked for plausibility. Values deemed implausible were imputed using the methodology described above.

Besides this general methodology, some components require specific computations.

Food Consumption

Computation of food consumption is complex because it involves products that are purchased in the market, where price information is available, and products that are home-produced or received as a gift, where price information is not available. Even when products are purchased, it is often difficult for

[1] Deaton, A. and S. Zaidi (2002), A Guide to Aggregating Consumption Expenditures, Living Standards Measurement Study, Working Paper 135. Available at: http://siteresources.worldbank.org/INTPA/Resources/429966-1092778639630/deatonZaidi.pdf

[2] Margaret Grosh and Juan Muñoz (1996). A Manual for Planning and Implementing the Living Standards Measurement Study Surveys. LSMS Working Paper #126, The World Bank. Available at: http://documents.worldbank.org/curated/en/1996/05/438573/manual-planning-implementing-living-standards-measurement-study-survey

household informants to report the precise market value of the amounts consumed by the household over the reference period, which often results in missing data.

The value of non-purchased food (and of any food missing value information), was imputed by transforming the amounts consumed by the household to a common reference unit (grams), and multiplying the local median value of that unit times the amount consumed. If a product is reportedly consumed, but amount information is missing, the median per capita amount consumed by local households was imputed.

A special case is the imputation of items that are reported in non- standard units. Imputing a value for consumption reported in non-standard units requires finding standard weight equivalences for these units. This equivalence was obtained via a survey of local markets. Non-standard unit/item combinations were identified during training. These units were then measured by taking measurements of each item/unit combination in markets in the program areas. Measurements were done in grams, using an electronic scale. These measurements were then used to transform non-standard units to a common reference unit (grams).

Assets

Purchases of durable goods represent large and relatively infrequent expenses. While almost all households incur relatively large expenditures on these at some point, only a small proportion of all households are expected to make such expenditures during the reference period covered by the survey. As indicated by Deaton & Zaidi (2002) "From the point of view of household welfare, rather than using expenditure on purchase of durable goods during the recall period, the appropriate measure of consumption of durable goods is the value of services that the household receives from all the durable goods in its possession over the relevant time period" (p. 33).

Consumption of durable goods was calculated as the annual rental equivalent of owning the asset. The preferred method to calculate this rental equivalent is the price of the asset in its current shape multiplied by the sum of the real interest rate and the depreciation rate:

$$S_t P_t \, (r_t - \pi_t + \delta)$$

Where $S_t P_t$ is the current price of the asset, $r_t - \pi_t$ is the real rate of interest, and δ is the depreciation rate for the durable good. However the case of Zimbabwe is special in that official real rates of interest are not available[3]. Consumption of durable goods was thus calculated based on the estimated remaining life of the asset, as recommended by Deaton & Zaidi (2002): First, the average age for each durable good, $\bar{T}$, was calculated from the data on the current age of the particular respondent's asset recorded in the survey (T). The average lifetime of each durable good was estimated as $2\bar{T}$ under the assumption that purchases are uniformly distributed through time. This uniform distribution is defined over the continuum 0 to $2\overline{\mathrm{T}}$ and has a mean of $\overline{\mathrm{T}}$. The remaining life of each good was calculated as $2\bar{T} - T$. A rental equivalent estimating the daily per capita flow of services from the durable goods is then derived by dividing the current replacement value of the good by its expected remaining life in years, over the number of members in the household and the 365 days of a year. For example, in a household with one member, an asset with 1 year of remaining lifetime, and a current replacement value of 365 dollars would be equivalent to a daily per capita rental of 1 dollar.

[3] http://data.worldbank.org/indicator/FR.INR.RINR/countries

Average daily per capita expenditures

This indicator is usually computed as the average of daily per capita expenditures, expressed in constant 2010 US dollars at 2005 PPP adjusted to 2010 US prices. As in the case of the prevalence of poverty (described in the next section), it was difficult to compute per capita expenditures for Zimbabwe using the standard methodology in the absence of a PPP conversion rate. An approximation is suggested by using the national poverty line as a proxy for the international $1.25 line, using the following steps:

1) Convert the US$1.25 poverty line from 2005 prices to current prices by multiplying by the US CPI for the survey period, with 2005 = 100. Using the US CPI[4] for the survey months of March and April 2014, the $1.25 line would be equivalent to:
    a. March 2014 = $1.25*1.2099=$1.5124.
    b. April 2014 = $1.25*1.2139=$1.5174.

2) Use the ratio of this adjusted poverty line to the Zimbabwe poverty line as a proxy for the PPP conversion rate. Assuming $3.3547 as the national daily per capita poverty line, the PPP conversion rate would be:
    a. March 2014 = 3.3547/1.5124= 2.2181.
    b. April 2014 = 3.3547/1.5174=2.2108.

    This would indicate that in March 2014, 2.2181 US dollars in Zimbabwe can purchase the same amount of goods and services as 1 US dollar would purchase in the United States.

3) Divide reported consumption data by these PPP conversion rates.

4) Deflate to 2010 prices by using the ratio of the CPI in Zimbabwe between 2010 and the survey dates in 2014[5]:
    a. March 2014 = 108.79.
    b. April 2014 = 109.44.

For transparency and ease of interpretation, both the 2010 adjusted consumption data and the raw consumption data are reported.

Prevalence of Poverty

Computing the prevalence of poverty in Zimbabwe using international standards presents several challenges. Zimbabwe has been a dollarized economy since 2009, when it abandoned the Zimbabwe dollar in favor of a multi-currency regime prominently featuring the US dollar. This should not represent a problem if the $1.25 line could be adjusted using a PPP rate to account for the different purchasing power of a US dollar in the United States and Zimbabwe. Unfortunately, neither the World Bank nor the IMF publish data on PPP rates for Zimbabwe, either currently or for some baseline year.

Zimbabwe has however conducted a Poverty, Income, Consumption and Employment Survey (PICES) as recently as 2011[6]. This survey has been used to construct a Poverty Datum Line, including a Food

[4] The 2013 CPI is only used for illustrative purposes. Actual conversions in the final report will refer to the applicable CPI inflation rates for the survey months in 2014, available from: http://www.bls.gov/cpi/cpid1406.pdf
[5] Available from http://www.zimstat.co.zw/dmdocuments/PRICES/April_2014.pdf

Poverty Line (FPL) and a Total Consumption Poverty Line (TCPL). The FPL is based on the standard 2100 calories criterion, whereas the TCPL incorporates an allowance for non-food requirements, including housing, clothing, transportation, health care etc.

When developing its latest poverty line standards, the World Bank based its calculations on an average of national TCPLs, and chose the $1.25 cut-off to be representative of the poverty lines found amongst poor countries[7]. For this reason, and in the absence of PPP rates for Zimbabwe, it is recommended that the national poverty line[8] is used to compute the poverty headcount ratio indicator for Zimbabwe. While this poverty line may not be directly comparable with the international $1.25 standard, it should be a close approximation, and it would be based on official data published by Zimbabwe's national statistics office.

The poverty line would be calculated as the Total Per Capita Poverty Datum Line (TPCPDL), which is a monthly measure, over the average of 30.466 days in a month. Considering that the latest TPCPDL published by Zimstat is $102.04 (February 2014), the resulting daily per capita poverty line would be $3.3547.

Mean depth of poverty

This indicator is useful to understand the average, over all people, of the gaps between poor people's living standards and the poverty line. It indicates the extent to which individuals fall below the poverty line (if they do).

Mean depth of poverty is sometimes also called the poverty gap index (PGI). The PGI is computed as the average of the differences between an individual's total daily per capita consumption and the poverty line, divided by the poverty line, with individuals over the poverty line having a contribution to the PGI of 0. The PGI is given by the formula:

$$PGI = \left(\frac{1}{N}\sum_{i=1}^{N}\left(\frac{z-y_i}{z}\right)\right) \times 100$$

Where N is the total number of individuals in the population, z is the poverty line and y_i is the daily per capita consumption of individual i. For individuals above the poverty line, set $y_i = z$so so that contribution to PGI is 0 for those individuals.

[6] See PICES (2011) report, available: http://www.zimstat.co.zw/dmdocuments/Finance/Poverty2011.pdf
[7] See World Bank (2008) "Dollar a day revisited". Available at: http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2008/09/02/000158349_20080902095754/Rendered/PDF/wps4620.pdf
[8] Total Per Capita Poverty Datum Line is available from Zimstat: http://www.zimstat.co.zw/index.php?option=com_content&view=article&id=63

ANNEX 6
Tabular Summary of Indicators
Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

Table A6.1. Title II Baseline Indicators - Overall Program Area
Indicators, 95% Confidence Intervals and Base Population [Zimbabwe, 2014]

	Indicator Value	95% CI		Number of Records	Weighted Population	Standard Error	Standard Deviation	DEFT
		Lower	Upper					
HOUSEHOLD LEVEL INDICATORS								
Average Household Dietary Diversity Score (HDDS)	5.1	5.0	5.2	4,609	133,660	0.06	4.07	2.0
Prevalence of households with moderate or severe hunger (HHS)	27.7	25.6	30.0	4,916	144,436	1.1	44.8	1.8
Adult Female no Adult Male	27.7	24.1	31.6	1,258	36,822	1.9	44.8	1.5
Adult Male no Adult Female	21.2	15.6	28.0	214	5,850	3.1	40.8	1.1
Male and Female Adults	28.1	25.9	30.4	3,428	101,340	1.1	45.0	1.5
Child No Adults	26.7	7.8	61.0	16	425	12.4	44.2	1.1
Percentage of households using an improved drinking water source	44.3	40.7	47.9	4,965	145,690	1.8	49.7	2.6
Percentage of households using improved sanitation facilities	33.0	30.6	35.5	4,965	145,690	1.2	47.0	1.8
Percentage of households with soap and water at a handwashing station commonly used by family members	2.2	1.7	2.9	4,962	145,572	0.3	14.7	1.4
AGRICULTURAL INDICATORS								
Percentage of farmers who used financial service in the past 12 months	11.2	9.6	13.1	6,298	185,987	0.9	31.6	2.3
Male farmers	12.9	10.9	15.2	2,644	79,351	1.1	33.5	1.7
Female farmers	10.0	8.3	11.9	3,654	106,636	0.9	30.0	1.8
Percentage of farmers who practiced value chain activities promoted by the project in the past 12 months	75.6	72.7	78.2	6,293	185,767	1.4	43.0	2.6
Male farmers	74.5	71.3	77.4	2,642	79,316	1.5	43.6	1.8
Female farmers	76.4	73.4	79.1	3,651	106,451	1.4	42.5	2.0
Percentage of farmers who used at least five sustainable agriculture (crop, livestock, NRM) practices and/or technologies in the past 12 months	63.8	61.4	66.2	6,215	183,253	1.2	48.0	2.0
Male farmers	68.2	65.4	70.9	2,608	78,161	1.4	46.6	1.5
Female farmers	60.6	57.9	63.1	3,607	105,092	1.3	48.9	1.6
Percentage of farmers who used at least five sustainable crop practices and/or technologies (past 12 months)	36.5	34.4	38.7	6,281	185,329	1.1	48.1	1.8
Percentage of farmers who used at least three sustainable livestock practices and/or technologies (past 12 months)	25.6	24.0	27.4	6,296	185,826	0.9	43.7	1.6
Percentage of farmers who used at least three sustainable NRM practices (past 12 months)	15.0	13.2	16.9	6,278	185,308	0.9	35.7	2.1
Percentage of farmers who used improved storage practices in the past 12 months	17.2	14.5	20.2	6,195	182,073	1.4	37.7	3.0
Male farmers	18.3	15.4	21.5	2,601	77,694	1.5	38.6	2.0
Female farmers	16.4	13.7	19.5	3,594	104,379	1.5	37.0	2.4
WOMEN'S HEALTH AND NUTRITION INDICATORS								
Prevalence of underweight women	8.6	7.5	9.9	3,046	138,430	0.6	28.0	1.2
Women's Dietary Diversity Score	3.1	3.1	3.2	3,405	152,145	0.04	2.33	1.8
CHILDREN'S HEALTH AND NUTRITION INDICATORS								
Prevalence of underweight children under 5 years of age (Total)	10.8	9.4	12.2	3,115	91,455	0.7	31.0	1.3
Prevalence of underweight children under 5 years of age (Male)	10.9	9.3	12.7	1,601	46,633	0.9	31.2	1.1
Prevalence of underweight children under 5 years of age (Female)	10.6	8.8	12.8	1,514	44,822	1.0	30.8	1.3
Prevalence of stunted children under 5 years of age (Total)	29.4	27.5	31.4	3,115	91,455	1.0	45.6	1.2
Prevalence of stunted children under 5 years of age (Male)	32.3	29.8	35.0	1,601	46,633	1.3	46.8	1.1
Prevalence of stunted children under 5 years of age (Female)	26.4	24.0	28.9	1,514	44,822	1.3	44.1	1.1
Prevalence of wasted children under 5 years of age (Total)	2.1	1.6	2.7	3,115	91,455	0.3	14.4	1.1
Prevalence of wasted children under 5 years of age (Male)	2.4	1.7	3.3	1,601	46,633	0.4	15.3	1.1
Prevalence of wasted children under 5 years of age (Female)	1.8	1.2	2.6	1,514	44,822	0.3	13.3	1.0
Percentage of children under age 5 with diarrhea in the last two weeks (Total)	21.6	19.7	23.5	3,786	111,980	0.9	41.1	1.4
Percentage of children under age 5 with diarrhea in the last two weeks (Male)	22.2	19.8	24.7	1,940	56,860	1.2	41.5	1.3
Percentage of children under age 5 with diarrhea in the last two weeks (Female)	20.9	18.6	23.5	1,846	55,120	1.2	40.7	1.3
Percentage of children under age 5 with diarrhea treated with ORT (Total)	76.9	73.1	80.2	764	24,128	1.8	42.2	1.2
Percentage of children under age 5 with diarrhea treated with ORT (Male)	74.8	69.8	79.2	399	12,602	2.4	43.4	1.1
Percentage of children under age 5 with diarrhea treated with ORT (Female)	79.1	74.6	83.0	365	11,526	2.1	40.6	1.0
Prevalence of exclusive breastfeeding of children under six months of age	39.2	33.5	45.2	320	9,201	3.0	48.8	1.1
Prevalence of exclusive breastfeeding of children under six months of age (Male)	37.2	29.6	45.5	168	4,775	4.0	48.3	1.1
Prevalence of exclusive breastfeeding of children under six months of age (Female)	41.3	33.3	49.7	152	4,425	4.1	49.2	1.0
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD)	4.7	3.5	6.4	1,073	31,969	0.8	21.2	1.1
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD) (Male)	4.2	2.6	6.8	527	15,543	1.1	20.1	1.2
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD) (Female)	5.2	3.5	7.7	546	16,426	1.1	22.2	1.1

NOTE: Prevalence of wasted children is included but is not a required FFP indicator

Table A6.2. Title II Baseline Indicators - Amalima

Indicators, 95% Confidence Intervals and Base Population [Zimbabwe, 2014]

	Indicator Value	95% CI		Number of Records	Weighted Population	Standard Error	Standard Deviation	DEFT
		Lower	Upper					
HOUSEHOLD LEVEL INDICATORS								
Average Household Dietary Diversity Score (HDDS)	5.3	5.2	5.4	2,374	49,468	0.05	2.44	1.2
Prevalence of households with moderate or severe hunger (HHS)	29.3	26.5	32.2	2,426	50,610	1.5	45.5	1.3
Adult Female no Adult Male	32.0	27.6	36.8	627	13,075	2.3	46.7	1.1
Adult Male no Adult Female	21.9	14.6	31.5	125	2,655	4.2	41.4	1.0
Male and Female Adults	28.9	25.9	32.0	1,663	34,651	1.6	45.3	1.2
Child No Adults	15.8	1.8	66.2	11	229	13.5	36.5	1.1
Percentage of households using an improved drinking water source	44.5	39.6	49.6	2,452	51,026	2.5	49.7	2.1
Percentage of households using improved sanitation facilities	40.6	36.9	44.5	2,452	51,026	1.9	49.1	1.6
Percentage of households with soap and water at a handwashing station commonly used by family members	1.6	1.0	2.4	2,452	51,026	0.3	12.4	1.1
AGRICULTURAL INDICATORS								
Percentage of farmers who used financial service in the past 12 months	5.4	4.2	7.0	3,025	62,989	0.7	22.6	1.5
Male farmers	5.3	3.8	7.4	1,190	24,966	0.9	22.5	1.1
Female farmers	5.5	4.2	7.1	1,835	38,023	0.7	22.7	1.2
Percentage of farmers who practiced value chain activities promoted by the project in the past 12 months	71.8	67.5	75.7	3,025	62,987	2.1	45.0	2.1
Male farmers	67.8	62.6	72.7	1,188	24,932	2.5	46.7	1.6
Female farmers	74.4	70.1	78.2	1,837	38,054	2.0	43.7	1.7
Percentage of farmers who used at least five sustainable agriculture (crop, livestock, NRM) practices and/or technologies in the past 12 months	56.8	52.6	60.8	2,999	62,362	2.1	49.5	1.9
Male farmers	58.8	53.5	63.8	1,180	24,718	2.6	49.2	1.5
Female farmers	55.4	51.3	59.5	1,819	37,644	2.1	49.7	1.5
Percentage of farmers who used at least five sustainable crop practices and/or technologies (past 12 months)	28.2	25.2	31.4	3,021	62,865	1.6	45.0	1.6
Percentage of farmers who used at least three sustainable livestock practices and/or technologies (past 12 months)	28.2	25.5	31.0	3,026	62,991	1.4	45.0	1.4
Percentage of farmers who used at least three sustainable NRM practices (past 12 months)	8.7	6.7	11.4	3,024	62,957	1.2	28.2	1.9
Percentage of farmers who used improved storage practices in the past 12 months	15.0	13.0	17.3	3,000	62,422	1.1	35.7	1.4
Male farmers	16.5	13.9	19.4	1,180	24,762	1.4	37.1	1.1
Female farmers	14.0	11.8	16.5	1,820	37,660	1.2	34.7	1.2
WOMEN'S HEALTH AND NUTRITION INDICATORS								
Prevalence of underweight women	13.9	12.0	15.9	1,430	47,397	1.0	34.6	0.9
Women's Dietary Diversity Score	2.8	2.7	2.9	1,579	52,261	0.04	1.59	1.3
CHILDREN'S HEALTH AND NUTRITION INDICATORS								
Prevalence of underweight children under 5 years of age (Total)	14.6	12.7	16.6	1,609	33,610	1.0	35.3	0.9
Prevalence of underweight children under 5 years of age (Male)	15.4	12.7	18.5	839	17,565	1.4	36.1	1.0
Prevalence of underweight children under 5 years of age (Female)	13.7	11.3	16.4	770	16,045	1.3	34.4	0.9
Prevalence of stunted children under 5 years of age (Total)	31.7	29.3	34.4	1,609	33,610	1.3	46.5	0.9
Prevalence of stunted children under 5 years of age (Male)	34.6	31.2	38.1	839	17,565	1.7	47.6	0.9
Prevalence of stunted children under 5 years of age (Female)	28.6	25.3	32.2	770	16,045	1.7	45.2	0.9
Prevalence of wasted children under 5 years of age (Total)	3.6	2.8	4.8	1,609	33,610	0.3	18.7	0.9
Prevalence of wasted children under 5 years of age (Male)	3.8	2.6	5.5	839	17,565	0.5	19.2	0.9
Prevalence of wasted children under 5 years of age (Female)	3.4	2.3	5.1	770	16,045	0.3	18.2	0.9
Percentage of children under age 5 with diarrhea in the last two weeks (Total)	15.8	13.6	18.4	1,881	39,429	1.2	36.5	1.2
Percentage of children under age 5 with diarrhea in the last two weeks (Male)	16.5	13.9	19.4	986	20,738	1.4	37.1	1.0
Percentage of children under age 5 with diarrhea in the last two weeks (Female)	15.1	11.8	19.1	895	18,691	1.8	35.8	1.3
Percentage of children under age 5 with diarrhea treated with ORT (Total)	71.3	64.8	77.1	294	6,243	3.1	45.2	1.0
Percentage of children under age 5 with diarrhea treated with ORT (Male)	67.3	58.6	75.0	160	3,416	4.1	46.9	0.9
Percentage of children under age 5 with diarrhea treated with ORT (Female)	76.2	68.4	82.6	134	2,827	3.6	42.6	0.8
Prevalence of exclusive breastfeeding of children under six months of age	44.9	37.1	52.9	167	3,514	4.0	49.7	0.9
Prevalence of exclusive breastfeeding of children under six months of age (Male)	45.1	35.8	54.6	92	1,958	4.7	49.8	0.8
Prevalence of exclusive breastfeeding of children under six months of age (Female)	44.7	32.5	57.6	75	1,555	6.3	49.7	0.9
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD)	3.4	2.0	5.8	510	10,647	1.0	18.1	1.0
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD) (Male)	4.0	2.0	7.9	256	5,321	1.5	19.6	1.0
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD) (Female)	2.8	1.3	6.0	254	5,326	1.2	16.5	0.9

NOTE: Prevalence of wasted children is included but is not a required FFP indicator

Table A6.3. Title II Baseline Indicators - ENSURE

Indicators, 95% Confidence Intervals and Base Population [Zimbabwe, 2014]

