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IMPACT EVALUATION OF USAID NURTURE IN LAO PEOPLE'S DEMOCRATIC REPUBLIC

Endline Evaluation Report

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DISCLAIMER

This report was made possible by the support of the American people through the United States Agency for International Development (USAID). The contents of this report are the sole responsibility of Social Impact and do not necessarily reflect the views of USAID or the United States Government.

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This document was produced by Alison Smith, Carley Clontz, Irene Lorete, and Mike Duthie of Social Impact, Inc.

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ACRONYMS

AHAN	Accelerating Healthy Agriculture and Nutrition
ANC	Antenatal Care
CCEH	Center of Communication and Education for Health
CEM	Coarsened Exact Matching
CF	Community Facilitator
CLTS	Community-Led Total Sanitation
CU5	Children Under Five
CU2	Children Under Two
DHS	Demographic and Health Surveys
DID	Difference in Differences
DNC	District Nutrition Committee
DHO	District Health Office
EBF	Exclusive Breastfeeding
ET	Evaluation Team
FGD	Focus Group Discussion
GMP	Growth Monitoring and Promotion
GOL	Government of Lao PDR
IE	Impact Evaluation
IEC	Information, Education, and Communication
IFA	Iron and Folic Acid
iNuW	Integrated Nutrition and WASH
IMAM	Integrated Management of Acute Malnutrition
IPTT	Indicator Performance Tracking Table
IRL	IndoChina Research Laos
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
MAD	Minimum Acceptable Diet
MDD	Minimum Dietary Diversity
MMF	Minimum Meal Frequency
MOH	Ministry of Health
MOU	Memorandum of Understanding
NAMSAAT	National Centre of Environmental Health and Water Supply
ODF	Open Defecation Free
PDR	People's Democratic Republic
PLW	Pregnant and Lactating Women
PNC	Postnatal Care
PSM	Propensity Score Matching
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SBCC	Social and Behavior Change Communications
SDA	Small Doable Actions
SI	Social Impact, Inc.
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHV	Village Health Volunteer
VIC	Village iNuW Committee
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WRA	Women of Reproductive Age

EXECUTIVE SUMMARY

EVALUATION OBJECTIVES

The United States Agency for International Development (USAID) Nurture Impact Evaluation (IE) Endline Report documents a mixed-methods quasi-experimental approach that evaluates the efficacy of a USAID-funded Improving Nutrition and Community Sanitation Activity. The Activity focused on improving nutrition and water, sanitation, and hygiene (WASH) practices and behaviors at the household and community levels in the Lao People's Democratic Republic (PDR). The IE was implemented by Social Impact, Inc. (SI) in cooperation with local data collection partner IndoChina Research Laos (IRL) between 2016 and 2022. The endline evaluation focused on four Evaluation Questions:

1. What is the effectiveness of the USAID Nurture approach in improving the nutritional status of children under two (CU2) in target areas?
2. To what extent did each of the individual components of the USAID Nurture approach (maternal health and nutrition, infant and young child feeding [IYCF], and WASH) contribute to the effectiveness of the overall approach?
3. What is the current outlook for sustainability of each of the individual components of the USAID Nurture approach (maternal health and nutrition, IYCF, and WASH)?
4. What were the key successes and challenges in implementation over the course of the USAID Nurture activity?

PROGRAM BACKGROUND

The Activity focused on improving the nutritional status of women and children to reduce stunting in targeted provinces, districts, and villages in Lao PDR. The program model was anchored by four strategies: 1) creating a supportive enabling environment through capacity-building of government authorities, 2) strengthening the quality of health services through capacity building at the health facility level, 3) capacity building to improve quality service delivery, and 4) demand creation for the use of nutrition, health, and WASH services and products.

EVALUATION DESIGN

The Activity was evaluated through a mixed-methods quasi-experimental approach, incorporating elements of coarsened exact matching (CEM) to identify a comparison group for the evaluation. At baseline, the evaluation team (ET) completed interviews with a total of 2,770 women of reproductive age (WRA) primary caregivers with CU2 years of age in 346 villages in person in Savannakhet and Khammouane provinces. At endline, the ET completed interviews with a total of 411 WRA primary caregivers in 257 villages over the phone. Additionally, the ET conducted qualitative interviews with key Activity stakeholders at midline and endline. At endline, the ET completed a total of 70 key informant interviews (KII) and one group interview. The interviews were conducted with national, provincial, and district officials and technical staff, health center staff, vendors, village-level officials and volunteers, Save the Children staff, and other donors. Data were collected in Vientiane and all six treatment districts covered by the IE: Atsaphangthong, Nhommalath, Mahaxay, Phine, Xaibouathong, and Xonboully. The change in sample size and methodology between baseline and endline was due to effects of the COVID-19 pandemic; **accordingly, the findings we report should be interpreted holistically; the strongest findings are not necessarily those where statistical significance is reported but are findings that are triangulated by multiple data sources.**

FINDINGS AND CONCLUSIONS

EVALUATION QUESTIONS I & II

Overall, the ET found that the Activity likely contributed to the improvement of several short- and medium-term outcomes over time, though a conclusion on the impact of the Activity on the long-term goals of stunting, wasting, and underweight status at endline cannot be made due to the lack of quantitative data at endline combined with minimal knowledge and discussion of these indicators among qualitative interview respondents. Though there were minimal mentions of stunting, wasting and underweight status specifically, respondents in 16 of the 70 qualitative interviews discussed positive changes in malnourished children in general and nine discussed positive changes in children's weight as a result of the Activity. However, the ET determined that these findings are not strong enough to confidently draw a conclusion about positive impacts on nutritional status of CU2.

Of the maternal health and nutrition outcomes measured, the ET found the strongest Activity impacts in women achieving a minimum acceptable diet (MAD) and receiving antenatal care (ANC) within the first 12 weeks of pregnancy. Quantitative results show that the Activity had a significant positive impact on self-reported nutritionally adequate diets for WRA ($p < 0.01$). This finding was triangulated by qualitative data. The likelihood of a woman receiving ANC within the first 12 weeks of pregnancy increased significantly in the treatment group as compared to the control group from baseline to endline as well ($p < 0.05$). Households where the head has low education were less likely both to achieve a MAD and receive ANC in the first trimester, while households with greater asset wealth were more likely for both indicators.

Evidence of Activity impacts on IYCF behaviors is less strong than in the areas of maternal health and nutrition and WASH, though there is evidence to support likely positive impacts on some breastfeeding outcomes. The median duration of breastfeeding with children 0-23 months of age increased by 2.1 months in the treatment group and decreased by 1.2 months in the control group, and the median duration of *exclusive* breastfeeding (EBF) increased by 4.3 months in the treatment group and 3.4 months in the control group. Though the impact of the Activity on these outcomes is not statistically significant, this may be due in part to the small sample size at endline relative to the baseline sample, as likely impacts of the Activity on breastfeeding are substantiated by qualitative data.

Of the WASH outcomes measured, the ET found likely impacts on open defecation and handwashing behaviors. Though the Activity fell short of its monitoring target for communities certified as open defecation free (ODF) and open defecation impacts were not statistically significant, qualitative respondents frequently spoke about the success of the open defecation interventions. Based on triangulation of the quantitative survey data, qualitative data, and Save the Children's monitoring data, it is likely that the open defecation interventions were effective among households who had the financial means to implement the SDAs and build a latrine, but much less so among households without the financial means.

The ET used the qualitative data to explore remaining barriers to success in each of the outcome areas (maternal health and nutrition, IYCF, and WASH). Barriers to improving WASH behaviors were mentioned the most frequently of these outcome areas. The most discussed barriers were economic barriers to building toilets (30 interviews), a lack of access to a water source for toilets (17 interviews), and a lack of access to materials, especially in rural areas (13 interviews). Food scarcity was commonly discussed as a barrier to improvement in both maternal health and nutrition outcomes (five interviews) and IYCF outcomes (ten interviews). Similarly, traditional beliefs were discussed as a barrier related to both maternal health and nutrition (11 interviews) and IYCF (eight interviews).

EVALUATION QUESTION III

Qualitative interview respondents generally spoke positively of the Activity's outlook for sustainability due to the capacity-building nature of many of the interventions and alignment with the Government of the Lao PDR (GOL). Respondents explained that because of the shared goals, the GOL will continue the nutrition and WASH work of the USAID Nurture program with the Ministry of Health as the primary implementer.

Despite an overall positive outlook, respondents also provided important feedback on some interventions that would require additional resources to implement. Respondents expressed the most concern around the WASH interventions. First, respondents reported that communities understand the importance of toilets but are not financially capable of building them. Second, respondents report that the work of the sales agents who link communities and vendors will not continue since the work of the sales agents was an agreement between the Activity and private sector vendors, and this is not in the plans of the GOL. Third, vendors perceive WASH products as a risky investment.

EVALUATION QUESTION IV

Qualitative interview respondents discussed three main successes of the Activity related to the enabling environment: the relationship between the GOL and Save the Children, the multi-sector collaboration of the District Nutrition Committee (DNC), and the alignment of the USAID Nurture program's activities and components with the national nutrition goals of the GOL. Related to training and capacity building, respondents spoke generally of the success of trainings for health center staff, the improved quality of the counseling services provided by health staff, and the success of the training of CFs and Social and Behavior Change Communication (SBCC) materials. Respondents considered the latrine package subsidies for poor households a success as well, though these were implemented following midline data collection and challenges with latrine affordability remained.

One primary challenge discussed by respondents overall was the long memorandum of understanding (MOU) approval process, which was not approved until after the first year of the Activity. Other implementation challenges frequently discussed were the language barrier in training and SBCC, the lack of demand for water filters, and vendors unwilling to travel to remote villages to sell latrine packages.

RECOMMENDATIONS

GOL IMPROVEMENTS WITH EXISTING OR MINIMAL RESOURCES

1. **Coordinate quarterly DNC meetings:** The GOL should assign a person or group responsible for ensuring the continuation of the quarterly district nutrition committee (DNC) coordination meetings, as the Activity was previously responsible for coordinating these meetings. Respondents discussed these quarterly meetings as essential for continued coordination between sectors all working in alignment with National plans.
2. **Promote postnatal care (PNC):** In addition to providing counseling on ANC visits, current CFs, VHVs, and health center staff can strongly recommend mothers continue with PNC. Increased interaction with health center staff following birth may support continuity in newly adopted breastfeeding, complementary feeding, and behaviors on growth monitoring promotion (GMP), as well as on sick or well child behaviors, such as immunization and on early essential newborn care.
3. **Target grandparents and other caregivers:** CFs and VHVs could be used to conduct additional community outreach to parents and other caregivers of children around IYCF

behavior change. Villages may consider implementing grandparent or caregiver peer groups to incorporate elements of positive deviance to this approach.

4. **Engage men and husbands:** The GOL should continue to engage men and husbands in counseling around women's nutrition, ANC, PNC, and IYCF to reduce the impacts of traditional roles of men on women's nutrition and health.
5. **Support CFs and VHVs to provide training and supervision for the first 1,000 days counseling by health center staff:** Advocate projects supporting health system strengthening, maternal and child health, or nutrition interventions to support the CFs and health center counseling set-up by the Activity.

FUTURE NUTRITION PROGRAMMING: GUIDANCE FOR ADDITIONAL RESOURCE ALLOCATION

1. **Direct funding to beneficiaries:** The GOL could provide funding directly to beneficiaries for toilet installation and maintenance and travel to health centers.
2. **Seek opportunities for collaboration:** Future nutrition programming should seek to collaborate with organizations working in food security and agriculture, and/or facilitate income-generating opportunities, especially for women, as a way to mediate the barrier of food scarcity in women's nutrition and IYCF.
3. **Prenatal and postnatal support to women:** Future nutrition programming should explore the possibility of providing women with alternative livelihoods to ease the economic impacts of EBF for six months and reduce the likelihood of extended stays in the rice fields. Additionally, future programs may consider food subsidies for pregnant and breastfeeding women.
4. **Planning for language barriers:** Future programs should plan for and address language barriers in training and counseling by delivering trainings of trainers in the local language and utilizing visual and pictorial aids to share SBCC messages.
5. **Supporting community outreach:** Current community outreach activities implemented through the Activity are continuing, but at a less-frequent pace. Future nutrition programming should consider funding outreach activities for CFs so that activities are able to happen more regularly.
6. **Employ adolescents:** In addition to funding current outreach activities, future programs should hire and pay adolescents as CFs to improve adolescent engagement with health services.
7. **Assess water resources:** Future programs should thoroughly assess current water resources or systems when providing recommendations on sanitation infrastructure or handwashing facilities. Since availability and access can vary greatly by district and village, these assessments should be done at the village level.
8. **Align project plans with sector counterpart plans:** Local sector offices depend on projects and programs to implement their development plans owing to chronic public budget deficits within the GOL. Project plans that are integrated into local sector plans allow government offices to attain local priorities and may encourage them to continue seeking or combining project funds that could sustain interventions and embody principles of aid effectiveness.

I. INTRODUCTION

The United States Agency for International Development (USAID) Nurture Impact Evaluation (IE) Endline Report documents a mixed-methods quasi-experimental approach that evaluates the effectiveness of a USAID-funded Improving Nutrition and Community Sanitation Activity in Lao People's Democratic Republic (PDR) (USAID Nurture, referred to throughout the document as "USAID Nurture" or "the Activity"). The Activity focused on improving the nutritional status of women and children through behavioral interventions in maternal health and nutrition; infant and young child feeding (IYCF); and a variety of water, sanitation, and hygiene (WASH) practices including addressing open defecation, safe drinking water, and handwashing behaviors. The IE was implemented by Social Impact, Inc. (SI) in cooperation with local data collection partner IndoChina Research Laos (IRL) between 2016 and 2022. This report provides an overview of the Activity's Theory of Change; summarizes the evaluation methodology; and presents the evaluation study's findings, conclusions, and recommendations at endline.

I.1 EVALUATION OBJECTIVES

The evaluation tests the effectiveness of the Activity in improving the nutritional status of women and children, especially children under two (CU2) and pregnant and lactating women. The endline evaluation focused on four Evaluation Questions. Questions one and two were included at baseline, midline, and endline; questions three and four were added at endline only and were answered primarily with qualitative data, in part due to changes necessitated by the COVID-19 pandemic. Other study changes and limitations as a result of COVID-19 are detailed in the Evaluation Design section.

1. What is the effectiveness of the USAID Nurture approach in improving the nutritional status of CU2 in target areas?
2. To what extent did each of the individual components of the USAID Nurture approach (maternal health and nutrition, IYCF, and WASH) contribute to the effectiveness of the overall approach?
3. What is the current outlook for sustainability of each of the individual components of the USAID Nurture approach (maternal health and nutrition, IYCF, and WASH)?
4. What were the key successes and challenges in implementation over the course of the USAID Nurture activity?

I.2. NUTRITION AND WASH CONTEXT

Between 1993 and 2019, the poverty rate in the Lao PDR fell from 46 percent to 18 percent and gross domestic product grew at an annual average rate of 7.3 percent.¹ Though the country has progressed in other key development areas including maternal and health and nutrition and IYCF, the progress has been relatively slower: the prevalence of stunting reduced from a national average of 44 percent in 2014 to 36 percent in 2015, and to 33 percent in 2017.² Likewise, the prevalence of underweight status fell from 27 percent in 2012 to 21 percent in 2017.³ In contrast, the prevalence of wasting increased from

¹ <https://www.worldbank.org/en/country/lao/publication/lao-pdr-poverty-profile-and-poverty-assessment-2020>.

² Stunting or "low height-for-age" is a reflection of chronic malnutrition as a result of failure to receive adequate nutrition over a long period of time and recurrent or chronic illness (*Fact Sheet on Malnutrition*, World Health Organization, 2021).

³ The underweight malnutrition rate is a composite form of undernutrition that can include elements of stunting and wasting. For example, an underweight child may have a low weight for their age because they are too thin for their height (Lao Statistics Bureau 2018); Ministry of Health and Lao Statistics Bureau, 2012; as of 2017 data, the percentage of children under five (CU5) who are underweight in Savannakhet and Khammouane are 20.2 percent and 23.3 percent, respectively (Lao Statistics Bureau 2018).

six percent in 2012 to nine percent in 2017. Lao PDR displayed modest progress in the context of reproductive health: the number of deliveries assisted by a skilled birth attendant increased by 26 percent from 38 percent in 2011 to 64 percent in 2017. The large decline in poverty combined with more modest changes in nutrition and maternal health outcomes suggests room to affect positive change in nutritional status through behavioral interventions.

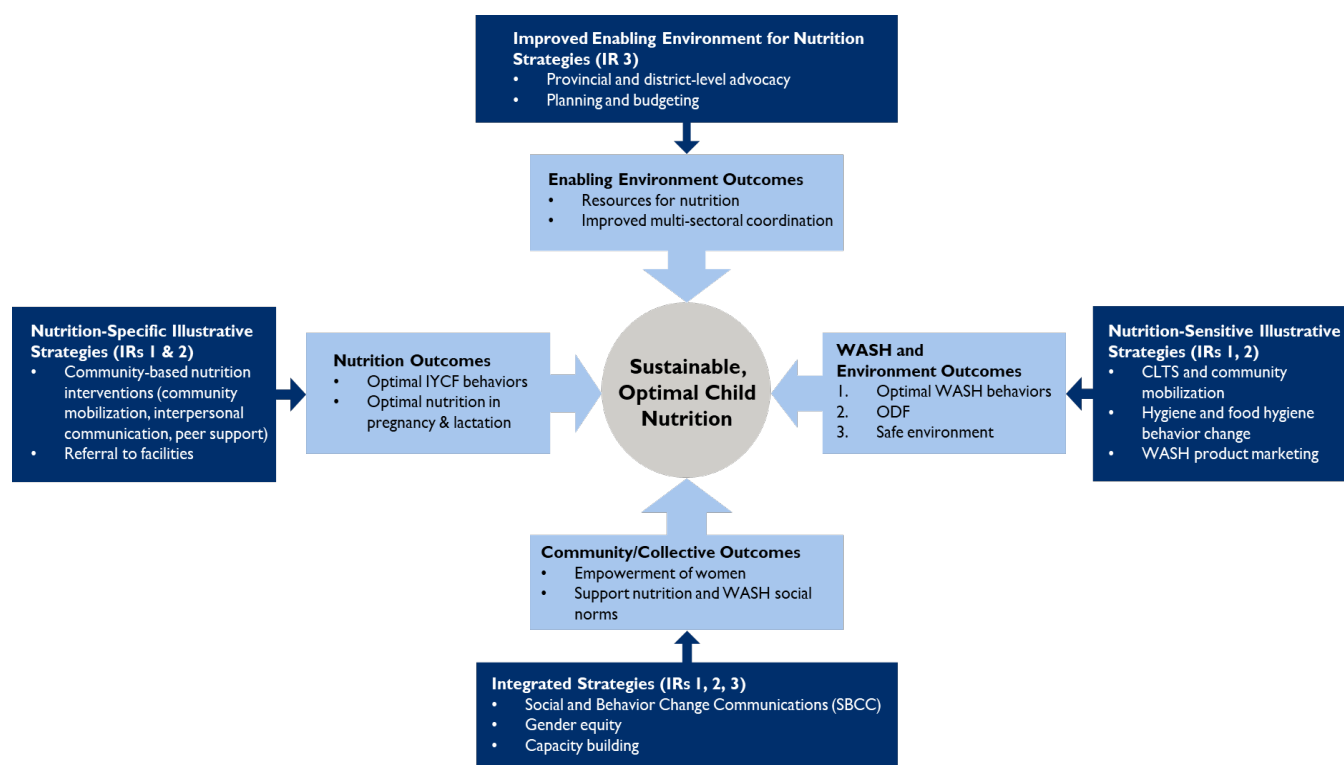
I.3 NURTURE ACTIVITY BACKGROUND

USAID implemented the Activity in partnership with Save the Children to deliver a set of multi-sectoral interventions aimed at improving the nutritional status of women and children in two provinces in Lao PDR: Khammouane and Savannakhet. The Activity delivered interventions in six districts and 471 villages.

The interventions worked to improve nutrition and WASH practices and behaviors at the household and community levels. The integrated delivery model by the Activity supported the Government of the Lao PDR (GOL) in its implementation of the National Nutrition Strategy to 2025, the National Plan of Action 2016-2020, and the National Social Behavior Change Communication (SBCC) Plan and paved the way towards sustainable, self-led interventions for the GOL.

The Activity focused on maternal and child nutrition during the first 1,000 days of life, which is a critical growth period for children during which irreversible cognitive and physical damage can occur due to undernutrition. The primary beneficiaries of the Activity included women of reproductive age (WRA) between 15 and 49 years of age, pregnant and lactating women (PLW), CU2, CU2's caregivers and caregivers' households, and adolescent girls. While these are the primary targeted populations, many of the program components such as mass media campaigns and village-based social mobilization, including community-led total sanitation (CLTS), awareness events, and cooking demonstrations involved the larger community, including older children and adolescents. The Activity's Theory of Change, displayed in Figure I below, acknowledges the integral importance of gender equality and women's empowerment in achieving improved nutritional status among PLW and CU2.

Figure 1. USAID Nurture Theory of Change



Source: Request for Task Order Proposal SOL-486-17-000002 Impact Evaluation of USAID Nurture in Lao PDR. USAID.

ACTIVITY COMPONENTS

The Activity model was anchored by four components that consider the realities of Lao PDR's institutional context where independence, democracy, and community participation are limited by top-down governance by a single party-led government. Save the Children, in close collaboration with the Ministry of Health (MOH) at national and sub-national levels and other partners strived to integrate all support initiatives.

Component 1: Supportive enabling environment

The Activity served to strengthen the enabling environment for multi-sectoral nutrition programs and integration at all levels by supporting a focused advocacy, SBCC, and social mobilization campaign to reduce stunting while also strengthening the capacity of local government authorities to manage, coordinate, and collaborate to increase government resource allocation and improved multi-sectoral coordination. A formative research study and gender analysis informed the strategies for SBCC and for WASH marketing, as well as the 10 Small Doable Actions (SDAs) and the integrated nutrition and WASH (iNuW) Toolkit. Promotion of improved WASH practices to first 1,000 days households also integrated CLTS to support achievement of full sanitation coverage (100 percent of households have latrines) and ODF certification by each village, in accordance with the National Strategy for Rural Water Supply, Sanitation, and Hygiene 2019-2030.

A set of 10 SDAs was designed to initiate behavior change and reinforce improved nutrition practices through the integrated nutrition and WASH community and household mobilization process guided by the iNuW Toolkit (Figure 2). The toolkit was based on a needs assessment and mapping of target villages conducted with local authorities, and consisted of eight steps involving sensitization, triggering,

reviews, and verification that were led by villagers. The SDAs were presented on posters and portable flipcharts, complemented by wall progress charts for reference at home.

Figure 2. Small Doable Actions (SDAs) Promoted by the Activity

10 Small Doable Actions			
	1. Eat extra food at every meal while pregnant		6. Dispose of baby stool safely
	2. Go for ANC services as soon as you know you are pregnant		7. Start feeding your child fun foods at 6 months so they have enough food to grow
	3. Breastfeed within the first hour of birth and keep your baby with you to breastfeed consistently		8. Wash your hands and your children's hands
	4. Wash your hands with soap and water before cooking and eating		9. Adolescent girls need to eat more at meals so they can become healthy women. Help your daughter eat more food at meals and take food to school so she will grow up strong and have healthy children
	5. Breastfeed frequently, breastmilk is all your baby needs for the first 6 months		10. When your child turns 6 months, feed your child family food with meat and vegetables (and blend or mince so that your child can eat it) and continue breastfeeding until 2 years old

The Activity then set up a Village iNuW Committee (VIC) led by village heads and composed of the existing Village Development Committee, WASH sales agents, and community facilitators (CFs). VICs developed nutrition and WASH village plans and were supervised by the district health office (DHO) counterparts and health center staff. VICs were also tasked to 1) oversee and facilitate implementation of iNuW behavior change activities in the community; 2) facilitate community-wide events that promoted SDAs; 3) lead discussions among village volunteers (CFs, sales agents) on implementation progress, challenges, solutions, and planning; and 4) monitor and ensure achievements of village iNuW targets. Their combined efforts stimulated the adoption of behaviors to improve nutrition and WASH practices by recognizing the first 1,000 days households who practiced the SDAs as “iNuW Star Families,” and encouraging communities to achieve ODF status through the CLTS process.

Component 2: Improved community nutrition, health, and WASH Services

The Activity utilized the 10 SDAs, community-wide events, and household visits to encourage and facilitate iNuW behavior adoption in target households via multi-sectoral efforts through CFs, sales agents, and VICs.

CFs were either existing village health volunteers (VHVs) or other selected villagers who made home visits to first 1,000 days households, coordinated with health centers, and conducted community-wide events with the VICs. Communities were encouraged to select female CFs and emphasized selection based on interest rather than literacy level. CFs were responsible for providing mothers and other caregivers with timely and relevant information and support during home visits and PLW households with newborn babies and infants required more intensive follow-up. Health center staff worked with CFs to promote community growth monitoring, use of health services, and use of antenatal care (ANC) and postnatal care (PNC). The program aimed to register all WRA, PLW, and CU2 together with the health centers and village heads, as part of routine primary care services and to improve capacity for using data in decision-making. As such, the Activity helped the community meet long-term nutritional health goals while also contributing to Lao PDR’s health sector reform strategy and framework by

having at least one village health worker who can work on health services and relevant data collection in rural villages.

Community-wide events were designed to be fun village fairs with participatory activities where demonstrations of key nutrition and WASH activities, such as handwashing and cooking, occurred. Household visits and community-wide events (CLTS, cooking demonstrations) replaced initially planned community support groups. During project extension, household visits and community-wide events also targeted adolescents and their parents.

The Activity supported communities to adapt the CLTS approach with the goal of achieving ODF certification. The iNuW Toolkit included community mobilization and triggering activities and was based on the National CLTS manual, with the addition of motivation for improved sanitation. VICs and CFs then visited households without sanitation facilities to explain the importance of sanitation for the households' health and the health of the entire community. Monitoring visits by district leaders, such as the Vice District Governors and District WASH, and exchange visits among VICs, has, to some extent, accelerated the process of becoming ODF certified.

To assist communities in adopting improved WASH behaviors, the Activity also coordinated with local private vendors of WASH supplies and services. This approach leveraged private sector relationships to facilitate the supply of WASH products such as latrines, handwashing products, water filters, safe water storage containers, and material for clean play spaces for infants and small children to first 1,000 days households. Sales agents, some of whom were drawn from the VICs, served as the link between villages and the 24 local private enterprises involved. At the onset, the Activity also engaged with Soap4Life, a local social enterprise that trained select CFs to produce and sell unscented soap products in the target villages. These modalities were outlined in a WASH Marketing Strategy that was informed by a WASH marketing assessment that identified supply chain barriers and modalities for connecting WASH suppliers to households and village groups. Monitoring and support visits by DHO WASH Units, together with Deputy District Governors, also improved the quality of sanitation products and efficiency of sanitation services by vendors.

Component 3: Capacity-building to improve quality service delivery

The Activity, together with the MOH Center of Communication and Education for Health (CCEH) trained primary care providers at health centers and at communities to promote sustainable iNuW behaviors and coached supervisors at the DHOs to oversee the quality of work by staff and volunteers. The Activity tapped into the underutilized, influential group of VHV that were augmented by other community volunteers and were collectively called CFs. Village leaders selected the sales agents and CF volunteers based on their willingness and good practices of iNuW behaviors to gain trust from other villagers. Capacity-building emphasized practical demonstrations and feedback by trainers and mentors, both during the training and during regular monitoring visits at their workplaces with USAID Nurture staff. Coaching supervisors on how to mentor was an ongoing task for Activity staff who worked in tandem with MOH national and sub-national counterparts; Save the Children staff also directly mentored CFs and health center staff during monitoring visits by tracking and reviewing performances using monthly reports. Additionally, USAID Nurture worked on recognition schemes to help motivate volunteers, which included remarks and certificates of appreciation during the community-wide events and small, non-monetary incentive packages.

Both CF and VIC members were trained on communication and facilitation skills to become effective agents during home visits and community-wide events, trainings included using monitoring forms over three days, with learning and practical sessions around the SDAs and counseling steps during home visits, with constructive feedback from trainers focusing on what they did well during their role-playing scenarios. This approach proved important because VHV made up around 38 percent of the CFs, so

guiding them to perform home visits helped strengthen and sustain this existing community health service system. VICs were also trained to develop community action plans for nutrition and WASH, which were shared with the village each quarter during community-wide events.

At health centers, Activity and CCEH staff aided the development of skills for nutrition behavior change counseling within primary care services that targeted pregnant women, new mothers, and caregivers of CU2. This reform centered on a first 1,000 days nutrition counseling course that utilized a competency-based, practical skills training centered on a “learning by doing” approach. Along with general counseling skills, the Activity assisted the MOH to strengthen staff capacity in nutrition counseling within health services by adding four training sessions focused on: nutrition counseling during ANC visits; support for successful breastfeeding; optimal complementary feeding practices after the first six months of life; and the nutritional needs of adolescent girls.

The new national maternal and child health handbook, a mother-child portable care record commonly called the Pink Book was finalized by the MOH in 2019 with significant inputs from the Activity, including the Pink Book User Guide and training-of-trainers curricula to ensure that ANC, birth, and well child services were delivered and charted at health centers nationwide. Activity staff provided training on the Pink Book to 79 health workers from 46 health centers; health centers then utilize Pink Books during nutrition counseling. With provincial and district health officers, the Activity also developed and implemented a process for supportive supervision and on-the-job coaching of healthcare workers.

The Activity also supported the development of village WASH and nutrition plans by the VIC but were unable to align the plan with the DNCs plans as originally intended. The multi-sectoral composition of DNCs, led and hosted by the DHO, make capacity-building a complex and difficult task that has rarely sustained or successfully supported a project. The MOH has neither the operational budget or capacity to continue this task, especially at sub-national level, and multi-sectoral coordination is not a natural process with the top-down hierarchical nature of the Lao PDR government.

Save the Children staff were trained by the Rural Development Agency to become WASH Master Trainers to promote WASH SDAs and implement CLTS during Phase I of the Activity. Activity staff then trained 454 sales agents on WASH marketing and introduced strategies to achieve ODF certification in collaboration with the National Centre of Environmental Health and Water Supply (NAMSAAAT) within the MOH and subnational offices at target provinces and districts. For quality assurance, the Activity coordinated with NAMSAAAT to develop a latrine checklist adapted from their Latrine Construction Manual, which was used during quality assurance visits by NAMSAAAT Officers and other local government officials. Coaching visits to sales agents and quarterly quality assurance visits were led by NAMSAAAT officers, the WASH marketing team, and district provincial officers.

Component 4: Demand creation for the use of nutrition, health, and WASH services and products.

Community-wide events promoted the 10 SDAs quarterly. During community-wide events, CFs presented SDAs or iNuW messages relating to IYCF and maternal nutrition, and VICs presented hygiene and sanitation messages. Sales agents presented latrine options and feasible choices of access. The events served as initial knowledge dissemination platforms for VICs to integrate iNuW messages into their monthly mandatory village meetings, which CFs re-emphasize during follow-up visits to target households.

Through this community and household engagement process, the Activity worked toward creating and reinforcing demand for improved IYCF and WASH services and products, while also building capacity of the village leaders and volunteers to generate demand for services and products through their village-wide and household health promotion activities. An SBCC campaign focused on stunting reduction

among first 1,000 days households to improve their IYCF and WASH behaviors, including regular attendance of growth monitoring and promotion (GMP) during outreach services by health centers, and participation in local initiatives such as the VICs and DNCs.

The Activity intended for communities to review village-level data based on summaries of reports by CFs and VICs during monthly iNuW meetings, quarterly project meetings at districts attended by VIC leaders, or the quarterly DNC meetings. However, the DNCs engage other sectors and ongoing projects and are not utilized solely for reflections and discussion on the Activity's outputs. Project quarterly meetings at the districts were attended by iNuW leads and were coupled with field monitoring visits with district leaders and district and provincial partners. The governance mechanisms strived to build leadership skills and empower communities to manage the CLTS campaign; collaborate with village authorities who acted as the main change agents; develop village action plans; and monitor progress. To support behavior change in households and within their communities, Save the Children and the Rural Development Agency developed IYCF and WASH promotional materials such as posters, flipcharts, and videos to encourage and reinforce good IYCF and WASH practices and behaviors that were based on barriers and motivators to behavior change identified by the formative and gender studies. Additional details of the Activity's technical approach are provided in Annex A.

2. EVALUATION DESIGN

2.1 RESEARCH METHODOLOGY

The evaluation was designed as a quasi-experimental IE comparing results from more than 2,700 households across 346 similar treatment and control villages based on sample size calculations conducted during the design. To identify the sample of villages, the ET excluded villages in the two Activity target provinces (Khammouane and Savannakhet) receiving interventions from other donors and then used coarsened exact matching (CEM) to identify a similar set of treatment and control villages.⁴ Within selected villages, the ET randomly selected eight households in each village with pregnant women or CU2, at baseline and midline.⁵ More detail on the quantitative methodology can be found in Annex B.⁶ The ET supplemented quantitative data collection with qualitative data collection at midline.

Though the ET had planned for the initial IE design to remain consistent from baseline to endline, COVID-19 necessitated modifications to the endline study design. First and foremost, the ET determined in collaboration with USAID that it was not possible to conduct in-person data collection, in part due to the close contact required to collect data on anthropometric indicators (i.e., weight and height). Accordingly, the ET adapted the approach to remote data collection. Given the remote context, the ET first explored the feasibility of drawing a sample for endline data collection using baseline and midline data. In November 2021, the ET worked with IRL to conduct a phone screen exercise among 100 randomly selected households from baseline and midline and found that about 25 percent of phone numbers were both still active and included a pregnant woman or CU5, the target group of households for the endline evaluation.

Drawing on findings from the phone screen, the ET decided in collaboration with USAID to move forward with a shortened version of the quantitative survey designed to be completed over the phone. IRL called all households from the baseline and midline data yet achieved a much lower response rate than during the pilot, completing 215 surveys from the baseline contact information and 161 from the midline contact information (376 surveys total).⁷ Accordingly, to maximize the endline sample size, the ET pulled a random sample of treatment and control villages from the baseline and midline survey data. IRL contacted the village heads in these villages for updated contact information for the baseline and midline households, as well as contact information for any new households in the village who may fall within the sample frame. After employing these strategies, the ET achieved an endline sample of 411 households (223 treatment and 188 control). Characteristics of the endline sample as well as limitations associated with the differences in sampling strategy and sample size across baseline, midline, and endline are detailed in the Limitations section below.

⁴ Stefano M. Iacus, Gary King, and Giuseppe Porro. 2012. Causal Inference Without Balance Checking: Coarsened Exact Matching. *Political Analysis*, 20, 1, Pp. 1-24.

⁵ The evaluation sampled first 1,000 days households, which include households with pregnant women or women with CU2, as these were the target households for the Activity.

⁶ Social Impact. Impact Evaluation of USAID Nurture in Laos Evaluation Design Report. USAID 2017.

⁷ The lower call success rate in the survey versus the phone screen is likely due to a GOL requirement for all mobile phone numbers to be registered by January 2022, which caused any unregistered phone numbers to be unable to make or receive calls, send SMS messages, or connect to the internet. <https://laotiantimes.com/2021/09/30/laos-extends-deadline-for-sim-card-registration-2/>.

2.2 DATA COLLECTION

The baseline data were collected in 2018, the midline data in 2019, and the endline data, although originally planned in 2020, were collected in 2022, following delays due to COVID-19. However, the Activity was also extended and ended in September 2021, as displayed in Figure 3 below.

Figure 3. Data Collection Timeline

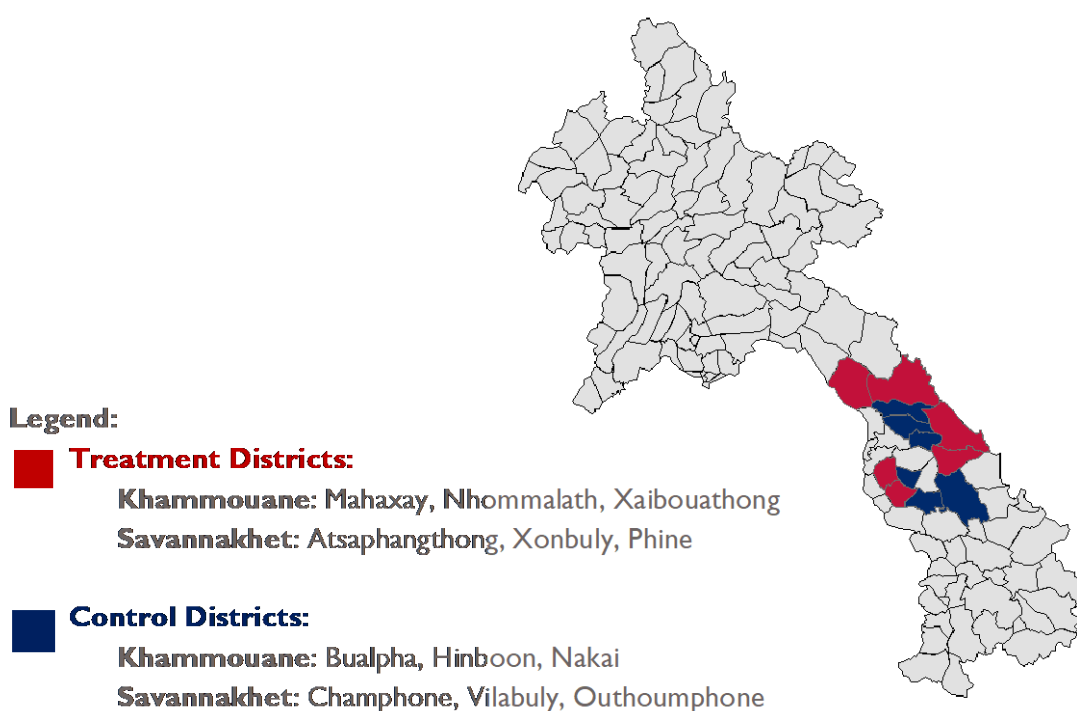
	2017				2018				2019				2020				2021				2022			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Nurture Implementation																								
Baseline Quantitative Data Collection																								
Midline Quantitative Data Collection																								
Midline Qualitative Data Collection																								
Endline Quantitative Data Collection																								
Endline Qualitative Data Collection																								

Note: Much of the Activity's first year of implementation (2017) was spent working on the Memorandum of Understanding (MOU) and waiting for required approvals; thus, while implementation began in 2017, a majority of the substantive activities did not begin until 2018.

At baseline, the ET completed in-person interviews with a total of 2,770 WRA primary caregivers with CU2 in 346 villages: 173 treatment and 173 control. At midline, the ET surveyed a new cross section of 2,767 households in the same villages from the baseline. Since the sampling targets first 1,000 days households with either pregnant women or women with CU2 these data may not be representative of all other households in targeted communities.

At endline, the ET sampled households with pregnant women or women with CU5 to maximize completed surveys within phone numbers that were available from baseline and midline data. Within targeted households, the ET collected data with one individual. This respondent was selected purposively within the household to maximize the indicators the ET could report on among the following respondent categories: pregnant women, CU5, and CU2. Additionally, the ET was not able to collect and report on anthropometric indicators due to the remote nature of the endline survey. The ET completed phone surveys with a total of 411 WRA primary caregivers in 257 villages. Ultimately, the ET collected data in six treatment districts and six control districts at each baseline, midline and endline, as displayed in Figure 4.

Figure 4. Evaluation Sample Districts



To supplement the quantitative data and provide evidence on program implementation and effectiveness of different program components, the ET conducted a total of 70 key informant interviews (KIIs) including one group interview with two participants at the endline. The interviews were conducted with national, provincial, and district officials, and technical staff (e.g., DHO, district agriculture office), health center staff, vendors of WASH products, village-level officials and VHVs, Save the Children staff, and other donors. Data were collected in Vientiane and all six treatment districts covered by the IE. Respondents were selected primarily purposively, with elements of random and convenience sampling. The number of interviews completed per category is listed in Table I below.

Table I. Qualitative Sample

INFORMANT CATEGORY	INFORMANT DETAILS	TOTAL NUMBER OF INTERVIEWS	TOTAL NUMBER OF PARTICIPANTS
Save the Children	Save the Children staff who managed implementation of the Activity	9	10
National-Level Officials and Technical Staff	MOH staff, Department of Hygiene and Health Promotion, National Nutrition Committee, National Centre of Environmental Health and Water Supply (NAMSAAT), the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Secretariat, Master Trainers	6	6
Provincial-Level Officials and Technical Staff	Provincial Health Office staff, Division of Hygiene and Health Promotion, PHD Coordinators, Trainers	8	8

INFORMANT CATEGORY	INFORMANT DETAILS	TOTAL NUMBER OF INTERVIEWS	TOTAL NUMBER OF PARTICIPANTS
District-Level Officials	DNC members, DHO staff, Nutrition and Family Statistics group members	20	20
Health Center Staff	Nurses	6	6
Vendors	Private vendors of WASH products	3	3
Village-Level Officials and Volunteers	CFs, VIC members and leaders, VHVs, WASH sales agents	16	16
Other Donors	WHO, World Vision	2	2
Total		70	71

2.3 ANALYTICAL APPROACH

QUANTITATIVE DATA

The ET used a Difference in Differences (DID) regression approach to estimate impacts on program outcomes. This DID approach uses baseline and follow-up data for both the treatment and control group to control for time-invariant outcome predictors. The regressions also control for household attributes hypothesized to affect outcomes of interest. Table 2 summarizes the outcomes and controls used at baseline, midline, and endline. As discussed above, stunting, wasting, and underweight status are not reported at endline due to lack of ability to collect anthropometric data. Four control variables, listed below, were removed at endline to shorten the phone survey duration. To determine control variables that could be removed for endline, the ET ran regressions using baseline and midline data and sequentially removed control variables that accounted for the least variance in key Activity outcomes while maintaining the strength of the overall model.

In addition to the standard DID approach described above, the ET also tested a weighting approach designed to account for known differences in the baseline and endline samples. This approach is described in further detail in Annex B. The ET found that results were the same when weighted for nearly all indicators, apart from three indicators. These differences are noted for each indicator in the body of the report.

Table 2. Regression Variables

CONTROLS	OUTCOMES
Included at Baseline, Midline, and Endline	
• Number of household members • Gender of household head • Age of household head • Education level of household head^a • Number of rooms in dwelling • Dwelling has electricity • Household has a farm or garden • Wealth (asset index) • Dwelling has improved roof^b • Province	• Participation in GMP • Minimum Acceptable Diet (MAD) for mothers • Seeking antenatal services • Iron/Folic Acid supplements for mothers • Information received during ANC • Information received post-delivery • Early initiation of breastfeeding • Exclusive Breastfeeding (EBF) • Minimum Dietary Diversity (MDD) for children • Minimum Meal Frequency (MMF) for children • MAD for children • Safe drinking water • Use of water treatment technologies • Handwashing and hygiene behaviors • Use of basic sanitation facility
Included at Baseline and Midline Only	
• Household has a member with a disability • Household owns dwelling • Legal land ownership • Household head non-Lao PDR mother tongue	• Stunting • Wasting • Underweight

^a A household was classified as “low education” if the household head either never went to school, completed only kindergarten or preschool, or completed only primary school. The low education variable was used as a dummy variable in the regression.

^b Households with roofs made of tile/sipax or zinc/metal were classified as having an “improved roof.” An “unimproved roof” was considered rudimentary wood planks or grass. The improved roof variable was used as a dummy variable in the regression, and as an additional proxy variable for economic status.

QUALITATIVE DATA

All interviews were recorded using digital recorders and detailed notes were created. The notes were used to analyze data and apply thematic codes via Dedoose, a qualitative coding and analysis software. The ET developed a preliminary code list based on emergent findings from interviews, as well as the intended outcomes of the Activity. This code list was further refined as additional interviews were coded and emergent codes not included in the preliminary list were added. After coding was completed, greater attention was given to the codes that were applied most frequently, most directly related to the evaluation questions, and related to predefined program components or outcomes.

2.4 REPRESENTATIVENESS OF THE ENDLINE SAMPLE

Because the sampling approach for the endline survey was different from the approach used at baseline and midline, as necessitated by COVID-19, the ET assessed how representative the endline sample was as compared to the baseline sample. Table 3 below displays key characteristics of the endline sample compared to baseline. The ET ran analysis of variance tests on each control variable used in the analysis to understand significant differences in the sample between baseline and endline for each of the treatment and control groups. Variables with significant differences are denoted by asterisks. Table 4 below displays the distribution of sampled households by district at each baseline, midline, and endline.

The limitations around the comparability of the samples and the representativeness of the endline sample are discussed in the Limitations section below.

Table 3. Comparison of Characteristics of Baseline and Endline Samples

	BASELINE CONTROL		ENDLINE CONTROL		DIFF.	BASELINE TREATMENT		ENDLINE TREATMENT		DIFF.
	MEAN	N	MEAN	N		MEAN	N	MEAN	N	
Household size	6.0	1,379	6.2	188	0.1	6.2	1,385	5.7	223	-0.5***
Female household head	11%	1,379	8%	188	-3 pp	12%	1,385	9%	223	-3 pp
Age of household head	43.1	1,379	45.4	188	2.2**	43.8	1,381	42.4	223	-1.4
Household head low education	68%	1,355	45%	184	-23 pp***	67%	1,371	40%	218	-27 pp***
Number of rooms used for sleeping	2.1	1,376	2.2	188	0.2**	2.2	1,380	2.1	223	-0.1
Electricity	80%	1,482	100%	188	20 pp***	76%	1,557	97%	223	21 pp***
Household farming	74%	1,376	91%	188	17 pp***	89%	1,380	91%	223	2 pp
Assets index	-0.2	1,348	1.2	188	1.3***	-0.2	1,367	0.9	223	1.1***
Improved roof	98%	1,368	100%	188	2 pp**	97%	1,375	97%	223	0 pp
Province: Khammouane	44%	1,482	46%	188	2 pp	39%	1,557	56%	223	17 pp***
Province: Savannakhet	57%	1,482	44%	188	-13 pp	60%	1,557	44%	223	-16 pp***

pp: percentage points; ** p<0.05; *** p<0.01

Table 4. Comparison of Districts of Baseline, Midline and Endline Samples

District	BASELINE		MIDLINE		ENDLINE	
	N	FREQ.	N	FREQ.	N	FREQ.
Treatment	1,557	51.2%	1,565	49.0%	223	54.3%
Atsaphangthong	404	13.3%	317	9.9%	41	10.0%
Mahaxay	270	8.9%	264	8.3%	40	9.7%
Nhommalath	252	8.3%	318	10.0%	63	15.3%
Phine	290	9.5%	285	8.9%	31	7.5%
Xaibouathong	96	3.2%	107	3.4%	21	5.1%
Xonbouly	245	8.1%	274	8.6%	27	6.6%
Control	1,482	48.8%	1,626	51.0%	188	45.7%
Bualapha	185	6.1%	180	5.6%	14	3.4%
Champhone	338	11.1%	379	11.9%	36	8.8%
Hinboon	331	10.9%	371	11.6%	47	11.4%

	BASELINE		MIDLINE		ENDLINE	
District	N	FREQ.	N	FREQ.	N	FREQ.
Nakai	128	4.2%	158	5.0%	26	6.3%
Outhoumphone	318	10.5%	344	10.8%	46	11.2%
Vilabuly	182	6.0%	194	6.1%	19	4.6%
Total	3,039	100%	3,191	100%	411	100%

2.5 LIMITATIONS

The limitations, which are primarily driven by COVID-19, are detailed below and include context on how best to interpret the findings given the limitations discussed.

Endline quantitative sample: As noted above, the endline sample for the IE was generated using different methods than at baseline, is much smaller than the baseline sample, and differs from the baseline sample on some key household characteristics. Table 3 above demonstrates that the endline sample as a whole is more educated and likely wealthier than the baseline sample, based on significant differences in education, asset index, and presence of electricity.

Importantly, the ET cannot say with certainty whether these differences reflect exogenous (non-Activity) changes in the communities over time, or if they imply that the baseline and endline samples are significantly different. That said, because the endline survey was conducted via phone rather than in-person, households were required to have a registered phone with a connection in order to participate. This could be expected to generate differences in the sample, as observed. This affects the representativeness of the sample relative to the full Activity beneficiary population, and therefore affects the ability to generalize findings from the sample to the full Activity beneficiary population. However, since the treatment and control samples at endline are both different from the baseline in similar ways, and more similar to each other, the ET is more confident in comparisons between the treatment and control group at endline, and less confident in comparisons over time, such as looking at trends in the treatment or control group from baseline to endline.

Regarding sample size, the substantially smaller endline sample size reduces the IE's power, meaning that for smaller Activity impacts, statistical significance may not be detected when it otherwise may have been with a larger endline sample.