	Indicator Value	95% CI Lower	95% CI Upper	Number of Records	Weighted Population	Standard Error	Standard Deviation	DEFT
HOUSEHOLD LEVEL INDICATORS								
Average Household Dietary Diversity Score (HDDS)	5.0	4.8	5.1	2,235	84,192	0.08	3.78	2.3
Prevalence of households with moderate or severe hunger (HHS)	26.9	24.0	30.1	2,490	93,826	1.5	44.3	2.0
Adult Female no Adult Male	25.3	20.5	30.8	631	23,747	2.6	43.5	1.7
Adult Male no Adult Female	20.5	13.0	30.9	89	3,195	4.5	40.4	1.2
Male and Female Adults	27.7	24.8	30.8	1,765	66,689	1.5	44.8	1.6
Child No Adults	39.5	6.7	85.6	5	196	22.9	48.9	1.2
Percentage of households using an improved drinking water source	44.2	39.4	49.0	2,513	94,664	2.4	49.7	2.8
Percentage of households using improved sanitation facilities	28.9	25.9	32.1	2,513	94,664	1.6	45.3	2.0
Percentage of households with soap and water at a handwashing station commonly used by family members	2.6	1.8	3.5	2,510	94,546	0.4	15.8	1.5
AGRICULTURAL INDICATORS								
Percentage of farmers who used financial service in the past 12 months	14.2	11.8	17.0	3,273	122,998	1.3	34.9	2.4
Male farmers	16.3	13.5	19.6	1,454	54,385	1.5	37.0	1.8
Female farmers	12.5	10.0	15.4	1,819	68,613	1.4	33.0	2.0
Percentage of farmers who practiced value chain activities promoted by the project in the past 12 months	77.5	73.7	80.8	3,268	122,780	1.8	41.8	2.8
Male farmers	77.5	73.5	81.1	1,454	54,383	1.9	41.8	2.0
Female farmers	77.5	73.5	81.0	1,814	68,397	1.9	41.8	2.2
Percentage of farmers who used at least five sustainable agriculture (crop, livestock, NRM) practices and/or technologies in the past 12 months	67.5	64.5	70.3	3,216	120,891	1.5	46.8	2.0
Male farmers	72.6	69.3	75.7	1,428	53,443	1.6	44.6	1.5
Female farmers	63.4	60.0	66.7	1,788	67,448	1.7	48.2	1.7
Percentage of farmers who used at least five sustainable crop practices and/or technologies (past 12 months)	40.7	38.0	43.6	3,260	122,463	1.4	49.1	1.9
Percentage of farmers who used at least three sustainable livestock practices and/or technologies (past 12 months)	24.3	22.2	26.6	3,270	122,834	1.1	42.9	1.7
Percentage of farmers who used at least three sustainable NRM practices (past 12 months)	18.2	15.8	20.9	3,254	122,351	1.3	38.6	2.2
Percentage of farmers who used improved storage practices in the past 12 months	18.3	14.6	22.8	3,195	119,651	2.1	38.7	3.4
Male farmers	19.1	15.2	23.8	1,421	52,933	2.2	39.3	2.3
Female farmers	17.7	13.8	22.5	1,774	66,719	2.2	38.2	2.8
WOMEN'S HEALTH AND NUTRITION INDICATORS								
Prevalence of underweight women	5.9	4.5	7.6	1,616	91,033	0.8	23.5	1.4
Women's Dietary Diversity Score	3.3	3.2	3.4	1,826	99,885	0.06	2.56	2.0
CHILDREN'S HEALTH AND NUTRITION INDICATORS								
Prevalence of underweight children under 5 years of age (Total)	8.6	6.9	10.6	1,506	57,845	0.9	28.0	1.5
Prevalence of underweight children under 5 years of age (Male)	8.2	6.4	10.5	762	29,068	1.0	27.4	1.2
Prevalence of underweight children under 5 years of age (Female)	8.9	6.6	12.0	744	28,777	1.4	28.5	1.5
Prevalence of stunted children under 5 years of age (Total)	28.1	25.4	30.9	1,506	57,845	1.4	44.9	1.4
Prevalence of stunted children under 5 years of age (Male)	31.0	27.4	34.8	762	29,068	1.9	46.2	1.3
Prevalence of stunted children under 5 years of age (Female)	25.1	21.9	28.7	744	28,777	1.7	43.4	1.2
Prevalence of wasted children under 5 years of age (Total)	1.2	0.7	2.1	1,506	57,845	0.5	11.0	1.3
Prevalence of wasted children under 5 years of age (Male)	1.5	0.8	2.8	762	29,068	0.7	12.3	1.2
Prevalence of wasted children under 5 years of age (Female)	0.9	0.4	1.9	744	28,777	0.7	9.5	1.1
Percentage of children under age 5 with diarrhea in the last two weeks (Total)	24.7	22.2	27.3	1,905	72,551	1.3	43.1	1.5
Percentage of children under age 5 with diarrhea in the last two weeks (Male)	25.5	22.2	29.0	954	36,122	1.7	43.6	1.4
Percentage of children under age 5 with diarrhea in the last two weeks (Female)	23.9	20.8	27.3	951	36,429	1.7	42.6	1.4
Percentage of children under age 5 with diarrhea treated with ORT (Total)	78.8	74.2	82.7	470	17,885	2.1	40.9	1.2
Percentage of children under age 5 with diarrhea treated with ORT (Male)	77.6	71.4	82.7	239	9,186	2.9	41.7	1.2
Percentage of children under age 5 with diarrhea treated with ORT (Female)	80.1	74.5	84.7	231	8,699	2.6	39.9	1.1
Prevalence of exclusive breastfeeding of children under six months of age	35.6	28.0	44.0	153	5,687	4.1	47.9	1.2
Prevalence of exclusive breastfeeding of children under six months of age (Male)	31.8	21.3	44.5	76	2,817	5.8	46.6	1.3
Prevalence of exclusive breastfeeding of children under six months of age (Female)	39.4	29.3	50.4	77	2,870	5.3	48.9	1.1
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD)	5.4	3.7	7.8	563	21,322	1.0	22.6	1.2
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD) (Male)	4.4	2.3	8.1	271	10,222	1.5	20.4	1.3
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD) (Female)	6.4	4.1	9.9	292	11,100	1.5	24.4	1.1

NOTE: Prevalence of wasted children is included but is not a required FFP indicator

Table A6.4. Title II FFP Baseline Indicators - Program Comparisons
Indicators and P-values for Test of Differences [Zimbabwe, 2014]

	Indicator Value		P-value
	Amalima	ENSURE	
HOUSEHOLD LEVEL INDICATORS			
Average Household Dietary Diversity Score (HDDS)	5.3	5.0	.00**
Prevalence of households with moderate or severe hunger (HHS)	29.3	26.9	.27
Adult Female no Adult Male	32.0	25.3	.06
Adult Male no Adult Female	21.9	20.5	.82
Male and Female Adults	28.9	27.7	.61
Child No Adults	15.8	39.5	.40
Percentage of households using an improved drinking water source	44.5	44.2	.92
Percentage of households using improved sanitation facilities	40.6	28.9	.00**
Percentage of households with soap and water at a handwashing station commonly used by family members	1.6	2.6	.07
AGRICULTURAL INDICATORS			
Percentage of farmers who used financial service in the past 12 months	5.4	14.2	.00**
Male farmers	5.3	16.3	.00**
Female farmers	5.5	12.5	.00**
Percentage of farmers who practiced value chain activities promoted by the project in the past 12 months	71.8	77.5	.04*
Male farmers	67.8	77.5	.00**
Female farmers	74.4	77.5	.26
Percentage of farmers who used at least five sustainable agriculture (crop, livestock, NRM) practices and/or technologies in the past 12 months	56.8	67.5	.00**
Male farmers	58.8	72.6	.00**
Female farmers	55.4	63.4	.00**
Percentage of farmers who used at least five sustainable crop practices and/or technologies (past 12 months)	28.2	40.7	.00**
Percentage of farmers who used at least three sustainable livestock practices and/or technologies (past 12 months)	28.2	24.3	.03*
Percentage of farmers who used at least three sustainable NRM practices (past 12 months)	8.7	18.2	.00**
Percentage of farmers who used improved storage practices in the past 12 months	15.0	18.3	.14
Male farmers	16.5	19.1	.31
Female farmers	14.0	17.7	.12
WOMEN'S HEALTH AND NUTRITION INDICATORS			
Prevalence of underweight women	13.9	5.9	.00**
Women's Dietary Diversity Score	2.8	3.3	.00**
CHILDREN'S HEALTH AND NUTRITION INDICATORS			
Prevalence of underweight children under 5 years of age (Total)	14.6	8.6	.02*
Prevalence of underweight children under 5 years of age (Male)	15.4	8.2	.00**
Prevalence of underweight children under 5 years of age (Female)	13.7	8.9	.02*
Prevalence of stunted children under 5 years of age (Total)	31.7	28.1	.16
Prevalence of stunted children under 5 years of age (Male)	34.6	31.0	.16
Prevalence of stunted children under 5 years of age (Female)	28.6	25.1	.16
Prevalence of wasted children under 5 years of age (Total)	3.6	1.2	.00**
Prevalence of wasted children under 5 years of age (Male)	3.8	1.5	.01*
Prevalence of wasted children under 5 years of age (Female)	3.4	0.9	.00**
Percentage of children under age 5 with diarrhea in the last two weeks (Total)	15.8	24.7	.00**
Percentage of children under age 5 with diarrhea in the last two weeks (Male)	16.5	25.5	.00**
Percentage of children under age 5 with diarrhea in the last two weeks (Female)	15.1	23.9	.00**
Percentage of children under age 5 with diarrhea treated with ORT (Total)	71.3	78.8	.05*
Percentage of children under age 5 with diarrhea treated with ORT (Male)	67.3	77.6	.04*
Percentage of children under age 5 with diarrhea treated with ORT (Female)	76.2	80.1	.38
Prevalence of exclusive breastfeeding of children under six months of age	44.9	35.6	.11
Prevalence of exclusive breastfeeding of children under six months of age (Male)	45.1	31.8	.09
Prevalence of exclusive breastfeeding of children under six months of age (Female)	44.7	39.4	.53
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD)	3.4	5.4	.16
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD) (Male)	4.0	4.4	.85
Prevalence of children 6-23 months of age receiving a minimum acceptable diet (MAD) (Female)	2.8	6.4	.07

* p <.05
** p <.01

Table A6.5. Title II Program-specific Indicators - Overall Title II Program Area
Indicators, 95% Confidence Intervals and Base Population [Zimbabwe, 2014]

	Indicator Value	95% CI		Number of Records	Weighted Population	Standard Error	Standard Deviation	DEFT
		Lower	Upper					
Food Security (All Households)								
Average Coping Strategies Index	30.5	28.7	32.2	4,888	143,309	0.89	62.48	1.8
Food Consumption Score								
Percentage of households with FCS =< 21 (Poor)	4.1	3.4	5.0	205	6,073	0.4	19.9	1.4
Percentage of households with FCS > 21 and FCS =< 35 (Borderline)	32.0	30.0	34.0	1,574	46,811	1.0	46.6	1.5
Percentage of households with FCS > 35 (Adequate)	63.9	61.7	66.1	3,214	93,598	1.1	48.0	1.6
Poverty (All Households)								
Per capita expenditures (as a proxy for income) of USG targeted beneficiaries	0.50	0.48	0.52	4,995	770,157	0.01	0.71	1.6
Adult Female no Adult Male	0.51	0.48	0.55	1,277	150,206	0.02	0.71	1.5
Adult Male no Adult Female	0.78	0.69	0.88	221	12,851	0.05	0.74	1.1
Male and Female Adults	0.49	0.47	0.51	3,481	605,972	0.01	0.59	1.4
Child No Adults	0.53	0.34	0.71	16	1,127	0.08	0.32	0.9
Percent of people living below the Total Per Capita Poverty Datum Line (TPCPDL)[1]	96.9	96.2	97.4	4,995	770,157	0.3	17.5	1.2
Adult Female no Adult Male	96.7	95.1	97.8	1,277	150,206	0.7	17.9	1.3
Adult Male no Adult Female	85.5	79.7	89.8	221	12,851	2.5	35.3	1.1
Male and Female Adults	97.1	96.5	97.7	3,481	605,972	0.3	16.7	1.1
Child No Adults	98.4	88.4	99.8	16	1,127	1.4	12.6	0.4
Mean depth of poverty (using the TPCPDL)	65.2	64.0	66.3	4,995	770,157	0.57	40.28	1.8
Adult Female no Adult Male	64.2	62.3	66.1	1,277	150,206	0.96	34.31	1.5
Adult Male no Adult Female	49.9	45.0	54.8	221	12,851	2.49	37.02	1.2
Male and Female Adults	65.7	64.5	66.9	3,481	605,972	0.59	34.81	1.6
Child No Adults	62.0	48.6	75.4	16	1,127	5.81	23.24	0.9
Water Treatment, Storage, and Handwashing (All Households)								
Percent of households practicing correct use of recommended household water treatment technologies	10.9	9.4	12.6	5,003	146,751	0.8	31.1	1.8
Percent of households practicing safe storage of drinking water	51.9	48.6	55.2	5,002	146,725	1.7	50.0	2.4
Percent of households with a handwashing station near a sanitation facility	2.7	2.0	3.6	2,545	76,401	0.4	16.2	1.2
Antenatal Care (Women 15-49 with pregnancy in the past 5 years)								
Average number of antenatal care visits by pregnant women	4.7	4.5	4.9	979	40,916	0.10	3.09	1.4
Number of months pregnant at time of first ANC visit								
Percent <4 months pregnant	20.8	18.0	24.0	205	8,514	1.5	40.6	1.2
Percent 4-5 months pregnant	40.8	37.3	44.4	388	16,700	1.8	49.1	1.1
Percent 6-7 months pregnant	25.8	22.5	29.4	256	10,566	1.8	43.8	1.3
Percent 8 or more months pregnant	6.9	5.4	8.9	76	2,825	0.9	25.4	1.1
Percent with no antenatal care	5.6	4.0	8.0	54	2,310	1.0	23.1	1.3
Gender (Primary Male and Female Decision Makers)								
Females								
Percentage who achieve adequacy in ownership of assets	86.3	84.9	87.7	4,566	140,358	0.7	34.4	1.4
Percentage who achieve adequacy in decision-making for purchase, sale or ownership of assets	72.3	70.0	74.4	4,559	140,118	1.1	44.8	1.7
Percentage who achieve adequacy in decisions on credit	32.2	30.1	34.3	4,499	138,637	1.1	46.7	1.5
Males								
Percentage who achieve adequacy in ownership of assets	93.7	92.5	94.8	2,624	92,942	0.6	24.2	1.3
Percentage who achieve adequacy in decision-making for purchase, sale or ownership of assets	83.9	81.3	86.3	2,622	92,887	1.3	36.7	1.8
Percentage who achieve adequacy in decisions on credit	30.0	27.5	32.6	2,591	92,056	1.3	45.8	1.4

[1] Based on Zimbabwe's Total Per Capita Poverty Datum Line (TPCPDL), equivalent to a daily per capita poverty line of 3.3547 USD

Table A6.6. Title II Program-specific Indicators - Amalima
Indicators, 95% Confidence Intervals and Base Population [Zimbabwe, 2014]

	Indicator Value	95% CI		Number of Records	Weighted Population	Standard Error	Standard Deviation	DEFT
		Lower	Upper					
Food Security (All Households)								
Average Coping Strategies Index	33.8	31.2	36.4	2,426	50,639	1.31	62.48	1.4
Food Consumption Score								
Percentage of households with FCS =< 21 (Poor)	4.0	3.2	5.0	99	2,075	0.4	19.9	0.9
Percentage of households with FCS > 21 and FCS =< 35 (Borderline)	31.4	29.1	33.8	779	16,209	1.2	46.6	1.1
Percentage of households with FCS > 35 (Adequate)	64.6	61.9	67.2	1,597	33,346	1.4	48.0	1.2
Poverty (All Households)								
Per capita expenditures (as a proxy for income) of USG targeted beneficiaries	0.45	0.43	0.47	2,473	283,480	0.01	0.50	1.3
Adult Female no Adult Male	0.45	0.42	0.48	638	57,231	0.01	0.25	1.0
Adult Male no Adult Female	0.67	0.57	0.76	130	6,371	0.05	0.57	1.0
Male and Female Adults	0.44	0.42	0.47	1,694	219,261	0.01	0.41	1.2
Child No Adults	0.42	0.19	0.65	11	618	0.10	0.33	0.8
Percent of people living below the Total Per Capita Poverty Datum Line (TPCPDL)[1]	98.2	97.6	98.6	2,473	283,480	0.3	13.4	0.8
Adult Female no Adult Male	98.7	97.6	99.4	638	57,231	0.4	11.1	0.8
Adult Male no Adult Female	88.6	83.4	92.3	130	6,371	2.2	31.8	0.7
Male and Female Adults	98.3	97.5	98.8	1,694	219,261	0.3	12.9	0.9
Child No Adults	97.1	83.2	99.6	11	618	2.3	16.9	0.4
Mean depth of poverty (using the TPCPDL)	68.5	67.2	69.8	2,473	283,480	0.66	32.82	1.4
Adult Female no Adult Male	68.1	66.1	70.0	638	57,231	0.99	25.01	1.1
Adult Male no Adult Female	55.5	49.6	61.4	130	6,371	2.98	33.98	1.1
Male and Female Adults	68.9	67.5	70.4	1,694	219,261	0.72	29.63	1.3
Child No Adults	69.9	53.5	86.2	11	618	7.08	23.48	0.8
Water Treatment, Storage, and Handwashing (All Households)								
Percent of households practicing correct use of recommended household water treatment technologies	8.6	7.1	10.4	2,482	51,800	0.8	31.1	1.3
Percent of households practicing safe storage of drinking water	49.7	44.0	55.3	2,481	51,774	2.8	50.0	2.4
Percent of households with a handwashing station near a sanitation facility	2.6	1.7	4.1	1,168	24,241	0.6	16.2	1.1
Antenatal Care (Women 15-49 with pregnancy in the past 5 years)								
Average number of antenatal care visits by pregnant women	4.7	4.4	5.0	419	12,894	0.15	3.09	1.2
Number of months pregnant at time of first ANC visit								
Percent <4 months pregnant	23.2	18.7	28.3	94	2,989	2.4	40.6	1.0
Percent 4-5 months pregnant	42.4	37.2	47.6	170	5,461	2.6	49.1	0.9
Percent 6-7 months pregnant	21.3	17.7	25.4	98	2,747	1.9	43.8	0.8
Percent 8 or more months pregnant	9.1	6.2	13.2	40	1,177	1.7	25.4	1.1
Percent with no antenatal care	4.0	2.2	7.4	17	520	1.2	23.1	1.1
Gender (Primary Male and Female Decision Makers)								
Females								
Percentage who achieve adequacy in ownership of assets	89.9	88.1	91.5	2,207	47,830	0.9	34.4	1.1
Percentage who achieve adequacy in decision-making for purchase, sale or ownership of assets	80.8	79.0	82.6	2,205	47,782	0.9	44.8	0.9
Percentage who achieve adequacy in decisions on credit	37.3	34.5	40.2	2,165	46,991	1.4	46.7	1.2
Males								
Percentage who achieve adequacy in ownership of assets	91.6	89.5	93.3	1,161	28,661	1.0	24.2	1.0
Percentage who achieve adequacy in decision-making for purchase, sale or ownership of assets	82.9	79.1	86.1	1,159	28,603	1.8	36.7	1.3
Percentage who achieve adequacy in decisions on credit	30.6	27.4	34.1	1,141	28,228	1.7	45.8	1.0

[1] Based on Zimbabwe's Total Per Capita Poverty Datum Line (TPCPDL), equivalent to a daily per capita poverty line of 3.3547 USD

Table A6.7. Title II Program-specific Indicators - ENSURE
Indicators, 95% Confidence Intervals and Base Population [Zimbabwe, 2014]

	Indicator Value	95% CI		Number of Records	Weighted Population	Standard Error	Standard Deviation	DEFT
		Lower	Upper					
Food Security (All Households)								
Average Coping Strategies Index	28.6	26.3	31.0	2,462	92,670	1.18	62.48	2.0
Food Consumption Score								
Percentage of households with FCS =< 21 (Poor)	4.2	3.2	5.5	106	3,999	0.6	19.9	1.6
Percentage of households with FCS > 21 and FCS =< 35 (Borderline)	32.3	29.5	35.1	795	30,602	1.4	46.6	1.7
Percentage of households with FCS > 35 (Adequate)	63.5	60.4	66.5	1,617	60,252	1.6	48.0	1.8
Poverty (All Households)								
Per capita expenditures (as a proxy for income) of USG targeted beneficiaries	0.53	0.51	0.56	2,522	486,676	0.01	0.50	1.7
Adult Female no Adult Male	0.56	0.51	0.60	639	92,975	0.02	0.51	1.6
Adult Male no Adult Female	0.90	0.75	1.05	91	6,480	0.07	0.67	1.1
Male and Female Adults	0.52	0.50	0.55	1,787	386,712	0.01	0.42	1.5
Child No Adults	0.66	0.36	0.96	5	509	0.13	0.29	1.1
Percent of people living below the Total Per Capita Poverty Datum Line (TPCPDL)[1]	96.1	95.1	96.9	2,522	486,676	0.4	19.4	1.3
Adult Female no Adult Male	95.4	92.9	97.1	639	92,975	1.0	20.9	1.4
Adult Male no Adult Female	82.4	71.7	89.6	91	6,480	4.5	38.1	1.2
Male and Female Adults	96.5	95.5	97.3	1,787	386,712	0.4	18.5	1.1
Child No Adults	100.0	100.0	100.0	5	509	0.0	0.0	0.0
Mean depth of poverty (using the TPCPDL)	63.2	61.6	64.8	2,522	486,676	0.82	41.18	1.9
Adult Female no Adult Male	61.8	59.0	64.7	639	92,975	1.43	36.15	1.6
Adult Male no Adult Female	44.4	37.2	51.5	91	6,480	3.62	34.53	1.2
Male and Female Adults	63.9	62.2	65.5	1,787	386,712	0.83	35.09	1.7
Child No Adults	52.5	30.9	74.0	5	509	9.35	20.91	1.1
Water Treatment, Storage, and Handwashing (All Households)								
Percent of households practicing correct use of recommended household water treatment technologies	12.1	10.0	14.6	2,521	94,951	1.2	31.1	2.0
Percent of households practicing safe storage of drinking water	53.2	49.1	57.2	2,521	94,951	2.0	50.0	2.3
Percent of households with a handwashing station near a sanitation facility	2.7	1.9	3.9	1,377	52,160	0.5	16.2	1.3
Antenatal Care (Women 15-49 with pregnancy in the past 5 years)								
Average number of antenatal care visits by pregnant women	4.7	4.4	4.9	560	28,022	0.13	3.09	1.5
Number of months pregnant at time of first ANC visit								
Percent <4 months pregnant	19.7	16.2	23.8	111	5,525	1.9	40.6	1.3
Percent 4-5 months pregnant	40.1	35.6	44.8	218	11,239	2.3	49.1	1.2
Percent 6-7 months pregnant	27.9	23.3	33.0	158	7,819	2.4	43.8	1.4
Percent 8 or more months pregnant	5.9	4.2	8.2	36	1,648	1.0	25.4	1.1
Percent with no antenatal care	6.4	4.2	9.6	37	1,790	1.3	23.1	1.4
Gender (Primary Male and Female Decision Makers)								
Females								
Percentage who achieve adequacy in ownership of assets	84.5	82.4	86.3	2,359	92,528	1.0	34.4	1.5
Percentage who achieve adequacy in decision-making for purchase, sale or ownership of assets	67.9	64.5	71.0	2,354	92,335	1.7	44.8	1.9
Percentage who achieve adequacy in decisions on credit	29.6	26.8	32.4	2,334	91,646	1.4	46.7	1.7
Males								
Percentage who achieve adequacy in ownership of assets	94.7	93.0	96.0	1,463	64,280	0.7	24.2	1.4
Percentage who achieve adequacy in decision-making for purchase, sale or ownership of assets	84.4	80.9	87.4	1,463	64,285	1.7	36.7	1.9
Percentage who achieve adequacy in decisions on credit	29.7	26.5	33.1	1,450	63,828	1.7	45.8	1.6

[1] Based on Zimbabwe's Total Per Capita Poverty Datum Line (TPCPDL), equivalent to a daily per capita poverty line of 3.3547 USD

Table A6.8. Title II Program-specific Indicators - Program Comparisons
Indicators and P-values for Test of Differences [Zimbabwe, 2014]

	Indicator Value		P-value
	Amalima	ENSURE	
Food Security (All Households)			
Average Coping Strategies Index	33.8	28.6	.00**
Food Consumption Score			
Percentage of households with FCS =< 21 (Poor)	4.0	4.2	.88
Percentage of households with FCS > 21 and FCS =< 35 (Borderline)	31.4	32.3	
Percentage of households with FCS > 35 (Adequate)	64.6	63.5	
Poverty (All Households)			
Per capita expenditures (as a proxy for income) of USG targeted beneficiaries	0.45	0.53	.00**
Adult Female no Adult Male	0.45	0.56	.00**
Adult Male no Adult Female	0.67	0.90	.01*
Male and Female Adults	0.44	0.52	.00**
Child No Adults	0.42	0.66	.18
Percent of people living below the Total Per Capita Poverty Datum Line (TPCPDL)[1]	98.2	96.1	.00**
Adult Female no Adult Male	98.7	95.4	.00**
Adult Male no Adult Female	88.6	82.4	.19
Male and Female Adults	98.3	96.5	.00**
Child No Adults	97.1	100.0	.00**
Mean depth of poverty (using the TPCPDL)	68.5	63.2	.00**
Adult Female no Adult Male	68.1	61.8	.00**
Adult Male no Adult Female	55.5	44.4	.02*
Male and Female Adults	68.9	63.9	.00**
Child No Adults	69.9	52.5	.18
Water Treatment, Storage, and Handwashing (All Households)			
Percent of households practicing correct use of recommended household water treatment technologies	8.6	12.1	.01*
Percent of households practicing safe storage of drinking water	49.7	53.2	.32
Percent of households with a handwashing station near a sanitation facility	2.6	2.7	.88
Antenatal Care (Women 15-49 with pregnancy in the past 5 years)			
Average number of antenatal care visits by pregnant women	4.7	4.7	.82
Number of months pregnant at time of first ANC visit			
Percent <4 months pregnant	23.2	19.7	.05*
Percent 4-5 months pregnant	42.4	40.1	
Percent 6-7 months pregnant	21.3	27.9	
Percent 8 or more months pregnant	9.1	5.9	
Percent with no antenatal care	4.0	6.4	
Gender (Primary Male and Female Decision Makers)			
Females			
Percentage who achieve adequacy in ownership of assets	89.9	84.5	.00**
Percentage who achieve adequacy in decision-making for purchase, sale or ownership of assets	80.8	67.9	.00**
Percentage who achieve adequacy in decisions on credit	37.3	29.6	.00**
Males			
Percentage who achieve adequacy in ownership of assets	91.6	94.7	.01*
Percentage who achieve adequacy in decision-making for purchase, sale or ownership of assets	82.9	84.4	.52
Percentage who achieve adequacy in decisions on credit	30.6	29.7	.70

* p <.05
** p <.01
[1] Based on Zimbabwe's Total Per Capita Poverty Datum Line (TPCPDL), equivalent to a daily per capita poverty line of 3.3547 USD

ANNEX 7
Multivariate Model Results
Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

Predictors of Stunting

To understand factors that might influence stunting, ordinary least-squares (OLS) regression models were run for height-for-age (HAZ) scores (or Z-scores) of children under 24 months of age for the total sample and separately for each program area, adjusted to take the sampling design effect into account. An OLS regression model can be useful to understand the relationship between a continuous dependent variable (in this case, HAZ) and several predictors or independent

The selection of the subgroup of children aged 0-23 months is based on a theoretical and practical rationale. From a theoretical perspective, growth retardation accumulates from pregnancy until 24 months of age. This loss is not recovered, and catch-up growth later on in childhood is minimal.[1] It is thus most critical to explore the drivers of stunting among this age group, as the drivers for older children will have to be found in children's nutritional history at an earlier time in their lives, data which is beyond the scope of this survey. As part of the baseline studies, ICF will explore contextual, demographic, food insecurity and feeding related factors that may most strongly be associated with children's growth faltering in the PVO areas, and also to potentially help guide program design/targeting. The second reason for selecting the sub-group of children aged 0-23 months is data availability. Data on IYCF practices, including dietary diversity, feeding frequency and breastfeeding status, is collected only for this age group in the survey. IYCF practices are a critical driver of stunting, and their inclusion will likely improve the fit of the multivariate model.