Taken together, this means that the quantitative results should be interpreted with caution, particularly when comparing results over time, as they may reflect changes in the sample groups rather than the outcome of interest, and when looking at statistical significance of relatively smaller changes, due to the smaller sample size. The ET anticipated these challenges when COVID-19 necessitated changes in the approach, and the team significantly strengthened the qualitative data collection effort completed at endline to support this smaller quantitative sample size.

Endline Timing: The endline evaluation was delayed more than one and half years from the initial plan due to restrictions caused by COVID-19. This presents two potential limitations. First, although the Activity was extended through September 2021, the Activity was completed approximately eight months prior to endline data collection. Since the endline evaluation was designed to investigate longer-term outcomes and potential for sustainability, this does not pose a significant limitation, but did somewhat constrain availability of some Activity stakeholders and their ability to recall details of program implementation. To mitigate this challenge, the ET sought responses from a wide range of stakeholders, many of whom were engaged with the Activity until its completion. Second, COVID-19, and in 2022, the war in Ukraine, had major impacts on the global economy, supply chains, and livelihoods, which were

also severely felt in the Lao PDR, with potential implications on Activity implementation, impacts, and the non-programmatic changes on the evaluation sample. The evaluation specifically included questions around COVID-19 and used a comparison group for the quantitative results to help mitigate this limitation.

Remote data collection: Because the endline survey was conducted via mobile phone, it could not include anthropometric data, meaning that results on these outcomes cannot be assessed at endline.

External programming: Though the ET collaborated with USAID to exclude areas from the sampling at baseline where other nutrition interventions were planned to occur, there were other nutrition-related programs delivered during the Activity's implementation period outside of the control of USAID or the ET. Leading up to endline data collection, the ET worked with USAID to identify these external programs and understand the potential effects on the IE. Table 8 and Table 9 in Annex C summarize the four activities the ET tracked including their timelines, objectives, activities, and implementation areas. It is unlikely that these external programs influenced the reported results since they either predated the Activity or were not implemented differentially between treatment and control groups; however, since the ET was not able to control for participation in external programs in the regression analysis, we note throughout the report areas where these external programs may have contributed to differential impacts across the study provinces.

Endline qualitative sample: Though the ET had planned to conduct KIs remotely with a small sample of beneficiaries at endline, the team was precluded from this by the lack of remaining potential respondents after completing quantitative data collection. Based on the 25 percent success rate of the phone screen, the ET had anticipated having plenty of baseline and midline households remaining from which to sample qualitative respondents; however, as discussed in the Research Methodology section above, IRL attempted all households from both the baseline and midline contact information in order to achieve the final endline sample, leaving no remaining households for qualitative interviews. The ET determined in collaboration with IRL that it would not be feasible to conduct qualitative interviews with households who had already responded to the quantitative survey as it would add undue burden on the part of the respondent. Thus, while the endline qualitative sample includes stakeholders who have had close interactions with beneficiaries and are in some ways beneficiaries of Activity interventions themselves (e.g., health center staff, CFs, village heads), the endline qualitative data does not include the perspectives of community member beneficiaries directly. The quantitative survey provides data on outcomes from beneficiary households, somewhat mitigating this limitation, but it provides more limited information on questions prioritized by the qualitative approach, such as the relative effectiveness of each component.

Because of these limitations, the findings reported below should be interpreted holistically; **the strongest findings are not necessarily those where statistical significance is reported but are findings that are triangulated by multiple data sources.**

3. FINDINGS

The following sections present the findings for each evaluation question integrating data from the quantitative IE, qualitative interviews, and Save the Children's USAID Indicator Performance Tracking Table (IPTT) data, which included monitoring data that was collected and reported on by Save the Children throughout the life of the Activity. In the discussion below, the ET prioritizes findings that are significant or are triangulated by the qualitative data, per the discussion of limitations above. Values for all indicators can be found in Annex E, and regression tables in Annex F.

➤➤➤➤➤➤➤➤ Guide to the Findings Section ➤➤➤➤➤➤➤➤

Quantitative IE Data: All IE findings displayed below are based on multivariate regression analysis, including controls. “Significant” throughout this report refers to statistical significance—the likelihood that a relationship between two or more variables represents a true difference, rather than random differences between the sample groups used in the evaluation. Statistical hypothesis testing is used to determine whether the difference between two groups is statistically significant. These tests provide a p value, representing the probability that random chance could explain the result. In this report, a p value of ten percent or lower is considered significant. In other words, when the report notes a finding is statistically significant, it means that the ET is at least 90 percent confident that the result is valid, representing a true difference between the two groups rather than differences due to chance or sampling. In the body of this report, “significant” is used to refer only to findings where the confidence level is at least 90 percent ($p < 0.1$). P values for all findings can be found in Annex F.

Qualitative Data: The qualitative data below are based on the qualitative interviews the ET completed at endline. The number in parentheses refer to the number of interviews in which the referenced subject was discussed. Important to note is that not all subject areas covered in the interviews were relevant to every respondent's involvement with the Activity; thus, frequencies reported should not be interpreted as percentage values.

3.1 EVALUATION QUESTION I

What is the effectiveness of the USAID Nurture approach in improving the nutritional status of children under two in target areas?

The primary indicators used to assess nutritional status of CU2 at baseline and midline were prevalence of stunting, wasting, and underweight. Due to the constraints on data collection that resulted from COVID-19, discussed further in the Limitations section above, the ET was unable to collect anthropometric data at endline. As such, there are no quantitative IE data on these indicators at endline.⁸ In the endline qualitative data, few respondents mentioned changes in stunting and wasting, though only a select group of respondents were likely to have the context to respond knowledgeably to this question (e.g., district-level health staff, of which there were 26 interviews). Some suggested that changes in stunting and wasting are best measured via survey and others said the changes in stunting and wasting that would result from the Activity would be slow to occur. However, respondents in 16 interviews reported positive changes in malnourished children in general, and nine discussed positive changes in children's weight as a result of the Activity; only one respondent reported seeing no change in nutritional status overall.

In nine interviews that discussed positive changes in malnutrition or children's weight, respondents discussed the change as a result of health monitoring and height and weight measurements happening through health center staff, which the Activity supported. The ET measured CU2 months receiving GMP as part of IE data collection. Though prevalence of CU2 months who received GMP services increased from baseline to endline in both treatment and control groups, there were no significant impacts of the Activity on GMP (Figure 5).⁹ Table 5 below displays quotes on nutritional status and GMP by theme.

Figure 5. CU2 Months Receiving GMP (not significant)

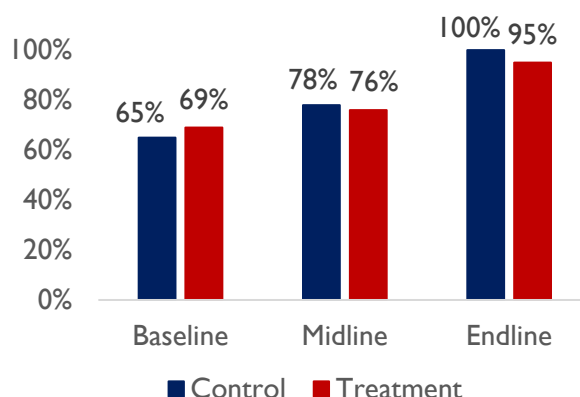


Table 5. Qualitative Perspectives on Nutritional Status

TOPIC	QUOTE
Malnutrition	<i>"In the past, the children in this village were small, thin, pale skin, and malnourished, often crying because they were hungry and unwell, and often had diarrhea. I saw a change when the program came to work in our village, the rate of malnourished children decreased, [...] Despite the parents focused on finding good food for their children, [...] they still were eaten a little."</i> – CF

⁸ For Activity impacts on the anthropometric indicators at midline, refer to Impact Evaluation of USAID Nurture in Laos: Midline Evaluation Report: https://pdf.usaid.gov/pdf_docs/PA00V7VWV.pdf

⁹ When applying weights to the regression analysis using the PSM method described in the Research Methodology section, the p-value for this indicator falls below the 0.1 threshold for determining significance ($p < 0.05$).

TOPIC	QUOTE
Weight	“Children who drink breast milk and eat more food are not underweight, have better skin, have fresh faces, and play happily. Because CF helps motivate parents often. Previously, children looked lazy, tired, want to sleep all the time, cry often, and often get sick.” – CF “I heard from the health workers that the weight change of the children in the community is better, according to the standard, probably because the mothers can practice breastfeeding better.” – CF
GMP	“After giving birth, every month the health team comes to monitor the growth of the child by weighing and measuring height in the community. Every family sees the importance, and parents actively take their children to see the health center team at every appointment. When the infant is sick, the parents will take the child to see the doctor at the health center.” – CF “For child nutrition, the program was considered to be doing well in paying attention to monitoring the growth of children in the community regularly. For example, there was a health check and weighing, height measurement, and vaccination for children as well as advising if the child is not growing according to the standard, thus, reducing the rate of malnutrition in children.” – District-level Health Staff, Xaibouathong “Parents do not bring their children to use the postnatal service at the health center. Return rates to monitor child growth and vaccinations at health centers remain low. When the health center team visited the community, it was found that the number of parents who brought their children to be vaccinated was still small, not reaching the target. Because some parents bring their children to be vaccinated and they are not feeling well, the baby cries and that’s why they do not continue to be vaccinated.” – Province-Level Official, Savannakhet “Health workers still use pink books as reference to guide mothers, using pictures to explain how to cook nutritious meals for infants. This pink book, we let my mother keep, but most women are illiterate, they can look at the pictures or ask their husbands to read it at home.” – District-level Health Staff, Atsaphangthong

3.2 EVALUATION QUESTION II

To what extent did each of the individual components of the USAID Nurture approach (maternal, IYCF, and WASH) contribute to the effectiveness of the overall approach?

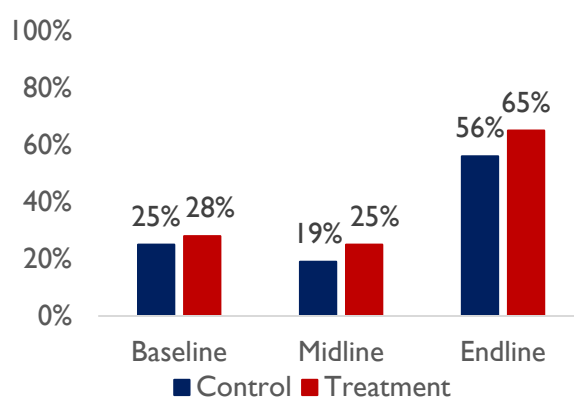
MATERNAL HEALTH AND NUTRITION

Women’s Nutrition: Save the Children nearly achieved their target for the number of pregnant women reached with nutrition interventions, reaching 25,462 women or 99 percent of the target.¹⁰ Achievement was much lower among adolescents: only 64 percent of the target was achieved for nutrition interventions among girls 10-19 years of age. This lack of achievement among adolescents is likely due to both delayed focus on adolescents until later in implementation, as well as challenges in reaching the adolescent population. One district-level health staff respondent in Phine explained, “Most adolescent girls are shy; they rarely join in public activity, and some of them can’t speak Laos.”

Following logically from the wide reach of Save the Children’s maternal health and nutrition interventions, there is evidence of an increase in recall of messages on nutrition-related actions among women in the first 1,000 days households from baseline to endline, as displayed in Figure 6 and supported by qualitative data; respondents in 11 of 70 qualitative interviews discussed nutrition-related actions shared by the Activity.¹¹ Though recall increased by 37 percentage points in Activity areas relative to 31 percentage points in control areas, the impact of the Activity was not statistically significant.¹²

The most frequently recalled messages on nutrition-related action at baseline was “lactating women exclusively breastfeed for the first six months,” which was recalled by 16 percent of households. At endline, the most frequently recalled action was “adolescent girls, pregnant women, lactating women eat a diverse diet, including animal source foods” which was recalled by 73 percent of households.

Figure 6. Recall of One or More Messages on Nutrition-related Actions (not significant)



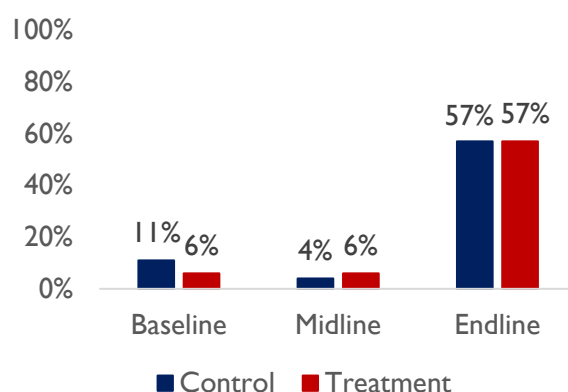
¹⁰ As Activity “targets” are set and agreed upon between the implementing partner and USAID, Activity targets do not necessarily reflect the entire population in target areas, but the ability of the implementing partner to reach the target population within the scope of the Activity.

¹¹ At each of the three stages of the evaluation, the question asked to respondents was: “Can you recall any nutrition-related actions that you heard from a health center, community health worker, or peer group that are intended to improve the health or nutrition of pregnant women or children?”

¹² Although the ET does not find direct evidence of spillovers, it is possible that some control households may have received spillover benefits, either by receiving services at health facilities in treatment areas or through communication with treatment households, even though treatment and control villages are always in different districts.

The high recall of information related to dietary diversity at endline is consistent with women's nutrition indicators: the likelihood of WRA achieving a MAD increased substantially from baseline to endline among both the treatment and control groups. Results of the IE show that the Activity had a significant positive impact on MAD for WRA and increased the odds of consuming a MAD from baseline to endline by 2.2 times¹³ relative to changes for WRA in control households ($p < 0.01$), as displayed in Figure 7. Additionally, as seen in Figure 7, while MAD increased substantially in both groups between midline and endline, the increases do not differ as substantially as those between baseline and midline. One reason MAD increased substantially but not differentially at endline may be differences in the endline sample: as discussed in the Limitations section above, the endline sample was both wealthier and more highly educated than the sample at baseline.

Figure 7. WRA Achieving a MAD ($p < 0.01$)



This finding was triangulated by qualitative data: in 12 of 70 interviews, respondents discussed positive changes in women's nutrition in Activity districts. No respondents reported negative changes or no change in women's nutrition. Among respondents who spoke of positive change, the following themes emerged regarding Nurture's contribution to improving women's nutrition:

- **Importance of frequent ANC visits (11 qualitative interviews):** "CFs urge women to go to the health center as soon as they find out they are pregnant for health check-ups, receive vitamin supplements and prenatal counseling, how to eat extra-food, drink clean water, adequate rest, and no overwork." – District-level health staff, Mahaxay
- **Changes in traditional behaviors (seven qualitative interviews):** "According to the ancient tradition, the elders let the women after giving birth sit on the fire [slow burning wood or hot coal placed under the bed] and eat rice and galangal for fear of infection after giving birth, otherwise, they may die. Now the mother eats more nutritious food such as meat, frog, and fish, but still has to stay on fire because it is believed to be good for the womb." – CF

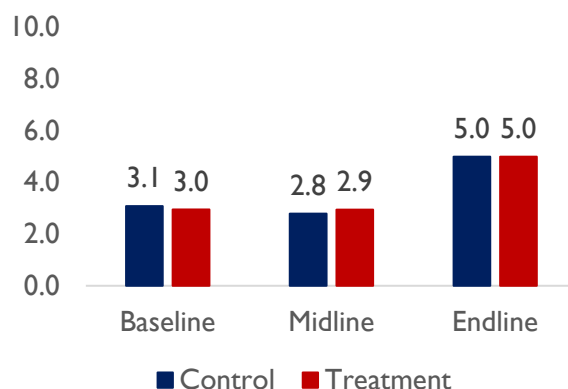
Households where the head has a low level of education were significantly less likely to achieve a MAD relative to other households ($p < 0.1$), and households with greater asset wealth were also more likely to achieve a MAD ($p < 0.001$). Households in Savannakhet were more likely to achieve MAD than in Khammouane ($p < 0.01$). As mentioned in the Limitations section above, World Vision's Accelerating Healthy Agriculture and Nutrition (AHAN) project that supported household nutrition focusing on

¹³ This figure is an Odds Ratio reported from the regression analysis which controls for several other variables. The charts included throughout the report present the means without controlling for other variables.

WRA worked in Savannakhet but not Khammouane during the Activity's implementation period, which may have amplified MAD results in Savannakhet over Khammouane.

While the Activity showed positive and significant impacts on MAD, the impact on the number of food groups consumed was not significant. As displayed in Figure 8, the lack of significance of the food group results relative to the significant MAD results is likely due to the fact that the endline means for both treatment and controls were 5.0, which is the cut-off point at which a woman is considered to have achieved a MAD.

Figure 8. Food Groups Consumed by WRA (not significant)



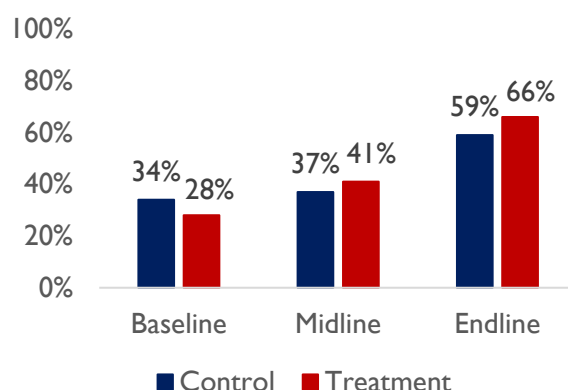
ANC: Quantitative data from the IE validates the perception of increased emphasis on ANC visits in Activity districts. The likelihood of a woman receiving ANC within the first 12 weeks of pregnancy increased significantly in the treatment group compared to the control group from baseline to endline ($p < 0.05$), as displayed in Figure 9. Households with more members ($p < 0.001$) and a household head with low education ($p < 0.001$) were less likely to receive ANC in the first trimester, while households with greater asset wealth were more likely to receive ANC in the first trimester ($p < 0.001$). Households in Khammouane were more likely to receive ANC in the first 12 weeks than households in Savannakhet ($p < 0.001$), and households with tile/sipax or zinc/metal roofs were more likely to receive ANC than households with wood plank or grass roofs ($p < 0.05$), triangulating with the asset wealth and indicating that household with a higher economic status were more likely to receive ANC in the first 12 weeks than those with lower economic status. Differential impacts with ANC visits in the first trimester may be due in part to external programming: as noted in the Limitations section above, while most of the tracked activities worked primarily in nutrition, the UNICEF Maternal and Child Health and Nutrition Programming activity implemented maternal and child health activities in more Khammouane districts than in Savannakhet districts.

Regarding the overall success of the ANC interventions, one district-level health staff member in Phine said, “The most successful aspect is pregnant women who came to receive the [ANC] service at [health center] increased by 30 percent [according to health center reports] from no one come to [health center] before. The increase was not large, but it was due to the systematic community stimulation concept of the Nurture Program.”

Though the prevalence of women receiving at least four ANC visits increased modestly in both the treatment and control groups from baseline to endline (60 percent to 89 percent in treatment, 61 percent to 89 percent in control), the impact of the Activity was not significant. Similarly, there were modest increases in mothers receiving breastfeeding information during ANC visits (63 percent to 90 percent in treatment, 60 percent to 88 percent in control), but there were no significant differences between the treatment and control groups. The prevalence of mothers receiving iron and folic acid

(IFA) during ANC visits was high to start at baseline (93 percent in treatment, 94 percent in control) and the Activity showed no significant impacts on this indicator from baseline to endline; however, endline values were close to 100 percent in both treatment and control areas (99 percent in treatment, 98 percent in control).

Figure 9. Women Receiving ANC within the First 12 Weeks of Pregnancy ($p < 0.05$)



Qualitative interview respondents discussed the benefits of USAID Nurture’s support to ANC visits at length. In almost half of interviews completed (31 of 70), respondents discussed the importance of ANC visits. One CF explained their role in encouraging visits:

“ I recommended that pregnant women go to use **ANC services** at the health center, explaining the benefits they would receive from consulting with the health center staff, such as getting vitamins, getting a baby check-up, getting advice on self-care and nutrition. This effected to increase access to health center services for pregnant women.

- CF ”

Within one interview, a respondent stated that ANC visits were the most successful aspect of the Activity explained that this was due to the “systematic community simulation” concept of the Activity and providing a training budget for the CFs and VHVs.

Though the Activity behavior change messaging also included information on post-delivery, there were no mentions of information provided on post-delivery in the qualitative data. Survey data show increases in the prevalence of mothers receiving help with positioning and attachment post-delivery (20 percent to 75 percent in treatment, 17 percent to 66 percent in control) though the impact of the Activity was not significant.

Barriers: Despite significant impacts of the Activity on women’s nutrition and ANC visits in the first trimester, as well as positive opinions of the maternal interventions, qualitative interview respondents discussed a few key challenges and gaps related to maternal health.

- **Traditional beliefs (11 qualitative interviews):** The most common barrier discussed to improvement in maternal health outcomes was traditional beliefs. This was discussed as being a more prevalent issue in areas with large ethnic populations. The beliefs discussed were that pregnant women should not eat too much for fear of “making the baby fat and [making it] difficult to give birth,” the mother eating only rice and galangals following birth, and the tradition

in some villages of giving birth in the forest. One respondent also explained that some women have the perception that they should only go to the health center when they are in pain.

- **Access to health centers (six qualitative interviews):** When discussing issues of access, respondents brought up the challenge of women spending time working in the fields and not having time to visit the health center, lacking transport options, and poor road conditions, especially in rural areas.
- **Scarcity of food (five qualitative interviews):** Respondents discussed the challenge of integrating the Activity's lessons when there is a lack of food in the community. Some also related the food scarcity to lack of economic opportunity, which is more prevalent in rural villages.
- **Traditional roles of men (five qualitative interviews):** Respondents discussed the ways in which traditional roles for men inhibit access to or implementation of maternal health services. Respondents explained that women often do not have the authority to make their own decisions about receiving ANC services: men do not allow their wives to use ANC services "because he does not want anyone to see and touch his wife's body." Additionally, women are unable to travel to health centers by themselves, but often the men are also "busy in the field or looking for food." One VHV explained, "...From my outside observation, three out of ten men can help their wives work during pregnancy. Find extra food for their wives and children to eat, such as fish and frogs. But most males still ignore the program tips, they still follow the old way."

IYCF

Breastfeeding: IYCF practices are increasingly recognized as major contributors to poor infant nutrition and faltering growth.¹⁴ USAID Nurture, through its SBCC campaign, promoted exclusive breastfeeding (defined as no other food or drink except for medicines and/or nutritional supplements) for the first six months of life, followed by the introduction of complementary foods after six months, with continued breastfeeding until the child is at least two years of age. Save the Children more than doubled their target for mothers and caregivers of children 0-23 months of age receiving direct maternal care on IYCF counseling, reaching 28,965 mothers or caregivers over the life of the Activity.

Despite the wide reach of the Activity IYCF interventions, there were minimal significant impacts of the Activity on breastfeeding outcomes, although this could also be influenced by the smaller sample size for this population at endline. As displayed in Figure 10 below, the prevalence of CU2 months being fed breastmilk decreased from baseline to endline in both the treatment and control groups, though the impacts of the Activity were significant with prevalence in the treatment group decreasing significantly less than prevalence in the control group (77 percent to 55 percent in treatment, 77 percent to 48 percent in control). There were increases in breastfeeding in the first hour after birth in both the treatment and control groups (13 percentage points and 18 percentage points, respectively), though no significant impacts of the Activity on the outcome (Figure 11). The median duration of breastfeeding with children 0-23 months of age increased by 2.1 months in the treatment group and decreased by 1.2 months in the control group (Figure 12), though the impacts of the Activity were also not significant.¹⁴ The median duration of EBF increased from baseline to endline as well, by 4.3 months in the treatment group and 3.4 months in the control group (Figure 13), though again the impact was not significant. A notable finding, however, is that the median duration of EBF increased to above the targeted duration of six months for exclusive breastfeeding at endline (6.2 months). These findings

¹⁴ Onyango AW, Borghi E, de Onis M, Casanovas Mdel C, Garza C. Complementary feeding and attained linear growth among 6-23-month-old children. Public health nutrition. 2014;17(9):1975-83. Epub 2013/09/21. pmid:24050753.

¹⁵ As discussed in the Limitations section above, the lack of significance with this relatively large change may be due in part to the small sample size at endline relative to the baseline sample.

indicate that the Activity may have been less effective in encouraging women to breastfeed, but more effective in extending the duration of breastfeeding among those who do.