HAZ is a continuous variable that indicates the difference, expressed in standard deviations (SD), between the child's height and the median height for children of the same sex and age in the reference population used for the WHO anthropometry standards. Children are considered "moderately and severely stunted" when they are two SDs below the WHO standard height for their age. Thus, even though "stunting" is a categorical variable and HAZ is a continuous variable, the two are related so that when HAZ scores increase, stunting rates decrease.

Specifying a model for multivariate analysis is a critical process that requires in-depth knowledge of the subject matter, the scientific literature and the context of the data. Meaningful IVs were selected by identifying the intersection between the IVs identified in the literature and previous studies, and those collected by the Title II survey. Independent variables in the model include the following:

- *Demographic characteristics of the child:* Sex, age, age squared,[2] a sex-by-age interaction term.[3]
- *Child nutrition:* Adequate infant and young child feeding practices,[4] breastfeeding status, consumption of vitamin-A rich fruits and vegetables and diarrhea status in the last two weeks.
- *Maternal and caretaker characteristics:* Presence of mother, maternal age, education of primary caretaker and maternal marital status.[5]
- *Socioeconomic status:* HDDS, HHS, FCS, food consumption and total consumption.

[1] Victora, Cesar G., et al., 'Worldwide Timing of Growth Faltering: Revisiting implications for interventions', Pediatrics, vol. 125, no. 3, 1 February 2010, p. 473.
[2] The literature indicates that the relationship between age and stunting is often non-linear, with HAZ declining faster during the first months of life. A visual inspection of the age by HAZ distribution shows that indeed the decline in zhaz is not linear. Age was thus included as a quadratic term to improve the non-linearity assumption.
[3] An interaction term allows for the coefficient of a given predictor to differ across groups of individuals. The sex by age interaction term tests the hypothesis that the linear relationship between age and stunting is different for male and female children.
[4] Adequate infant and young child feeding practices was computed as the combination of exclusive breastfeeding (for children under six months of age) and minimum acceptable diet for children 6-23 months of age.
[5] Marital status of mothers included Married/Living together, Divorced/Separated, Widowed, and Never Married/Living Together. All of these categories had more than 80 children in them.

- *Household composition:* Number of prime-aged adults (15-49 years of age), number of elder dependents (50 years of age or older), number of young dependents (5-14 years of age) and number of children (under five years of age).
- *Household water and sanitation:* Improved source of drinking water, water treatment before drinking, improved and not-shared sanitation facility, cleansing agent and water available at handwashing station.
- *District* (geographic location of household).

The distributional properties of all IVs were examined to verify that they met the requirements for multivariate analysis (normality, linearity, homoscedasticity). Several variable transformations were done as a result of this examination. Food consumption, total consumption and the Food Consumption Score are positively skewed, with the majority of households clustering at the bottom of the distribution. These variables were transformed using a logarithmic transformation with base 10 to improve the normality assumption. Additionally, the literature indicates that the relationship between age and stunting is often non-linear, with HAZ declining faster during the first months of life. A visual inspection of the age by HAZ distribution shows that indeed the decline in zhaz is not linear. Age was thus included as a quadratic term to improve the non-linearity assumption.

Homoscedasticity was tested through a visual inspection of residuals plotted against fitted values (see Figure 2), which disconfirmed the possibility of heteroskedasticity. This was formally tested using the Breusch-Pagan test, which tests the null hypothesis that the error variances are all equal versus the alternative that the error variances are a multiplicative function of one or more variables. In this case, the chi-square value was small and not statistically significant, confirming that heteroskedasticity was not a problem ($\chi^2 = 0.01$, $p = .93$).

A final test was done to check for the possibility of multi-collinearity, a condition that arises when the variables in the model are highly intercorrelated, leading to unstable coefficients and inflated standard errors. Variance inflation factors indicated that total consumption and food consumption were highly collinear, so total consumption was dropped from the model. Finally HDDS and HHS were also dropped to increase the total effective sample size and avoid redundancy in predictors. Since maternal age and marital status also reduces the effective sample size, due to the absence of some mothers, the initial models were estimated using maternal status only, and excluding maternal age and marital status.

Table A1 shows statistical results for the OLS models, including the β coefficients for each individual predictor. Separate models were computed for the total sample and each program. However, since the effective sample size is relatively small (n = 1,106), we focus on the total sample results in our discussion. The overall model shows an $R^2 = .18$, indicating that the independent variables in the models explain 18 percent of the variance in HAZ scores. Maternal variables (maternal age and marital status) were introduced as an attempt to improve model fit, with no additional gains in R^2.

This relatively low explanatory power is not surprising, considering that the model only includes a limited subset of the predictors that the literature identifies as relevant. Important child-level predictors that were not collected as part of the Title II baseline survey include birth weight (Adair, 1989), breastfeeding duration and initiation (Mbuya et al. 2010), immunization status (Adair, 1989), iron, zinc or vitamin A supplementation (Bhutta et al., 2008, Berger et al., 2007). Important maternal-level predictors of child HAZ were omitted as well, including maternal BMI and height (Mbuya et al., 2010, Adair & Guilkey, 1997), maternal health (Christian, 2009) or maternal supplementation with zinc, iron folate or micronutrients during pregnancy (Bhutta et al., 2008; Misra et al., 2005).

In a multiple OLS regression model, the β coefficient for individual predictors indicate the change in HAZ scores for a unit increase in the predictor variable, with all other predictors in the model held

constant. The following variables were significant predictors for HAZ (note the inverse relationship between HAZ and stunting; that is, when HAZ scores increase, stunting rates decrease)[6]:

- *Sex:* Female children have an advantage of 0.43 in HAZ over male children.
- *Age:* As the significant and negative "age in months squared" term indicates, the decline in HAZ is faster during the later months of an infant's life. An inspection of the age-by-HAZ relationship shows that Z-scores drop more markedly after 12 months of age.
- *Breastfeeding:* Children that are currently breastfed have a lower Z-score (-0.28) than non-breastfed children, which is counterintuitive in terms of what would be expected.
- *Number of children in the household (under five years of age)*: The presence of each additional child in the household is associated with a decline of -0.14 in Z-scores.
- *District:* Using Buhera district as the reference point, four districts have significantly lower Z-scores than the rest: Bikita (-0.95), Bulilima (-0.66), Tsholotsho (-0.43) and Zaka (-0.43).

The results of the multivariate analyses suggest that some specific population subgroups are in need of particular attention. For example, male children and children 12 months of age or older seem at greater risk of stunting. Households with many young children and those in the Bikita, Bulilima, Tsholotsho and Zaka districts are at greater risk of child stunting.

The negative relationship between breastfeeding and HAZ must be examined in combination with age and complementary feeding practices. A possible explanation is that children 24 months of age and older that are still breastfeeding may be doing so to compensate for the lack of age-appropriate alternatives, and may not be receiving adequate complementary feeding. This hypothesis can be formally tested by examining the prevalence of MAD for different age groups, which indeed shows a lower rate of MAD for older children than for younger children (Wald F = 7.497, p=.001).

[6] An example may clarify this negative relationship for the confused reader: a child that has an HAZ = -3SD would be stunted, but if the child's HAZ score increased to -1SD, the child would no longer be stunted. Therefore an increase in HAZ is associated with a decrease in stunting.

Table 21. Multiple OLS Models of Height for Age Z-score of Children 0-23 months

Dependent: Height for Age Z-score	Total (R^2 = .18)		Amalima (R^2 = .16)		ENSURE (R^2 = .22)	
Independent Variables	β (std. err.)	p-value	β (std. err.)	p-value	β (std. err.)	p-value
Child Characteristics						
Sex (Female)	0.43 (0.18)	*0.02**	0.43 (0.24)	*0.08*	0.43 (0.26)	*0.10*
Age in months	0.00 (0.03)	*0.94*	0.00 (0.05)	*0.95*	0.00 (0.04)	*0.92*
Sex*age interaction	-0.01 (0.01)	*0.30*	-0.01 (0.02)	*0.41*	-0.01 (0.02)	*0.58*
Age in months squared	-0.003 (0.00)	*0.01**	-0.002 (0.00)	*0.21*	-0.004 (0.00)	*0.03**
Child had diarrhea in the last 2 weeks	-0.20 (0.11)	*0.06*	0.08 (0.17)	*0.65*	-0.33 (0.13)	*0.02**
Currently breastfeeding	-0.28 (0.13)	*0.04**	0.02 (0.18)	*0.89*	-0.45 (0.19)	*0.02**
Adequate IYCF	0.02 (0.14)	*0.87*	0.15 (0.18)	*0.41*	-0.07 (0.20)	*0.73*
Consumed Vitamin A rich fruits and vegetables yesterday	0.07 (0.09)	*0.43*	-0.04 (0.12)	*0.76*	0.17 (0.13)	*0.18*
Characteristics of Primary Caretaker/Mother						
Education level of primary caretaker (Primary)	-0.16 (0.23)	*0.50*	-0.46 (0.29)	*0.12*	-0.02 (0.30)	*0.96*
Education level of primary caretaker (Secondary or higher)	0.03 (0.23)	*0.91*	-0.46 (0.29)	*0.12*	0.26 (0.30)	*0.40*
Mother absent	0.11 (0.17)	*0.51*	0.09 (0.21)	*0.67*	0.13 (0.25)	*0.60*
Mother deceased	-0.26 (0.31)	*0.39*	-0.56 (0.36)	*0.13*	-0.04 (0.38)	*0.92*
Household Composition						
Number of prime-aged adults (15-49)	0.02 (0.03)	*0.57*	0.03 (0.04)	*0.44*	0.02 (0.05)	*0.75*
Number of elder dependents (50 or older)	-0.01 (0.05)	*0.86*	0.04 (0.07)	*0.54*	-0.04 (0.08)	*0.57*
Number of young dependents (5-14)	0.01 (0.03)	*0.82*	0.03 (0.04)	*0.47*	-0.01 (0.04)	*0.75*
Number of children (0-4)	-0.14 (0.06)	*0.04**	-0.03 (0.08)	*0.76*	-0.21 (0.09)	*0.02**
Number of farmers	-0.08 (0.06)	*0.20*	-0.19 (0.10)	*0.05*	-0.02 (0.08)	*0.77*
Household Socioeconomic Status						
Daily per capita food consumption (log)	-0.25 (0.31)	*0.42*	-0.46 (0.37)	*0.22*	-0.15 (0.44)	*0.73*
Food Consumption Score (log)	0.47 (0.35)	*0.17*	0.01 (0.50)	*0.98*	0.69 (0.46)	*0.14*
Household Water and Sanitation						
Improved, not shared sanitation facility	0.02 (0.1)	*0.81*	0.14 (0.12)	*0.24*	-0.03 (0.13)	*0.81*
Improved source of drinking water	-0.05 (0.09)	*0.60*	-0.03 (0.11)	*0.80*	-0.10 (0.13)	*0.45*
Cleansing agent and water available at handwashing station	-0.3 (0.32)	*0.35*	0.87 (0.49)	*0.08*	-0.97 (0.32)	*0**
Safe storage of drinking water	-0.02 (0.09)	*0.87*	0.00 (0.12)	*1.00*	-0.02 (0.13)	*0.91*
Water treatment prior to drinking	-0.1 (0.14)	*0.46*	-0.28 (0.22)	*0.20*	0.00 (0.18)	*0.98*
District						
Buhera (Manicaland)	*Reference district*		-	-	*Reference district*	
Chimanimani (Manicaland)	-0.07 (0.28)	*0.82*	-	-	-0.10 (0.29)	*0.74*
Chipinge (Manicaland)	-0.26 (0.19)	*0.18*	-	-	-0.21 (0.20)	*0.29*
Tsholotsho (Matebeleland North)	-0.43 (0.2)	*0.04**	0.24 (0.16)	*0.15*	-	-
Bulilima (Matebeleland South)	-0.66 (0.21)	*0.00***	*Reference district*		-	-
Mangwe (Matebeleland South)	-0.46 (0.25)	*0.06*	0.26 (0.15)	*0.08*	-	-
Gwanda (Matebeleland South)	-0.31 (0.23)	*0.18*	0.46 (0.17)	*0.01**	-	-
Bikita (Masvingo)	-0.95 (0.28)	*0.00***	-	-	-1.03 (0.31)	*0.00***
Chivi (Masvingo)	-0.02 (0.36)	*0.96*	-	-	-0.08 (0.37)	*0.84*
Zaka (Masvingo)	-0.42 (0.21)	*0.04**	-	-	-0.49 (0.22)	*0.03**
(Constant)	0.49 (0.59)	*0.41*	-0.08 (0.84)	*0.93*	0.55 (0.72)	*0.45*
Number of children (0-23 months) in final model	1,106		563		543	

* p <.05 ** p <.01

Outputs

Figure 1. Age by HAZ scatterplot

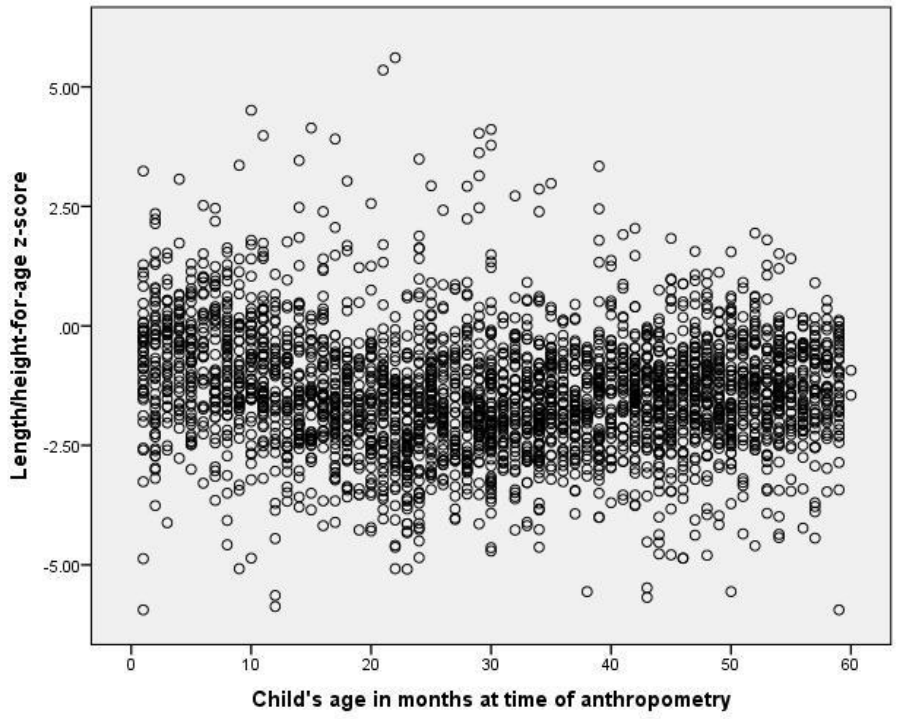


Figure 2. Residuals versus fitted values

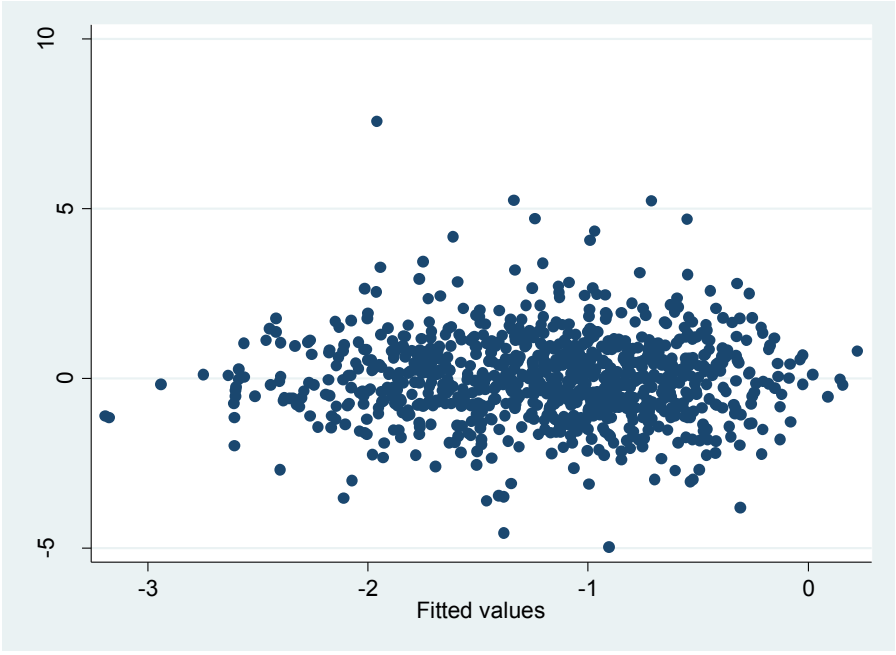


Figure 3. Height for Age Z-score by Age and Breastfeeding Status

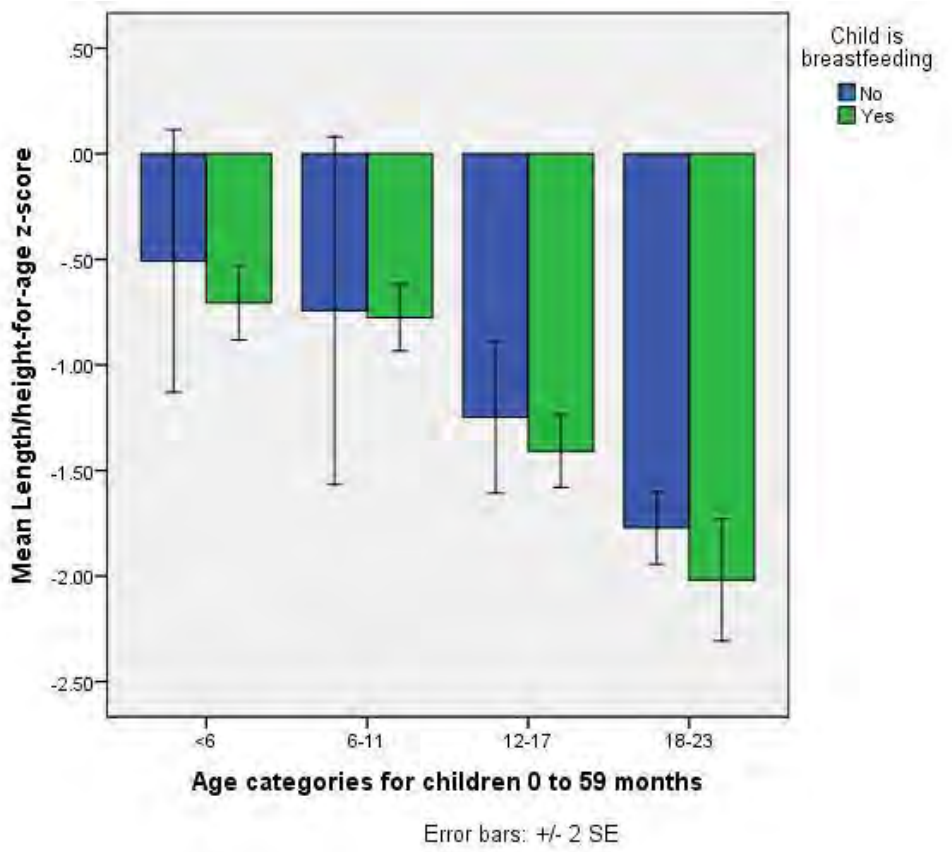
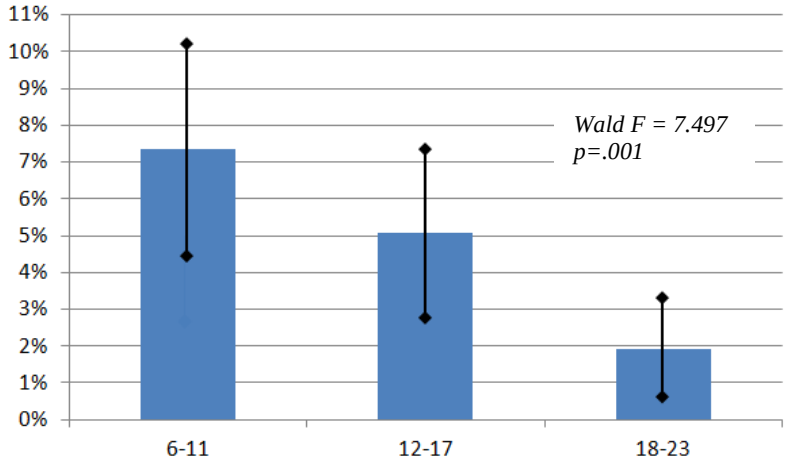


Figure 4. Prevalence of MAD by Age



Note: Error bars represent the 95% confidence interval

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ANNEX 8
Qualitative Study Interview Guide in English and Ndebele
Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

RECORD KEEPING	
Date	
Interviewer Name/ Note-taker Name	
District	
Ward	
Interview Type	
Duration	
Description of interviewee (e.g. 35 year old pregnant woman with kids 18 months and 3 years old) Age: Gender: # of Children: Occupation:	*to be post coded*

OVERVIEW OF THE PROJECT AND ITS AIMS
THEME: Household Vulnerabilities & Food Insecurity *TOPICS: Livelihoods, Access to Food, Food Allocations, Family Dynamics, Resilience*
THEME: Maternal, Child Health & Nutrition *TOPICS: Pregnancy, Breastfeeding, Childcare, WASH, Access to Services*
THEME: Livelihoods & Agricultural Productivity *TOPICS: Sustainability, Resource Accessibility, Farming Techniques, Agricultural Challenges, Livestock Management*
THEME: Gender Equity & Empowerment *TOPICS: Roles, Responsibilities, Decision-Making, Equity & Justice, Societal Perception*

INTERVIEWING TECHNIQUES	
1) DO KNOW WHAT IT IS YOU WANT TO FIND OUT 2) DO BECOME FAMILIAR WITH INTERVIEW GUIDE 3) DO ASK FOLLOW UP QUESTIONS 4) DO SPEND MORE TIME LISTENING THAN TALKING	1) DON'T STRAY AWAY FROM THE INTERVIEW GUIDE 2) DON'T READ QUESTIONS WORD FOR WORD 3) DON'T ASK LEADING QUESTIONS 4) DON'T TAKE OVER THE CONVERSATION

'EXPLAIN THE QUALITATIVE STUDY AND PURPOSE OF THE INTERVIEW
READ THE INFORMED CONSENT STATEMENT
ENSURE THE INTERVIEWEE UNDERSTANDS ~ TAKE ANY QUESTIONS

GETTING TO KNOW THE INTERVIEWEE ~ AN INTRODUCTORY CONVERSATION

IF PROGRAM LEVEL INTERVIEW PROCEED TO PAGE 2
IF FOCUS GROUP DISCUSSION SKIP TO PAGE 6
IF HOUSEHOLD LEVEL INTERVIEW SKIP TO PAGE 8

PROGRAM LEVEL INTERVIEW
IMIBUZO EQONDANE LESIBANGA SOHLELO

START THE INTERVIEW
Qala ukubuza

***Keep in mind who you are interviewing – Community Health Worker; Lead Mother ; WASH Officer ; Organizer of VS& L Group, Lead Farmer; Nutrition Specialist; Care Group Volunteer; Organizers of Agricultural Producer/Working Group*

***Recognize that the interviewee will be knowledgeable on these topics, your goal is a discussion, and the interview should take approximately one hour.*
***Certain interviewees may be more knowledgeable about topic are versus another, keep this in mind and gain seek to gain the most information about the topics in which they are most knowledgeable.*

Introductory Conversation/Questions
Inkulumo yesambulelo kumbe imibuzo

I just wanted to say thanks again for taking the time to meet with me. Are you ready to start?
To begin, could you tell me about your job? [*Probes Include: Roles and Responsibilities, Duration at current position, Type of work, where they work*].
Ngibonga ithuba lokuthi sihlangane sixoxisane. Sesingaqala na? Ungaqala nokungitshela ngomsebenzi owenzayo? [Dingisisa ukuthi wenza msebenzi bani,ugoqela ukwezani, uselesikhathi esiganani esenza lomsebenzi, usebenzela ngaphi lomhlobo womsebenzi}

Are you familiar with the term food insecurity (not having adequate food)? If so, can you describe for me what food insecurity means in the Zimbabwean context? [*Probes Include: What factors contribute to food insecurity, is variation in other provinces/areas- tell me which areas, why/what are reasons for this variation*].
Uy uzwe na ngebala elithi food insecurity (ukuswelakala kokudla)? Tshono ngamafitshane ukuthi kushoni ukuswelakala kokudla e Zimbabwe [Dingisisa ukuthi kungani kulokuswelakala kokudla, qathanisa ukuswelakala kokudla elibhekane lakho lawkezinye lezigabaziqintil (provinces) kulomehluko , umehluko lo udalwa yini?

<u>Household Vulnerabilities & Food Insecurity</u>
Ingozi imuli ezibhekane lazo mayelana lokutholakala kokudla

When you think about the average household in the communities in which you work, can you describe how, generally speaking, decisions about food are made within households? Including what food adults and children eat (and don't eat). And if different people in the house eat different foods, and why? [*Probe to see if any regional (within Zimbabwe), traditional, or religious variation exists*]
Uma ukhangela umumo jikelele esigabeni sakini , ngubani othatha isinqumo ngokuthi kudliwani kumuzi ngamunye ngamunye.Abantwana labadala bandlani njalo kuyini abangakundliyo? Kukhona yini okungadliwayo ngamanye amalunga emuli, yiziphi izizatho? [Ukhangelel iZimbabwe, Dingisisa umehluko ukhangelela inkolo, imithetho yendulo lendawo ezehlukeneyo

Are there any specific foods, or certain habits around eating that are generally considered taboo in Zimbabwe? What about in the communities in which you work? [Make sure to ask which area or community they are taking about). [Probe to see if this varies by age, gender, culture, religion]
Kukhona na ukudla kumbe indlela zokudla ezizilayo ezweni laseZimbabweblili, kumbe lapho osebenzela khona? (Dingisisa kumbe kuyehlukana ngeminyaka, ngobulili, ngenkolo langesiko)

What are some strategies that people utilize to cope with various household vulnerabilities (challenges such as loss of income, loss of life, drought) and food insecurity?
Tshono ezinye indlela ezisetshenziswa ngabantu besigabeni sakini ukuqeda udubo lokuswelakala kokudla. (Indubo ezifana lokulahlekelwa yinzuzo, imfa, indlala)

Maternal, Child Health & Nutrition
Impilakahle kanye lokudla okwakha umzimba kubomama abazithweleyo lasebantwaneni

Can you describe the state of maternal and child health (and nutrition in the communities in which you work? Are there any challenges exist around providing adequate health care and nutrition for children and pregnant & lactating women? If yes, can you tell me about these challenges are [probe to see what strategies have been taken to help address the challenges.
Chaza umumo okhona esigabeni uma ukhangela udaba lokukhulelwa,impilakahle yegane lokupha ukudla okwakha umzimba. Kulenkinga na ekutholeni ukudla okwakha umzimba, ukunakekela impilakahle yegane, leyabomama abazithweleyo lalabo abamunyisayo?

Again, in thinking about the average household in the communities in which you work, what do you feel are some of the biggest challenges that pregnant women face? [*Probe to see which factors are contributing to these challenges*]
Uma ukhangele emizini eminengi lapho osebenza khona, ngombono wakho yiziphi inhlupho ezihlangana labomama abazithweleyo [Dingisisa ukuthi lezi nhlupho zibangelwa yini]

What are some of the biggest challenges that lactating women face? [*Probe to see which factors are contributing to these challenges, including cultural challenges, familial challenges*]
Yiziphi inkinga ezibhekane labomama abamunyisayo? (Dingisisa ukuthi imbangela yalokhu)

Once a mother (and a father) have a young child what does caring for that child involve? [Probe to see what are some of the challenges that they face in caring for their child].
Kuyini okudingekayo kumama lobaba ukuthi banakekele igane yabo? (Dingisisa ukuba yiziphi inkinga abahlangana lazo ekunakekeleni ingane)

Livelihoods & Agricultural Productivity
Okuphilisa imuli lenzuzo kwezokulima

What would you say are the primary forms of income for the individuals/household in the communities in which you work? [Probe to see if there are any variations in the communities, probe to see if there is seasonal variation , probe to find out what are are some alternative livlihooods]
Yiziphi indlela ezithenjiweyo zokuthola inzuzo kunengi yabantuesigabeni osebenzela khona? (Dingisisa umehluko lakwezinye ixzigaba)

What are the practices/activities around agriculture (farming) and livestock in the communities in which you work? [*If respondent works directly in agriculture/livestock sector ask about their/their organizations specific roles, responsibilities and goals*].
Yiziphi indlela/imsebenzi yokukulima lokunakekela izifuyo esetshenziswayo esabelweni osebenza kuso?. [uma umbuzo lo uqondene lesisebenzi esisebenzela inhlanganiso yezokulima kumbe abakhangela impilakahle yezifuyo, buza ngejongo langemisebenzi yaleyo nhlanganiso]

Can you tell me about what types of crops and livestock are normally grown/raised? Are these crops/livestock grown/raised for self-consumption or for sale? [*Probe to see if there are differences between what is sold/consumed in the home and reasons behind this*]
Yiziphi izilimo ezilinywayo kumbe izifuyo ezigcinwayo yizakhamizi? Lezi zilimo lezifuyo zihloswe ukuthengiswa kumbe ukudliwa ngabalimi kumbe abafuyi? [Dingisisa ukuthi kulomehluko phakathi kokudliwayo kumbe okuthengiswayo]

What are some challenges that individuals and families in these communities face in regards to agriculture and livestock? What are some strategies that are utilized to help mitigate/address these challenges?
Yiziphi inhlupho okuhlanganwa lazo ngabalimi labafuyi emisebenzini yabo na? Benzani ukuvimbela lezinhlupho?

Gender Equity & Empowerment
Ukulinganiswa kwamalungelo abesilisa labesifazana, lokubathuthukisa

Can you tell me about gender equity? (fariness/equal opportunities between men and women) In what ways, if any, do issues around gender equity arise in your line of work? [probe on decision-making, male vs. female headed households & households when male mirgrate]
Chaza ngokulinganiswa kwabesilisa labesifazana kuzo zonke izinto? Uma usazi yiziphi indaba zokulinganiswa kwabesilisa labesifazana ezenzakalayo emsebenzini wakho?

To what degree do you think gender equality exists in Zimbabwe? Be specific and think about how attitudes have (or have not) changed over time. [*Probe to see if there is any regional variation/variation in the communities in which you work or variation among various traditional/religious groups*]
Ukulinganiswa kwamathuba abobaba labo mama sekufike ebanga elinjani ezweni laseZimbabwe? Ngombono wakho kulenguko na kundlela abantu abemukela ngayo ukulinganiswa kwamathuba phakathi kwabomama labobaba? [Qathanisa ukuba umumo lo uyehlukana na lakwezinye indawo - ukhangele amasiko lenkolo]

FOCUS GROUP DISCUSSION
UKUXOXISANA LEQEMBU

START THE FOCUS GROUP DISCUSSION
Asiqale ingxoxo yeqembu

Introductory Conversation/Questions

I just wanted to say thanks again for taking the time to meet with me. Are you ready to start?
Ngibonga ithuba onginike lona ukuthi sixoxisane. Sesingaqala?

To begin, I'd like learn a bit more about each of you.
Ngithanda ukuthi sazane ngamunye ngamunye.

I was thinking we could go around the room and introduce each other. Your name, age (if comfortable stating), occupation, how many children you have, their ages, and anything you'd like to add.
Kungabakuhle ukuthi umuntu ngamunye ngamunye azethule emphakathini ukuthi ungubani, uleminyaka emingaki (uma ekhululekile ukuyitsho) wenza msebenzi bani,ulabantwana abangaki njalo baleminyaka emingaki. Umuntu uyavunyelwa ukubika okunye afuna ukukutshela umphakathi.

After you introduce yourself, follow along with what each person says and map out how the group is seated in the room in relation to where you are sitting.
Beqeda ukuzethula kumphakathi, landelela ngokudweba indlela iqembu elihleli ngayo, uqathanisa lomabuza.

Map out the group here (add demographics)
Dweba lapha indlela iqembu eihleli ngayo (ubulili, iminyaka yomuntu)

HOW TO CONDUCT AND MANAGE THE FOCUS GROUP DISCUSSION

- **Assign each member of the focus group a number, each time before the person speaks, they should state their number**
- The focus group is no different than an interview, just there are more people
- Use the household level interview guide, just adjust the wording slightly when you speak
- In some instances go around and have everyone individually answer the question
- In some instances pose a question and let the group discuss
- Note who the focus group is with (all women, all men, mixed, pregnant women, mothers, etc.)
- Prior to the focus group mark the questions you will pose

UYIQUBA KANJANI INGXOXO YEQEMBU

- Ingxoxo yeqembu kayehlukananga kangako lengxoxo yomuntu oyedwa. Ingxoxo yeqembu ilabantu abanengi
- Sebenzisa interview guide yomuzi, kodwa utshitsha amabala ambalwa
- Uyanelisa ukuqonda ilunga le qembu ubuze imibuzo.
- Kwesinye isikhathi uyanelisa ukubuza umbuzo, ubusu sekela amalunga eqembu ambalwa ukuthi baxoxisane ngodaba lolu.
- Nazelela ukuthi iqembu lilabantu abanjani (Omama bodwa, obaba bodwa, bahlangene,Omama abazithweleyo,Omama etc.)
- Ungakaqali lezigxoxo hlela imibuzo ozayibuza.

HOUSEHOLD LEVEL INTERVIEW
ISININGILIZO SEBANGENI LOMNDENI

START THE INTERVIEW
QALISA ISININGILIZO

Introductory Conversation/Questions
Ingxoxo/ Imibuzo Yokungenisa

I just wanted to say thanks again for taking the time to meet with me. Are you ready to begin?
To begin, I'd like learn a bit more about you and what you do.

Bengifisa ukukubonga njalo ngokuvuma ukukhuluma lami. Usulungele yini ukuqalisa?
Okokuqala, ngingathanda ukwazi okunengi mayelana lawe lokwenzayo.

Note: In a way that is comfortable to you, ask about the information in the table below.
Nanzelela: Ngendlela ekukhululekeleyo, buza uthole ulwazi oluqondane lokuqukethwe etafuleni elandelayo.

Age Iminyaka Yokuzalwa	
Occupation Umsebenzi Wakho	
Currently Living In Lapho Ohlala Khona Khathesi	
Originally From Lapho Odabuka Khona	
Remember that some of this information you have already learned in conversation up to this point ***Khumbula ukuthi olunye lwalolulwazi usulutholile kudala kungxoxo eyandulele lesisiqendu***	

TRANSITION TO CONTINUE THE INTERVIEW
YENZA UKUTHI ISININGILIZO SIQHUBEKELE PHAMBILI

It's really great to meet you and to learn more about you and your family.
Kuyangithokozisa kakhulu ukuthola lelithuba lokuthi ngihlangane lawe njalo ngifunde okunengi ngawe lomndeni wakho.

I'd like to move forward with the interview questions.
Ngithanda ukuthi siqhubekele phambili lemibuzo yethu.

SKIP TO PAGE 10
YEQELA KUKHASI 10

PART I ~ HOUSEHOLD SITUATION
ISIGABA SAKUQALA – UMUMO WEMNDENI
INTRO: To start, I'd like to ask you some questions about how things work in your household.
ISINGENISO: Okokuqala, ngingathanda ukwazi ukuthi izinto zihamba njani emndenini wakwenu.

TIPS	**Make this a conversation not a string of questions answered yes or no** ➢ Take note if it's men or women who are migrating and ask why ➢ Ask about primary and secondary sources of income and resources ➢ Inquire if they do other informal work. Do they ever trade goods for services? ➢ Your goal is to explore how the household functions. Notably in relation to money and decision-making.

1) Who lives in your household? (Note familial marker, age, etc.) What are the roles and responsibilities of each member of the household? [Probe for all types of responsibilities & roles]

Uhlala lobani ngekhaya? (Chaza ubudlelwano benu, baleminyaka emingaki, ubulili balomuntu? Tshono imsebezi lemilandu yelunga linye ngalinyei?

2) Does anyone in the household migrate to distant locations? If so, how does it work/can you tell me about it? Please explain the details (i.e., where, for how long, what are they doing, etc.)How would life for you and your family be different without this?

Bakhona na phakathi kwemuli abayake behambe kundawo ezikhatshana okwesikhathil esithile? (chaza ukuthi likuhambisa kanjan, bayabe besiyangaphi, okwesithathi esingakanani, njalo besenzani?) Kungekho lokhu impilo yemuli ingehluka kanjani?

3) Can you tell me about the ways that decisions are made in this household? [probe- to see who the primary decision maker in your household? Is there agreement within the household that this person is the primary decision-maker? Why or why not?

Chaza indlela elithatha ngayo izinqumo ngekhaya? (Ngubani othatha iziqumo eziqakathekileyo ngekhaya)? Kulesivumelwano na ukuthi lowomuntu nguye othatha izi ziqumo eziqakathekileyo. Tshono izizatho zalokhu.

4) What types of decisions do women in the household make? Versus decisions men make? Is there ever disagreement surrounding women or men making decisions? [*Probe on various types of decision making including infant/young child and maternal nutrition decisions*].

Yiziphi izinqumo ezithathwa ngabesifazana, zehlukene yini lalezo ezithathwa ngabesilisa? Kulengxabano na ekuthini ngubani othatha lezi ziqumo? (Dingisisa ukuthi yiziphi iziqumo ezithathwa mayelana lokuzithwala lo ukubeletha kwabomama, ukukhulisa lokunakekelwa kwegane lezempilakahle]

5) What would you say is the primary resource for this household? What are some of the assets\resources that you own or use to help meet your needs? [*Probe on physical (land, seed, livestock), financial (income, savings, credit), social (help from family, neighbors, organizations)*]. Who makes decisions on how to spend money and other use other resources that the household has? Is the decision-maker automatically the same person who earns money/has access to the resource? Why or why not?

Kuyini okuphilisa imulini yenu? Mpahla bani elilazo eziphathisa imuli ukuthi iphile? (Hlolisisa okubambekayo (umhlabathi, inhlanyelo lezifuyo), Imali (umholo, imali egciniweyo, isikwelede) uncedo lomphakathi (uncedo oluvela kumalunga emuli, omakhelwane lenhlanganiso ezithile). Ngubani othatha isiqumo sokuthi imali izasetshenziswa kanjani emulini,njalo ngaphi?. Umuntu oletha inzuzo nguye othatha lesi siqumo na, njalo ulelungelo lokuyisebenzisa. Chasisa?

6) Is there ever disagreement over household resources? [Probe if there is disagreement on how to use them, share/allocate them]. If so, is this more common with particular resources?
Can you give an example? And how do you resolve these disagreements?

Kuyake kube lengxabano ekusebenziseni inzuzo yemuli na? Uba kunjalo nzuzo ziphi ezilenkinga le? Phana umzekeliso. Iqendwa kanjani lengxabano?

7) What are all the sources/ways that the household generates money/income?

Yiziphi indlela/amaqhinga imuli eziphilisa ngayo?

8) Do you feel like there's enough resources for the household?
If not, what are the obstacles to having more?
And what are the impacts of not having enough?

Kusiya ngaweokuphilisa imuli kuyenela na? Nxa kunganeli, tshono okubangela lesi simo? Ukungeneli lokhu, kuphazamisa njani impilo yenu?

PART 2 ~ FOOD ACCESS
ISIGABA SESIBILI – UKUTHOLAKALA KOKUDLA
INTRO: Now, I'd like to ask about food and what is eaten in the household
ISINGENISO: Okwamanje bengicela sixoxisane ngezokudlalokudliwayo ngekhaya

TIPS	**Be sure the questions you ask aren't stating the answer within the question** ➢ Remember to use phrases like that's very interesting or can we talk about that some more ➢ Dig deep and probe to see if certain foods are taboo. Find out why ➢ This set of questions is about food, who decides what to eat/buy, who eats what and why ➢ Find out about locally grown foods where appropriate

1) In looking back to the last week, on a typical/average/normal day how many meals do you eat? What did these meals include? Is everyone in the household eating the same number of meals?
Uma ukhangela kuviki ephelileyo, udle kagaki ngelanga? Njalo ubusidlani? Amalunga wonke emuli abesidla ukudla okufanayo kumbe okulinganayo na?

2) Is there any type of food you must have for you to consider a meal to be a meal? Why? Does everyone in the household feel the same?
Uma usithi udlile okuzwayo yikuphi ukudla ofanele ukuthi ukudle? Yindaba? Amanye amalunga emuli acabangani ngalolu daba?

3) Does the type of food you eat change in different times of the year? In what ways?
Ukudla elikudlayo kuyaguquka na kusiya ngezikhathi ezehlukeneyo zomnyaka na? Chasisa?

4) What foods do you regularly eat? And why? What foods do you rarely eat? And why? Are there any foods you should not or do not to eat? And why (Probe as to the reason why for example taboo, health or religious) Is this the same for other memebers of the household?
Yikuphi ukudla elijayele ukukudla? Kungani? Yikuphi ukudla elingajayelanga ukukudla? Kungani? Kulokudla elingakudliyo kumbe elingafanelanga ukukudla (okuzilayo)? (Dingisisa izizatho ezingabangelwa yikuzila, yimpilakahle lokholo)

5) How are decisions made about what food is eaten? Who makes decisions? What's the process? Does everyone in the household eat the same food? Who eats what and why?

Zithathwa njani iziqumo zokuthi yikuphi ukudla okufanele kudliwe? Ngubani othatha lesi siqumo? Kwenzakala kanjani? Amalunga wonke emuli adla ukudla okufanayo na? Ngubani odla okuthile njalo ngexayani?

6) Would for example, a family member eat less to ensure that someone else in the house ate enough (for example a young child or pregnant woman)? What family member? Have there been instances where this has created tension? Please explain.

Kukhona ilunga lemuli elidla okulutshwana lisenzela ukuthi omunye osemulini abelokudla okwaneleyo (umzekeliso kungaba yingane kumbe umama ozithweleyo)? Yiliphi lelolunga? Kwakube lesikhathi lapho lesi senzakalo sidala ingxabano emulini? Chasisa?

7) Have there been instances when you are hungry and there is no food? If so, how did you cope and what was the experience like? Have there been instances where there was not enough food? If so, how did you manage that situation? What strategies did you use?

Sekuke kwaba lesikhathi lapho owabanjwa liphango, kodwa waswela ukudla? Umakunjalo wazizwa njani, wenzani ngakho? Uma ukudla kungeneli lenzani ngakho?

Suke wabhekana lodubolokungeneli kokudla? Wenzani ngalokho?

8) Where does the majority of food you eat come from? (Is it produced or bought?). Is the balance how you want it (source)? Or would you prefer to have more produced or bought food? Why? Is there any food that You want but you cannot afford?

Ukudla okunengi elikudlayo likuthatha ngaphi? (Liyakulima kumbe liyakuthenga?) Ukutholakala lokhu liyasuthiseka ngakho na? Kumbe lingafisa ukuthola okunengi ngokuzilimela kuqathaniswa lokuthengwayo? Chasisa. Kukhona na ukudla elifisa ukukuthola kodwa lingenelisi ukukuthenga?

PART 3 ~ HEALTH & NUTRITION (ADULT)
ISIGABA SESITHATHU – IMPILAKAHLE LOKUDLA OKWAKHA UMZIMBA (UMUNTU OMDALA)

INTRO: I am going to ask you some questions related health and nutrition.
ISINGENISO: Silokhe sikwezokudla, ngileminye imibuzo mayelana lempilakahle lokudla okwakha umzimba.

*** Take note that you will word the questions differently depending on if you are speaking with a woman or a man***
*** Qaphela ukuthi utshiyanise indlela obuza ngayo kusiya ngokuthi umuntu ombuzayo ungongubaba kumbe umama***

TIPS	**Make sure you are asking the right questions to get the information you are after** ➢ Use encouraging words and introduce related and new topics as appropriate ➢ Why is going to be one of your most used words in every interview ➢ If necessary ask the same question twice, just word it differently ➢ Keep in mind the ways that questions about money, about food, about health are related

1. Can you tell me about how you and your family maintain your health? What, if any, have been some of the health problems that individuals in the household have experienced? What was done in these situations?
Ungangixoxela ngendlela elinakekela impila kahle yenu emulini? Ingaba khona yini imikhuhlane ekhathaza amalunga emuli yakho. Lenzani ngalokho?

2. When you have health problems, where do you seek help (treatment/care/healing)? Does this vary depending on what type health problem you have? [Probe to all kinds of health problems including pregnancy related health if speaking to a woman]
Uma ungezwkahle emzimbeni, usizo uluthola ngaphi? Lokhu kuyehlukana na kusiya ngomkhuhlane olawo? (Dingisisa ngayo yonke imikhuhlane umuntu angahlangana layo kuhlanganisa imikhuhlane yabazithweleyo)

3. In what instances do you choose to visit the doctor, nurse, clinic, etc.? Would you like to see the doctor more often? Or not as much? Why?
Uhamba sekutheni ukuyabona umongi, udokotela lesibhedlela? Ulesifiso sokubona udokotela izikhathi ezimbalwa kumbe hatshi? chasisa

4. Have you been given any advice on food (type of food, when to eat, what to eat, and how much to eat)and nutrition for yourself or your children? What has this advice been? Please be specific—what were you told and who told you? Is the advice ever conflicting? In what ways? Why do think this is? Does this ever lead to arguments?