Findings around increased breastfeeding behaviors are supported by qualitative data: within six of the 70 qualitative interviews, respondents described positive changes in breastfeeding behaviors in Activity districts, while no respondents discussed neutral or negative change. One health center staff member explained:

“ In the past, parents fed rice to their infants immediately after birth, which caused the infants to have stomach problems and probably die, which is an old belief. But after learning from the training, I took the new knowledge to explain to the parents, using the picture of the infant's stomach growth in the pink book to help parents understand more and **let the baby eat only breast milk until six months.**

- Health Center staff, Xaibouathong ”

Another CF respondent explained the ways in which USAID Nurture contributed to changes in breastfeeding behaviors saying, “The program selected a mother who followed their recommendations well and have healthy children as a case study. Groups are organized to exchange experiences with other mothers and compare the actual results in the community. For example, [name] was selected as a breastfeeding model from birth to six months. the infant is a girl, well developed, emotionally well, communicates well with others, and learns quickly. Now a two-year-old girl, she speaks fluently and does not often cry.”

Figure 10. CU2 Fed Breastmilk ($p < 0.1$)

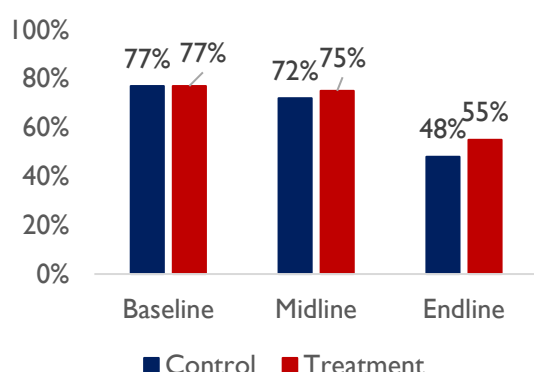


Figure 12. Median Duration of Breastfeeding CU2 (not significant)

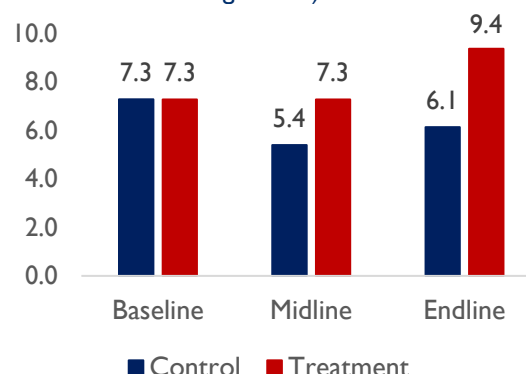


Figure 11. Breastfeeding in First Hour (not significant)

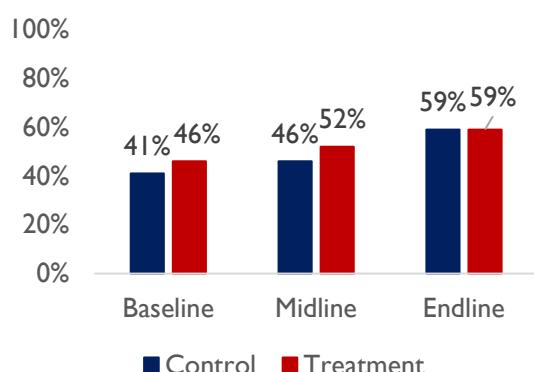
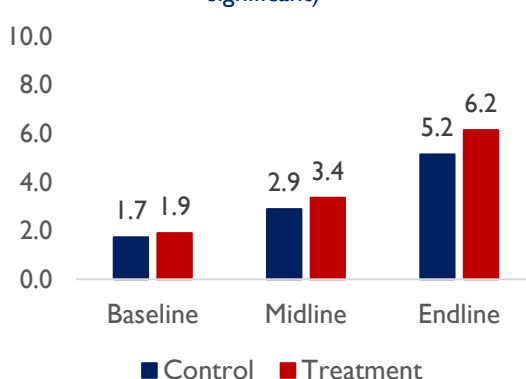


Figure 13. Median Duration of EBF for CU2 (not significant)



Complementary Feeding: The Activity provided training on the five food groups, food preparation, ANC, and PNC through home visits and encouraged women and men to visit health centers through monthly follow-up home visits from the CF at the village level. The appropriate timing of complementary food introduction and optimum quantity and quality of consumed foods were examined. According to the WHO's recommendation, complementary feeding should start when a child reaches six months and continue until 23 months and beyond.¹⁶ The ET measured complementary feeding practices through three main outcomes: minimum meal frequency (MMF), minimum dietary diversity (MDD), and MAD. These measures are defined as follows:

MDD: Proportion of children 6-23 months of age who receive food from four or more of seven food groups: grains, roots, and tubers; legumes and nuts; dairy products; meat, fish, and poultry; eggs; vitamin-A rich fruits and vegetables; and other fruits and vegetables.

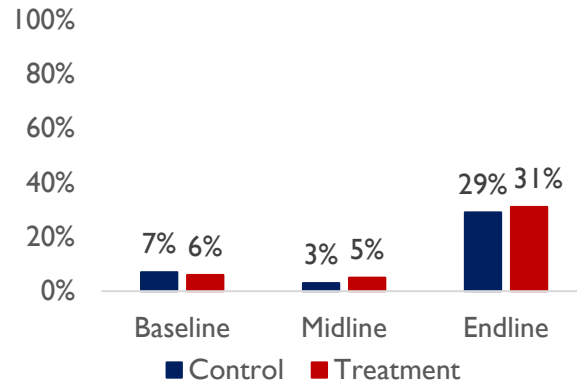
MMF: Proportion of breastfed and non-breastfed children 6-23 months of age who receive solid, semi-solid, or soft foods, also including milk feeds for non-breastfed children, a minimum number of times or more, i.e., two times or more for breastfed infants 6-8 months, three times or more for breastfed children 9-23 months, and four times or more for non-breastfed children 6-23 months.

MAD: Proportion of children 6-23 months of age who receive a MAD apart from breast milk; the indicator is a composite of MDD and MMF.

Quantitative data showed no significant impacts of the Activity on child MDD, MMF, or MAD. Child MMF remained generally consistent from baseline to endline in both the treatment and control groups (55 percent to 57 percent in treatment, 56 percent to 63 percent in control), while child MDD increased more substantially in both treatment and control (12 percent to 48 percent in treatment, 14 percent to 47 percent in control). Though prevalence of children 6-23 months achieving a MAD increased by 25 percentage points in the treatment group and 22 percentage points in the control group, as displayed in Figure 14, the impact of the Activity was not significant. There was also no significant impact on any of the six food group categories, defined above, used for calculating the MDD component of the MAD indicator for non-breastfed children. However, the Activity had a significant impact on child consumption of fried foods: though consumption of fried foods increased from baseline to endline in each the treatment and control groups (zero percent to two percent in treatment districts, zero percent to four percent in control districts), consumption increased significantly less from baseline to endline in the treatment group relative to the control group ($p < 0.1$).

¹⁶ World Health Organization/United Nations Children's Fund. Global Strategy for Infant and Young Child Feeding. Geneva: WHO Press: WHO/UNICEF (2003).

Figure 14. Children 6-23 Months Achieving MAD (not significant)



Results from the qualitative data similarly showed some progress in complementary feeding, but progress was not as positive or as specific as the qualitative findings related to women’s nutrition, ANC visits, and breastfeeding practices. In only one of 70 interviews did a respondent explicitly discuss seeing positive changes related to complementary feeding in children; no respondents discussed neutral or negative changes. Though there was a lack of discussion around changing outcomes in complementary feeding in the qualitative data, a greater number of respondents (four) discussed and verified what was taught by the Activity in the training of health center staff. One district-level health staff member in Nhommalath said:

“ ***I learned to introduce child nutrition, using the Nurture program poster.***
Introduce mothers to cooking porridge using locally sourced ingredients such as taro, sweet potato, pumpkins, fish, and eggs. Also, teach how to make dried food to eat for a long time or out of season.
 - District-level health staff, Nhommalath ”

Barriers: Respondents discussed the following issues as remaining challenges or barriers to improved IYCF practices, some which were similar to the maternal health barriers discussed above.

- **Scarcity of food (10 qualitative interviews):** The most frequent barrier to improved IYCF practices discussed was food scarcity. In addition to general economic constraints, one respondent mentioned an inability to grow and raise their own food due to a lack of water resources in some villages.
- **Leaving children with grandparents (nine qualitative interviews):** Some women, especially women in ethnic groups, need to work at home or spend time in the fields so they leave their children with grandparents, inhibiting the ability to maintain EBF. Additionally, respondents explained that elders are more likely to follow the traditional beliefs discussed above, such as feeding children water and rice, especially when the child cries.
- **Traditional beliefs (eight qualitative interviews):** The main traditional belief discussed as a barrier to improved IYCF practices was the belief that children need to eat water and rice in order to feel full. This was discussed mainly in relation to complementary feeding but was mentioned twice as a barrier to breastfeeding practices as well. One respondent mentioned taboos around not wanting to over-feed children for risk of the child being overweight.

- **Busy/lack of time to prepare food (seven qualitative interviews):** Outside of women's work schedules that necessitate them leaving children with grandparents or other caregivers, respondents discussed the challenge of women not having time to prepare nutritious food for their children. A member of the district supervision team explained:

“ In practice, even though the Nurture program suggested that parents prepare nutritious food for young children. But **they are always busy in the rice fields, and they do not have time to prepare food or add extra foods to feed their young children** such as eggs, chicken, fish, or vegetables, especially during the harvest season when parents have to stay overnight in the rice field. As a result, the rate of malnourished young children in this city has not decreased significantly.

- District supervision team member ”

WASH

Global evidence shows that WASH practices are a critical underlying determinant reducing malnutrition. The IE examined rates of essential hygiene practices, including handwashing, open defecation, use of a basic sanitation facility, and baby WASH practices that impact nutritional outcomes for the first 1,000 days households. The IE also examined the enabling environment and approaches for promoting the Activity's iNuW approach.

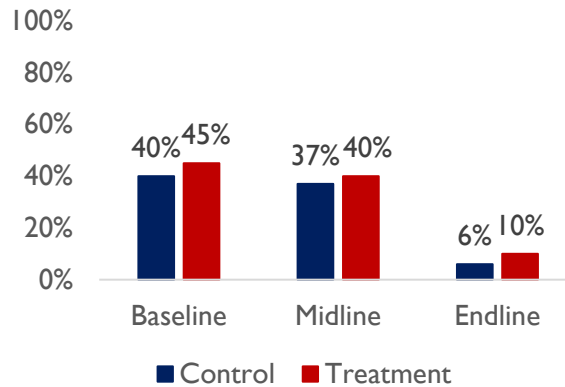
It should be noted for interpretation of the WASH data that many of the WASH indicators reported below were constructed using observation questions at baseline and midline; since observation of toilet and handwashing facilities was not physically possible at endline due to the remote nature of data collection, these questions were asked to respondents directly over the phone.

Sanitation: The Activity exceeded its target for access to basic sanitation facilities by about 100 percent, reaching 33,394 households. However, the Activity fell short of the target for communities certified as ODF, certifying 140 communities as ODF free as a result of United States government assistance (85 percent of the target). Important to note when considering the WASH results below are the changes in the WASH approach over the course of the Activity: the strategy was amended in the final year to subsidize 30 percent of toilet costs for the most vulnerable households.

There is evidence of positive trends in open defecation among household members (45 percent to ten percent in treatment, 40 percent to six percent in control), use of basic sanitation facilities (54 percent to 90 percent in treatment, 60 percent to 94 percent in control), and safe disposal of infant and young child feces (seven percent to 65 percent in treatment, ten percent to 66 percent in control), though IE data show no significant impacts of the Activity on these indicators.¹⁷ These improvements were validated by qualitative data. In 17 interviews, respondents discussed positive changes in open defecation. Village-level officials and beneficiaries spoke about the success of the Activity's WASH interventions much more frequently than any other outcome area as well.

¹⁷ When applying weights to the regression analysis using the propensity score matching method described in the Research Methodology section, the p-value for the safe disposal of infant and young child feces indicator falls below the 0.1 threshold for determining significance ($p < 0.1$).

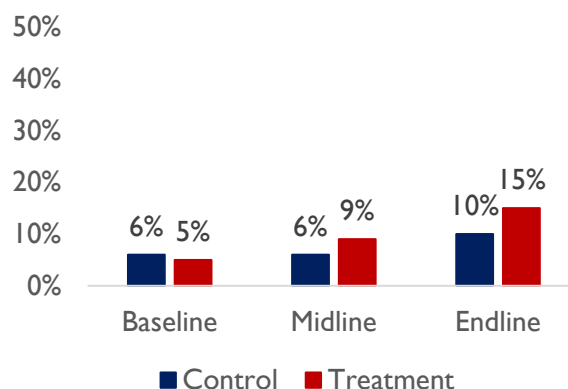
Figure 15. Households Practicing Open Defecation (not significant)



Hygiene: Using the quantitative survey data, the ET analyzed the following handwashing behaviors: presence of soap and water at the handwashing station, caregivers washing the child’s hands before eating, caregivers washing the child’s hands after defecating, children playing in a clean space, caregivers washing hands before preparing a young child’s food, adults washing their hands after defecating, and caregivers washing their hands after cleaning an infant’s bottom. There is evidence of improvement in several of these areas, though no significant impacts of the Activity on these indicators.¹⁸ Prevalence of caregivers washing the child’s hands after defecating showed the most improvement in treatment relative to control households as displayed in Figure 16 below, though this result was not significant.

Despite the lack of statistically significant results related to hygiene behaviors, qualitative interview respondents spoke frequently about improvements in handwashing behaviors in general. In 11 of 70 interviews, respondents discussed improvements in handwashing behavior. There were no mentions of neutral or negative changes regarding handwashing. One village head said, “In the past, people did not know how to use soap, there was no toilet, and when they took a bath, they went to bathe in the river. But now, most of them have toilets, parents use soap to clean, bathe and wash their children’s hands regularly, clean the house, create a clean play area for their children, and wash their clothes every day.”

Figure 16. Caregivers Washing Child’s Hands After Defecating (not significant)



Water: Results related to improved water sources were more mixed than other WASH indicators. There were modest improvements in households giving safe drinking water to children 6-23 months of age from baseline to endline in both the treatment and control groups (Figure 17), but these were not

¹⁸ See Annex E for indicator values at baseline and endline.

attributable to the Activity. Correct use of water treatment technologies such as boiling, filtering, purchasing water, and treating water with chlorine or aluminum sulfate increased slightly from baseline to endline as well in both groups after small decreases at midline (Figure 18), but again there were no impacts of the Activity on this outcome. Seven of 70 interviewed respondents discussed improvements in safe drinking water. Of six respondents at the village or health center levels who discussed improvements, four mentioned themselves and/or others learning to drink clean water generally, three mentioned boiling water for young children, and one mentioned using a water filter.¹⁹

Figure 17. Safe Drinking Water (not significant)

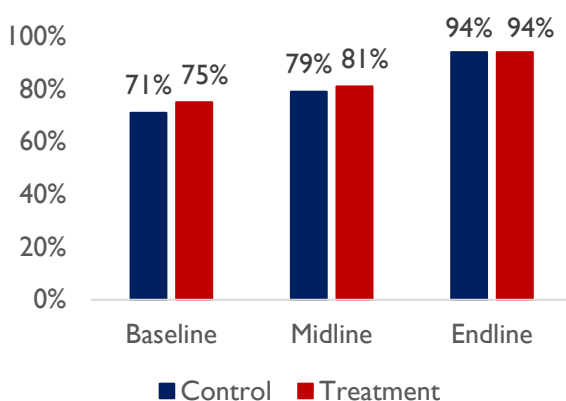
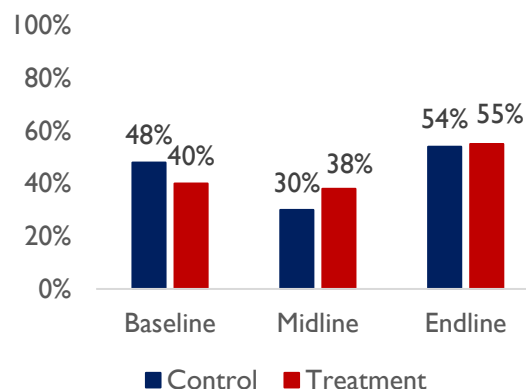


Figure 18. Water Treatment Technologies (not significant)



One VHV said:

“**My family and I changed our behavior a lot after learning from the program.** In the past, my house did not have a toilet, we defecated on the edge of the forest, drinking water from a stream (not clean), did not wash our hands with soap, eating raw, dirty house, raising chickens under the house, which often makes us sick. But not now, to keep the whole family free from diarrhea and malaria, I and my family changed to new behavior as the Nurture suggested.

- VHV ”

Barriers

- Economic barriers (30 qualitative interviews):** The most commonly discussed barrier to improved WASH behaviors by far was economic. Within each of the 30 interviews in which respondents discussed this barrier, respondents discussed it in relation to building toilets and open defecation. However, respondents discussed economic barriers to buying soap for handwashing during only two interviews. Regarding economic barriers and open defecation, one village head explained, “Although the program has been working to publicize the effects of diarrhea and communicable diseases in the community, as well as coordinating vendors to facilitate the purchase of toilet kits, the poorest people still do not have the money to buy toilets.”²⁰ Similarly, in four interviews, respondents explained that when faced with economic constraints, households prioritize food and nutrition over maintaining healthy WASH behaviors.

¹⁹ The disaggregate values do not sum to seven since some respondents mentioned more than one method.

²⁰ Further information on the toilet subsidies provided by the Nurture Activity and related challenges is provided under Evaluation Question 4 below.

- **Lack of access to water source for toilets (17 qualitative interviews):** The next-most-commonly discussed barrier to improved WASH practices was lack of access to a reliable water source. One respondent explained, *“Although some households already have toilets, they find it difficult to access distant water sources and have to travel to fetch water, which is inconvenient, so they have returned outside to defecate.”*
- **Lack of access to materials (13 qualitative interviews):** In several interviews, respondents also explained that if a household was interested in building a toilet, the materials can be difficult to access in rural areas due to poor road infrastructure, as vendors are hesitant to travel to rural areas to avoid damaging the materials.
- **Lack of access to clean drinking water sources (five qualitative interviews):** Though most respondents who discussed lack of available water sources discussed this challenge in relation to groundwater for toilets, some respondents also discussed basic economic barriers to accessing clean water for drinking (e.g., inability to afford bottled water, filters, or filter maintenance).
- **Cost and time burden of filters (five qualitative interviews):** Within five interviews, respondents explained that the filters promoted by the sales agents and sold by vendors were difficult to use. One provincial-level official in Savannakhet explained the issue: *“Water filters price is 300,000-400,000 kips but cannot filter groundwater well, the filter head dirties quickly within one to two days and needs to be washed frequently, useful life is only three to six months, and people do not have time to maintain them because they have to spend the most time working in the field. In this area, there is a drinking water factory that delivers drinking water at a cheap price (20 liters for 5,000 kips) to their house, or if the village is far away, people boil water for drinking, they think it is more convenient than using a water filter.”* Despite the challenges with water filters, one respondent discussed their utility when working in the fields, explaining that it is easier to buy drinking water from factories when at home, but more convenient to filter water in the fields than carrying drinking water each time. Interestingly, another mentioned that drinking clean water is difficult to achieve when people are working far from their villages, as it is inconvenient to bring enough water to drink for several days, especially during the harvest season when workers stay overnight at the rice fields. This respondent did not know how to address this barrier and did not mention the use of filters in the fields.
- **Traditional behaviors (four qualitative interviews):** Though traditional behaviors were mentioned much less frequently as a barrier to improved WASH practices relative to other barriers described, respondents in four interviews discussed the issue. One member of the DHO in Atsaphangthong explained, *“In this district, there are ethnic villages that still believe in the old tradition, such as the father cannot use the bathroom with his son-in-law, the mother cannot use the bathroom with the daughter-in-law, and not call each other by name, otherwise, it will be unfortunate, or sick. Therefore, in this village, people still refuse to use the toilet.”*

3.3 EVALUATION QUESTION III

What is the current outlook for sustainability of each of the individual components of the USAID Nurture approach (maternal health and nutrition, IYCF, and WASH)?

Qualitative interview respondents generally spoke positively of USAID Nurture’s outlook for sustainability. Overall, about half of the respondents (36 of the 70 qualitative interviews) said that all aspects of the program will be sustained in the absence of the Activity. Of these interviews, respondents from 31 interviews described how that all aspects of the program will be sustained because the Activity components and activities align with the GOL’s goals as outlined in the National Nutrition Strategy to 2025 and the National Plan of Action for Nutrition 2016–2020. Respondents said that, as result of the shared goals, the GOL will continue the nutrition and WASH work of the Activity with the MOH as the primary implementer.

“ All aspects of the USAID Nurture program still sustain because all the Nurture works were moving in the same direction as the [GOL’s] goals. Therefore, the [GOL], especially the [MOH], is responsible for continuing these activities.

- District-level health staff, Xonnabuly ”

Despite the positivity around alignment with GOL plans, one Save the Children staff member expressed concern that the quarterly DNC coordination meetings, which are critical to implementation of these plans, may not continue in the absence of the Activity’s coordination efforts. However, this concern was not raised by any other respondent group. Moreover, the DNCs are mandated with implementing the National Plan of Action on Nutrition (2021–25), so there is a responsibility by the MOH and its provincial and district offices to seek support from other projects given its limited operational funds.

MATERNAL HEALTH & NUTRITION AND IYCF

Respondents in seven qualitative interviews, including four with national-level officials, explained that health center staff will continue to implement the nutrition and behavior change counseling learned through the Activity training for pregnant women, new mothers, and caregivers. The respondents say that the health center staff will continue the counseling services because it is now mainstreamed into their health care services and routines. Respondents also mentioned that health center staff did not receive financial incentives from the Activity to adapt their counseling styles, but rather were given the opportunity to improve their communication skills, which respondents thought was well received. Respondents thought that counseling will be sustained because it made both the staff happier to provide counseling and patients happier to receive it.

“ As for me, sometimes I still visit households with women who are pregnant or have a new baby. I like to go for counseling, ask about their situation and advise on self-care, nutrition, and breastfeeding. Sometimes, pregnant women or women who have just given birth come to consult or ask me for advice.

- CF ”

There were a few positive comments from village-level officials on the sustainability of the awareness raising efforts of the village heads and village committees. These respondents (four interviews) noted that the village heads and village committees will continue their community mobilization efforts for

maternal and child health behavior change. Three village-level officials specifically mentioned how the Maternal and Child Health Awareness Campaign and WASH activities were sustained by the village committee in charge of outreach and mobilization as they contribute to the well-being of the community.

“Community mobilization in the aspect of WASH, maternal and child nutrition campaigns, and encouraging pregnant women to use hospital services are also sustained and implemented by the village head and village committees. Because it has a positive effect on the health of people in the community and we have experience in disseminating information.

- VIC member

Respondents did not have much insight into the sustainability of the programming targeting adolescents. However, one national-level respondent did not view it as sustainable in comparison to programming targeted at other demographics, such as pregnant women; they specified that the culture in Lao PDR is a barrier to adolescent counseling and the activity would need more support to succeed. This respondent believed if adolescent counseling was implemented in the first year of the Activity rather than the last year, then the Activity might have seen more success. Additional challenges with reaching adolescents are discussed under Evaluation Question 4 below.

WASH

In several qualitative interviews (14), respondents thought that the village committees and/or village heads will continue to mobilize the community to carry out WASH activities because their capacity and knowledge have both improved from the Activity; of these 14 interviews, 12 were with village-level officials. The respondents describe how the DHO will continue to work with the village committees to support them in their mobilization efforts, which is in line with the national CLTS guideline that aims to attain nationwide ODF status by 2025. As previously mentioned, three village-level officials stated that the awareness campaigns for WASH and maternal and child health were sustained by the village committees. Lastly, in two interviews, respondents mentioned that the village committees will continue to encourage new households to build toilets.

Barriers to the sustainability of WASH outcomes are primarily centered within activities of Component 3, which included interventions designed to improve the availability of entrepreneurs and WASH product providers in the project locations. Within a few qualitative interviews (seven), respondents discussed how aspects of WASH marketing and private sector engagement will not be sustained. One aspect that four respondents noted will not be sustained in the absence of the Activity is the work of the sales agents, since this is not included in GOL plans. Respondents described how there was not demand for the water filters and latrine packages that were marketed by sales agents, even during Activity implementation. One province-level official described how, “WASH marketing and [the] engagement of the private sector was not sustained because people already understand the importance of toilets, but they are not financially ready, I think when they are ready, they will buy their toilets, there is no need for a sales representative to work in the community.”