Kulomuntu oseke wakweluleka mayelana lokudla, langokudla okwakha umzimba lange mpilakahle yemuli yakho?. Yiziphi izeluleko akuphe sona? Tshono ngokugcweleyo ukuthi wathini ? Uyavumelana laye na? Chasisa

5. Are you aware of particular weight or height that women should be? Are there women in your community that are too short or too thin or too large? What are some of the reasons behind this? What do you think is the ideal weight and height?

Uyazi na ukuthi umuntu wesifazi kumele abelesisindo esigakanani uma elobude obuthile? Bakhona abantu besifazana esigabeni abacake kakhulu, abazimuke kahulu loba abafitshanekakhulu? Chaza ukuthi kungani kunjalo? Wena ucabanga ukuthi umuntu wesifazi kumele abelomzimba onjani?

6. During pregnancy, what do you feel are the most important things a woman needs to do to take care of herself and the baby? What leads you to believe this?

[If speaking with a woman, ask about her experiences when she was pregnant.]

Wena ucabanga ukuthi umuntu wesifazana ozithweleyo, kuyini okuqakathekileyo okumele akwenze ukuze azinakelele yena losane yakhe? Ukutsho ngani lokhu?. Uma ukhuluma lomuntu wesifazi, umbuze ukuthi ukhumbulani ngesikhathi ezithwele.]

7. Do you feel there are certain foods pregnant women should eat? Should not eat? What are your reasons?

Ngombono wakho kukhona yini ukudla okumfaneleyo kumbe okungamfanelanga umama ozithweleyo? Yiziphi izizatho?

8. What do you feel are some of the biggest reasons women experience difficulties during pregnancy? [If speaking with a woman, ask about her experiences when she was pregnant.]

Ucabanga ukuthi yiziphi izizatho ezanza omama bahlangane lenkinga ngesikhathi bezithwele? [Uma ukhuluma lomuntu wesifazi buza ngadlula kukho ngesikhathi ezithwele]

9. Do you feel it is important for women to breastfeed? Why? Or why not?

Ngombono wakho, kuqakathekile na ukumunyisa igane? Kungani? Uma kungaqakathekanga chaza?

10. Are you aware mothers are encouraged to exclusively breastfeed children for 6 months? If yes, who encourages exculstive breastfeeding of children for 6 months? In instances when exclusive breastbeeding does not happen, what do you think are some of the reasons?

Uyakwazi na ukuthi omama bayakhuthazwa ukumunyisa igani uchago lukamama kuphela okwenyanga eziyisithupha? Uma ukwazi lokhu, ngunani obakhuthazayo? Uma kungenjalo, kubangelwa yini?

11. In instances when exclusive breastfeeding for 6 months does not happen, what foods/liquids are given instead of breast milk?

Uma igani ingamunyiswa uchago lukamama kuphela kunyanga eziyisithpha zokuqala, uphiwa kudla bani?

PART 4 ~ HEALTH & NUTRITION (CHILD)
ISIGABA SESINE – IMPILAKAHLE LOKUDLA OKWAKHA UMZIMBA (UMNTWANA)

INTRO: I have some additional questions about your children
ISINGENISO: Singaxoxa ngempilakahlelokudla okwakha umzimba sikhangelane labantwana

*** Take note that you will word the questions differently depending on if the interviewee has children*
*** Qaphela ukuthi utshiyanise amagama emibuzo yakho kusiya ngokuthi umuntu ombuzayo ulabantwana loba hatshi***

TIPS	**Gauge what the interest/comfort level of the interviewee is and offer appropriate reassurances** ➢ Don't be reading the questions in this guide word for word ➢ Keep track of time—when people have interesting things to say let them talk ➢ Keep track of time—when people are bored by the question consider moving on ➢ It's unlikely you will ask every single question on this guide, let a conversation develop

1) In general, in your family at what age are infants introduced to foods/liquids other than breast milkWhat foods/liquids are given? Why are these foods/liquids given?

Kumuli yakini usane lwadise ukuqala solungakanani ukuphiwa ukudla okungasichago lukamama kuphela?. Yikuphi lokho kudla? Kungenxayani libapha lokho kudla? Kumuli yenu lizipha kudla bani ngalesisikhathi?

2) Who are the family members that feed children? Can you describe how the child is fed [probe: how is the food prepared, served and feeding practices].

Kumuli yenu ngobani abapha isane ukudla? Chaza indlela usane oluphiwa ngayo ukudla. (Dingisia ngendlela lokhu kudla okuphekwa, kuphakululwe aphiwe njani umntwana?

3) Do your kids ever have diarrhea? If so, why do you think this is the case? What is your strategy for treating diarrhea? Is there anything you do to try to prevent diarrhea?

Abantwana bakho bake babanjwa ngukhuhlane wesihundo? Uma kunjalo sasibangelwa yini? Ulamacebo bani okulapha lomkhuhlane? Wenza cebo bani ukuthi uvikele lomkhuhlane?

4) What do you think about your children's height and weight? Has the health provider told you anything about your childs weight and height? What has the helath provider told you about the height and weight of your child? And do you agree or disagree?

Ngombono wakho ucabangani ngemizimba yegane zakho, sikhangela ubude lesisindo somzimba? UDokotela useke wakwaluleka ngobude langesisindo sengane zakho na? Uyavumelana labo kumbe hatshi?

5) What do you think is the ideal weight and height for a child? Why do you think this is the ideal? What are thefactors that make it hard for children to attain an ideal height and weight?

Ngombono wakho ucabanga ukuthi ubude lesisindo somzimba esenele umntwana yisiphi? Ukutsho ngani? Kuyini okubangela abantwana behluleke ukukhula kahle na?

6) Are there foods that you think are particularly important for kids to eat so that they grow big and strong? [Probe to see if there are any practices]

Kukhona ukudla okufanele igane zikudle ukuze zikhule kahle, zilesisindo somzimba lobude obufaneleyo?

7) In instances where you have concerns that your children are not receiving enough food, how do you try to address this?

Uma ukhathazeka ukuthi igane zakho azitholi ukudla okwaneleyo wezani ukulungisisa loludaba na?

8) Are you aware of the relationship between food and growth?
And do you recognize when growth has been impacted? What do you see?
Do you worry that your children will not grow to their full potential? Why and please explain.

Uyabazi ubudlelwane phakathi kokudla lokukhula kahle?
Uyenelisa yini ukunanzelela uma kubelokukhula emntwaneni? Yisiphi isibonelo?
Uyakhathazeka ngomqondo wokuthi igane zakho azisoze zanelise ukukhula zifike esimeni esifaneleyo?

PART 5 ~ WATER, SANITATION & HYGIENE (WASH)
ISIGABA SESIHLANU –Ukuthola kwamanzi, ukwakhiwa kwezambuzi lokuhlanzeka leWASH
INTRO: I would like to talk to you about water, toilet use and hygiene
ISINGENISO: Ngicela ukukhuluma lawe mayelana lamanzi, ukusetshenziswa kwezambuzi kanye lokuhlanzeka

Water ~ Access & Quality
Amanzi – Ukutholakala lesimo sawo

1) Who is responsible for getting water? Where do you get water from? How long does it take you to get water and how often do you get water? [probe to understand how far the water source is and how much time is spent at the water source] And does the water you drink, water you cook with, and water you bathe with come from the same place?

Ngumsebenzi/ ngumlandu kabana owokukha amanzi? Liwakha ngaphi? Kuthatha isikhathi esiganani ukuyakukha amanzi njalo liwakha kangaki? (Dingisisa ukuthi kukhatshana kangakanani okukhiwa khon amanzi njalo kuthatha isikhathi esinganani) Amanzizi okuhlamba, okupheka lawokunatha athathwa endaweni efanayo na?

2) I want to ask you about any concerns you have about water. What are the concerns you have about water?

Ngicela ukwazi ukuthi kukhona ongasuthiseki ngakho ngokutholakala kwamanzi? Nkinga bani elihlangana lazo ekutholeni amanzi?

3) In terms of access to water, do you have any concerns? What, if any, are the challenges you face in accessing water? What have you or people in the community done to improve access to water.

Ungabe ulensolo sikhangelane lokutholakala kwamanzi? Zikhona na inking elibhekane lazo ekutholeni amanzi? Selenzeni ukuqeda loludubo lokuswelakala kwamanzi?

4) In terms of the quality of the water you have access to? What challenges do you face? What are your strategies to improve the quality of the water? {For example, do you boil your water before you drink it?}

Ukuhlanzeka kwamanzi uyasuthiseka ngakho na? Nkinga bani ohlangana lazo? Macebo bani ongawenza ukuguqula isimo sokuhlazeka kwamanzi ?(isitshengiselo, liyabilisa amanzi lingakawanathi na)

Toilet ~ Access & Quality
Izambuzi – Ukutholakala Lokwakhiwa kwazo

1) Do you have a toilet? If yes, what kind of toilet do you have? Do you use your toilet, why or why not?
Kulesambuzi na ngekhaya? Uma sikhona, ngesohlobo luphi? Uyasisebenzisa na? Yindaba?

2) If you do not have a toilet, where do you go to relieve yourself? What procedures do you follow?
Ma ungelasambuzi uqonda ngaphi uma ufuna ukuzikhulula? Wenza kanjani?

3) Do you have any concerns about where you use the toilet? For example, in thinking about toilet use in your community, are there any fears (or taboos) related to the use of toilets/where toilet are located?
Ungaba lokukhathazeka na lalapho oyakhona ma ufuna ukuzikhulula? Umzekeliso, nxa ukhangela ukusetshenziswa kwesambuzi kukhona yini ukwesaba kumbe ukuzila esigabeni sakini? Nxa sikhangelane lokusetshenziswa kwezambuzi lalapho ezakhelwe khona ukwesaba ukuzisebenzisa?

4) What are your strategies to improve your access to a toilet?
Wenza macebo bani ukwengeza amathuba okuthola isambuzi?

5) What are your strategies to improve the quality of the toilet you use?
Wenza macebo bani okuphucula isambuzi osesebenzisayo?

Hygiene ~ Access & Quality
Ukuhlanzeka – Ukutholakala lokuphucuka

1) How often do you wash your hands? At what times? And why those times? [probe to see if there is a handwashing station near the toilet]
Ugeza kangaki izandla zakho? Ngaziphi izikhathi? Ngenxa yani ugeza ngalezozikhathi? (Dingisisa ukuthi kulendawo yokugezela izandla duze lesambuzi)

2) What do you regularly use to wash your hands? Why do you use it and why do you think its important? What else do you use and why, does this vary depending on what you are doing?
Usebenzisani uma ugeza izandla ? Kuqakatheke ngani? Okunye okusebenzisayo kuyini njalo ngasizatho bani?

3) What do you think about soap? Is it important why or why not?
Ucabangani ngomkhuba wokusebenzisa isepa ekugezeni izandla? Iqakathekile na? Chaza?

4) Do you have any problems buying soap? If for example, money is tight, is soap a high or a low priority? If this is the case, why do you see soap as a lower priority?
Uyanelisa na ukuthenga isepa? Isibonelo, awula mali, kumbe isepa iqakathekile kumbe kayiqakathenga kuwe. Uma ingaqakathekanga tshono isizatho?

PART 6 ~ LIVELIHOODS AND AGRICULTURAL PRODUCTIVITY
ISIGABA SESITHUPHA – OKUPHILISA IMULI LENZUZO KWEZOKULIMA

INTRO: I would like to talk to you about livelihoods and agricultural productivity
ISINGENISO: Ngicela sixoxisane ngokuphilisa imuli lezokulima

****Please ask if the individual is able to speak about matters around agricultural/farming and livelihoods before proceeding with this line of questioning.*

** *Buza maqala ukuthi lumuntu uyenelisa na ukukhuluma mayelana lezokulima kanye lezindlela zokuziphilisa ungakaze uqhubekele phambili lalimibuzo.*

1) Can you tell me about what type of farming you and your family members do or what type of animals you raise? What are the individuals' roles and responsibilities around farming and raising animals? Are there different roles that men, women, or children have? If so, what are the differences and why do they exist?

Ungatshela ukuthi wena lemuli yakho lilimani, njalo yiziphi izifuyo elilazo? Tshono ukuthi yiwaphi amalunga emuli aphatheka ekulimeni lekufuyeni?. Ekulimeni lekufuyeni inyamazana omama, obaba labantwana baphatheka kukuphi kwakhona? Kungani?

2) How did you or your household decide to farm and/or raise animals? How did you learn how to farm and/or raise animals?

Wena le muli yakho lawuthola kuphi umcabango wo kulima kumbe ukufuya? Lakufundela ngaphi ukulima/ ukufuya?

3) Do you grow food for sale or for home consumption? Are there particular crops that you grow for sale and others that you grow for consumption? Why or why not? How are these decisions made and who makes these decisions?

Ulimela ukuthengisa kumbe ukudla? Ulezilimo ezokuthengisa ube lezinye ezokudla na, Chaza? Ngubani othatha iziqumo lezi, njalo lezi ziqumo zithathwa kutheni?

4) Do you raise animals for sale or for home consumption? Which ones are for sale or for home consumption? Are there certain animals that you sale and others that you consume? Why or why not? Are there particular times when you are more or less likely to sell or consume a particular animal? What are these times? Who makes the decision about when to sell or consume an animal? Why?

Ufuyela ukuthengisa kumbe ukudla? Ulezifuyo ozithengisayo, ubelezinye ezokudla na, chaza? Kukhona izikhathi lapho obona ukuthi kungcono ungathengise kumbe udle inyamzana? Yiziphi lezo zikhathi? Ngubani othatha isinqumo sokuthi inyamazana iyathengiswa kumbe iyadliwa yimuli, chaza?

5) What do you do with your crops after they are harvested? [Probe do you store them? If so, where and how do you store them?]

Wenzani ngezilimo zakho, uma uqeda ukuvuna? Uyazigcina na? uma uzigcina uzigcina kuphi/ kanjani?

6) Can you tell me about some of the challenges that you have faced around agriculture/farming? What did you do when these challenges occurred? Where there any individuals or groups that helped you when you had these challenges? If yes, can you tell me about them?

Yiziphi inhlupho ohlangana lazo ekulimeni? Wenzani uma lezi nkinga zikuvelela? Ngubani kumbe ngobani abakusizayo uma uvelelwa yilezi nkinga? Uma bekhona chaza kabazi ngabo kumbe ngaye?

7) Can you tell me about some of the challenges that you have faced around animal rearing? What did you do when these challenges occurred? Where there any individuals or groups that helped you when you had these challenges? If yes, can you tell me about them?

Yiziphi inkinga ohlangana lazo ekufuyeni inyamazana?Wenzani uma ubhekana lenkinga? Ngubani kumbe ngobani abakusizayo uma ubhekane lenkinga lezi? Uma bekhona chaza kabanzi ngabo kumbe ngaye?

8) Is there anything that you have done to help improve the way that you farm or take care of your livestock? Can you tell me about this?

Yiwaphi amacebo osuwathethe ukuthuthukisa ukulima izilimo zakho kumbe ukufuya izifuyo zakho? Unga chaza kabanzi ngakho?

PART 7~ GENDER & EMPOWERMENT
ISIGABA SESIKHOMBISA – UBULILI LOKULINGANISWA KWAMATHUBA

INTRO: I would like to talk to you about gender and some of the differences between men and women
ISINGENISO: Bengithanda ukukhuluma lawe mayelana lobulili langeminye imehluko ekhona phakathi kwabesilisa labesifazana

1) What do you see as the roles and responsibilities of women within the household? What about men?
Tshono ukuthi ucabanga ukuthi imisebenzi/ imilandu wabesifazi yiwuphi emulini? Owabesilisa yiwuphi?

2) How do these vary throughout a woman's life course? (Differences in Older/Younger, Pregnant/Non Pregnant, Mother, Single/Married). How do they vary throughtout a man's life course?
Le imisebenzi iyehluka na kusiya empilweni sowesifazana? [umahluko phakathi komntwan oyinkazana lomama osekhulile, umama oyendileyo kumbe ongendangaa, umama ozithweleyo kumbe ongazithwalanga] Le imisebenzi iyehluka na empilweni yowesilisa?

3) Who makes the decisions about the various assets that you have? Such as when to sell them, give them away or when to purchase a new one? Does this vary depending on what item it is? How does this vary?
Ngubani othatha iziqumo ngempahla ezitshiyeneyo yemuli, lokhu kugoqela ukuthengisa, ukunika kanye lokuthenga okutsha? Amandla okuthatha isinqumo kuyatshiyana na kusiya ngokuthi yimpahla bani? Kutshiyana ngani?

4) To what extent are the women in your household involved in decision-making? Which decision? Does this depend on if there is a man present or not? If the man travels or migrates, can the woman then make decisions? Which decisions? Why or why not?
Abantu besifazana emulini yakho bayaphatheka ekuthatheni iziqumo? Yiziphi lezi zinqumo? Uma kunjalo, kuya ngokuthi bakhona abesilisa kumbe hatshi? Uma umuntu wesilisa ehambile kumbe engahlali ekhaya sonke sikhathi bayenelisa na abesifazana ukuthatha iziqumo ekhaya? Chaza impendula yakho

5) In your household do men and women make decisions together? If joint decision-making is present, what are some examples of how it is carried out?

Kumuli yakho abesifazana labesilisa bayathatha iziqumo bendawonye na? Uma kusenzeka lokhu phana izibonelo

6) Do you feel men and women are equal? Why or why not?
In what aspects are they equal?
In what aspects (if any) are they unequal?

Ucabanga ukuthi abantu besilsa labantu besifazana bayalingana na?
Balingana ngaluphi uhlobo?
Abalingani ngaluphi uhlobo?

7) What do you see as barriers in your community to men and women being equal? What can be done to improve gender equity?

Kuyini okuvimbela ukuthi abesilisa labesifazana bangalingani esigabeni na? Kungenziwani ukuthukisa isimo lesi

ANNEX 9
Qualitative Study Interview Guide in English and Shona
Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

RECORD KEEPING	
Date	
Interviewer Name/ Note-taker Name	
District	
Ward	
Interview Type	

Description of interviewee (e.g. 35 year old pregnant woman with kids 18 months and 3 years old) Age: Gender: # of children & ages: Occupation:	*to be post coded*

OVERVIEW OF THE PROJECT AND ITS AIMS
THEME: Household Vulnerabilities & Food Insecurity *TOPICS: Livelihoods, Access to Food, Food Allocations, Family Dynamics, Resilience*
THEME: Maternal, Child Health & Nutrition *TOPICS: Pregnancy, Breastfeeding, Childcare, WASH, Access to Services*
THEME: Livelihoods & Agricultural Productivity *TOPICS: Sustainability, Resource Accessibility, Farming Techniques, Agricultural Challenges, Livestock Management*
THEME: Gender Equity & Empowerment *TOPICS: Roles, Responsibilities, Decision-Making, Equity & Justice, Societal Perception*

INTERVIEWING TECHNIQUES	
1) DO KNOW WHAT IT IS YOU WANT TO FIND OUT 2) DO BECOME FAMILIAR WITH INTERVIEW GUIDE 3) DO ASK FOLLOW UP QUESTIONS 4) DO SPEND MORE TIME LISTENING THAN TALKING	1) DON'T STRAY AWAY FROM THE INTERVIEW GUIDE 2) DON'T READ QUESTIONS WORD FOR WORD 3) DON'T ASK LEADING QUESTIONS 4) DON'T TAKE OVER THE CONVERSATION

EXPLAIN THE QUALITATIVE STUDY AND PURPOSE OF THE INTERVIEW
READ THE INFORMED CONSENT STATEMENT
ENSURE THE INTERVIEWEE UNDERSTANDS ~ TAKE ANY QUESTIONS

GETTING TO KNOW THE INTERVIEWEE ~ AN INTRODUCTORY CONVERSATION
IF PROGRAM LEVEL INTERVIEW PROCEED TO PAGE 2
IF FOCUS GROUP DISCUSSION SKIP TO PAGE 7
IF HOUSEHOLD LEVEL INTERVIEW SKIP TO PAGE 9

PROGRAM LEVEL INTERVIEW
NHAURIRANO YEDZIDZO

START THE INTERVIEW
TANGISA NHAURIRANO

***Keep in mind who you are interviewing – Community Health Worker; Lead Mother ; WASH Officer ; Organizer of VS& L Group, Lead Farmer; Nutrition Specialist; Care Group Volunteer; Organizers of Agricultural Producer/Working Group*

***Recognize that the interviewee will be knowledgeable on these topics, your goal is a discussion, and the interview should take approximately one hour.*
***Certain interviewees may be more knowledgeable about certain topic areas versus another, keep this in mind and gain seek to gain the most information about the topics in which they are most knowledgeable.*

Introductory Conversation/Questions
Nhaurirano yekutangisa kubvunza

1) I just wanted to say thanks again for taking the time to meet with me. Are you ready to start?
To begin, could you tell me about your job? [*Probes Include: Roles and Responsibilities, Duration at current position, Type of work, where they work*].

Ndinoda kukutendai zvakare nemukana wamatipa kuti tisangane. Makasununguka here kuti tichitangisa? Tichitanga kudai, munganditaurira here nezvebasa renyu? [PROBE: Chinzvimbo neBasa, Nguva yavagara pabasa vari pachinzvimbo chavari, Rudzi rwebasa, Kwavanoshandira].

2) Are you familiar with the term food insecurity (not having adequate food)?If so, can you describe for me what food insecurity means in the Zimbabwean context? [*Probes Include: What factors contribute to food insecurity, is there variation in other provinces/areas- tell me which areas, why/what are reasons for this variation*].

Munoziva here zvinoreva izwi rekuti kushaya chengeteko mukuwana zvekudya? (Kushayikwa kwechikafu chakakwana munzvimbo kana munharaunda)Mungatitsanagurirewo here zvinoreva chengeteko mukuwana zvekudya sekuzivikanwa kwazvinoitwa muZimbabwe? [*PROBE: Zvii zvinoita kuti pashaye chengeteko mukuwana zvekudya, zvinosiyana here nematunhu, zvinokonzeresa musiyano yacho chingava chii?*]

Household Vulnerabilities & Food Insecurity
Kuve muNjodzi kweMhuri & Kushaya Chengeteko Mukuwana zveKudya
(Kushayikwa kwechikafu chakakwana munzvimbo kana munharaunda)

1) When you think about the average household in the communities in which you work, can you describe how, generally speaking, decisions about food are made within households? Including what food adults and children eat (or don't eat). And if different people in the house eat different foods, and why? [***Probe*** *to see if any regional (within Zimbabwe), traditional, or religious variation exists*]

   Semaonero enyu mumhuri zhinji munharaunda yamunoshandira, mungakwanisa here kutsanangura kuti nyaya dzine chekuita nezve kudya dzinofambiswa sei mudzimhuri idzi? Zvichisanganisira zvinodyiwa nevakuru uye nevadiki (uye zvavasingadyewo). Vanhu vari mumhuri imwe chete vanodya chikafu chakasiyana here? Sei zvakadaro [*Probe :kana pane mitsauko inoenderana nekusiyana kwematunhu, tsika namagariro evanhu, kanawo zvine chekuita nekusiyana kwezvitendero zviripo*]

2) Are there any specific foods, or certain habits around eating that are generally considered taboo in Zimbabwe? What about in the communities in which you work? [Make sure to ask which area or community they are taking about). [Probe to see if this varies by age, gender, culture, religion]

   Pane zvimwe zvekudya here zvinonzi zvinoera (kana zvisingabvumidzwe mutsika dzedu dzemuZimbabwe)? kana tsika (kana maitiro) dziri maererano nekudya dzisingadiwi zvachose kana dzingatorwa sedzinoera muZimbabwe? Ko kana takatasirana nemunharaunda mamunoshandira ? [Probe: Nzvimbo dzavarikutaura nezvadzo,zvinosiyana here nemakore emunhu, kana kuti zvinosiyana here pakati pevarume nevakadzi, zvinosiyana here pakati petsika , nezvitendero]

3) What are some things that people do to cope with various household vulnerabilities (challenges such as loss of income, loss of life, drought) and food insecurity?

   Ndedzipi dzimwe nzira dzinoshandiswa nevanhu vane mhuri dziri munjodzi yekushaya kuwana chengeteko mukuwana zvekudya?(njodzi dzakaita sekubudiswa basa, kushayaikwa kwemari, kufirwa nemunhu anounza mari mumhuri, nzara (drought))

Maternal, Child Health & Nutrition
Utano hwaMai neMwana & Kuwana cheKudya Chakakwana

1) Can you describe the state of maternal and child health (and nutrition) in the communities in which you work? Are there any challenges that exist around providing adequate health care and nutrition for children and pregnant & lactating women? If yes, can you tell me about these challenges are [probe to see what strategies have been taken to help address the challenges.

Munokwanisa here kutsanagura mamiriro akaita nyaya yeutano hwamai nemwana takatarisana nekuwana kwavo kudya kunovaka muviri munharaunda yamunoshandira? Ndaapi (kana aripo)matambudziko anosanganikwa nawo takatarisana nenhau yekuwanisa utano hwakakwana uye kudya kunovaka muviri kuvana vadiki, madzimai akazvitakura nemadzimai anoyamwisa? [Probe : Ndezvipi zvavarikuita kugadzirisa matambudziko aya]

2) Again, in thinking about the average household in the communities in which you work, what do you feel are some of the biggest challenges that pregnant women face? [*Probe to see which factors are contributing to these challenges*]

Zvakare, semaonero enyu mumhuri munharaunda yamunoshandira ndeapi mamwe ematambudziko makuru anosanganikwa nawo nemadzimai akazvitakura? [*Probe: ndezvipi zviri kukonzeresa matambudziko acho*]

3) What are some of the biggest challenges that lactating women face? [*Probe to see which factors are contributing to these challenges*]

Ndeapi matambudziko makuru anosanganwa nawo nemadzimai anoyamwisa [*Probe: ndezvipi zviri kukonzeresa matambudziko acho*]

4) Once a mother (and a father) have a young child what does caring for that child involve? [Probe to see what are some of the challenges that they face in caring for their child].

Ko kana mai (nababa) vakaita mwana mudiki, kuchengeta mwana uyu kunosanganisira chii?[Probe : Ndeapi mamwe matambudziko avanosangana nawo mukuchengeta mwana uyu]

Livelihoods & Agricultural Productivity
Nzira dzeKurarama Nadzo & Mabasa eKurima

1) What would you say are the primary forms of income/income generation for the individuals/household in the communities in which you work? [Probe to see if there are any variations in the communities]

Chii chamungati ndicho chekutangatanga chinowanisa vanhu/mhuri mari munharaunda mamunoshanda? [Probe: Zvinosiyana siyana here nematunhu]

2) Can you tell me about what types of crops and livestock are normally grown/raised? Are these crops/livestock grown/raised for self-consumption or for sale? [*Probe to see if there are differences between what is sold/consumed in the home and reasons behind this*]

Munokwanisa here kunditaurira mhando dzembeswa dzinonyanyorimwa munharaunda muno? Ko zvipfuyo zvinonyanya kupfuyiwa munharaunda ? Izvi zvinochengeterwa kudya here kana kutengesa? [PROBE*: kana pane mutsauko pakati pezvinotengeswa neizvo zvinodyiwa pamba uye zvikonzero zvinoita kuti pave nemutasuko*]

3) What are the practices/activities around agriculture (farming) and livestock in the communities in which you work? [*If respondent works directly in agriculture/livestock sector ask about their/their organizations specific roles, responsibilities and goals*].

Ndeapi mabasa anoitwa takatarisana nekurima uyewo kupfuya zvipfuyo anoitwa nevanhu vemunharaunda mamunoshandira? [PROBE *:kana sachishanda ari muchikamu chezvebasa rekurima kana kuchengeta zvipfuyo bvunza nezvemabasa nezvinangwa chaizvo zvinoitwa nevaari kushandira*].

4) What are some challenges that individuals and families in these communities face in regards to agriculture and livestock? What are some strategies that are utilized to help mitigate/address these challenges?

Ko ndeapi mamwe matambudziko anosanganikanwa nawo nevanhu pamwe nedzimhuri takatarisana nemabasa ekurima pamwe nekupfuya zvipfuyo munharaunda muno? Ndedzipi dzimwe nzira dzinoshandiswa kutapudza matambudziko aya?

Gender Equity & Empowerment
Kuenzaniswa kweVakadzi neVanhurume & Kuwaniswa Masimba

1) Can you tell me about gender equity? (fariness/equal opportunities between men and women) In what ways, if any, do issues around gender equity arise in your line of work? [Probe to see if gener based violence is something that they come across in their line of work and their perception on how rampant GBV is in the community].

Munganditaurirawo here nezve kuenzaniswa kwevanhukadzi nevanhurume? (kuwaniswa mikana yakafanana) Ko nyaya yeruenzaniso pakati pevanhukadzi nevanhurume inowanikwa papi mubasa ramunoita?

2) To what degree do you think gender equality exists in Zimbabwe?
Be specific and think about how attitudes have (or have not) changed over time. [*Probe to see if there is any regional variation/variation in the communities in which you work or variation among various traditional/religious groups*]

Munofunga kuti ruenzaniso pakati pevanhukadzi nevanhurume runocherechedzwa zvakakura sei muZimbabwe? Domai chaizvo chaizvo uye cherechedzai kuti matarisirwo anoitwa nyaya iyi asanduka (kana kusasanduka) nekufamba kwenguva here? [PROBE: *kana paine mitsauko inoenderana nekusiyana kwenzvimbo kana mitsauko ine chekuita netsika namagariro kana nechitendero*]

FOCUS GROUP DISCUSSION
NHAURIRANO NEBOKA REVANHU

START THE FOCUS GROUP DISCUSSION
TANGISI NHAURIRANO NEBOKA REVANHU

Introductory Conversation/Questions
Nhaurirano yekutangisa kubvunza

I just wanted to say thanks again for taking the time to meet with me. Are you ready to start?
Ndanga ndichida kukutendai zvakare nenguva yamazviwanisa kuti musangane neni. Magadzirira here kutangisa nhaurwa?

To begin, I'd like learn a bit more about each of you.
Chekutanga, ndinoda kuziva zvishoma pamusoro pemumwe nemumwe wenyu.

I was thinking we could go around the room and introduce each other. Your name, age (if comfortable stating), occupation, how many children you have, their ages, and anything you'd like to add.
Ndanga ndichifunga kuti tinokwanisa kutenderera sekugara kwatakaita muno tichizivana. Ipai zita renyu, makore (kana mungave makasununguka kuataura), basa ramunoita, kuwanda kwevana vamuinavo, mazera avo, uyewo kana pane zvimwe zvamungada kutaurawo.

After you introduce yourself, follow along with what each person says and map out how the group is seated in the room in relation to where you are sitting.
Wapedza kuzvizivisa iwe pachako, tevedza zvataurwa nemumwe nemumwe wevanhu uchitaridza magariro avo mumba zvichienderana nepawakagara iwe.

Map out the group here (add demographics)
Taridza magariro eboka pano

HOW TO CONDUCT AND MANAGE THE FOCUS GROUP DISCUSSION
NZIRA YEKUITA NAYO NHAURIRANO NEBOKA REVANHU VANENGE VACHIBVUNZWA

- **Assign each member of the focus group a number, each time before the person speaks, they should state their number**
- The focus group is no different than an interview, just there are more people
- Use the household level interview guide, just adjust the wording slightly when you speak
- In some instances go around and have everyone individually answer the question
- In some instances pose a question and let the group discuss
- Note who the focus group is with (all women, all men, mixed, pregnant women, mothers, etc.)
- Prior to the focus group mark the questions you will pose

HOUSEHOLD LEVEL INTERVIEW
MIBVUNZO YAKANANGANA NEMHURI

START THE INTERVIEW
TANGISA KUBVUNZA

Introductory Conversation/Questions
Nhaurirano yekutangisa kubvunza

I just wanted to say thanks again for taking the time to meet with me. Are you ready to begin?
To begin, I'd like learn a bit more about you and what you do.

Ndinoda kukutendai zvakare nemukana wamatipa kuti tisangane. Makasununguka here kuti tichitangisa? Tichitanga kudai, ndinoda kuziva zvimwe zvishoma maererano nebasa renyu?

Note: In a way that is comfortable to you, ask about the information in the table below
Cherechedzo: Uchitaura nenzira yaunofara nayo, bvunza maererano nezvakanyorwa mubhokisi riri pazasi

Age Zera	
Occupation Basa	
Currently Living In Kwamuri kugara parizvino	
Where were you raised Kwamaimbogara pakutanga	
Remember that some of this information you have already learned in conversation up to this point ***Yeuka kuti zvimwe zvacho zvinhu zvawatombonzwa nechekare munhaurirano kubvira pakutanga kusvika ikozvino***	

TRANSITION TO CONTINUE THE INTERVIEW
KUSANDURA NEKUENDERERA MBERI NEKUBVUNZA

It's really great to meet you and to learn more about you and your family.

I'd like to move forward with the interview questions.

Chinhu chikuru kwazvo kusangana nemi nekuziva nezvenyu pamwewo nemhuri yenyu.
Ndinoda kuenderera mberi nekukubvunzai

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ENDA KUPEJI 10

PART I ~ HOUSEHOLD SITUATION **CHIKAMU I ~ MAMIRIRO EMUMHURI** ***INTRO: To start, I'd like to ask you some questions about how things work in your household.***	
TIPS	**Make this a conversation not a string of questions answered yes or no** ➢ Take note if it's men or women who are migrating and ask why ➢ Ask about primary and secondary sources of income and resources ➢ Inquire if they do other informal work. Do they ever trade goods for services? ➢ Your goal is to explore how the household functions. Notably in relation to money and decision-making.

1) Who lives in your household? (Note familial marker, age, etc.) What are the roles and responsibilities of each member of the household?

   Ndivanani vamunogara navo mumhuri yenyu? (Cherechedza chiratidzo chemhuri, baba, amai, mwana, zera, etc.) Mungandiudzewo zvinzvimbo nemabasa zvemumwe nemumwe mumhuri yenyu?

2) Does anyone in the household migrate to distant locations?
   If so, how does it work/can you tell me about it? Please explain the details (i.e., where, for how long, what are they doing, etc.)How would life for you and your family be different without this?

   Pane here wemumhuri anomboenda achinogara kunzvimbo dziri kure?
   Kana aripo, zvinofamba sei? Mungatsanangure zvizere here? (anoenda kupi, kwenguva yakareba sei uye achinoiteiko? etc.)
   Upenyu hwenyu nehwemhuri zvingadai zvakasiyana sei nezvazviri dai pasina kufamba uku?

3) Can you tell me about the ways that decisions are made in this household? [Probe- to see who the primary decision maker in your household? Is there agreement within the household that this person is the primary decision-maker? Why or why not?

   Mungandiudzewo here kuti munoronga sei zvinoitwa mumhuri menyu? [Probe: Ano nyanyo ronga zvinoitwa mumhuri menyu ndiani?]
   Pane kutenderana here mumhuri yenyu kuti munhu uyu ndiye ane simba rekuronga nekutara zvinofanira kuitwa? Sei zvakadaro kana kusadaro?

4) What types of decisions do women in the household make? Versus decisions men make?
Is there ever disagreement surrounding women or men making decisions? [**Probe** *on various types of decision making including infant/young child and maternal nutrition decisions, family planning/birth spacing*].

Ndezvipi zvinorongwa kana kutarwa nevanhukadzi mumhuri menyu? Kana tichivaenzanisa nezvinorongwa kana kutarwa nevanhurume?
Pane here makakatanwa kana kusawirirana kunowanikwa pakati pavanhurume nevanhukadzi maererano nekuronga nekutara zvinofanira kuitwa?[PROBE: ***maererano nekutara zvinofanira kuitwa panhau dzakatsaukana zvinosanganisa kudya kunovaka muviri kwerusvava, vana vadiki nezvinodyiwa navanhukadzi vakazvitakura kana vachangobva mukupona/kusununguka, uye nepanyaya dzekuronga mhuri*****]**

5) What would you say is the primary livelihood resource for this household? What are some of the assets\resources that you own or use to help meet your needs? [*Probe on physical (land, seed, livestock), financial (income, savings, credit), social (help from family, neighbors, organizations)*]. Who makes decisions on how to spend money and other resources that the household has? Is the decision-maker automatically the same person who earns money/has access to the resource? Why or why not?

Chii chamungati ndicho chinonyanya kuraramisa mhuri yenyu? Ndezvipi zvinhu kana midziyo zvamuinazvo kana zvamunoshandisa zvinokubatsirai kukuwanisai zvamunoda? [Probe: ***zvinhu zvinobatika (minda, mbeu, zvipfuyo), zvemari (mari inowanikwa, iri kubhengi, zvikwereti), mukugarisana (rubatsiro kubva kune vamwe vemhuri, vavakidzani, masangano*****] Ndiyani anoronga nekutara kuti mari nezvimwewo zvinhu zvemhuri zvinoshandiswa nenzira ipi? Ko wacho anotara mashandisirwo emari ndiye here munhu wakare anoitambira kana kuti muridzi wezvinhu zvemusha? Sei zvakadaro kana kusadaro?**

6) Is there ever disagreement over household resources? [Probe if there is disagreement on how to use them, share/allocate them]. If so, is this more common with particular resources?
Can you give an example? And how do you resolve these disagreements?

Panomboita here makakatanwa maererano nezvinhu zvemumhuri? [Probe : Kana pane makakatanwa pakushandiswa kwazvo kana kugoverwa kwazvo] Kana paine makakatanwa , zvinowanzokonzeresa makakatanwa aya ndezvipi? Pane here imwe midziyo kana zvinhu zvino wanzokonzeresa makakatanwa aya? Mungape muenzaniso here? Munogadzirisa sei makakatanwa acho?

7) What are all the sources/ways that the household generates money/income?

Ndezvipi zvinhu zvenyu zvese kana nzira dzinoshandiswa nemhuri yenyu kuti muwane mari?

8) Do you feel like there are enough resources for the household?
If not, what are the obstacles to having more?
And what are the impacts of not having enough?

Munoona sekuti zvinhu zvamuinazvo zvinokwanirana here nemhuri yenyu?
Kana zvisi izvo, ndezvipi zvimhingamupini zvamunosangana nazvo kuti musawana zvakawanda?
Kushaya zvakakwana kunokukanganisai nenzira dzipi?

PART 2 ~ FOOD ACCESS
CHIKAMU 2 ~ KUWANA CHEKUDYA
INTRO: Now, I'd like to ask about food and what is eaten in the household
KUTANGISA: Ikozvino ndinoda kubvunzai pamusoro pezvekudya uyewo zvinodyiwa nemhuri

TIPS	**Be sure the questions you ask aren't stating the answer within the question** ➢ Remember to use phrases like that's very interesting or can we talk about that some more ➢ Dig deep and probe to see if certain foods are taboo. Find out why ➢ This set of questions is about food, who decides what to eat/buy, who eats what and why

1) In looking back to the last week, on a typical/average/normal day how many meals do you eat? What did these meals include? Is everyone in the household eating the same number of meals?

   Kana muchidzokera shure kusvondo rakapera pazuva munodya kangani? Zvamainge muchidya zvaisanganisira chii? Munhu wese anodya kakwanda zvakafanana here mumhuri yenyu?

2) Is there a type of food you must have for you to consider a meal to be a meal? Why? Does everyone in the household feel the same?

   Pane here kumwe kudya kwamunofanira kudya kuti munzwe kutindanyatsodya? Sei muchidaro? Ko munhu wese ari mumhuri ndiwo manzwiro kana maonerowo akewo here?

3) Does the type of food you eat change in different times of the year? In what ways?

   Ko zvamunodya zvinosanduka here zvichienderana nemwaka yegore? Nenzira dzipi?

4) What foods do you regularly eat? And why? What foods do you rarely eat? And why? Are there any foods you should not or do not to eat? And why (Probe as to the reason why for example taboo, health or religious) Is this the same for other memebers of the household?

   Ndechipi chikafu chamunonyanyodya? Sei zvakadaro? Ndekupi kudya kwamunodya nenguva dziri kure kure? Sei zvakadaro? Pane here chimwe chikafu chamusingafanire kudya kana kuti chamusingadye (kunge sekuti zvinoera, zveutano, zvechitendero)? Sei? Zvimwechete here nevamwe varimumhuri yenyu?

5) How are decisions made about what food is eaten? Who makes decisions? What's the process? Does everyone in the household eat the same food? Who eats what and why?

Munoronga sei kana kutara kuti izvi ndizvo zvinodyiwa? Ndiyani anoronga nekutara izvi? Zvinofamba sei kuzosvika pakuronga kana kutara kwacho? Munhu wese ari mumhuri anodya kudya kwakafanana navamwe vose here? Ndiyani anodya chii uye nemhaka yei?

6) Would, for example, a family member eat less to ensure that someone else in the house ate enough (for example a young child or pregnant woman)? What family member(s)? Have there been instances where this has created tension? Please explain.

Semuenzaniso zvinowanikwa here kuti pane wemumhuri angadya zvishoma kuitira kuti vamwe vawane kudya kwakakwana (angave semwana mudiki kana mudzimai akazvitakura)? Ndiyani kana kuti ndivanaani vanozviita? Pane dzimwe nguva here dzekuti kuita kwakadai kwakasvika pakugumburisana kwevanhu? Ndokumbira kuti mundi tsananguriirewo zvizere.

7) Have there been instances when you are hungry and there is no food? If so, how did you cope and what was the experience like? Have there been instances where there was not enough food? If so, how did you manage that situation? What strategies did you use?

Pane dzimwe here nguva dzekuti mainzwa nzara asi pasina chekudya?
Kana zvakamboitika , makaita sei uye makazviona zviri zvinhu zvaka dii? Pakamboita nguva here yekuti panoshaikwa chikafu chakakwana?
Pazvakaitika makazvifambisa sei? Makashandisa nzira dzipi?

8) Where does the majority of food you eat come from? (Is it produced or bought?).
Is the balance how you want it (source)? Or would you prefer to have more produced or bought food? Why? Is there any food that You want but you cannot afford?

Ko kudya kwakawanda kwamunako kunobva kupi? (Munozvirimira mega here kana kuti munotenga?)
Kusiyana kwekudya kunotengwa nekwamunozvirimira ndizvo here zvamunenge muchida kuti zvive? Kana kuti mungade kudya kwakawanda kuve kwamunozvirimira pane kutenga? Sei muchidaro? Pane kudya here kwamungade asi musingakwanise kutenga? [Probe: Chikafu chipi?]

PART 3 ~ HEALTH & NUTRITION (ADULT)
CHIKAMU 3~ UTANO NEKUDYA KUNOVAKA MUVIRI (VANHU VAKURU)
INTRO: I am going to ask you some questions related health and nutrition.
KUTANGISA: Takatarisana nezvekudya, ndinewo mimwe mibvunzo iri pamusoro peutano nekudya kunovaka muviri

*** Take note that you will word the questions differently depending on if you are speaking with a woman or a man***

TIPS	**Make sure you are asking the right questions to get the information you are after** ➢ Use encouraging words and introduce related and new topics as appropriate ➢ Why is going to be one of your most used words in every interview ➢ If necessary ask the same question twice, just word it differently ➢ Keep in mind the ways that questions about money, about food, about health are related

1) Can you tell me about how you and your family maintain your health? What, if any, have been some of the health problems that individuals in the household have experienced? What was done in these situations?
Mungandiudzawo kuti munochengetedza sei utano hwenyu nehwemhuri yenyu? Ndeapi, kana aripo, matambudziko eutano nevemumhuri menyu ? Chii chamakaita zvadai?

2) When you have health problems, where do you seek help (treatment/care/healing)? Does this vary depending on what type health problem you have? [Probe to all kinds of health problems including pregnancy related health if speaking to a woman]
Kana muchinge masangana nematambudziko eutano munowana rubatsiro kupi? Zvinosiyana here nekuti mune dambudziko reutano rakaita sei? [Probe : zvirwere zvakasiyana siyana sekusananganisira zvemadzamai akazvitakura]

3) In what instances do you choose to visit health providers (ie. doctor, nurse, clinic, etc.)
Would you like to see the health provider more often? Or not as much? Why?
Munonoona vezveutano kana zvaita sei (doctor,nurse,clinic)?
Mungada here kuonekwa nevezveutano kakatiwandei? Kana kuti kwete zvakanyanya? Sei muchidaro?

4) Have you been given any advice on food (type of food, when to eat, what to eat, and how much to eat) and nutrition for yourself or your children? What has this advice been? Please be specific—what were you told and who told you? Is the advice ever conflicting? In what ways? Why do think this is? Does this ever lead to arguments?

Pane here ruzivo rwamakambopiwa ruri maererano nezvekudya (mhando yechikafu, nguva dzekudya , zvakawanda sei?) zvinovaka muviri wenyu kana wevana venyu? Chii chamakaudzwa?
Domai chaizvo zvakanangana nezvamakaudzwa. Chii chamakaudzwa? Uye nani?
Ruzivo urwu runopota ruchipikisana here? Nenzira dzipi? Sei muchifunga kudaro? Izvi zvinombozosvika pakumutsa gakava here?

5) Are you aware of particular weight or height that women should be? Are there women in your community that are too short or too thin or too large? What are some of the reasons behind this? What do you think is the ideal weight and height?

Pane here kureba kana kurema kwamunoziva kuti vanhukadzi vanofanira kunge vari? Pane here vanhukadzi vari munhauraunda menyu vanonzi vakanyanya kupfupika ,kutetepa, vakarebesa uye vane muviri muhombe? Zvii zvingava zvimwe zvezvikonzero zvemamiriro akadai evanhukadzi? Munofunga kuti huremu uye hurefu hwakafanira chaiwo ndehupi?

6) During pregnancy, what do you feel are the most important things a woman needs to do to take care of herself and the baby? What leads you to believe this?

[If speaking with a woman and she has been pregnant, ask about her experiences when she was pregnant.]

Kana munhukadzi akazvitakura munofunga kuti ndezvipi zvezvinhu zvakanyanya kukosha zvaanofanira kuita senzira yekuzvichengeta iye pamwe chete nemwana? Chii chinoita kuti mutendere mune zvamuri kutaura?
[Kana uchitaura nemunhukadzi akamboita mwana, bvunza pamusoro pezvaainzwa kana aine nhumbu]

7) Do you feel there are certain foods pregnant women should eat? Should not eat? What are your reasons?

Sekuona kwenyu pane kudya here kunofanira kudyiwa nemadzimai akazvitakura? Kana kwavasingafaniri kudya? Zvikonzero zvenyu ndezvipi?

8) What are some of the difficulties women experience during pregnancy?[If speaking with a woman and she has been pregnant, ask about her experiences when she was pregnant.]
Ndezvipi zvimwe zvinetso (matambudziko) zvinosanganikwa nemadzimai akazvitakura?
[Kana uchitaura nemunhukadzi akamboita mwana, bvunza pamusoro pezvaainzwa kana aine nhumbu]

9) Do you feel it is important for women to breastfeed? Why? Or why not?
Munofunga kuti zvakakosha here kuti madzimai ayamwise? Sei muchifunga kudaro?