This sentiment was a theme that arose from respondents across all groups. Another province-level respondent noted that, “the work of sales agents [will] not be sustained as this activity is an agreement between the Nurture program and the private sector, not in the plans and roles of the government.” In relation to the sustainability of the vendors, one respondent from Save the Children described how, “social marketing would have worked if the vendors saw interest and if the market had the demand for it.” This respondent went on to describe how vendors are reluctant to invest in the latrine packages because

they are small businesses and perceive the packages to be a risky investment. The respondents further explain how the expected returns on investment are hampered by poor road conditions that risk damaging the items being transported. Additionally, the respondents mentioned how the investment is risky because some households are unable to meet payment terms—and a few vendors even reported that they are still owed payments. Lastly, during three interviews, respondents noted that the sale of water filters would not be sustained because there was no demand.

GENERAL

The increased capacity and knowledge of the health center staff and CFs was thought to be sustainable by several of the respondents. Respondents from 16 of the 70 qualitative interviews, ten of which were district-level officials, said that because the district- and province-level health center staff and CFs have been trained by the Activity, they will continue to use the skills and knowledge to continue community visits and outreach activities. The respondents have an even greater positive outlook on the sustainability of the health center staff's increased capacity. During many of the qualitative interviews (24), respondents noted that the Activity has trained health center staff, so they can use the technical knowledge and soft skills obtained. During nine qualitative interviews, six of which were with village-level officials, respondents described how health center staff will continue their community visit work with the support of the DHO. However, monthly outreach is not sustainable; hence guidelines stipulate outreach to villages beyond a certain distance from the nearest health facility, especially in the absence of roads.

“ Nutrition and WASH works are the goals of the [GOL]. The Nurture program has built capacity for health workers at each level, especially at the district and village levels. Therefore, they are the ones who continue the activities of the program to keep it sustainable.

- District-level technical staff, Phine ”

However, a key barrier to the sustainability of the health center staff's community outreach is the GOL's limited budget. In some of the qualitative interviews (12), half of which were with district-level officials, respondents said that the health center staff's community outreach might not be possible every month due to the government's limited budget and the community visits might be reduced to once per quarter.

The sustainability to the CFs' increased capacity is not without its barriers, while sustaining VHV have always been contentious because their work and incentives are often associated with development projects. Despite the positive outlook of several respondents' perception of the sustainability of the CFs, several respondents, including village, district, and national-level officials, are wary of the sustainability of this component. During six qualitative interviews, respondents described how the activities of the CFs and VHVs are less likely to be sustained because they have no incentive to work, and they are unlikely to continue the community mobilization activities without the financial stimulus from the Activity. These respondents described how CFs and VHVs are often poor and are unable to pay for fuel for their motorbikes and the telephone services that are required to conduct visits. Additionally, respondents described how the time that CFs and VHVs would take to conduct household visits is time when they could be generating income through other work or contributing to family responsibilities. Additionally, one CF respondent explicitly said that they conducted fewer household visits after the Activity ended because there was not anyone to hold them accountable:

“ While the Nurture program worked in this village, 100 percent of the pregnant women gave birth at the health center. But after the program ended, the number of pregnant women giving birth at home increased. Now I less visit the household because no one is encouraging and following me, I only publish information at the village meeting, but people do not pay attention.

- CF ”

Outreach, VHVs, and CFs overall are important primary health care components that increase awareness and demand for services such as ANC and PNC, which is what the Activity has promoted over its lifespan. Prioritizing villages by child malnutrition status will be necessary to balance the sustainability of these initiatives with available human and monetary resources.

3.4 EVALUATION QUESTION IV

What were the key successes and challenges in implementation over the course of the USAID Nurture Activity?

While evaluation questions one through three above discuss the effectiveness, contributions, and sustainability of the Activity by the three main outcome areas of maternal health and nutrition, IYCF, and WASH, the section below provides information on the successes and challenges of the Activity by component.

SUCCESSSES

Component I: Supportive enabling environment

Qualitative interview respondents discussed three main successes of the Activity related to Component I: the relationship between the GOL and Save the Children, the multi-sector collaboration of the DNCs, and the alignment of the USAID Nurture program's activities and components with the national nutrition goals of the GOL.

Qualitative interview respondents frequently mentioned the positive relationship between the GOL and Save the Children as a success of the Activity. During 22 qualitative interviews, 16 of which were with district-level officials, respondents described how the cooperation between the GOL and Save the Children went well, without any major problems.

Additionally, during eight qualitative interviews, all of which were with district-level officials, respondents mentioned how the three main ministries of the DNCs worked well together: the MOH, the Ministry of Education, and the Ministry of Agriculture. Together, the ministries have a multi-sectoral plan for nutrition services that was developed within the DNCs in each district. One DHO staff member described how every quarter, these sectors hold meetings to plan, set up joint activities, and report results in collaboration with community organizations such as women's unions, youth unions, and trade unions. However, one respondent from Save the Children expressed doubt regarding the sustainability of the DNCs. This respondent described how the strategy and policy is in place for the DNCs to succeed, but that the GOL does not have the capacity to encourage the coordination of the DNCs.

Lastly, as mentioned above, respondents described how the Activity was successful in aligning its components and activities with the GOL's national goals as outlined in the National Nutrition Strategy to 2025 and the National Plan of Action 2016–2020. Two respondents from Save the Children mentioned how the updated National Reproductive Maternal, Neonatal, Child and Adolescent Strategy 2021–2025 was successful because it is now inclusive of adolescents, first 1,000 days counseling, and supervision of health staff as part of the national standard,²¹ though this was only mentioned by Save the Children. Counseling is also being mainstreamed beyond maternal and child healthcare in all hospital facilities, and discussions are underway to include it in the pre-service curriculum.

²¹ As presented in Table I, health staff refers to both district health officers and health center staff; this was how respondents would refer to these groups during qualitative interviews.

Component 2: Improved community nutrition, health, and WASH services

The primary implementation success discussed by qualitative interview respondents under Component 2 was the improved quality of the counseling services provided by health staff. During many of the qualitative interviews (30), the respondents described how the counseling services provided by health staff improved as a result of the Activity. With this, respondents described how the counseling services positively affected the first 1,000 days families by increasing their understanding and leading them to make behavior changes. Respondents also described how there was an increase in the demand for nutrition and health services provided by the health centers due to this improvement. Specifically, in half of the 30 interviews in which respondents noted an improvement in counseling, respondents also perceived that more pregnant women sought out ANC services because of the counseling that they received, which is a perception that aligns with the findings presented in Evaluation Question 2.

The improved counseling services can be linked to the increased capacity of health staff due to the training provided by the Activity. During many of the qualitative interviews (24), respondents said that the Activity was successful in training health staff within the health centers and DHOs. Specifically, respondents described how the Activity was effective in training these staff members to conduct community outreach and provide counseling to the first 1,000 days families on nutrition, IYCF, and maternal care for pregnant women, husbands, caregivers, and adolescents. Health center and DHO staff described how they now have the skills, knowledge, and confidence to counsel and communicate with pregnant and postpartum women. As explained by one district-level health staff member:

“ After the training, I was more confident and have a reference to give information and advice to the 1000-day families. Learning how to ask questions that encourage women to talk more, I observe and listen intently to find problems. Before, I talk more than listen. But now, I listen more than I talk. Make women trust me because I understand their problems more.

- District-level health staff, Atsaphangthong ”

One district-level health staff member even noted that staff are more knowledgeable about how to counsel adolescent girls from USAID Nurture program training:

“ I have never taught nutrition to adolescent girls before. Thanks to the new education program, I know how to guide them to eat a variety of nutritious foods, drink clean water, and not restrict food for strong health. When they are pregnant, they must consult with the health workers at the health center to reduce the health risks for both mother and child.

- District-level health staff, Nhommalath ”

Respondents not only discussed how the Activity training was effective in training health staff, but also in training CFs and VHVs.

Component 3: Capacity-building to improve quality service delivery

Under Component 3, respondents discussed the following successes: a general improvement in the overall understanding among mothers regarding nutrition, health, and IYCF; changes among mothers concerning these three types of behaviors; an increase in pregnant women seeking out ANC services; the training of CFs; and the WASH, IYCF, and maternal nutrition behavior change messaging materials.

Within many of the qualitative interviews (23), respondents mentioned how understanding among mothers and caregivers improved as a result of the CFs' community mobilization activities (i.e., home visits, informational posters, and nutrition and food preparation demonstrations). Respondents primarily described how CFs helped mothers understand the importance of breastfeeding infants in the first six months, receiving ANC, eating a variety of food, consuming vitamins, and giving themselves adequate rest and avoiding overwork. Additionally, respondents described how community members improved their understanding of handwashing, using toilets, and processing and preserving food as a result of the CFs' mobilization outreach efforts.

However, this increase in understanding from the work of CFs only led to behavior change in a few cases. In several qualitative interviews (11), respondents described how the number of pregnant women who sought ANC services increased as a result of CFs' outreach work. They described how this improvement was a result of the joint community mobilization efforts of the CFs, the DHO, and health center staff. Additionally, respondents in eight qualitative interviews mentioned that the increased understanding among mothers about the importance of breastfeeding and providing nutritious food for their children led to behavior changes. As mothers learned how to breastfeed properly, they would breastfeed more during these first six months. A few respondents also commented on how mothers started to feed their children more nutritious food after the CFs' demonstrations.

Like the implementation successes in Component 2, the increased understanding and perceived behavior change described above can be linked to the Activity's training of CFs and VHVs in how to conduct community outreach activities, visits, and demonstrations. Like in the case of the health staff, respondents discussed how the Activity training was effective in its training of CFs and VHVs. Save the Children's IPTT data shows their success with the reach of their nutrition-related training: Save the Children reached 2,268 individuals with nutrition-related professional training (96 percent of their target). During many of the qualitative interviews (33), respondents commented on how the CFs, VHVs, and health center staff would conduct monthly community mobilization activities, including in remote and indigenous villages, and said that this raised community members' understanding and led to behavior change with WASH and nutrition.

Like the feedback from health center and DHO staff, several CF respondents commented that the Activity training improved their knowledge, skills, and confidence in counseling pregnant women. Respondents describe how CFs now urge women to go to the health center as soon as they find out they are pregnant for health check-ups and to receive vitamin supplements and prenatal counseling. They also describe how CFs now feel empowered to counsel pregnant women on the importance of eating extra food, drinking clean water, receiving adequate rest, and avoiding excess exertion. For example, one CF described their improved capacity from the Activity's training:

“After the training, I feel more confident, because of the new knowledge I have learned, and my explanation skills have improved, making me dare to speak and advise other parents and caregivers. They listened to me more, cooperated more, and caused a behavior change.

The man takes his wife to the health center every time and listens to the advice of the health center doctor. Make them understand how to take care the pregnant women more. This is different from the past when doctors did not know how to give advice, and the number of people who go to use the service was also small.

- CF ”

The training of CFs and VHVs in combination with the training of health center and DHO staff, including coaching district health officials on supervision skills, led these groups to have the language and communication skills needed to explain the importance of WASH, IYCF, and maternal health and nutrition. In addition to this implementation success, respondents in over half of the qualitative interviews (43) said that they believed that the different types of messaging and awareness-raising communication strategies used by these groups to promote behavior change were effective. CFs and health center staff promoted nutrition-related maternal and child health behaviors (ANC, PNC, IYCF) that increased utilization of, and eventually demand for, ANC services when mothers shared their positive experiences to friends and other women.

Respondents noted that the most useful behavior promotion materials for the first 1,000 days families included multimedia information, education, and communication (IEC) materials such as brochures, posters, and videos on nutrition and IYCF. Respondents described how the visual methods of health care messaging were especially useful for women who did not speak Laos, which respondents often correlated with as being from rural areas. This is consistent with Save the Children's 2021 report, which stated that "providing routine support to community actors and providing tools appropriate to their literacy levels increases their confidence and effectiveness in promoting optimal behaviors in their communities."²²

Another messaging strategy that was seen as effective was cooking demonstrations for the first 1,000 days families. Thirteen respondents commented that the cooking demonstrations were helpful in learning how to utilize extra food that is available in the community, as well as how to process food so that families could maintain a regular source of nutrition for their children. Respondents from eight of 70 qualitative interviews specifically mentioned that the demonstration on how to dry and process food so that families could keep it as a longer-term nutritious food source was helpful.

Respondents also commented on how the peer-to-peer support groups among mothers were helpful in progressing the program's community mobilization efforts. Respondents from seven of the 70 qualitative interviews described how mothers who followed the program's recommendations well were selected to participate in this peer group to exchange and compare their experiences and results with other mothers. They described how these mother support groups were helpful in increasing the understanding of nutrition and IYCF behaviors amongst mothers; for example, mothers shared their experiences and knowledge on breastfeeding behaviors:

“ It became word of mouth among the mother group that, "giving the baby breast milk is convenience and [you] save money. You don't have to waste money [to] buy powdered milk for your baby."

- Provincial Health Office Official, Kaysone Phomvihane district ”

However, one Save the Children respondent mentioned that it was challenging to encourage the mothers to discuss sensitive topics in the groups.

²² Save the Children. USAID Nurture Final Report 2021. <https://resourcecentre.savethechildren.net/document/usaaid-nurture-final-report/>.

Component 4: Demand creation for the use of nutrition, health, and WASH services and products

There was not a strong consensus among qualitative interview respondents on successful aspects of Component 4, though respondents did mention the success of the latrine package subsidy for poor households. Respondents from nine of the 70 qualitative interviews stated that villages were able to progress towards ODF status because the Activity provided a 30 percent subsidy to poor households for their purchase of latrine packages; six of these nine interview respondents were from Savannakhet. This finding aligns with a learning lesson from Save the Children's 2021 Final Report, which noted that "pro-poor subsidies enable the poorest households to purchase latrines which accelerates progress toward the achievement of ODF for the community."²³ However, the subsidy was implemented in the last year of the program, so not every poor household was able to buy a toilet in the limited timeframe.

“ Eight households that did not have a toilet are the poorest, they received funds [worth] 50 percent from the Nurture program to purchase sets of toilets. Now every household in this village has a toilet.

- Village-level official, Nhommalath

CHALLENGES

General: An implementation challenge that affected all components was the long MOU approval process. This process took the full first year of the program, which subsequently led to a year-long delay in the implementation of the Activity. Save the Children staff explained that during this time they worked on tools, but they were limited to what work they could begin implementing in the field. This barrier was brought up both in KIIs and in the 2021 Annual Report, where Save the Children reported, "Despite [Save the Children's] strong relationship with the GOL, the MOU process was lengthy and challenging to navigate. Must take this process into account when planning and discussing timeline expectations at start-up."²⁴ Thus, this delay was a barrier to the success of all the components because they were implemented at least a year later than intended.

Component 1: Respondents did not discuss this component outside of the long MOU process. No further barriers/challenges arose from the interviews.

Components 2 and 3: The primary implementation challenges discussed under Components 2 and 3 were language barriers in the context of spreading awareness on WASH, IYCF, and maternal health and nutrition behaviors within the different communities, particularly with older parents and ethnic communities.

In some qualitative interviews (12), respondents described how the language barrier was a challenge to implementation. This challenge was faced by both health center and DHO staff, as well as CFs and VHVs in their respective community awareness and behavior change promotion work. The respondents mentioned that language barriers were more present among older parents and ethnic communities, and especially women within these groups. A district-level official from the Atsaphangthong District describes the challenge below:

²³ Ibid.

²⁴ Ibid.

“ This district has many ethnic minorities, most of them are still poor and live in remote areas. They also believe in traditional customs, and have their language, men speak Lao better than women. Communication barriers when disseminating nutrition information and WASH is still the main challenge, the health team is not sure whether they understand the information provided. Although the program uses ethnic interpreters. But I'm not sure how much the villagers understand, because when everyone replied that they understood. But some villages, people did not change behavior in nutrition and WASH.

- District-level official, Atsaphangthong ”

Language barriers presented a challenge to a fully inclusive dissemination of information by CFs, VHVs, and health center and DHO staff, thus impacting Components 2, 3 and 4. Within Component 2, the counseling services of health staff displayed improvements, but these improvements might have only affected those who spoke Lao. Similarly, regarding Component 4, the implementation successes of increased understanding and perceived behavior change might have only impacted individuals who spoke Lao due to the language capacities of those who were disseminating the information. However, respondents did not comment on this possible connection during qualitative interviews.

Component 4: Respondents generally reported more challenges with Component 4 than the other components. The most frequent challenges discussed were the lack of household demand for latrine packages and water filters and vendors not traveling to remote villages to sell latrine packages. Though the Activity trained 454 sales agents on how to motivate households and sell WASH products, respondents said that the sales agents sold very few latrines because the price of the latrine packages was too expensive. Accordingly, monitoring data show that Save the Children met only 16 percent of their target for WASH products sold monthly by sales agents.²⁵

In 11 qualitative interviews, respondents said that if a household wanted to purchase a latrine package, they would go to the store and buy the package themselves, since the market price was cheaper than the price that the sales agents were offering. The respondents also mentioned that families did not want to pay the delivery fee charged by the sales agents. They clarified that it was only the families who could afford the latrine packages who would go to the store to buy the package; there were some families who could not afford the latrine package, regardless of the source. The pro-poor subsidy for the latrine packages targeted these families. Upon receiving the subsidy, the poorest households were said to be able to buy the latrine packages from the sales agents, although some households had to buy the latrine packages part by part until they had a complete set. One VIC member explained the challenges with the price of the latrine packages:

“ The community has a high demand for toilet sets. But there are only three to four households that bought through [sales agent], they were the poorest households and received half of the funding (200,000 kips) from the Nurture program. As for the households that are not eligible to receive funding from the program, they went to buy at the market.

- Village Committee Member ”

An additional implementation challenge to the sale of the latrine packages was that vendors did not want to travel to some villages because the quality of the roads was difficult to travel with the toilet products. Eighteen respondents mentioned that vendors feared breaking their products when traveling, so they

²⁵ Data from IPTT Indicator Sub-Intermediate Result 2.2.3: Number of WASH products sold monthly by sales agents

chose to not travel to certain remote villages. Additionally, during a qualitative interview, one vendor described how once the Activity ended, the demand for the latrine packages decreased, which meant that the sales agents stopped marketing the latrine packages. These challenges present significant barriers to the sustainability of this component.

“ The new products that Nurture suggested, it really useful to my business during the program implementation and [sales agents] supported marketing in villages. But after the Nurture ended, there was no demand from people anymore. Because [sales agents] stopped marketing support.

- Vendor

A similar implementation challenge was seen with the marketing of the water filters. Almost half of the respondents (29 of 70 qualitative interviews) said there was no demand for the water filters. In 27 of these 29 interviews, respondents said that this was because in some areas there was already a water factory nearby that was less expensive, with free home delivery. The respondents also noted the water filters were perceived by communities as requiring too much maintenance, especially for those who spend most of their day working. One vendor describes this perspective:

“ Water filters are not popular in communities: due to slow filtration, cannot filter groundwater well, the filter head dirty quickly within one to two days and needs to be washed frequently, and people do not have time to maintain them because they have to spend most time working in the field.

- WASH Vendor

COVID-19

The main implementation challenge resulting from COVID-19 was the temporary pause in all USAID Nurture activities. During qualitative interviews, eight respondents said that COVID-19 was a challenge because lockdown measures meant that implementation was not able to occur. One respondent from Save the Children specifically mentioned that latrine production, delivery services, and ODF verification were put on hold during the lockdowns.²⁶

Additionally, one respondent from Save the Children said that both CFs and the first 1,000 days families did not want to interact with one another during the peak of COVID-19. During two interviews, respondents mentioned that the Activity adapted to this barrier by disseminating information through the local community radio. Another part of the Activity that was adapted was the coaching of CFs and sales agents, which continued through phone calls.

However, many respondents noted how the Activity helped health staff manage the spread of COVID-19 by spreading awareness on protection measures and supplying equipment. Respondents from 25 of the 70 qualitative interviews described how the Activity assisted the DHOs in disseminating information on COVID-19 protection, mobilizing people for vaccinations, and providing protective equipment such as hand-wash gels, gloves, soap, and alcohol for distribution at health centers and communities.

²⁶ The first COVID-19 lockdown in Lao PDR was implemented on April 1, 2020. The second lockdown was implemented on April 22, 2021.

4. CONCLUSIONS

Overall, the ET found that the Activity likely contributed to the improvement of several short- and medium-term outcomes over time. However, the impact of the Activity on the long-term goals of stunting, wasting, and underweight status is unclear due to the lack of quantitative data at endline, combined with minimal knowledge and discussion of these indicators among qualitative respondents. Aspects of each of the maternal health and nutrition, IYCF, and WASH approaches contributed to positive changes in short- to medium-term outcomes in each area, and in particular on provider capacities strengthened within the health system at primary care level. Respondents were generally optimistic that Activity interventions would continue due to the capacity-building nature of many of the interventions and alignment with GOL goals; respondents also provided important feedback on some interventions that would require additional resources to complete or sustain.

MATERNAL HEALTH AND NUTRITION

Of the maternal health and nutrition outcomes measured, the ET found the strongest Activity impacts in women achieving a MAD and receiving ANC within the first 12 weeks of pregnancy. Each of these outcomes align with a SDA promoted by the Activity: “eat extra food at every meal while pregnant,” and “go for ANC services as soon as you know you are pregnant.” Activity interventions that most contributed to the impacts in MAD and ANC visits were the interventions under Component 3, capacity-building to improve quality service delivery, where health center staff were trained on the first 1,000 days counseling, and Component 4, capacity-building to mobilize communities, where CFs conducted home visits to advise PLWs, husbands, and/or mother in-law caregivers and referred the mothers to seek ANC and PNC and deliver at health centers. These two Components are inter-linked because health center and DHO staff supervised CF tasks, and both home visits and ANC attendance at health centers increased demand for services. Demand was also influenced by mothers who went for ANC sharing their positive experience with counseling with other mothers. Qualitative interview respondents frequently discussed and spoke highly of the quality of these interventions, specifically citing the effectiveness of training health staff within the DHOs and health centers to provide counseling to families and conducting community outreach. Respondents are generally optimistic that the nutrition and behavior change counseling taught by Activity staff will continue since counseling is recognized as integral to routine care at health centers when patients come to seek services. However, there are remaining barriers to the effectiveness of the counseling services and implementation challenges experienced during the Activity that should be addressed. These include traditional beliefs around women’s nutrition during and after pregnancy; a lack of access to health centers due to working in the fields, lack of transport options, and poor road conditions; food scarcity and economic challenges; the traditional roles of men affecting the autonomy women have over decisions around nutrition and ANC services; accessing and engaging adolescents; and language barriers in training and in conducting community directed SBCC.

IYCF

Evidence of the Activity’s impacts on IYCF behaviors is less strong than in the areas of maternal health and nutrition and WASH, though there is evidence to support likely positive impacts on some breastfeeding outcomes. The Activity promoted two breastfeeding actions through the SDAs: “breastfeed within the first hour of birth and keep your baby with you to breastfeed consistently,” and “breastfeed frequently, breastmilk is all your baby needs for the first six months.” Though the evidence does not support impacts on breastfeeding in the first hour, the quantitative and qualitative data suggest likely impacts on the median duration of breastfeeding and the median duration of EBF, especially for mothers already breastfeeding. Additionally, the median duration of EBF exceeded the recommended six months in the Activity areas at endline. Evidence does not support impacts on other complementary

feeding behaviors, including MAD achievement. This aligns with the lack of continuity of PNC counseling, despite a reported increase in births at the health centers.

Like the maternal health outcomes, the Activity interventions that most directly contributed to the likely impacts on breastfeeding were the interventions under Component 3, capacity-building to improve quality service delivery. Respondents discussed the utility of the posters and other visual learning aids in Laos and other ethnic languages. As mentioned in the maternal health and nutrition conclusions above, respondents were generally optimistic that the nutrition and behavior change counseling will continue. However, there are remaining barriers to effectiveness of the counseling services on IYCF that should be addressed, including food scarcity; traditional beliefs around children needing rice and water to feel full; women needing to leave children with grandparents or other caregivers while working in the fields, and caregivers sticking to traditional feeding practices; lack of time among working women to prepare nutritious food for their children; and language barriers in training and for community-based activities.

WASH

Of the WASH outcomes measured, the ET found the strongest impacts on open defecation and handwashing behaviors. There was no SDA promoted around open defecation, but an SDA aligned with the second outcome: “wash your hands and your children’s hands.” The Activity fell short of its target for communities certified as ODF (85 percent of target) and the ODF impacts were not statistically significant, but respondents spoke frequently about the successes of the interventions around open defecation. The Activity interventions that most directly contributed to the improvements in ODF status were the market interventions under Component 3 and the training and CLTS activities under Component 4. Based on triangulation of the quantitative survey data, qualitative data, and Save the Children’s monitoring data, it is likely that the open defecation interventions were effective among households who had the financial means to implement the SDAs and build a toilet, but much less so among households without the financial means. Progress towards achieving ODF status was advanced by the toilet subsidies as well. Though many qualitative interview respondents spoke about the success of the open defecation interventions, it is important to note the large barriers that remain to achieving ODF status, especially in rural villages and with poor families, such as economic barriers to building toilets, lack of access to a water source for piped running water inside toilets and in houses, lack of access to building materials, and traditional behaviors around sharing toilets among family members. These are basic needs to be addressed amid the GOL’s intention to eliminate open defecation by 2025, which is among its health and socio-economic development priorities to attain middle-income status by 2030.

There were critical implementation challenges as well that affected the success of the interventions and the likelihood of these interventions being sustained. First, respondents reported that communities understand the importance of latrines, but some are not financially capable of building them, even with the 30 percent subsidy offered by the Activity. Second, respondents report that the work of the sales agents who link communities and vendors will not continue, since their work was an agreement between the Activity and private sector vendors; the GOL does not plan to continue the agreement. Third, vendors perceive WASH products as a risky investment. As mentioned by some respondents, household WASH investments often take second priority to more immediate needs, like food. Additionally, vendors experienced a lack of demand for water filters during Activity implementation due to many communities having cheaper clean water sources nearby.

CAPACITY STRENGTHENING OF HEALTH STAFF AND COMMUNITY PARTNERS

Promotion of nutrition and WASH behaviors to first 1,000 days households and their communities depended, to a large extent, on the relationships established by health staff, and the leaders and CFs in villages. This enabled an environment for potentially sustaining new behaviors, such as communication and facilitation for managing and engaging with the wider community and with each household, and for building reciprocal relationships with health staff who provide primary care. Overarching successes of these capacity building efforts were: 1) a shift from old training techniques to demonstrations and facilitated learning with trainers' feedback that fostered self-reliance among volunteer VICs, sales agents, CFs, and among government health staff; and 2) continued coaching visits with debriefing sessions to discuss Activity updates and reflect on challenges, which constructively addressed feedback received around performance. Regular coaching visits enhanced both the volunteers' and supervisors' confidence and motivation to effectively deliver community mobilization activities; the visits also improved reporting skills. During follow-up visits, USAID Nurture staff acted as coaches and gave technical and advisory support to district health officers on how to mentor the volunteers and health center staff to deliver community-wide events and home visits to first 1,000 days households. These joint field trips were then called coaching visits.

The Activity's Senior Health Specialist also took a "learning by doing" approach in developing the counseling training manual and its trainers: the central level CCEH Masters Trainers and provincial trainers. The approach was taken to address a misunderstood belief among health staff that they cannot be experts. The success of the first 1,000 days counseling course and training program has been recognized both by the Laos PDR MOH and the WHO, and in 2021 was mainstreamed for health counseling within all health facilities with the CCEH as the Master Trainers; integration into pre-service training courses is also in discussion.

These approaches taken by the Activity addressed basic gaps in public administration in the Laos PDR, owing to a top-down culture of governance. These individual and institutional developments were crucial to improved primary health care that naturally integrates nutrition within maternal and child health and WASH, and to some extent reflects rural development gaps, such as absence of water systems and roads, to allow change in nutrition behaviors.

Counseling has improved efficiency in service delivery in-facility, which allows health center staff to continuously provide RMNCAH services for the mother and her child, from planning fertility to pregnancy, birth, postpartum, and well and sick childcare, according to the Maternal and Child Health Book. The CFs have bridged the gap in primary healthcare outreach by extending promotion of the same nutrition and WASH messages at home to the caregivers and fathers/husbands. At the same time, leaders who came to understand these primary healthcare needs made the community-wide events possible. For these, the Activity was perceived as successful in coordinating these interventions and institutionalizing good practices into the health system, particularly at the primary care level.

5. RECOMMENDATIONS

Based on the integrated findings of the IE, the ET makes the following set of recommendations for each for the GOL which are designed to be doable with no or limited additional resources, and a set of recommendations for future nutrition programming, which are designed to require additional resources as available.

GOL IMPROVEMENTS WITH EXISTING OR MINIMAL RESOURCES

1. **Coordinate quarterly DNC meetings:** The GOL should assign a person or group responsible for ensuring the continuation of the quarterly DNC multi-sectoral coordination meetings that the Activity was responsible for. The DNCs are the third level of a multi-sectoral coordination structure also consisting of the provincial and national nutrition committees, mandated to realize the National Nutrition Strategy and its five-year action plans, the National Nutrition Strategy 2016-25, and the National Plan of Action for Nutrition 2021-25. Respondents mentioned that these quarterly meetings were essential for continued coordination between the sectors to work in alignment with national-level plans. Moreover, the DNC can be used as a platform to utilize growth data (underweight, stunting, wasting) when prioritizing and identifying target villages and districts; anthropometric and nutrition counseling data are now routinely collected by District Health Information Software 2 through health centers, although data quality improvement is needed. Lastly, DNCs can be used to elevate governance and rural development issues, such as lack of water and roads, to higher levels such as sector heads or governors in districts and provinces.
2. **Promote PNC:** In addition to providing counseling on ANC visits, current CFs, VHV, and health center staff can strongly recommend mothers continue with PNC. Increased interaction with health center staff following birth may support continuity in newly adopted breastfeeding, complementary feeding, and behaviors on GMP, as well as on sick or well child behaviors, such as immunization and on early essential newborn care. This is crucial for mothers who can adopt these practices continuously for successive pregnancies, and for adolescent mothers and parents who can still maintain quality of life with family planning, ANC, PNC, and facility deliveries.
3. **Target grandparents and other caregivers:** CFs and VHV could be used to conduct additional community outreach to parents and other caregivers of children around IYCF behavior change. Villages may consider implementing grandparent or caregiver peer groups to incorporate elements of positive deviance to this approach. Carers, many of whom are grandparents, were primary beneficiaries during home visits. However, PNC was weak, which meant there was a lack of a discussion around IYCF, both at home or in villages, and there was no added intervention to address the traditional feeding of children by grandparents when most mothers left infants and young children with them to return to routine tasks.
4. **Engage men and husbands:** The GOL should continue to engage men and husbands in counseling around women's nutrition, ANC, PNC, and IYCF to reduce the influence of traditional roles of men on women's nutrition and health. Men also hold a pivotal role as heads of households among Laos families and in other ethnic groups that influence both their wife and elders' beliefs and customary practices regarding maternal and child health. Women in rural areas also depend on men for transportation and in communicating in the Laos language. Young, adolescent husbands will also benefit from early awareness about critical maternal and child health issues, including family planning and delivery in facilities.
5. **Support CFs and VHV to provide training and supervision for the first 1,000 days counseling by health center staff:** Advocate projects supporting health system

strengthening, maternal and child health, or nutrition interventions to support the CFs and health center counseling set-up by the Activity. Building on these modalities will be cost-effective and abide with RMNCAH priorities, e.g., counseling trainers have been integrated into national health system strengthening as per the 2018-20 Essential Health Care Package. The GOL has a limited operational budget, which has made the role of VHVs and additional CFs contentious as part of the public health cadre. However, the Activity has shown that CFs and VHVs are essential in changing maternal and child health nutrition behaviors when supported consistently and supervised within the health system.

FUTURE NUTRITION PROGRAMMING: RECOMMENDATIONS FOR ADDITIONAL RESOURCE ALLOCATION

1. **Direct funding to beneficiaries:** The GOL could provide funding directly to beneficiaries for toilet installation and maintenance, and travel to health centers. Though the Activity started to subsidize the latrine packages in response to recommendations from the midline report, respondents still reported at endline that beneficiaries struggled to finance the full latrine sets.
2. **Seek opportunities for collaboration:** Future nutrition programming should seek to collaborate with organizations working in food security and agriculture within their target areas and to facilitate income-generating opportunities, especially for women, as a way to mediate the barrier of food scarcity in maternal health and nutrition and IYCF. GOL offices do not necessarily seek to coordinate inputs and funding from development projects, so donors and implementers need to initiate collaboration on their own at all levels and stages of implementation. This is necessary for programs and projects within or between sectors. Collaboration also avoids differences in benefits to GOL staff (e.g., food and transport) that may discourage the GOL to even consider coordinating with other projects or disparage smaller projects having similar development intentions.
3. **Prenatal and postnatal support to women:** Future nutrition programming should explore the possibility of providing women with alternative livelihoods to ease the economic impacts of EBF for six months and reduce the likelihood of extended stays in the rice fields. Additionally, future programs may consider food subsidies for pregnant and breastfeeding women and sourcing locally for material food subsidies.
4. **Planning for language barriers:** Future programs should plan for and address language barriers in training and counseling by delivering training-of-trainers in the local language and utilizing visual and pictorial aids to share SBCC messages.
5. **Supporting routine outreach:** Current outreach services by health centers implemented through the Activity are continuing, but at a less-frequent pace. Future nutrition programming should consider sustainable support to routine outreach activities and the role of VHVs and CFs, so they can occur more regularly according to local health system capacity and national guidelines. Outreach and additional VHVs may be problematic and unsustainable amid limited public funds for operations, but when planned efficiently, they can effectively reduce disparities in health care access for households and villages in remote areas. Village consolidation in Lao PDR intends to increase access to public services, facilities, and infrastructure; however, some households have not moved and remain remotely located within a large, consolidated village and may be speaking ethnic languages.
6. **Employ adolescents:** In addition to funding current outreach activities, future programs should hire and pay adolescents as CFs. Engagement of adolescents as CFs could help programs better understand how to reach adolescents and design programming that appeals to this demographic. At the same time, engaging adolescents as paid CFs will improve adolescents' own

knowledge and skills while providing them an income, enabling them to demonstrate positive health practices to their communities.

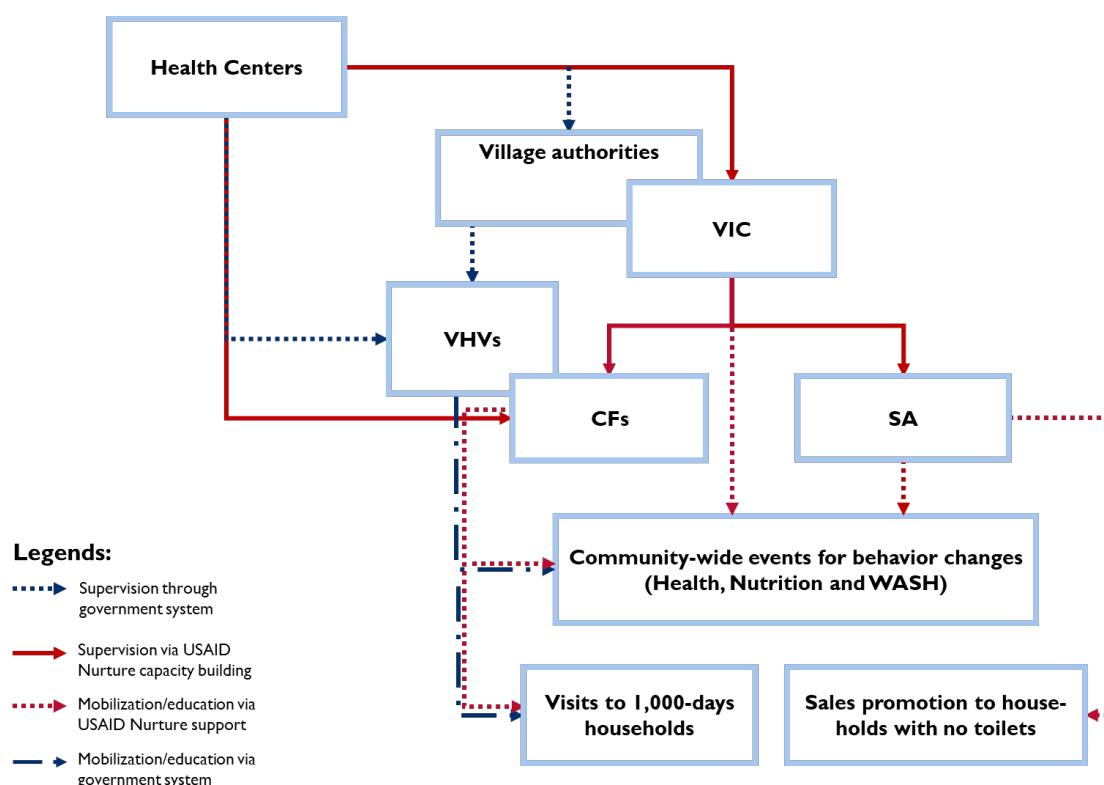
7. **Assess water resources:** Future programs should thoroughly assess current water resources or systems when providing recommendations on sanitation infrastructure or handwashing facilities. Since the availability and access can vary greatly by district and village, these assessments should be done at the village level.
8. **Align project plans with sector counterpart plans:** Local sector offices depend on projects and programs to implement their development plans owing to chronic public budget deficits within the GOL. Project plans that are integrated into local sector plans allow government offices to attain local priorities and may encourage them to continue seeking or combining project funds that could sustain interventions and embody principles of aid effectiveness.

6. ANNEXES

ANNEX A: NURTURE ACTIVITY TECHNICAL APPROACH

The approaches and implementation modalities for realizing strategies were modified during the first year of the Activity to encourage and facilitate behavior adoption in target households based on results of a formative research and gender analysis. During this period, changes in geographies and partners occurred to account for changes between Activity design and implementation. The analyses conducted in Year 1 identified the barriers and facilitators to optimal adolescent and maternal health and nutrition, IYCF, WASH, and healthcare-seeking behaviors, which informed several new approaches for strengthening both community and health system capacities, which made up the Activity's social and behavior change plan. The diagram in Figure 19 illustrates the relationships and linkages that the Activity capitalized on, providing continuous capacity-building through this structure. An alternative training approach coupled by coaching to district health officers on how to supervise boosted the skills and confidence of 1,930 community volunteers consisting of CFs (913), VICs (885), and sales agents (454). Village leaders selected the volunteers based on their willingness and good practices of iNuW behaviors that gained the trust from other villagers via village awareness events, CLTS, and home visits.

Figure 19. Linkage of Community and Health System Approaches

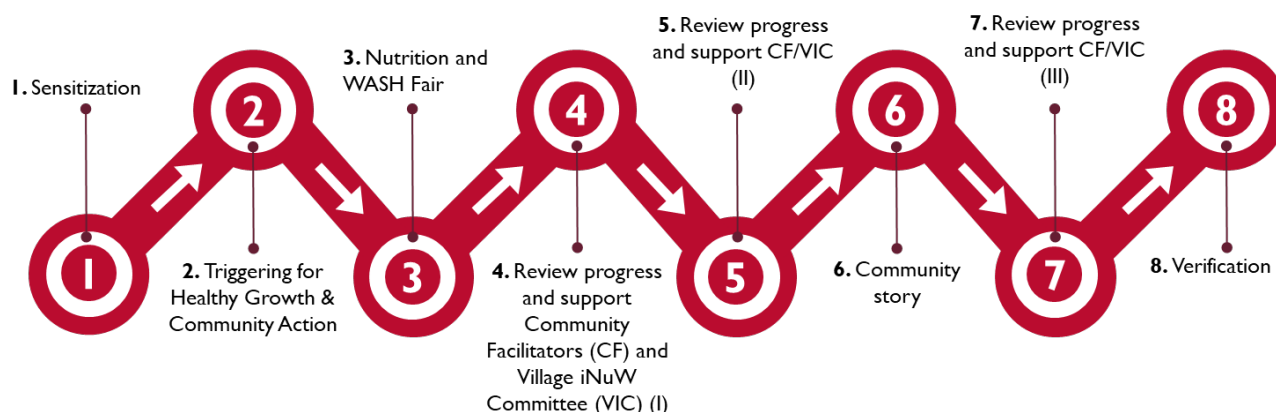


Community capacity strengthening for sustainable behavior change

Approach 1: The 10 SDAs, as displayed in Figure 2, were created as a simple tool for target households to strive for iNuW behaviors. These were a core component of the iNuW toolkit that guided the community-led process of building awareness on the importance of improving both nutrition and WASH behaviors through an eight-step process (Figure 20). These SDAs were presented on attractive and informative posters and flipcharts at household visits and shared during community-wide

events to draw attention and improve community understanding. The team also distributed portable flipcharts and wall progress charts for reference at home. In Year 4, nutrition for adolescents was added as the ninth SDA, promoted during quarterly community-wide events and home visits to households with female adolescents. Households that demonstrate the SDAs are given the “iNuW Star Family” certification during community-wide events, which recognizes them as a community role model.

Figure 20. Roadmap Building Awareness of the Importance and Integration of Nutrition and WASH



Approach 2: Community-wide events were used to promote the 10 SDAs every quarter to reach the whole village. VICs, CFs and sales agents facilitated the events with support from health center and DHO staff. CFs presented all SDAs or iNuW messages relating to IYCF and maternal nutrition, and VICs presented hygiene and sanitation messages. Sales agents presented latrine options and feasible choices of access. Villagers from both the first 1,000 days and non-first 1,000 days households participated in the events that served as initial knowledge dissemination platforms for VICs to integrate iNuW messages into their monthly mandatory village meetings. CFs re-emphasized these messages during their follow-up visits to target households. District Agriculture and Forestry Offices also promoted consumption of nutrient-dense local foods and cultivation techniques pertaining to home gardens, pest control, and home composting at the community-wide event.

Approach 3: Male and female CFs paid visits to the first 1,000 days households to reinforce their decision-making when households adopted an SDA following the community-wide events. The visits occurred monthly or bi-monthly, depending on the number of the first 1,000 days households in each village. Starting in 2018, CFs visited 10,379 target households in 471 villages and revisited more than 8,500 households each year. During the visits, CFs met with mothers and encouraged participation from husbands and others who provided childcare. During each follow-up visit, CFs marked any adopted SDAs on the progress wall chart as a reminder to track the new practice in the household and introduced another SDA to the household for adoption.

The Activity also employed ongoing capacity-building and coaching visits by ACTivity and DHO staff as modalities for boosting the skills, confidence, and motivation of the VHVs, CFs, VICs and sales agents selected by village leaders. Recipients were chosen based on their willingness and good practices of iNuW behaviors to gain trust from other villagers. CFs took on similar roles to VHVs regarding community mobilization, home visits to the first 1,000 days households, and collecting relevant maternal and child health data. They received communication and facilitation skills training centered on encouraging the SDAs and performing their awareness-raising tasks. These VHVs were the key actors that promoted health services, since government health staff have limited resources for community campaigns.

Health system capacity strengthening on nutrition counseling

Save the Children and the CCEH developed an original course on the first 1,000 days counseling for nutrition where trainers modelled desired behaviors and core counseling competencies to encourage a people-focused approach, which was espoused by the new Maternal and Child Health Book. The experiential learning course had three modules on ANC, breastfeeding, and complimentary feeding that were delivered through a “learning by doing” approach where learners were guided to participate in repeated practical simulations of realistic care encounters, and to conduct a briefing at the session’s end. Learning was cooperative and learners were encouraged to think critically about applying lessons in their workplaces, including system and resource barriers, as well as other challenges. These were finalized over three rounds of training of trainer “pilot, feedback, and revise” sessions and roll outs that led to a higher quality of trainers and trainings. In the end, participants had grasped the basic counseling principles and techniques applied to ANC, breastfeeding, and complimentary feeding, and had gained practical experience to help improve nutrition from conception to 24 months. The particular training method employed was critical for the longevity of counseling sessions where skilled trainers model the core competencies during training, cultivate the impulse for empathy, and introduce the concept of soft accountability. The method also allocated sufficient time for participants to feel confident in performing tasks, feel that they can easily utilize the new skills upon returning to their duty stations, and where the role of supervisors are to sustain that confidence. Nutrition counseling specific to the needs of adolescents was adapted into the counseling modules in Year 4.

To sustain the counseling capacities built at health centers, the Activity also modified the health system approach to supportive supervision with training and follow-up on-the-job coaching visits conducted with provincial and district health officers. Four supportive supervision trainings focused on cross-cutting supportive supervision skills, such as how to provide and use constructive feedback, through an integrated focus on the technical areas of early essential newborn care, well child visits, and ANC. Four training sessions on supportive supervision were provided to 32 supervisors for 49 district health units.

The six counseling competencies were included in the 2019 national ANC guidelines as “respectful care competencies” and have been incorporated into the pilot Supportive Supervision Approaches for Health Care Supervisors. Counseling is a core component of the newly introduced and adopted well child care guidelines, and its SDA approach has been incorporated into the official Mother and Child Health Book, a portable care record known locally as the Pink Book, and into the District Health Information System monitoring forms used by health centers.

Private sector engagement in sanitation marketing

The Activity partnered with 24 small businesses to supplement its support to the national ODF by 2025 campaign that was being achieved through the CLTS approach. This approach was informed by a WASH Marketing Assessment included in the formative research in Year 1. Vendors were engaged through liaison with village sales agents and the district WASH staff (NAMSAT staff) to improve product quality, expand their geographic reach, improve marketing strategies and increase efficiency of latrine set sales and installation services. The private-public sector business model was designed to increase household and community access to basic sanitation services through latrine packages with installment payments plans, and in Year 4, included a pro-poor subsidy to accelerate purchases by households with lower incomes, widows, and elderly.²⁷ Monitoring and support visits by WASH staff also ensured that vendors complied with product quality standards and delivered products on time and in a satisfactory

²⁷ Latrine packages refer to different types of sets sold to households for different prices (e.g., households were given different options to purchase such as a fully constructed set that consisted of a ceramic squat toilet, tiles, and cement, or only certain components of the toilet set such as the cement and/or ring mold only to be built via self-construction).

manner. Attaining ODF status was also influenced through community leader exchange visits with villages that have achieved ODF status. The exchanges focused on successfully mobilizing communities; how sanitation work is arranged, monitored and managed; and facilitating easy access to sanitation products for households. These approaches were also meant to help the project reach overly-ambitious ODF targets with its limited resources and challenging external factors.