10) Are you aware mothers are encouraged to exclusively breastfeed children for 6 months? If yes, who encourages exculsive breastfeeding of children for 6 months? In instances when exclusive breast feeding does not happen, what do you think are some of the reasons?
Munozviziva here kuti vanhukadzi vanokurudzirwa kuyamwisa pasina kupa vana kumwe kudya kwemwedzi mitanhatu yekutanga yekuberekwa? Kana zvirizvo ndiani anokurudzira kuti mwana ayamwiswe chete pasina kupa mwana chimwe chekudya kwemwedzi mitanhatu yekutanga yekuberekwa? Panguva dzekuti mwana haayamwiswe chete pasina kupa mwana kumwe kudya mwedzi mitanhatu isati yakwana munofunga zvikonzero zvacho zvingava zvei?

11) In instances when exclusive breastfeeding for 6 months does not happen, what foods/liquids are given instead of breast milk?
Ko kana pari pekuti mwana haasi kungorarama nemukaka wamai chete chete kwemwedzi mitanhatu yekutanga yekuberekwa, anopiwa kudya/zvinwiwa zvipi zvacho pachinzvimbo chemukaka wamai?

PART 4 ~ HEALTH & NUTRITION (CHILD)
CHIKAMU 4 ~ UTANO & NEKUDYA KUNOVAKA MIVIRI (VANA)
INTRO:I have some additional questions about your children
KUTANGISA: Ndine mimwe mubvunzo kuwedzera pane yekutanga pamusoro pevana venyu

*** Take note that you will word the questions differently depending on if the interviewee has children*

TIPS	**Gauge what the interest/comfort level of the interviewee is and offer appropriate reassurances** ➢ Don't be reading the questions in this guide word for word ➢ Keep track of time—when people have interesting things to say let them talk ➢ Keep track of time—when people are bored by the question consider moving on ➢ It's unlikely you will ask every single question on this guide, let a conversation develop

1) In general, in your family at what age are infants introduced to foods/liquids other than breast milk?What foods/liquids are given? Why are these foods/liquids given?

   Kana tichingotaurawo zvedu zvinowanikwa, vana vanotanga kupihwa kudya/zvinwiwa zvisiri mukaka waamai wavo vakura sei mumhuri yenyu? Ndezvipi zvekudya kana zvinwiwa zvavanopihwa ? Sei kudya uku kana kunwa uku kuriko kunopihwa?

2) Who are the family members that feed children? Can you describe how the child is fed [probe: how is the food prepared, served and feeding practices].

   Ndiyani anopa vana chikafu mumhuri? Munganditsanaguririwo here kuti mwana anopihwa chikafu sei [Probe: magadzirirwo echikafu chacho, mapakurirwo acho, nekudyiswa/kufidwa kunoitwa mwana]

3) Do your kids ever have diarrhea? If so, why do you think this is the case? What is your strategy/how do you treat diarrhea? [if ORT is mentioned probe to see how it is prepared] Is there anything you do to try to prevent diarrhea?

   Vana venyu vanomboita manyoka here? Kana vachimboita , munofunga kuti chikonzero chacho chii? Munoshandisa nzira ipi kurapa manyoka? Pane here zvamunoita kuedza kudzivirira manyoka? [Probe if mentioned: ORT inogadzirwa sei]

4) How do you think about your children's height and weight? Has the health provider told you anything about your childs weight and height? What has the health provider told you about the height and weight of your child? And do you agree or disagree?

Munofungei maererano nemhumhu (hurefu nehuremu) hwevana venyu? Vezveutano vane zvavakambotaura pamusoro pehuremu nehurefu hwemwana wenyu here? Vakati chii? Munobvumirana nazvo here kana kuti kwete ?

5) What do you think is the ideal weight and height for a child? Why do you think this is the ideal? What are thefactors that make it hard for children to attain an ideal height and weight?

Sekuona kwenyu ndeupi huremu nehurefu wakafanira kumwana?Ndezvipi zvimwe zvezvinhu zvinoita kuti vana vasave nekureba pamwe nekurema kwakanaka?

6) Are there foods that you think are particularly important for kids to eat so that they grow big and strong? [Probe to see if there are any practices]

Pane kumwe here kudya kwavana kwamunofunga kuti kwakakosha zvikuru kuti vakure pamwe chete nekuva vakasimba? [Probe: ona nezvemaitiro]

7) In instances where you have concerns that your children are not receiving enough food, how do you try to address this?

Panguva dzamunenge muchishushika na kuti vana havasi kuwana kudya kwakakwana, munozvifambisa sei?

8) Are you aware of the relationship between food and growth?
And do you recognize when growth has been impacted? What do you see?
Do you worry that your children will not grow to their full potential? Why and please explain.

Munoziva here kufambidzana/hukama huri pakati pekudya nekukura?
Munokwanisa kuona here kuti kukura kwakanganisika? Munoona chii?
Munonetsekana here kuti vana venyu havazokuri kusvika chaipo chaipo pavanofanira? Tsanagurai kuti sei madaro?

PART 5 ~ WATER, SANITATION & HYGIENE (WASH)
CHIKAMU 5 ~ MVURA, KUSHAMBIDZIKA NEUTSANA
INTRO: I would like to talk to you about water, toilet use and hygiene
KUTANGISA: Ndinoda kukubvunzai pamusoro pemvura, kushandiswa kwechimbuzi neutsanana

Water ~ Access & Quality
Kuwana Mvura & Kushambidzika kwayo

1) Who is responsible for getting water? Where do you get water from? How long does it take you to get water and how often do you get water? [probe to understand how far the water source is and how much time is spent at the water source] And does the water you drink, water you cook with, and water you bathe with come from the same place?

   Ndiani anoita basa rekutsvaga mvura? Munowanepi mvura? Zvinokutorerai nguva yakareba zvakadini kuti muchere mvura? Munochera mvura kakawanda zvakadii? [Probe: Mvura inowanikwa kure zvakadii uye nguva inotorwa patsime pacho]
   Ko mvura yamunonwa, yamunobikisa neyamunogezesa inobva panzvimbo imwe chete here?

2) I want to ask you about any concerns you have about water. What are the concerns you have about water?

   Zvii zvamunofunga maererano nemvura? Ndezvipi zvinoita kuti munyanye kunyunyuta panyaya yemvura?

3) In terms of access to water, do you have any concerns? What, if any, are the challenges you face in accessing water? What have you or people in the community done to improve access to water.

   Panyaya yekuwanikwa kwemvura mune here zvamunonyunyuta nazvo? Kana zviripo ndezvipi zvimhingapinyi zvamuno sangana nazvo pakuwana mvura? Ndezvipi zvamakaita kana zvakaitwa nevanhu vemunharaunda kuti kuwanikwa kwemvura kuite nyore?

4) In terms of the quality of the water you have access to do you have any concerns? What, if any, challenges do you face? What are your strategies to improve the quality of the water? {For example, do you boil your water before you drink it?}

   Maererano nekushambidzika kwemvura yamunowana mune zvamunonyunyuta nazvo here? Pane matambudziko here, kana aripo amunosangana nawo? Kana zviripo ndezvipi zvimhingamupinyi zvamuno sangana nazvo? Nzira dzamunoshandisa kuti mvura inge iri nani ndedzipi? (Semuenzaniso, munofashaidza here mvura musati mainwa?)

Toilet ~ Access & Quality
Chimbuzi ~ Mawanire & Kushambidzika

1) Do you have a toilet? If yes, what kind of toilet do you have? Do you use your toilet, why or why not?

   Mune chimbuzi here? Kana munacho ndechemhando ipi? Munochishandisa here? Nemhaka yeyi?

2) If you do not have a toilet, where do you go to relieve yourself? What procedures do you follow to promote hygiene ?

Kana musina chimbuzi munozvibatsira kupi? Pane zvamunoita here kuchengetedza utsanana pamunozvibatsira?

3) Do you have any concerns about where you use the toilet? For example, in thinking about toilet use in your community, are there any fears (or taboos) related to the use of toilets/where toilet are located?

   Mune zvamunonynyuta nazvo here nepamuno shandisira chimbuzi sokuti mashandisirwo echimbuzi munharaunda menyu? Pane zvamunotyira here kana zvinoera maerarano nemashandisirwo ezvimbuzi kana nzvimbo yazviri zvimbuzi izvi?

4) What are your strategies to improve your access to a toilet?

   Zvii zvamunoita kuti mukwanise kuvandudza mawaniro enyu echimbuzi?

5) What are your strategies to improve the quality of the toilet you use?

   Mune nzira dzipi dzekuvandudza kushambidzika kwechimbuzi chamunoshandisa?

Hygiene ~ Access & Quality
Utsanana ~ Mawaniro & Kunaka Kwahwo

1) How often you wash your hands? At what times? And why those times? [probe to see if there is a handwashing station near the toilet]

   Munogeza maoko kakawanda zvakadini? Panguva dzipi? Sei muchizviita panguva idzodzo? [Pane pekugeza maoko pedyo nechimbuzi here?]

2) What do you regularly use to wash your hands? Why do you use it and why do you think its important? What else do you use and why, does this vary depending on what you are doing?

Chii chamunowanzo shandisa kana muchigeza maoko? Sei muchishandisa ichocho uye munofunga kuti chakakosherei? Chii Chimwe chamunoshandisa uye nemhaka yei? Zvinosiyana here nekuti munenge muchiitei?

3) What do you think about soap? Is it important why or why not?

   Munofungei nezvesipo? Yakakosha here kana kuti haina ? Nemhaka yei?

4) Do you have any problems buying soap? If for example, money is tight, is soap a high or a low priority? If this is the case, why do you see soap as a lower priority?

   Mune matambudziko here nekutenga sipo? Ngatitii mari ishoma, sipo chinhu chamunokoshesa kutenga here kana kuti inogona kumbomira kutengwa zvayo? Kana zvakadaro, sei muchiona sipo sechinhu chinogona kumbomira zvacho?

PART 6 ~ LIVELIHOODS AND AGRICULTURAL PRODUCTIVITY
NZIRA DZEKURARAMA NADZO &MABASA EKURIMA
INTRO:I would like to talk to you about livelihoods and agricultural productivity

****Please ask if the individual is able to speak about matters around agricultural/farming and livelihoods before proceeding with this line of questioning.*

1) Can you tell me about what type of farming you and your family members do and what type of animals you raise? What are the individuals' roles and responsibilities around farming and raising animals? Are there different roles that men, women, or children have? If so, what are the differences and why do they exist?

Type/mhando yefarming yenyu ndeyipi? Munochegeta zvipfuyo zvipi? Mumwe nemumwe wemumhuri anoita mabasa api maerarano nekurima pamwe chete nekupfuya zvipfuyo? Pane here kusiyana kwemabasa anoitwa nevanhurume, vanhukadzi kana nevana? Kana zvakadaro, misiyano yacho ndeyei uye sei zvakadaro?

2) How did you or your household decide to farm and/or raise animals? How did you learn how to farm and/or raise animals?

Makasarudza nenzira ipi, imi kana kuti mhuri yenyu, kuti munge muchiita zvekurima kana kuchengeta zvipfuyo? Makadzidza sei kurima kana kuchengeta zvipfuyo?

3) Do you grow food for sale or for home consumption? Are there particular crops that you grow for sale and others that you grow for consumption? Why or why not? How are these decisions made and who makes these decisions?

Munorimira kutengesa here kana kudya kwenyu pamba? Pane here zvirimwa zvamunorimira kutengesa nezvimwe zvamunorimira kudya? Sei, kana kuti sei zvisina kudaro? Munosvika pakusarudza zvamunozoita nenzira dzipi uye ndiyani anotara zvinezenge zvichizo tevedzwa?

4) Do you raise animals for sale or for home consumption? Which ones are for sale or for home consumption? Why or why not? Are there particular times when you are more or less likely to sell or consume a particular animal? What are these times? Who makes the decision about when to sell or consume an animal? Why?

Ndezvipi zvipfuyo zvamuno tengesa uye ndezvipi zvamunodya imimi? Sei, kana kuti sei zvisina kudaro? Pane nguva here dzamuno nyanyonzwa kuda kutengesa kana kunzwa kusada kutengesa zvipfuyo zvenyu? Inguva dzipi idzodzo? Pane nguva here dzamuno nyanyonzwa kuda kana kusada kudya chipfuyo? Inguva dzipi idzodzo? Ndiyani anotara kuti chipfuyo chotengeswa kana kuurayiwa? Sei zvakadaro?

5) What do you do with your crops after they are harvested? [Probe do you store them? If so, where and how do you store them?]

Ko kana makohwa, munoita sei negoho renyu? Munorichengeta here? Kana zvakadaro, munorichengetera pai? Uye munorichengetedza sei?

6) Can you tell me about some of the challenges that you have faced around agriculture/farming? What did you do when these challenges occurred? Were there any individuals or groups that helped you when you had these challenges? If yes, can you tell me about them?

Munganditaurirawo here mamwe matambudziko amakasangana nawo mumabasa ekurima? Makaita sei matambudziko aya paakamuka? Pane vanhu here kana mamwe masangano akakubatsirai pamakasangana nematambudziko aya? Kana mati hongu, nditaurirei nezvawo.

7) Can you tell me about some of the challenges that you have faced around animal rearing? What did you do when these challenges occurred? Were there any individuals or groups that helped you when you had these challenges? If yes, can you tell me about them?

Munganditaurirawo here mamwe matambudziko amakasangana nawo pakuchengeta zvipfuyo? Makaita sei matambudziko aya paakamuka? Pane vanhu here kana mamwe masangano akakubatsirai pamakasanga nematambudziko aya? Kana mati hongu, nditaurirei nezvawo.

8) Is there anything that you have done to help improve the way that you farm or take care of your livestock? Can you tell me about this?

Pane here zvimwe zvamakaita kubatsira kuvandudza nzira dzamunorima kana kuchengeta zvipfuyo nadzo? Nditaurirewo nezvazvo.

PART 7~ GENDER & EMPOWERMENT
RUENZANISO RWEVANHUKADZI NEVANHURUME & KUWANISWA MASIMBA
INTRO: I would like to talk to you about gender and some of the differences between men and women
KUTANGISA: Ndinoda kutaura nemi pamusoro peruenzaniso pakati pevanhukadzi nevanhurume nemitsauko iri pakati pavo

1) What do you see as the roles and responsibilities of women within the household? What about men?

   Munoona sekuti chinzvimbo nemabasa evanhukadzi mumhuri ndeei? Ko varume?

2) How do these vary throughout a woman's life course? (Differences in Older/Younger, Pregnant/Non Pregnant, Mother, Single/Married). How do they vary throughtout a man's life course?

   Zvinosiyana nenzira ipi muupenyu hwese hwemunhukadzi? (Kusiyana kweVakuru/Vadiki, Vakazvitakura/Vasina, Vane Vana, Vasina Kuroorwa/Vakaroorwa)? Zvinosiyana nenzira ipi muupenyu hwese wemunhu rume (Kusiyana kweVakuru/Vadiki, Vane Vana, Vasina Kuroora/Vakaroora)

3) Who makes the decisions about the various assets that you have? Such as when to sell them, give them away or when to purchase a new one? Does this vary depending on what item it is? How does this vary?

   Ndiyani anotonga zvinhu kana midziyo zvakasiyana siyana zvamuinazvo? Zvakaita sekuti mozvitengesa rini kana, kuzvipa vamwe kana kutenga zvitsva rinhi ? Zvinosiyana here kuti chinege chiri chii chacho? Zvinosiyana nenzira dzipi?

4) To what extent are the women in your household involved in decision-making? Which decision? Does this depend on if there is a man present or not? If the man travels or migrates, can the woman then make decisions? Which decisions? Why or why not? {Probe about decisions made at community level}

   Vanhukadzi vari mumhuri menyu vanopiwa mukana wakadi wekutara kana kuronga zvinofanira kuitwa? Ndezvipi zvirongwa zvacho? Izvi zvinoenderana here nekuti pane munhurume aripo kana kuti kwete? Ko kana murume akafamba kana kutama, vanhukadzi vanenge vave kukwanisa here kutara nekusarudza zvinofanira kuitwa? Zvipi zvacho? Sei zvakadaro kana kusadaro?

5) In your household do men and women make decisions together? If joint decision-making is present, what are some examples of how it is carried out? [If not joint decision-making, probe to why joint decisions are not made]

Mumhuri menyu varume nevanhukadzi vanoronga nekusarudza zvinofanira kuitwa vari pamwechete here? Kana kusarudza nekutara zvinofanira kuitwa zvichiitwa pamwe. Ipai mimwe mienzaniso yemafambisirwo azvinoitwa.

6) Do you feel men and women are equal? Why or why not?
In what aspects are they equal?
In what aspects (if any) are they unequal?

Semaonero enyu vanhukadzi nevanhurume vakaenzana here ? Sei madaro?
Vakaenzana panezvipi/ nenzira dzipi?
Ndemune zvipi zvacho (kana zviripo) zvavasina kuenzana?

7) What do you see as barriers in your community to men and women being equal? What can be done to improve gender equity?

Munoona sekuti munharaunda menyu chii chinodzivirira kana kukonesa kuenzanisa (jechetere) pakati pavanhukadzi nevanhurume? Zvingaita kuvandudza ruenzaniso rwevanhukadzi nevanhurume

Thank you for your time. Would you like to add anything else in regards to the topics what we have discussed?

ANNEX 10
Tally Sheet of Qualitative Focus Group Discussions and Interviews Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

INTERVIEW CODE	TYPE*	DATE	DURATION	TOTAL	MALE	FEMALE	AGE	PREG	0 to 6	6 to 23	24 to 59	59 +	KIDS	OCCUPATION
***Amalima* Program Areas**														
BL_21_FGD_ZN_02_01	FGD	8/1/2014	3 hr 5 min	11	5	6								
GW_17_FGD_1_ZN_2_01	FGD	7/25/2014	2 hrs	8	7	1								Migrant Workers
TS_2_FGD_1_TD_1_01	FGD	7/28/2014	1 hr 43min	8	2	6								Village Health Workers
TS_2_FGD_1_TD_03_01	FDG	7/30/2014	2 hr 30 min	10	0	10		1						
BL_21_PLI_1_ZN_01_01	PLI	7/31/2014	37 min	1	1	0	60						4	Lead farmer
BL_7_PLI_1_TD_02_01	PLI	8/1/2014	40 min	1	0	1	48						4	Para-Vet Facilitator
GW_17_PLI_1_TD_1_01	PLI	7/24/2014	33 min	1	0	1	38	1					0	Lead farmer
GW_18_PLI_1_ZN_2_02	PLI	7/25/2014	45 min	1	0	1	59						7	Village Health Worker
TS_2_PLI_1_ZN_1_01	PLI	7/28/2014	44 min	1	0	1	27						1	Environmental Health Tech.
TS_2_PLI_1_ZN_3_3	PLI	7/30/2014	27 min	1	1	0	68						6	Lead farmer
AM_PLI_1_ZN	PLI	7/23/2014	30 min	1	1	0								Agricultural Specialist
AM_PLI_1_TD	PLI	7/23/2014	33 min	1	0	1								Nutrition Specialist
BL_7_HLI_1_ZN_03_01	HLI	8/2/2014	53 min	1	0	1	24			1	1	1	3	
BL_7_HLI_1_ZN_02_01	HLI	8/1/2014	40 min	1	1	0	64						7	Farmer
BL_7_HLI_1_TD_03_01	HLI	8/2/2014	1 hr 1 min	1	0	1	17		1				1	
BL_7_HLI_1_TD_02_02	HLI	8/1/2014	1 hr 32 min	1	0	1	33						0	Lead Mother
BL_21_HLI_1_TD_01_01	HLI	7/31/2014	1 hr 5 min	1	0	1	17						1	
BL_21_HLI_1_ZN_01_02	HLI	7/31/2014	52 min	1	1	0	33		1				4	Farmer/Shop Keeper
GW_18_HLI_1_TD_02_03	HLI	7/25/2014	57 min	1	0	1	27				1	1	2	
GW_18_HLI_1_TD_2_02	HLI	7/25/2014	1 hr 13 min	1	1	0	27			1		1	2	
GW_18_HLI_1_ZN_2_03	HLI	7/25/2014	1 hr 45 min	1	0	1	53						12	Village Head Wife
GW_18_HLI_1_TD_2_01	HLI	7/25/2014	1 hr 30 min	1	1	0	64						2	Lead farmer
GW_17_HLI_1_ZN_1_01	HLI	7/24/2014	1 hr	1	0	1	40						5	
GW_17_HLI_1_TD_1_02	HLI	7/24/2014	59 min	1	0	1	20						1	Farmer
TS_15_HLI_1_TD_02_01	HLI	7/29/2014	2 hr 10 min	1	0	1	35				2	2	4	Lead Mother
TS_15_HLI_1_ZN_2_01	HLI	7/29/2014	1 hr 13 min	1	0	1	40				1	2	3	Casual Laborer
TS_15_HLI_1_ZN_2_03	HLI	7/29/2014	52 min	1	1	0	55				2	4	6	Farmer
TS_15_HLI_1_ZN_2_02	HLI	7/29/2014	42 min	1	0	1	40			1		2	3	Farmer
TS_15_HLI_1_TD_02_02	HLI	7/29/2014	1 hr 44 min	1	0	1	19	1					0	School Leaver
TS_2_HLI_1_ZN_3_01	HLI	7/30/2014	1 hr 13 min	1	1	0	65					8	8	Lead farmer/Village Head
TS_2_HLI_1_ZN_3_05	HLI	7/30/2014	1 hr 6 min	1	0	1	32						5	Lead farmer
TS_2_HLI_1_ZN_3_04	HLI	7/30/2014	1 hr 12 min	1	0	1	63					4	4	Lead farmer
TS_2_HLI_1_ZN_3_02	HLI	7/30/2014	1 hr 7 min	1	0	1	37				1	3	4	Lead farmer
TOTALS/AVERAGE				66	23	43	40.9	3	2	3	8	28	3.7	
ENSURE Program Areas														
BI_4_FGD_2_TM_3_1	FGD	8/8/2014	2 hr 22 min	8	8	0								Migrant Workers
BU_29_FGD_2_JM_6_1	FGD	8/14/2014	2 hr 56 min	8	0	8								
CH_5_FGD_2_JK_2_1	FGD	8/7/2014	2 hr 40 min	8	5	3								Farmers
CV_14_FGD_2_JK_7_1	FGD	8/15/2014	2 hr 19 min	6	0	6		6						
BI_4_PLI_2_TM_3_2	PLI	8/8/2014	34 min	1	0	1	--							Farmer
BU_17_PLI_2_JM_5_2	PLI	8/13/2014	32 min	1	0	1	50					4	4	
CH_5_PLI_2_JM_2_1	PLI	8/7/2014	45 min	1	0	1	57					6	6	
CV_25_PLI_2_TM_8_2	PLI	8/16/2014	34 min	1	1	0	--							Lead farmer
CV_25_PLI_2_JM_8_1	PLI	8/16/2014	57 min	1	0	1	64					6	6	
EN_PLI_2_JK	PLI	8/4/2014	46 min	1	0	1								Gender Advisor
EN_PLI_2_TM	PLI	8/4/2014	38 min	1	1	0								WASH Officer
BI_2_HLI_2_JM_4_1	HLI	8/9/2014	1 hr 32 min	1	0	1	33				1	1	2	
BI_2_HLI_2_JK_4_1	HLI	8/9/2014	1 hr 11 min	1	0	1	31	1			1	1	2	
BI_2_HLI_2_TM_4_1	HLI	8/9/2014	1 hr 33 min	1	1	0	40				2	4	6	Farmer
BI_4_HLI_2_JK_3_1	HLI	8/8/2014	1 hr 18 min	1	0	1	74			1		3	4	
BI_4_HLI_2_JM_3_1	HLI	8/8/2014	1 hr 19 min	1	0	1	67					6	6	Farmer
BU_17_HLI_2_JK_5_1	HLI	8/13/2014	1 hr 29 min	1	0	1	35			1		4	5	
BU_17_HLI_2_JM_5_1	HLI	8/13/2014	1 hr 28 min	1	0	1	17	1					0	
BU_17_HLI_2_TM_5_1	HLI	8/13/2014	1 hr 15 min	1	1	0	82			1				Farmer
BU_29_HLI_2_JK_6_1	HLI	8/14/2014	1 hr 59 min	1	0	1	42	1			1	5	6	
BU_29_HLI_2_TM_6_1	HLI	8/14/2014	1 hr 6 min	1	1	0	42			1	1	4	6	Farmer
CH_4_HLI_2_JM_1_1	HLI	8/6/2014	58 min	1	0	1	60						6	Farmer
CH_4_HLI_2_TM_1_2	HLI	8/6/2014	1 hr 33 min	1	1	0	43					3	3	Farmer
CH_4_HLI_2_JK_1_1	HLI	8/6/2014	1 hr	1	0	1	44				1	2	3	
CH_5_HLI_2_JM_1_2	HLI	8/6/2014	1 hr 22 min	1	0	1	37	1			1	5	6	Farmer
CH_5_HLI_2_TM_1_1	HLI	8/6/2014	1 hr 8 min	1	1	0	48						4	Farmer
CV_25_HLI_2_TM_8_1	HLI	8/16/2014	1 hr 37 min	1	1	0	41					6	6	Farmer/Shop Owner
CV_25_HLI_2_JK_8_1	HLI	8/16/2014	1 hr 29 min	1	0	1	43			1		3	4	Lead farmer
CV_14_HLI_2_JM_7_1	HLI	8/15/2014	1 hr 16 min	1	0	1	27		1		1	1	3	
CV_14_HLI_2_TM_7_1	HLI	8/15/2014	1 hr 24 min	1	0	1	18			1			1	
CV_14_HLI_2_TM_7_2	HLI	8/15/2014	1 hr 28 min	1	1	0	63						4	Lead farmer/Village Head
TOTALS/AVERAGE				57	22	35	46	10	1	6	9	64	4.2	

* FGD- Focus Group Discussions; PLI- Program Level Interview; HLI- Household Level Interview

ANNEX 11
ATLAS.ti Code Book for Coding
Focus Group Discussions and Interviews
Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

Each transcript was coded using ATLAS.ti software. The goal with data coding is to topically categorize and organize the content of the transcripts. Development of the codebook was an iterative process, with both the organization and specific codes informed by the goals of the ENSURE and *Amalima* programs, the content of the interview guide and knowledge of the preliminary indicator values.