Figure 21. WASH Promotion and ODF Strategy

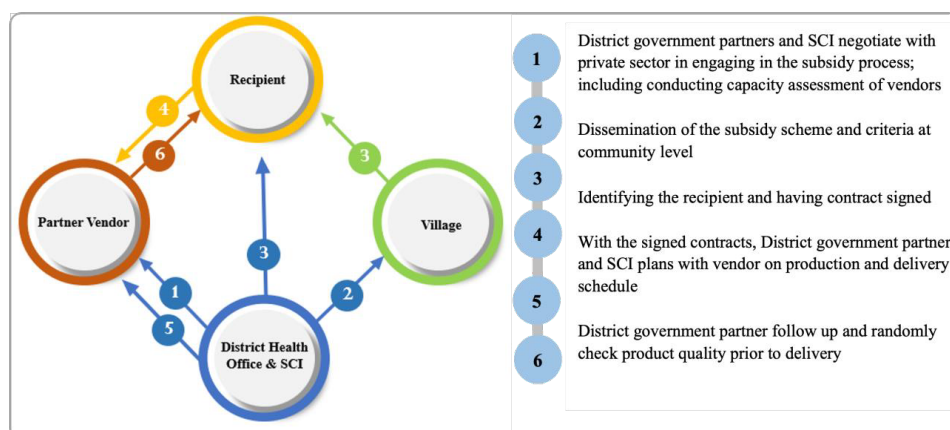


Figure 22. Adolescent Nutrition Poster

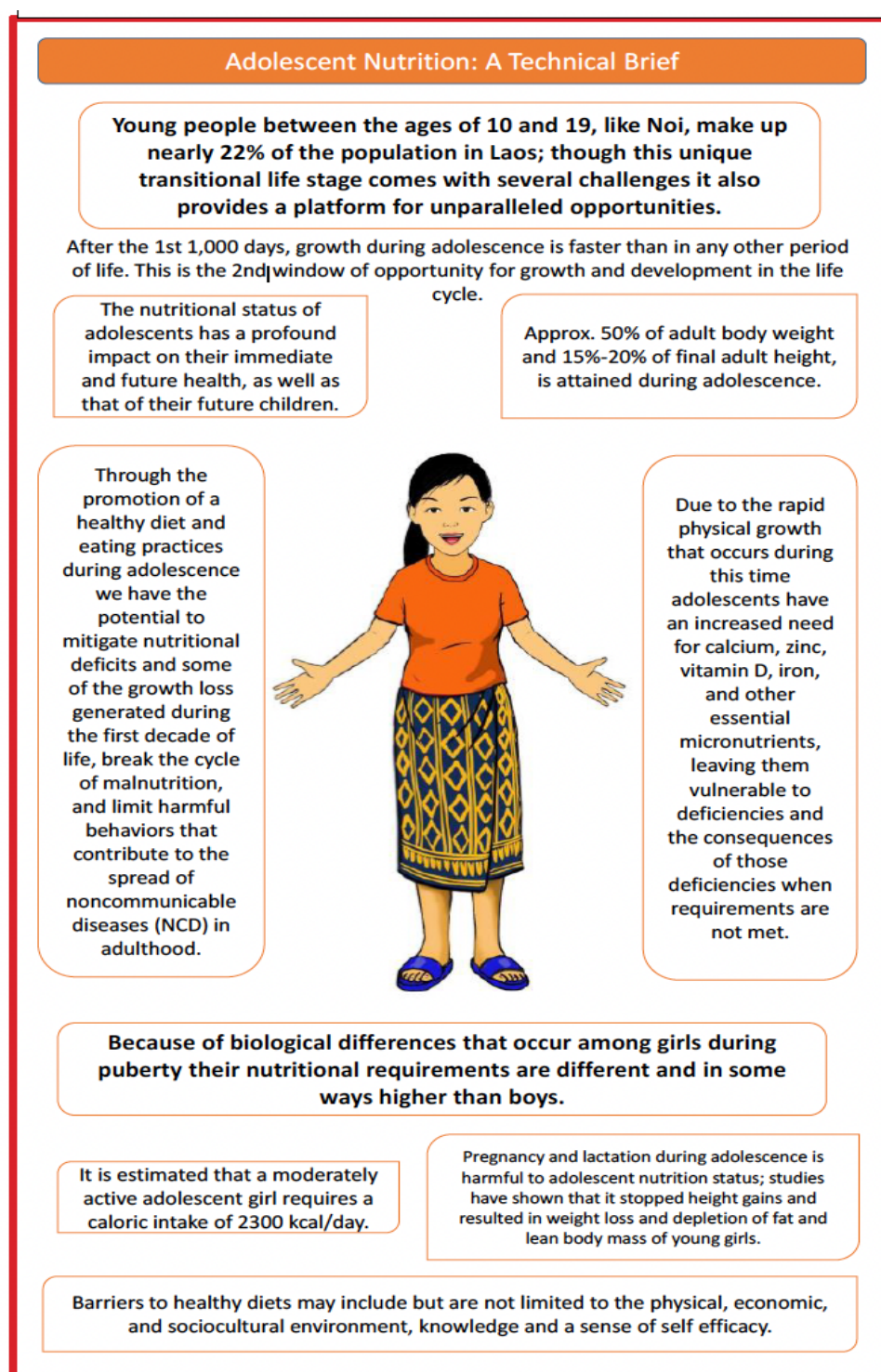


Figure 23. First 1,000 days Counseling Manual



ANNEX B: QUANTITATIVE METHODOLOGY

BASELINE AND MIDLINE

Sampling

Power analysis: To conduct power analysis, the ET used Multiple Indicator Cluster Survey 2012 data to estimate the likelihood of stunting, wasting, and underweight CU2 in the Laos PDR as well as the corresponding degree of intra-class correlation for these outcome variables. Assuming 80 percent power, 15 percent variation in outcomes explained through household-level controls, and a five percent level of significance, the ET estimated the total number of villages in both treatment and control areas to be 375, with eight households per village for a total sample size of 3,000 households.

Villages: To select a similar, yet representative set of treatment and comparison villages for the evaluation, the ET used the following process:

1. Identify the sample frame of potential comparison villages: In order to understand the effects of USAID Nurture, the ET needed to compare treatment villages with similar villages that did not receive a targeted nutrition intervention. This required mapping other donor nutrition interventions in Savannakhet and Khammouane Provinces. Based on discussions with Save the Children and on results from a 2016 donor mapping exercise, the ET identified and excluded from the sample frame villages and districts that were targeted by other interventions.
2. Identify variables associated with treatment: Using the 2015 census data at the village level, the ET ran a logit model to determine which variables were predictive of treatment, as these variables were used in the matching approach to identify similar treatment and comparison villages. SI identified the following variables, which were then used in matching:
 - a. Percent of households with electricity
 - b. Average age of household head
 - c. Average age of first birth for female head of household
 - d. Number of CU2
 - e. Ethnicity
 - f. Percent Buddhist
 - g. Average total number of children in the household
 - h. Average percent of CU5 who died before reaching five years of age
 - i. Percent of household heads who can read in Lao PDR
 - j. Percent female headed households
 - k. Average number of household members
 - l. Average education of household head
 - m. Percent of household heads who are employed
 - n. Total population
 - o. Rural/Urban
 - p. Water supply in village
 - q. Health center in village
3. Select similar treatment and comparison villages: From the sample frame of eligible treatment and comparison villages, the ET sought to sample a set of similar treatment and comparison villages, which were also as representative as possible of the targeted area as a whole. Matching approaches tend to have a trade-off on internal and external validity—by selecting treatment and comparison villages that are as similar as possible and increasing internal validity, we often find this reduces the overall number of matches and their representativeness relative to the full target population, or

external validity. The ET tested variations of two different matching approaches, PSM and CEM, to find which approach offered the best balance on internal and external validity.

- a. In the CEM approach, the ET temporarily “coarsened” the variables used for matching into distinct bins or strata. Every combination of coarsened values for all variables included in the matching represented a unique stratum, and observations with the same coarsened value on every included variable were placed into the same strata. The ET then generated exact matches between treatment and comparison units within the strata of these coarsened variables. Strata that included only treatment or only control observations were pruned from the dataset as they were considered outside a region of common support among the treatment and comparison sample frames. The remaining matched sample (either randomly pruned or weighted in strata with an imbalanced number of treatment and control units) was analyzed using the original, uncoarsened variables. The advantage of this approach was that it allowed for an ex ante determination of the level of imbalance through the researcher’s choice of the degree of coarsening, though with the caveat that finer degrees of coarsening tend to decrease the sample size under common support. To develop the final CEM model, we set the bin sizes for each variable. Some variables have natural bin sizes, such as presence of a health center. For the other variables, we tested multiple permutations of bin sizes, while ensuring that we maintained at least the minimum number of matched treatment and comparison villages, at least required based on our power analysis, at least 173 of each.
- b. Alternatively, PSM allows the researcher to develop a model to predict treatment based on pre-intervention data, which is used to develop a single score that represents the propensity or likelihood of being selected into treatment based on the model variables. These propensity scores can be used for matching. Again, we tested multiple ways of using the propensity scores to determine matches, including taking the nearest neighbors, taking the highest scores, and sampling proportional to district or province populations.
- c. Across all of the CEM and PSM models, we tested each model on:
 - i. Imbalance: We tested for differences between the matched treatment and comparison villages on more than 30 variables from the census data; and
 - ii. External validity: We also tested for differences between the treatment sample and full population of treatment villages on those same 30 variables.
- d. Based on those tests, we found that the PSM model, which sampled treatment-comparison matched pairs with the lowest propensity score difference from each province proportionate to the treatment populations in each province, performed the best.
- e. Using this model, we selected 173 treatment and 173 comparison villages for inclusion in the evaluation.

Households: Our primary unit of analysis around which the sampling approach was designed are first 1,000 days households of pregnant women or women with CU2. To generate our sample, we incorporated multiple stages of sampling. Villages were selected based on the matching approach described above. Within those villages, we randomly selected eight households with pregnant women or CU2 using the following approach:

1. Step 1: We coordinated with district officials to send the survey introduction letter to inform the village head in advance. The letter included the date of survey, target respondents, and information that we needed. We also asked the village head to communicate with the VHV to make a list of households who have CU2.
2. Step 2: The ET took the list from the VHV and checked it with each unit head; this was very important to ensure all relevant households are included in the list by using the questions listed below:

- a. Have any households moved into this village with children but are not included in our list?
- b. Are there any households who just gave birth and are not included in our list?
- c. Are there any households that you are not sure about the age of children and did not include them in our list?

Based on this process, we developed a list of households with CU2 and took a random sample from the list, along with replacements. This process has been used successfully for recent nutrition surveys in Lao PDR.

Within households: Within each selected household, the ET collected data on all pregnant women and all CU5, disaggregated with CU2 and children between six and 23 months of age.

Quantitative Analysis

For quantitative analysis at the midline and endline follow-up points, the ET primarily relied on a DID model that included a range of control variables, shown below. The DID model controls used baseline and follow-up data from the treatment and control groups to control for time invariant factors that might impact outcomes. The model relied on a “parallel trends” assumption, or that the treatment and control villages would have exhibited the same trends in outcomes in the absence of the program. If that assumption was valid, any observed deviation in trends between the treatment and control group could be attributed to the Activity. The ET was limited in ability to test the parallel trends assumption, as there was no repeated pre-intervention data to test whether trends were moving in parallel prior to the intervention. However, by using matching to make the treatment and control groups as similar as possible, the ET reduced the likelihood that trends in outcome would have been different in the absence of the intervention.

As a robustness check, the ET also estimated impacts for each outcome with 10 additional models:

1. DID with PSM at baseline and midline using the standard controls
2. DID with no controls
3. Multiple regression with standard controls using midline observations only
4. Multiple regression with standard controls plus the average outcome at the village level at baseline as an additional control, using midline observations only
5. CEM using midline observations only (various bin sizes tested)
6. CEM using midline observations only (various bin sizes tested) with standard control the average outcome at the village level at baseline as an additional control
7. PSM using nearest neighbor matching with midline observations only
8. PSM using regression adjusted inverse propensity weighting with midline observations only
9. PSM using kernel density matching with midline observations only
10. PSM using regression adjusted kernel density matching with midline observations only

With the exception of the first two alternate models, no other alternates were able to fully utilize baseline data to account for initial differences between treatment and control villages. It is important to consider that matching approaches are more constrained when using cross-sectional data, as is required in this study due to the nature of the target population because households with CU2 at baseline may not be households with CU2 at midline and endline. Accordingly, this report presents results from the primary model, since *a priori* the ET identified it as the most rigorous.

Table 6. Regression Variables at Baseline and Midline

Controls	Goals
Child Demographics	• Stunting
• Age	• Wasting
• Sex	• Underweight
Household Demographics	Outcomes
• Age of Household head	• Early initiation of breastfeeding
• Education level of household head	• Exclusive breastfeeding
• Household head gender (dummy)	• Minimum dietary diversity for children
• Household head non-Lao mother tongue (dummy)	• Minimum meal frequency for children
• Household member with disability	• Minimum Acceptable Diet for children
• Number of people living in home	• Minimum Acceptable Diet for mothers
• Sex of Household head	• Safe drinking water
• Wealth (Asset index)	• Use water treatment technologies
Household Environment	• Hand Washing and hygiene
• Dwelling has electricity	• Basic Sanitation Facility
• Dwelling has roof	• Seeking antenatal services
• HH owns dwelling	• Iron folic acid supplements for mothers
• Household member farms or gardens	• Participate in GMP
• Legal land ownership	• Information received during ANC
• Number of rooms in dwelling	• Information received post-delivery
• Province	

ENDLINE

Sampling

Villages: The ET conducted data collection at endline in a sample of the same villages surveyed at baseline and midline.

Households: Our primary unit of analysis around which the sampling approach was designed are 1,000 days households of pregnant women or women with CU5. To generate our sample, we incorporated multiple stages of sampling:

1. SI worked with IRL to conduct a small phone screen exercise among a random sample of households from baseline and midline (n=100) and found that about 25 percent of phone numbers collected at baseline and midline were both still active and fell within our sample frame.
2. Drawing on results of the phone screen, the ET estimated the sample size that would be feasible by assuming a 25 percent success rate among households with phone numbers recorded at baseline (630 households).
3. IRL attempted each *baseline* household in a random order, making three attempts to contact each household before moving on in the list.
4. IRL attempted each *midline* household in a random order, making three attempts to contact each household before moving on in the list.
5. The ET next pulled a random sample of villages from these baseline and midline data, both treatment and comparison, that IRL contacted for updated contact information for the baseline

and midline households in each village. In order to maximize the endline sample while working within contractual timeline constraints, IRL contacted the sampled village heads to ask for both updated contact information of the baseline and midline households as well as contact information for any new households in the village who may fall within our sample frame.

Within households: Upon reaching the household via phone, the ET first delivered a brief set of screening questions to determine whether the household qualified to participate in the endline survey. If the household was eligible to participate, the ET then worked with the household to select an appropriate respondent. The ideal respondent was a woman of reproductive age who is the primary caregiver of a CU2 and is available for the call. If this was not feasible, the next preferred option was a woman of reproductive age who is the primary caregiver of a CU5 and is available for the call. This method was selected in order to maximize the indicators we can report on with limitations of the phone survey approach.

Quantitative Analysis

The ET used a DID regression approach to estimate impacts on program outcomes at endline. This DID approach uses baseline and follow-up data for both the treatment and comparison group to control for time-invariant outcome predictors. The regressions also control for household attributes hypothesized to affect outcomes of interest. Table 6 summarizes the outcomes and controls used at baseline, midline, and endline. As discussed above, stunting, wasting, and underweight status are not reported at endline due to lack of ability to collect anthropometric data at endline. Four control variables, listed below, were removed at endline to shorten the phone survey duration. To determine control variables that could be removed for endline, the ET ran regressions using baseline and midline data and sequentially removed control variables that accounted for the least variance in key Activity outcomes while maintaining the strength of the overall model.

In addition to the standard DID approach described above, the ET also tested a weighting approach designed to account for known differences in the baseline and endline samples. First, the ET used propensity score matching (PSM) to predict the likelihood for each household of being included in the baseline sample, using the regression control variables as independent variables in the matching. Next, the ET replaced the PSM score with a value of one for all households that were baseline households. Finally, the ET ran the full quantitative analysis using the PSM scores as weights in the regressions. The ET found that results were the same when weighted for nearly all indicators, with the exception of three indicators that went from not significant to significant: 1) percent of households practicing safe disposal of infant/young child feces, 2) percent of households that practice key hygiene behaviors, and 3) percent of children 0-23 months of age who received GMP services. These differences are noted for each indicator in the report body above.

Table 7. Regression Variables

CONTROLS	OUTCOMES
Included at Baseline, Midline, and Endline	
• Number of household members • Gender of household head (dummy) • Age of household head • Education level of household head (dummy) • Number of rooms in dwelling • Dwelling has electricity • Household member farms or gardens • Wealth (asset index) • Dwelling has improved roof • Province	• Participation in GMP • MAD for mothers • Seeking antenatal services • IFA supplements for mothers • Information received during ANC • Information received post-delivery • Early initiation of breastfeeding • EBF • MDD for children • MMF for children • MAD for children • Safe drinking water • Use of water treatment technologies • Handwashing and hygiene behaviors • Use of basic sanitation facility
Included at Baseline and Midline Only	
• Household has a member with a disability • Household owns dwelling • Legal land ownership • Household head non-Laos mother tongue (dummy)	• Stunting • Wasting • Underweight

ANNEX C: EXTERNAL PROGRAMMING

Table 8. External Programming Descriptions

PROJECT	TIMELINE	OBJECTIVE	ACTIVITIES
HPA	September 2017 – August 2021	To improve the nutritional status and food security of 5,000 vulnerable households in 100 villages in six districts, with a special focus on [CU5], women of childbearing age, including minority women, remote poor people and vulnerable groups.	Training, farmer groups, demo plots, behavior change, women's groups, cooking demos, WASH activities, capacity building for govt. staff, coordination with health departments.
AHAN (World Vision)	October 2017 – September 2021	The Accelerating Healthy Agriculture and Nutrition (AHAN) Project will enhance household nutrition focusing on [WRA] and [CU5], from 2018 to 2021, with funding from the European Union.	Ag trainings, farmer groups, village health volunteers, WASH activities, gender analysis, behavior change, coordination of nutrition initiatives.
UNICEF Maternal and Child Health Implementation	Not reported	Khammouane: PNC, DNC, provincial facilitator salary, outreach, IMAM training, joint monitoring Savannakhet: PNC, DNC, provincial facilitator salary, outreach, IMAM training, joint monitoring, prior to 2019 also MNP distribution and IYCF counseling including food demos and other nutrition activities, management of newborn and childhood illness, clinical supervision, capacity building of district health management team.	
UNICEF COVID-19 Support	August 2020 – present	The procurement of key supplies continues in Lao PDR, with hygiene and recreation kits being distributed to Government protection shelters and residential care institutions in total eleven provinces, benefitting 1,084 children.	

Table 9. External Programming Locations

STUDY GROUP	PROVINCE	DISTRICT	HPA IMPLEMENTATION	AHAN (WORLD VISION) IMPLEMENTATION	UNICEF MATERNAL AND CHILD HEALTH IMPLEMENTATION	UNICEF COVID 19 SUPPORT
Treatment	Savannakhet	Atsaphangthong,				Yes
Treatment	Savannakhet	Phine		Yes		Yes
Treatment	Savannakhet	Xonbouly		Yes		Yes
Treatment	Khammouane	Mahaxay	Yes			
Treatment	Khammouane	Nhommalath	Yes			
Treatment	Khammouane	Xaibouathong	Yes			
Control	Savannakhet	Champhone				Yes
Control	Savannakhet	Outhoumphone				Yes
Control	Savannakhet	Vilabuly			Yes	Yes
Control	Khammouane	Bualapha	Yes			
Control	Khammouane	Hinboon			Yes	
Control	Khammouane	Nakai			Yes	

ANNEX D: INDICATORS FOR USAID NURTURE INDEPENDENT EVALUATION

Table 10. Indicator Descriptions and Notes

INDICATOR	SUMMARY DESCRIPTION & UNIT OF MEASUREMENT	NOTES
IYCF PRACTICES: BREASTFEEDING		
Percent of children 0-23 months with breastfeeding initiated in the first hour	This indicator is a measure of early initiation of breastfeeding after birth for the age group 0-23 months	Early initiation of breastfeeding is associated with higher rates of EBF and predominant breastfeeding. EBF for the first six months decreases morbidity and mortality among infants.
Percent of children under six months exclusively breastfed	Percentage of children 0-5 months of age who were exclusively breastfed during the day preceding the survey. EBF may include oral rehydration salts, vitamins, minerals, and medicines, but no other food or liquids	
Median duration of EBF	Measures the median duration of EBF, which WHO recommends be for six months	
Median duration of breastfeeding among children 0-23 months of age	Measures the median duration of breastfeeding, which the WHO recommends continues to at least two years	
Percent of children 12-15 months of age who are fed breastmilk	Measures the continued breastfeeding rate at one year of age	Continued breastfeeding provides nutrition and protection from illness to infants and young children. In Save the Child intervention areas, breastfeeding usually stops at 12-15 months, according to Save the Children's formative research.
Percent of children 0-23 months who are fed breastmilk	Measures the continued breastfeeding rate at two years of age	
Percent of children 0-23 months of age fed using a bottle or teat in the past 24 hours	Measures the frequency of bottle and teat use	Bottle-fed infants are at higher risk of death and disease.
IYCF PRACTICES: COMPLEMENTARY FEEDING		
Percent of children age 6-23 months of age who consume a MAD	MAD measures both the MMF and MDD as appropriate for various age groups. It will measure if a child meets the MMF and MDD for their age group and breastfeeding status	MAD is a standard indicator with a tested module of infant and young child nutrition.
Percent of children 6-23 months of age receiving an animal source protein in the past 24 hours	Measures the pattern of providing an animal source protein (e.g., egg, meat) to children	Nutrient-rich animal-source foods are a diet-nutrient gap in most developing countries, including Lao PDR. Research has shown that increasing such foods in these contexts can improve infant and child growth.

INDICATOR	SUMMARY DESCRIPTION & UNIT OF MEASUREMENT	NOTES
Percent of children 6-23 months of age who received solid, semi-solid, or soft foods of appropriate frequency in the last 24 hours	Measures the pattern of the frequency of introducing complementary foods	Feeding frequency is a component of MAD.
Percent of children 6-23 months of age actively fed in the last 24 hours	Measures if a child is actively or responsively fed by a caregiver	Few studies show a positive association between responsive feeding and child growth, however, there is evidence that caregiver verbalizations during feeding increase child acceptance of food. There is a lack of uniformity in the definition of responsive and active feeding.
Percent of children 0-23 months of age who continued to breastfeed during their episode of illness, among children whose mothers reported fever or diarrhea in the last two weeks	Measures if a child was appropriately fed during last-reported illness	Inadequate feeding during and following infant and young child illness is common in developing countries and contributes to poor growth. Stunting can be related to repeated periods of illnesses in young children.
Percent of children 6-23 months of age who were fed one additional meal in the days following their last episode of fever or diarrhea	Measures if a child was fed appropriately after last-reported illness	
WASH		
Percent of population in target areas practicing open defecation (USAID outcome indicator)	Percent of population have changed their behavior in open defecation to use the sanitation facility and government has certified the ODF	USAID outcome indicator and standardized WASH indicator for evaluating CLTS approaches.
Percent of households using a basic sanitation facility (USAID outcome indicator)	Measures the proportion of households that have use of an improved (basic) sanitation facility	
Percent of caregivers in first 1,000 days households giving safe drinking water to children 6-23 month of age	Measures the proportion of caregivers in first 1,000 days households that give safe drinking water either via boiling, filtering, or purchasing to children 6-23 months of age	Providing safe drinking water for children 6-23 months of age is one of the four to five critical practices included first 1,000 days WASH programs.

INDICATOR	SUMMARY DESCRIPTION & UNIT OF MEASUREMENT	NOTES
Percent of first 1,000 days households in target areas practicing correct use of recommended household water treatment technologies (<i>USAID outcome indicator adjusted for first 1,000 days household focus</i>)	Measures if household have adopted new technology for water treatment: chlorination-chemical disinfection or flocculant and disinfectant (physio-chemical disinfection) - Filtration (physical removal) - Solar disinfection (ultraviolet/heat disinfection) - Boiling (disinfection via heat)	
Percent of first 1,000 days households with soap and water at a handwashing station commonly used by family members (<i>USAID outcome indicator adjusted for first 1,000 days household focus</i>)	Measures if a handwashing station with soap is visible during survey	USAID outcome indicator adjusted for Baby WASH.
Percent of caregivers in first 1,000 days households washing child's hands before eating	Measures if a caregiver in a first 1,000 days household washes child's hands with soap before eating	Washing child's hands before eating is one of the critical handwashing times to decrease disease transmission. Washing young child's hands is promoted in first 1,000 days WASH programs.
Percent of caregivers in first 1,000 days households washing hands after defecating	Measures if a caregiver in a first 1,000 days household washes hands with soap after defecating	Washing hands after defecating is one of the critical handwashing times promoted to decrease disease transmission.
Percent of first 1,000 days households using a clean play space for children six to 24 months of age	Measures if first 1,000 days households have made a clean play space for their young children and if it is used	A clean space will lessen the exposure of young children to animal feces and dirt. Animal feces and dirt carry high amount of e coli bacteria. Establishing a clean play space for young children is one of the four to five activities promoted in Baby WASH programs.
Percent of first 1,000 days households practicing safe disposal of infant and young child feces	Measures if first 1,000 days households are safely disposing of young child feces	Standard measure of CLTS programs, particularly ones adapted to first 1,000 days households.
Percent of caregivers washing hands before preparing young child's food	Measures if caregivers in first 1,000 days households are washing hands before preparing families' and young child's food	One of the critical times to wash hands to decrease transmission of disease.
Percent of caregivers washing hands after cleaning an infant's bottom and disposing of his/her child's feces	Measures if caregivers in first 1,000 days households are washing hands after changing an infant or young child and disposing of their feces	One of the critical times to wash hands to decrease transmission of disease.