DOCUMENT FAMILIES	CODE FAMILIES
IT-1 Focus Group Discussion IT-2 Program Level Interview IT-3 Household Level Interview **All Interview Types* LO-1 Gwanda LO-2 Tsholotsho LO-3 Bulilima LO-4 Chimanimani LO-5 Bikita LO-6 Chivi LO-7 Buhera **All Interview Types* PVO-1 AMALIMA PVO-2 ENSURE **All Interview Types* SX-1 Male SX-2 Female **Household Level Interview Only* AG-1 Ages 18 to 20 years AG-2 Ages 20-49 years AG-3 Ages 49+ years **Household Level Interview Only*	ADULT HEALTH & NUTRITION (AHN) AGRICULTURAL PRODUCTIVITY & LIVELIHOODS (APL)** CHILD HEALTH & NUTRITION (CHN) FOOD INSECURITY & FOOD ACCESS (FIFA) GENDER & EMPOWERMENT (GEN) HOUSEHOLD SITUATION (HHS) OTHER (OTH) WASH **All Interview Types* ***This Document Family is unique to Zimbabwe*

AHN—ADULT HEALTH & NUTIRTION	Definition/Notes
AHN—Breastfeeding Beliefs/Practices	Particularly in relation to reasons women not able to exclusively breastfeed 0 to 6 mo
AHN—Community Health Agent (Haiti) or Village Health Worker (Zimbabwe)	
AHN—Disease and/or Illness	
AHN—Doctor, Nurse, Clinic, or Hospital	Including beliefs about, guidance, distance to
AHN—Exclusive Breastfeeding (0 to 6 mo)	Including challenges and successes
AHN—Experiences During Pregnancy	Including challenges
AHN—Health Promotion and/or Illness Prevention Practices	
AHN—Home Remedies	
AHN—Medical Care and/or Health Seeking Behavior	
AHN—Midwife or Traditional Birth Attendant	
AHN—Reproductive Health/Family Planning	Including spacing of children
AHN—Traditional Healer/Traditional Medicine	
AHN—Underweight Women	
AHN—Women's Diet	

APL—Agricultural Productivity & Livelihoods (APL)	Definition/Notes
APL—Agricultural Inputs	Seeds, livestock, fertilizer or other inputs used for agriculture
APL—Agricultural Techniques/Practices	Any mention of techniques or practices that the respondent is performing in relation to agriculture, will likely be cross-coded with other codes (i.e. livestock or crop) to indicate what the technique or practice related to
APL—Crop	
APL—Drought/Water Shortage	
APL—Environmental Degradation/Poor Soil	
APL—Farming (For Income Generation)	Farming to sale
APL—Farming (For Subsistence)	Farming for home consumption
APL—Financial Services (for savings, credit or insurance)	

APL—Livestock	
APL—Market Access	
APL—Rain/Flooding	
APL—Seasonality	
APL—Storage Practices	

CHN-CHILD HEALTH & NUTRITION	Definition/Notes
CHN—Awareness of Malnutrition	
CHN—Combatting Under Fed Children	
CHN—Diarrhea (Instances and/or Reasons)	
CHN—Diarrhea (Preventing)	
CHN—Diarrhea (Treating)	
CHN—Infant Young Child Feeding Practices	Including breastfeeding, complementary foods, child's diet
CHN—Key Foods for Children	
CHN—Parenting/Childcare	Non-food related
CHN—Weight or Height of Children	Including parental perceptions and guidance from doctor
CHN—Worries/Fears for Children	

FIFA—FOOD INSECURITY & FOOD ACCESS	Definition/Notes
FIFA—Food (Bought)	
FIFA—Food (Choices & Practices)	Food consumption, nutrition, and diversity
FIFA—Food (For Pregnant Women)	
FIFA—Food (Meals per Day)	
FIFA—Food (Other Source)	
FIFA—Food (Produced)	
FIFA—Food (Rarely Eaten)	
FIFA—Food (Regularly Eaten)	Likely, the reality of what's available

FIFA—Food (Taboos)	Even if respondent doesn't use the word taboo, but the question is asked as about taboo.
FIFA—Food (What Makes a Meal)	Including discussion of cultural significance of certain foods (i.e. rice, sadza, meat, etc.)

GEN—GENDER & EMPOWERMENT	Definition/Notes
GEN—Barriers to Equality	
GEN—Changes Over Time	
GEN—Equality/Equal Treatment	
GEN—Gender & Culture	Including gender beliefs/practices
GEN—Ownership	
GEN—Reasons for Inequities	
GEN—Women's Rights/Opportunities	

HHS—HOUSEHOLD SITUATION	Definition/Notes
HHS—Decision Making (Final Say)	
HHS—Decision Making (Joint)	
HHS—Decision Making (Men)	
HHS—Decision Making (Women)	
HHS—Employment/Unemployment	
HHS—Income Source	Including money, non-money resources, assets, remittances
HHS—Migration/Impacts of Migration	Both within and outside of the country
HHS—Poverty	More about money less about food
HHS—Roles (Children)	
HHS—Roles (Men)	
HHS—Roles (Women)	

OTH—OTHER	***Definition/Notes***
OTH-Challenges	Would be cross-coded
OTH-Disagreement	If response is "no disagreement" only code if respondent gives reason, approach, etc. to avoid disagreement
OTH-Good Quotes	
OTH-Information Source	Would be cross-coded
OTH-NGO/Aid/Donor	
OTH-Problem Solving	What was done to solve a particular problem or rectify a negative situation
OTH-Religious/Traditional Beliefs	
OTH-School/Education	
OTH-Social Support (or lack of)	
OTH-Food Assistance	
OTH- Savings/Village Loan & Savings Group	

WASH—WASH	**Definition/Notes**
WASH—Hand Washing (Frequency, Where)	
WASH—Hygiene	
WASH—Soap (Buying, Affordability, Prioritizing)	Including other cleansing agents
WASH—Soap (Feelings & Beliefs)	Including other cleansing agents
WASH—Toilet Construction	Including affordability, donors constructing toilets
WASH—Toilet Use Procedures/Practices	
WASH—WASH-Related Challenges	
WASH—WASH-Related Taboos	
WASH—Water (Source & Access)	
WASH—Water Collection (Time, Distance, Who)	Including water availability or unavailability
WASH—Water Treatment	

ANNEX 12
Additional Tables for Indicator Analysis
Baseline Study of the Title II Development Food Assistance Programs in Zimbabwe

Table A12.1. Household sanitation and drinking water

Sanitation facility, source of drinking water and treatment for drinking water by program area
[Zimbabwe, 2014]

	Total	Amalima	ENSURE
Improved, not shared sanitation facility			
Flush to piped sewer system	0.2	0.0	0.3
Flush to septic tank	0.2	0.2	0.3
Flush to pit latrine	0.0	0.0	0.0
Ventilated improved latrine	19.4	26.1	15.8
Pit latrine with slab	13.2	14.6	12.4
Improved, shared sanitation facility			
Flush to piped sewer system	0.6	0.0	0.9
Flush to septic tank	0.1	0.0	0.1
Flush to pit latrine	5.6	2.2	7.4
Ventilated improved latrine	6.3	3.3	7.9
Pit latrine with slab	5.6	2.2	7.4
Non-improved sanitation facility			
Flush to somewhere else	0.0	0.1	0.0
Flush, don't know where	0.0	0.0	0.0
Pti latrine without a slab/open pit	10.1	3.6	13.7
Hanging latrine (pile)	0.2	0.2	0.3
Bucket toilet	0.0	0.0	0.0
No facility/bush/field	43.7	49.5	40.5
Other	0.2	0.2	0.2
Improved source of drinking water			
Piped water into dwelling	0.8	0.1	1.1
Piped water into yard	2.0	0.4	2.9
Public tap/ Standpipe	0.8	0.9	0.8
Tubewell or Borehole	55.2	62.2	51.3
Protected well	15.6	8.3	19.5
Protected spring	0.4	0.4	0.4
Rainwater	0.2	0.3	0.1
Non-improved source of drinking water			
Surface water (river/dam/ lake/ponds/stream/canal/irrigation channel)	9.8	11.8	8.7
Unprotected well	9.5	5.7	11.6
Unprotected spring	2.0	1.4	2.4
Tanker truck	0.2	0.0	0.2
Digging into a dry riverbed	3.3	8.1	0.7
Car with small tank	0.1	0.1	0.2
Other	0.1	0.2	0.1
Water availability			
Water is generally available from this source year round (% 'Yes')	65.6	67.9	64.3
Water was not available for a day or more during the last two weeks (% 'No')	77.6	80.0	76.2
Water treatment prior to drinking			
Boil	4.3	5.5	3.7
Bleach/chlorine added	6.4	2.6	8.5
Strain through a cloth	0.3	0.5	0.1
Water filter	0.1	0.0	0.1
Solar disinfection	0.0	0.0	0.0
Let it stand and settle	0.5	0.4	0.5
Sand filtration	0.0	0.0	0.0
Other	0.0	0.0	0.0
No treatment	89.1	91.4	87.9
Number of households	5,003	2,482	2,521

Table A12.2. Financial services used by farmers

Percentage of farmers by financial service by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Type of Financial Service			
Credit	7.5	3.8	9.4
Savings	5.0	1.8	6.7
Insurance	0.1	0.1	0.1
Number of farmers	6,306	3,032	3,274

Table A12.3. Value chain activities

Percentage of farmers by value chain activity by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Value Chain Activities			
Purchase Inputs	21.5	13.8	25.5
Mobile financial services	0.9	0.4	1.1
Financial services other than mobile	0.8	0.9	0.8
Training and extension services	22.2	21.1	22.7
Contract Farming	7.4	2.4	10.0
Feed lots or pen feeding	3.0	2.4	3.3
Drying produce	61.4	59.2	62.5
Processing produce	22.2	24.4	21.0
Trading or marketing produce	5.4	1.3	7.5
Formal marketing systems for livestock	2.5	4.8	1.3
None of these activities	24.4	28.2	22.5
Number of farmers	6,293	3,025	3,268

Table A12.4. Sustainable agricultural practices

Percentage of farmers by agricultural practice by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Crops			
Micro dosing	20.6	15.0	23.5
Manure	37.0	27.0	42.1
Compost	13.7	5.9	17.6
Planting basins	14.0	15.1	13.5
Mulching	11.3	8.8	12.5
Weed control	62.7	71.7	58.1
Dry planting	24.1	20.8	25.8
Ripping into residues	9.3	13.3	7.2
Clean ripping	12.5	16.2	10.5
Tied ridges	3.4	1.8	4.2
Pot-holing	9.7	5.7	11.7
Crop rotations	37.1	30.0	40.7
Intercropping	37.0	31.1	40.1
Integrated pest management (IPM)	8.6	2.6	11.7
Early planting or planting with first rains	36.0	35.2	36.4
Use of improved crop varieties	29.4	31.0	28.6
Dead level contours	4.9	1.7	6.5
Ridging into separate lines	9.8	3.6	13.0
Did not sue any of these practices	3.6	3.4	3.7
Did not raise any crops	9.5	10.1	9.2
Livestock			
Improved animal shelters	26.0	14.1	32.1
Vaccinations	35.4	37.2	34.4
Deworming	14.2	24.3	9.1
Homemade animal feeds	29.1	21.2	33.1
Animal feed supplied by stockfeed manufacturer	4.2	6.7	3.0
Artificial Insemination	0.1	0.3	0.1
Pen Feeding	3.5	4.3	3.1
Fodder production and/or veld reinforcement	2.9	0.5	4.2
Community animal health workers/paravets	8.8	12.3	7.0
None of these activities	17.2	25.2	13.2
Did not raise any livestock	22.2	12.1	27.4
Natural Resource Management			
Management/protection of watersheds/water catchments	14.3	17.4	12.6
Agro-forestry	23.1	4.5	32.7
Management of forest plantation	27.0	14.5	33.4
Regeneration of natural landscapes	15.2	10.8	17.5
Sustainable harvesting of forest products	31.5	31.2	31.6
None of these activities	44.7	56.6	38.6
Number of farmers	6,215	2,999	3,216

Table A12.5. Improved storage practices

Percentage of farmers by storage practice by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Storage practices (Sorghum)			
Hermetic storage	1.1	1.7	0.8
Improved granary	4.6	7.5	3.1
Warehousing or cereal banks	0.4	0.4	0.4
Use of traps	0.4	0.3	0.4
Grain bag with pesticides	11.0	5.2	14.0
Did not use any of these methods	14.2	15.9	13.4
Did not store sorghum	69.1	69.6	68.8
Storage practices (Groundnuts)			
Hermetic storage	1.0	1.5	0.8
Improved granary	2.9	4.2	2.2
Warehousing or cereal banks	0.1	0.1	0.2
Use of traps	0.5	0.6	0.5
Grain bag with pesticides	4.8	2.5	6.0
Did not use any of these methods	14.3	11.0	16.1
Did not store groundnuts	76.6	80.5	74.6
Number of farmers	6,195	3,000	3,195

Table A12.6. Physiological status of women

Women below 145 cm, mean BMI and BMI levels by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Percent less than 145 cm	1.6	1.7	1.5
Mean Body Mass Index (BMI)	23.4	22.4	23.9
Normal			
18.5-24.9 (total normal)	62.8	64.7	61.7
Underweight			
<18.5 (total underweight)	8.6	13.9	5.9
17.0-18.4 (mildly underweight)	6.7	9.9	5.0
<17 (moderately and severely underweight)	1.9	4.0	0.9
Overweight/obese			
≥25 (total overweight or obese)	28.6	21.4	32.4
25.0-29.9 (overweight)	20.4	15.4	23.0
≥30.0 (obese)	8.2	6.1	9.4
Number of women [1]	3,046	1,430	1,616

Does not include pregnant or post-partum women (2 months)

Table A12.7. Stunting and underweight by age (months)

Prevalence of stunted and underweight children by age by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Prevalence of stunted children			
<6	14.5	12.5	15.7
6-11	12.5	15.4	10.9
12-17	32.5	37.1	30.2
18-23	44.3	46.4	43.0
24-29	36.6	41.4	33.9
30-35	40.5	41.4	39.9
36-41	31.0	37.0	27.2
42-47	26.3	30.7	23.8
48-53	27.8	25.9	28.8
54-59	21.9	22.7	21.3
Prevalence of underweight children			
<6	4.9	8.6	2.7
6-11	7.2	4.3	8.8
12-17	12.4	19.6	8.8
18-23	17.7	20.0	16.3
24-29	12.9	17.3	10.4
30-35	10.5	15.9	7.3
36-41	10.5	12.4	9.3
42-47	9.8	13.2	7.9
48-53	10.7	17.7	7.2
54-59	9.7	15.1	5.7
Number of children	3,115	1,609	1,506

NOTE: The results for these subgroup analyses are not as precise as those for the overall indicator and may be unreliable.

Table A12.8. Prevalence of diarrhea by WASH status

Percentage of children under age five who had diarrhea in the two weeks preceding the survey, by household WASH status [Zimbabwe, 2014]

	Total	Amalima	ENSURE
WASH (All Households)			
Source of drinking water	21.5	15.8	24.6
Improved	20.5	17.0	22.4
Unimproved	22.3	15.0	26.2
Toilet Facility	21.5	15.8	24.6
Improved	18.8	15.4	21.8
Unimproved	22.7	16.1	25.6
Water and cleansing agent at handwashing station	21.5	15.8	24.6
Available	14.4	13.7	14.8
Not available	21.7	15.9	24.8
Water treatment	21.5	15.8	24.6
Treated	19.1	12.8	21.5
Not treated	21.9	16.2	25.2
Storage of drinking water	21.5	15.8	24.6
Safe	20.0	15.2	22.5
Unsafe	23.1	16.5	26.9
Handwashing station near a sanitation facility	21.4	15.9	24.1
Present	15.4	6.2	19.1
Not present	21.5	16.0	24.2
Number of children (under 5 years)	3,794	1,885	1,909

NOTE: Tests of differences were not conducted, so it is not known if the comparisons are statistically significant

Table A12.9. Components of minimum acceptable diet

Components of MAD indicator for children 6-23 months by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Breastfed children 6-8 months			
Percent with minimum meal frequency (2 or more)	40.9	53.2	35.5
Percent with minimum dietary diversity (4 or more)	5.1	2.8	6.2
Grains, roots, and tubers	81.8	83.3	81.1
Legumes and nuts	3.3	6.2	2.0
Dairy products (milk, yogurt, cheese)	10.7	17.2	7.9
Flesh foods (meat, fish, poultry, and liver/organ meats)	8.6	4.1	10.6
Eggs	3.5	0.0	5.1
Vitamin A-rich fruits and vegetables	23.4	25.2	22.6
Other fruits and vegetables	7.6	7.9	7.4
Number of children	156	69	87
Breastfed children 9-23 months			
Percent with minimum meal frequency (3 or more)	29.6	35.4	27.0
Percent with minimum dietary diversity (4 or more)	15.1	11.3	16.8
Grains, roots, and tubers	90.5	92.3	89.7
Legumes and nuts	20.5	17.3	21.9
Dairy products (milk, yogurt, cheese)	16.1	24.6	12.2
Flesh foods (meat, fish, poultry, and liver/organ meats)	18.6	12.4	21.4
Eggs	2.9	3.2	2.7
Vitamin A-rich fruits and vegetables	61.1	55.1	63.9
Other fruits and vegetables	18.2	14.6	19.8
Number of children	505	232	273
Non-breastfed children 6-23 months			
Percent with minimum meal frequency (4 or more + 2 milk)	4.8	6.1	4.0
Percent with minimum dietary diversity (4 or more)	17.8	10.4	22.2
Grains, roots, and tubers	96.1	96.8	95.7
Legumes and nuts	24.4	19.2	27.5
Dairy products (milk, yogurt, cheese)	26.1	35.3	20.6
Flesh foods (meat, fish, poultry, and liver/organ meats)	31.7	21.8	37.6
Eggs	7.4	6.7	7.8
Vitamin A-rich fruits and vegetables	67.5	54.6	75.1
Other fruits and vegetables	20.5	16.3	23.0
Number of children	412	209	203

NOTE: The results for these subgroup analyses are based on small sample sizes and may be unreliable.

Table A12.10. Breastfeeding status

Breastfeeding status for children 0-23 months by age by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Not breastfeeding			
<2	6.8	1.6	11.2
2-3	3.6	8.6	1.3
4-5	3.4	5.5	1.9
6-8	4.9	6.6	4.1
9-11	9.0	14.4	5.8
12-17	27.8	29.4	27.1
18-23	75.2	77.8	73.6
Exclusively breastfed			
<2	58.7	56.6	60.5
2-3	41.0	48.8	37.5
4-5	19.2	28.9	12.6
6-8	3.0	4.5	2.3
9-11	1.5	1.3	1.6
12-17	0.9	2.2	0.3
18-23	0.0	0.0	0.0
Breastfed and plain water only			
<2	13.6	18.1	9.8
2-3	11.0	15.5	9.0
4-5	20.9	15.7	24.5
6-8	11.9	7.2	14.0
9-11	5.7	3.5	7.0
12-17	3.1	2.0	3.5
18-23	1.3	0.5	1.8
Breastfed and non-milk liquids			
<2	8.2	3.6	12.0
2-3	22.4	13.5	26.5
4-5	16.9	12.8	19.6
6-8	11.7	8.3	13.1
9-11	3.1	2.0	3.7
12-17	0.6	0.8	0.6
18-23	0.0	0.0	0.0
Breastfed and other milk			
<2	4.4	9.7	0.0
2-3	3.6	6.2	2.4
4-5	0.9	2.2	0.0
6-8	0.0	0.0	0.0
9-11	1.0	0.0	1.5
12-17	0.0	0.0	0.0
18-23	0.0	0.0	0.0
Breastfed and complementary foods			
<2	8.3	10.4	6.5
2-3	18.4	7.4	23.4
4-5	38.7	34.9	41.3
6-8	68.6	73.4	66.5
9-11	79.7	78.8	80.2
12-17	67.7	65.5	68.6
18-23	23.5	21.8	24.6
Number of children	1,412	684	728

NOTE: The results for these subgroup analyses are based on small sample sizes and may be unreliable.

Table A12.11. Breastfeeding initiation and prelacteal feeding

Breastfeeding initiation for last birth in the past 2 years by program area [Zimbabwe, 2014]

	Total	Amalima	ENSURE
Initial Breastfeeding (All last borns)			
Percentage ever breastfed	98.1	97.8	98.2
Percentage who started breastfeeding within 1 hour of birth	82.9	80.8	83.9
Percentage who started breastfeeding within 1 day of birth[1]	94.5	91.5	95.9
Number of last born children in the last 2 years	988	424	564
Prelacteal feed (Ever breastfed last borns)			
Percentage who received a prelacteal feed [2]	7.4	7.4	7.3
Number of last born children in the last 2 years who were ever breastfed	976	417	559
Food taken (Ever breastfed last borns with prelacteal feed)			
Milk (other than breast milk)	9.3	8.4	9.6
Plain water	78.3	57.0	85.0
Sugar or glucose water	6.7	19.1	2.8
Gripe water	1.8	0.0	2.4
Sugar-salt-water solution	2.4	10.3	0.0
Fruit juice	0.0	0.0	0.0
Infant formula	6.1	25.8	0.0
Tea/infusions	4.0	0.0	5.3
Coffee	0.0	0.0	0.0
Honey	0.0	0.0	0.0
Other	0.0	0.0	0.0
Number of last born children in the last 2 years who were ever breastfed and received a prelacteal feed	75	34	41

[1] Includes children who started breastfeeding within one hour of birth

[2] Children given something other than breast milk during the first three days of life

NOTE: The results for these subgroup analyses are based on small sample sizes and may be unreliable.