INDICATOR	SUMMARY DESCRIPTION & UNIT OF MEASUREMENT	NOTES
HEALTH/NUTRITION SERVICES AND INFORMATION PROVIDED TO MOTHERS		
Percent of children 0-23 months of age who received GMP	Measures the proportion of children who received GMP as per national protocols delivered by the health care system	Evidence is mixed on the role GMP plays in promoting young child growth. The promotion component, including building the capacity of health staff to provide child feeding guidance and assess growth problems and counsel mothers, is key.
Percent of pregnant women with an MAD	Measures the proportion of pregnant women who eat an adequate diet that is diverse and of sufficient quantities and frequencies	Dietary diversity has been shown to be a proxy for dietary adequacy and a module to assess MDD has been developed and validated.
Percent of mothers of children 0-23 months of age who reported receiving breastfeeding information during ANC among those with at least one ANC visit	Measures the proportion of women who received breastfeeding information during ANC (among those with at least one ANC visit)	Health staff counseling and dissemination of information has been shown to be an effective breastfeeding promotion strategy.
Percent of mothers of children 0-23 months of age who reported receiving IFA during ANC, among those with at least one ANC visit	This indicator measures the percentage of women who received the recommended amounts of supplements for IFA during pregnancy. It provides information about the quality of ANC services and/or women's access to purchasing supplements through local pharmacies and community-based sources.	If according to Ministry of Health protocols, IFA supplements are distributed by health facilities during ANC visits, their provision is an indicator of the quality of the health system. Pregnant women who consistently take IFA supplements have less anemia, and better birth outcomes in turn.
Percent of mothers with children 0-23 months of age who reported receiving help with positioning and attachment from a health care provider post-delivery	Measures the proportion of women who received breastfeeding support from a health care provider after delivery	Health staff breastfeeding counseling and support has been shown to improve breastfeeding rates.
Percent of mothers who report receiving sick child feeding advice during their sick child visits	Measures the proportion of mothers who received information about continued breastfeeding and/or feeding an extra meal to children during illness and recovery, among women who reported seeking care for sick children	Repeated episodes of illness increase a young child's risk of poor growth; sick children suffer from poor appetites, and often caregivers feed sick children less than usual. Provision of appropriate feeding information during illness can help to support increased feeding and potentially minimize weight loss.

INDICATOR	SUMMARY DESCRIPTION & UNIT OF MEASUREMENT	NOTES
Percent of mothers who report receiving WASH information during their sick child visits	Measures the proportion of women who received information about any of the following: hand washing, household water treatment, safe disposal of feces, and clean play spaces for children among women who reported seeking care for sick children	One of the tenets of integrated programming is the provision and reinforcement of information and messages during client contact, particularly information related to new behaviors being promoted, such as reinforcing critical WASH information during sick child visits.

ANNEX E: SUMMARY OF KEY INDICATORS

Table 11. Household Indicators (Baseline-Endline)

INDICATOR	BASELINE CONTROL	ENDLINE CONTROL	CONTROL CHANGE	BASELINE TREATMENT	ENDLINE TREATMENT	TREATMENT CHANGE	DID	BASELINE SAMPLE SIZE	ENDLINE SAMPLE SIZE
Percent of population in targeted areas practicing open defecation	39.6%	6.4%	-0.33	45.4%	9.9%	-0.36	-0.02	2756	411
Khammouane	38.8%	5.7%	-0.33	52.9%	12.0%	-0.41	-0.08	1175	212
Savannakhet	40.2%	6.9%	-0.33	39.9%	7.1%	-0.33	0.01	1581	199
Percent of households using a basic (improved) sanitation facility	60.4%	93.6%	0.33	54.2%	89.7%	0.36	0.02	2756	411
Khammouane	61.2%	94.3%	0.33	46.4%	87.2%	0.41	0.08	1175	212
Savannakhet	59.8%	93.1%	0.33	60.0%	92.9%	0.33	0.00	1581	199
Percent of caregivers in first 1,000 days households giving safe drinking water to children 6-23 month of age	70.8%	94.1%	0.23	74.8%	93.7%	0.19	-0.04	2754	411
Khammouane	74.7%	93.1%	0.18	78.7%	94.4%	0.16	-0.03	1173	212
Savannakhet	67.8%	95.0%	0.27	72.0%	92.9%	0.21	-0.06	1581	199
Percent of first 1,000 days households in target areas practicing correct use of recommended household water treatment technologies	47.6%	54.3%	0.07	39.9%	55.2%	0.15	0.09	2751	411
Khammouane	51.5%	60.9%	0.09	47.3%	60.8%	0.14	0.04	1170	212
Savannakhet	44.6%	48.5%	0.04	34.3%	48.0%	0.14	0.10	1581	199

INDICATOR	BASELINE CONTROL	ENDLINE CONTROL	CONTROL CHANGE	BASELINE TREATMENT	ENDLINE TREATMENT	TREATMENT CHANGE	DID	BASELINE SAMPLE SIZE	ENDLINE SAMPLE SIZE
Percent of first 1,000 days households with soap and water at a handwashing station commonly used by family members	61.9%	84.6%	0.23	62.0%	89.2%	0.27	0.05	2667	411
Khammouane	56.1%	81.6%	0.26	61.7%	90.4%	0.29	0.03	1139	212
Savannakhet	66.2%	87.1%	0.21	62.3%	87.8%	0.26	0.05	1528	199
Percent of caregivers in first 1,000 days households washing child's hands before eating	19.8%	77.7%	0.58	19.5%	73.5%	0.54	-0.04	2754	411
Khammouane	26.6%	73.6%	0.47	22.7%	74.4%	0.52	0.05	1173	212
Savannakhet	14.7%	81.2%	0.67	17.2%	72.4%	0.55	-0.11	1581	199
Percent of caregivers in first 1,000 days households washing hands after defecating	5.7%	9.6%	0.04	4.8%	15.2%	0.10	0.07	2754	411
Khammouane	10.6%	8.0%	-0.03	6.3%	11.2%	0.05	0.08	1173	212
Savannakhet	2.0%	10.9%	0.09	3.7%	20.4%	0.17	0.08	1581	199
Percent of caregivers who wash their hands after defecating	20.4%	22.3%	0.02	19.6%	27.8%	0.08	0.06	2753	411
Khammouane	20.8%	16.1%	-0.05	24.2%	26.4%	0.02	0.07	1173	212
Savannakhet	20.2%	27.7%	0.08	16.2%	29.6%	0.13	0.06	1580	199
Percent of first 1,000 days households using a clean play space for children six to 24 months of age	44.5%	57.4%	0.13	41.5%	62.3%	0.21	0.08	2756	411
Khammouane	45.5%	62.1%	0.17	44.4%	65.6%	0.21	0.05	1175	212
Savannakhet	43.7%	53.5%	0.10	39.4%	58.2%	0.19	0.09	1581	199

INDICATOR	BASELINE CONTROL	ENDLINE CONTROL	CONTROL CHANGE	BASELINE TREATMENT	ENDLINE TREATMENT	TREATMENT CHANGE	DID	BASELINE SAMPLE SIZE	ENDLINE SAMPLE SIZE
Percent of first 1,000 days households practicing safe disposal of infant/young child feces	10.3%	66.1%	0.56	6.9%	64.5%	0.58	0.02	2637	406
Khammouane	10.4%	68.6%	0.58	4.6%	66.9%	0.62	0.04	1131	210
Savannakhet	10.2%	64.0%	0.54	8.6%	61.5%	0.53	-0.01	1506	196
Percent of caregivers washing hands before preparing young child's food	32.7%	34.0%	0.01	28.1%	36.3%	0.08	0.07	2753	411
Khammouane	34.0%	33.3%	-0.01	30.3%	40.8%	0.11	0.11	1173	212
Savannakhet	31.8%	34.7%	0.03	26.4%	30.6%	0.04	0.01	1580	199
Percent of caregivers washing hands after cleaning an infant's bottom and disposing of his/her child's feces	9.0%	3.7%	-0.05	5.1%	4.0%	-0.01	0.04	2753	411
Khammouane	9.2%	2.3%	-0.07	6.5%	5.6%	-0.01	0.06	1173	212
Savannakhet	8.9%	5.0%	-0.04	4.0%	2.0%	-0.02	0.02	1580	199
Percent of women achieving MAD	11.0%	57.0%	0.46	5.8%	57.2%	0.51	0.05	2756	380
Khammouane	7.3%	59.5%	0.52	4.6%	51.3%	0.47	-0.06	1175	201
Savannakhet	13.8%	54.5%	0.41	6.7%	64.8%	0.58	0.17	1581	179
Percent of women with a live birth who received at least 4 ANC visits	60.7%	88.8%	0.28	59.9%	89.4%	0.30	0.01	2702	387
Khammouane	64.8%	95.2%	0.30	67.1%	92.5%	0.25	-0.05	1171	204
Savannakhet	57.6%	83.2%	0.26	54.3%	85.2%	0.31	0.05	1531	183
Percent of women with a live birth in who received ANC within the first 12 weeks of pregnancy	34.3%	58.6%	0.24	27.8%	66.4%	0.39	0.14	2704	398
Khammouane	40.7%	69.0%	0.28	34.8%	79.5%	0.45	0.16	1171	206

INDICATOR	BASELINE CONTROL	ENDLINE CONTROL	CONTROL CHANGE	BASELINE TREATMENT	ENDLINE TREATMENT	TREATMENT CHANGE	DID	BASELINE SAMPLE SIZE	ENDLINE SAMPLE SIZE
Savannakhet	29.4%	49.5%	0.20	22.4%	49.5%	0.27	0.07	1533	192
Percent of first 1,000 days households who can recall a nutrition-related action	25.1%	56.3%	0.31	28.3%	64.8%	0.37	0.05	2756	402
Khammouane	17.7%	63.1%	0.45	27.0%	68.3%	0.41	-0.04	1175	207
Savannakhet	30.7%	50.5%	0.20	29.2%	60.4%	0.31	0.11	1581	195
Percent of mothers who reported receiving breastfeeding information during ANC, among those with at least 1 ANC visit	59.7%	88.2%	0.29	62.9%	90.0%	0.27	-0.01	2268	381
Khammouane	57.2%	88.0%	0.31	66.5%	89.2%	0.23	-0.08	1004	203
Savannakhet	61.6%	88.5%	0.27	60.0%	91.2%	0.31	0.04	1264	178
Percent of mothers who reported receiving iron and folic acid during ANC, among those with at least 1 ANC visit	94.0%	98.2%	0.04	93.0%	99.1%	0.06	0.02	2277	385
Khammouane	95.3%	98.8%	0.03	93.0%	99.2%	0.06	0.03	1007	205
Savannakhet	92.9%	97.7%	0.05	93.1%	98.9%	0.06	0.01	1270	180
Percent of mothers who reported receiving help with positioning and attachment from a health care provider post-delivery	17.4%	65.7%	0.48	20.4%	75.5%	0.55	0.07	2700	397
Khammouane	20.0%	69.0%	0.49	23.4%	77.0%	0.54	0.05	1167	206
Savannakhet	15.5%	62.9%	0.47	18.2%	73.4%	0.55	0.08	1533	191

INDICATOR	BASELINE CONTROL	ENDLINE CONTROL	CONTROL CHANGE	BASELINE TREATMENT	ENDLINE TREATMENT	TREATMENT CHANGE	DID	BASELINE SAMPLE SIZE	ENDLINE SAMPLE SIZE
Percent of households that practice key hygiene behaviors (feces disposal, treating water, and handwashing)	4.5%	33.9%	0.29	2.8%	35.0%	0.32	0.03	2547	406
Khammouane	4.7%	38.4%	0.34	1.3%	40.3%	0.39	0.05	1092	210
Savannakhet	4.3%	30.0%	0.26	4.0%	28.1%	0.24	-0.02	1455	196
Mean number of food groups consumed by WRA	3.08	4.99	1.91	2.95	4.99	2.03	0.12	2756	380
Khammouane	2.77	5.04	2.27	2.92	4.71	1.79	-0.48	1175	201
Savannakhet	3.31	4.96	1.64	2.98	5.34	2.37	0.72	1581	179

Table 12. Household Indicators (Midline-Endline)

INDICATOR ^a	MIDLINE CONTROL	ENDLINE CONTROL	CONTROL CHANGE	MIDLINE TREATMENT	ENDLINE TREATMENT	TREATMENT CHANGE	DID	MIDLINE SAMPLE SIZE	ENDLINE SAMPLE SIZE
Percent of mothers who report receiving sick child feeding advice during their sick child visits	41.6%	56.4%	0.15	48.1%	65.2%	0.17	0.02	1,716	85
Khammouane	46.2%	55.6%	0.09	49.6%	74.1%	0.24	0.15	764	45
Savannakhet	38.2%	57.1%	0.19	46.9%	52.6%	0.06	-0.13	952	40
Percent of mothers who report receiving WASH information during their sick child visits	41.7%	58.3%	0.17	51.6%	72.3%	0.21	0.04	1,720	83
Khammouane	48.3%	64.7%	0.16	53.8%	70.4%	0.17	0.00	764	44
Savannakhet	36.7%	52.6%	0.16	49.7%	75.0%	0.25	0.09	956	39

^a The questions for these indicators were revised between baseline and midline; thus, we report midline-endline comparisons rather than baseline-endline.

Table 13. Roster Indicators (Baseline-Endline)

INDICATOR	BASELINE CONTROL	ENDLINE CONTROL	CONTROL CHANGE	BASELINE TREATMENT	ENDLINE TREATMENT	TREATMENT CHANGE	DID	BASELINE SAMPLE SIZE	ENDLINE SAMPLE SIZE
Percent of CU2 with breastfeeding initiated in the first hour (colostrum)	41.4%	59.1%	0.18	45.5%	58.9%	0.13	-0.04	2820	100
Khammouane	38.9%	75.0%	0.36	47.8%	64.5%	0.17	-0.19	1198	51
Savannakhet	43.2%	45.8%	0.03	43.8%	52.0%	0.08	0.06	1622	49
Male	39.8%	62.5%	0.23	45.9%	66.7%	0.21	-0.02	1435	54
Female	43.1%	55.0%	0.12	45.1%	50.0%	0.05	-0.07	1385	46
Percent of children 12-15 months who are fed breastmilk	77.2%	57.1%	-0.20	73.3%	66.7%	-0.07	0.14	462	23
Khammouane	79.4%	80.0%	0.01	79.6%	60.0%	-0.20	-0.20	190	10
Savannakhet	75.4%	44.4%	-0.31	69.5%	75.0%	0.05	0.37	272	13
Male	75.8%	37.5%	-0.38	73.1%	60.0%	-0.13	0.25	244	13
Female	78.4%	83.3%	0.05	73.5%	75.0%	0.02	-0.03	218	10
Percent of CU2 who are fed breastmilk	76.8%	47.7%	-0.29	76.6%	55.4%	-0.21	0.08	2812	100
Khammouane	76.9%	65.0%	-0.12	76.8%	58.1%	-0.19	-0.07	1198	51
Savannakhet	76.7%	33.3%	-0.43	76.4%	52.0%	-0.24	0.19	1614	49
Male	76.9%	29.2%	-0.48	73.3%	50.0%	-0.23	0.24	1430	54
Female	76.7%	70.0%	-0.07	80.0%	61.5%	-0.19	-0.12	1382	46
Percent of CU2 fed using a bottle or teat in the past 24 hours	37.8%	70.7%	0.33	30.1%	61.5%	0.31	-0.02	2843	93
Khammouane	30.6%	63.2%	0.33	28.0%	60.7%	0.33	0.00	1198	47

INDICATOR	BASELINE CONTROL	ENDLINE CONTROL	CONTROL CHANGE	BASELINE TREATMENT	ENDLINE TREATMENT	TREATMENT CHANGE	DID	BASELINE SAMPLE SIZE	ENDLINE SAMPLE SIZE
Savannakhet	42.9%	77.3%	0.34	31.6%	62.5%	0.31	-0.04	1645	46
Male	37.2%	81.0%	0.44	32.2%	58.6%	0.26	-0.17	1446	50
Female	38.3%	60.0%	0.22	27.8%	65.2%	0.37	0.16	1397	43
Percent of children 6–23 months who achieve MMF	55.8%	63.4%	0.08	55.0%	56.9%	0.02	-0.06	1884	92
Khammouane	38.6%	68.4%	0.30	57.6%	51.9%	-0.06	-0.36	822	46
Savannakhet	69.2%	59.1%	-0.10	53.0%	62.5%	0.10	0.20	1062	46
Male	58.5%	71.4%	0.13	57.6%	57.1%	-0.01	-0.13	946	49
Female	53.3%	55.0%	0.02	52.3%	56.5%	0.04	0.03	938	43
Percent of children 6–23 months who achieve MDD	13.5%	46.5%	0.33	12.1%	48.2%	0.36	0.03	1906	99
Khammouane	13.1%	42.1%	0.29	11.2%	51.6%	0.40	0.11	840	50
Savannakhet	13.8%	50.0%	0.36	12.8%	44.0%	0.31	-0.05	1066	49
Male	14.6%	52.2%	0.38	11.6%	53.3%	0.42	0.04	959	53
Female	12.5%	40.0%	0.28	12.6%	42.3%	0.30	0.02	947	46
Percent of children age 6–23 months of age who consume a MAD	7.5%	29.3%	0.22	6.4%	31.4%	0.25	0.03	1888	92
Khammouane	3.9%	21.1%	0.17	5.3%	33.3%	0.28	0.11	824	46
Savannakhet	10.2%	36.4%	0.26	7.3%	29.2%	0.22	-0.04	1064	46
Male	9.3%	33.3%	0.24	6.2%	35.7%	0.30	0.06	948	49
Female	5.7%	25.0%	0.19	6.7%	26.1%	0.19	0.00	940	43

INDICATOR	BASELINE CONTROL	ENDLINE CONTROL	CONTROL CHANGE	BASELINE TREATMENT	ENDLINE TREATMENT	TREATMENT CHANGE	DID	BASELINE SAMPLE SIZE	ENDLINE SAMPLE SIZE
Percent of children 6-23 months receiving an animal source protein in the past 24 hours	51.5%	72.1%	0.21	54.7%	57.1%	0.02	-0.18	2048	99
Khammouane	49.2%	73.7%	0.25	57.5%	48.4%	-0.09	-0.34	872	50
Savannakhet	53.3%	70.8%	0.18	52.6%	68.0%	0.15	-0.02	1176	49
Male	54.2%	69.6%	0.15	53.8%	63.3%	0.10	-0.06	1030	53
Female	48.9%	75.0%	0.26	55.6%	50.0%	-0.06	-0.32	1018	46
Percent of children 6-23 months of age who were fed one additional meal in the days following their last episode of fever or diarrhea	1.6%	4.9%	0.03	1.5%	1.9%	0.00	-0.03	1909	93
Khammouane	2.9%	5.3%	0.02	2.9%	0.0%	-0.03	-0.05	825	47
Savannakhet	0.6%	4.5%	0.04	0.4%	4.2%	0.04	0.00	1084	46
Male	1.3%	0.0%	-0.01	1.4%	3.4%	0.02	0.03	955	50
Female	1.9%	10.0%	0.08	1.5%	0.0%	-0.02	-0.10	954	43
Percent of CUS who received GMP services	65.5%	97.8%	0.32	69.3%	96.3%	0.27	-0.05	1921	402
Khammouane	66.4%	98.8%	0.32	75.8%	100.0%	0.24	-0.08	828	207

INDICATOR	BASELINE CONTROL	ENDLINE CONTROL	CONTROL CHANGE	BASELINE TREATMENT	ENDLINE TREATMENT	TREATMENT CHANGE	DID	BASELINE SAMPLE SIZE	ENDLINE SAMPLE SIZE
Savannakhet	64.8%	97.0%	0.32	64.4%	91.7%	0.27	-0.05	1093	195
Male	64.6%	100.0%	0.35	69.5%	97.2%	0.28	-0.08	961	197
Female	66.3%	95.7%	0.29	69.1%	95.5%	0.26	-0.03	960	205
Percent of CU2 who received GMP services	65.5%	100.0%	0.35	69.3%	94.6%	0.25	-0.09	1921	100
Khammouane	66.4%	100.0%	0.34	75.8%	100.0%	0.24	-0.09	828	51
Savannakhet	64.8%	100.0%	0.35	64.4%	88.0%	0.24	-0.12	1093	49
Male	64.6%	100.0%	0.35	69.5%	96.7%	0.27	-0.08	961	54
Female	66.3%	100.0%	0.34	69.1%	92.3%	0.23	-0.11	960	46
Median duration of EBF	1.7	5.1	3.41	1.9	6.2	4.25	0.84	2845	93
Khammouane	1.9	6.2	4.23	2.2	6.0	3.76	-0.47	1198	47
Savannakhet	1.6	4.3	2.68	1.7	6.3	4.67	1.99	1647	46
Male	1.7	4.8	3.10	1.7	7.2	5.46	2.36	1447	50
Female	1.8	5.5	3.74	2.1	4.8	2.76	-0.98	1398	43
Median duration of breastfeeding	7.3	6.1	-1.15	7.3	9.4	2.09	3.24	667	48
Khammouane	9.0	8.0	-1.02	9.0	8.9	-0.04	0.99	288	20
Savannakhet	6.0	5.3	-0.65	6.0	9.8	3.85	4.50	379	28
Male	7.3	6.2	-1.09	7.1	8.0	0.93	2.02	362	32
Female	7.3	6.0	-1.29	7.5	11.4	3.87	5.16	305	16

Table 14. Roster Indicators (Midline-Endline)

INDICATOR ^a	MIDLINE CONTROL	ENDLINE CONTROL	CONTROL CHANGE	MIDLINE TREATMENT	ENDLINE TREATMENT	TREATMENT CHANGE	DID	MIDLINE SAMPLE SIZE	ENDLINE SAMPLE SIZE
Percent of CU2 actively fed in the last 24 hours	79.8%	76.7%	-0.03	77.1%	82.1%	0.05	0.08	1,913	99
Khammouane	88.9%	73.7%	-0.15	81.2%	80.7%	-0.01	0.15	838	50
Savannakhet	72.8%	79.2%	0.06	73.9%	84.0%	0.10	0.04	1,075	49
Male	80.5%	69.6%	-0.11	76.4%	80.0%	0.04	0.15	971	53
Female	79.0%	85.0%	0.06	77.9%	84.6%	0.07	0.01	942	46

^a The questions for these indicators were revised between baseline and midline; thus, we report midline-endline comparisons rather than baseline-endline.

ANNEX F: REGRESSION TABLES

Variables	Percent of population in targeted areas practicing open defecation		Percent of households using a basic (improved) sanitation facility		Percent of caregivers in first 1,000 days households giving safe drinking water to children 6-23 month of age		Percent of first 1,000 days households in target areas practicing correct use of recommended household water treatment technologies	
	Coefficient	p value	Coefficient	p value	Coefficient	p value	Coefficient	p value
Endline Nurture	0.1471	0.749	-0.1808	0.695	-0.2657	0.581	0.3846	0.157
Number of household members	0.1493	0	-0.147	0	-0.1297	0	-0.0209	0.355
Female household head	-0.2213	0.185	0.2414	0.151	0.1372	0.424	-0.0318	0.8
Age of household head	-0.0285	0	0.028	0	0.0154	0	0.0051	0.138
Low education of household head	0.6784	0	-0.6961	0	-0.473	0	-0.186	0.039
Number of rooms in dwelling	-0.1159	0.039	0.1103	0.047	0.0668	0.272	0.0336	0.474
Dwelling has electricity	0.0824	0.644	-0.0793	0.656	-0.1306	0.442	0.4694	0.002
Household member farms or gardens	0.4061	0.004	-0.4188	0.003	-0.1983	0.151	0.1179	0.292
Wealth (asset index)	-0.7911	0	0.7941	0	0.6031	0	0.0601	0.086
Dwelling has improved roof	0.6031	0.065	-0.5313	0.1	-1.0956	0	-0.0216	0.944
Province	0.0493	0.748	-0.0303	0.844	-0.5623	0	-0.4876	0

Variables	Percent of first 1,000 days households with soap and water at a handwashing station commonly used by family members		Percent of caregivers in first 1,000 days households washing child's hands before eating		Percent of caregivers in first 1,000 days households washing hands after defecating		Percent of caregivers who wash their hands after defecating	
	Coefficient	p value	Coefficient	p value	Coefficient	p value	Coefficient	p value
Endline Nurture	0.4612	0.233	-0.2858	0.288	0.617	0.129	0.3923	0.144
Number of household members	-0.1042	0	-0.0373	0.171	-0.0586	0.167	-0.0843	0.002
Female household head	0.269	0.105	0.1911	0.144	0.3601	0.15	0.018	0.907
Age of household head	0.0055	0.138	-0.001	0.815	0.0095	0.122	0.0134	0.001
Low education of household head	-0.545	0	-0.2405	0.02	-0.5894	0.001	-0.5755	0
Number of rooms in dwelling	0.1087	0.046	0.073	0.214	0.0374	0.704	0.0633	0.217
Dwelling has electricity	-0.0292	0.856	0.0484	0.782	-0.4801	0.09	-0.0413	0.83
Household member farms or gardens	-0.0551	0.655	-0.3885	0.002	-0.4748	0.015	-0.0616	0.633
Wealth (asset index)	0.5	0	0.1445	0	0.2022	0.001	0.2147	0
Dwelling has improved roof	-0.2192	0.429	0.293	0.458	-0.664	0.273	-0.075	0.839
Province	0.0828	0.433	-0.4428	0	-0.7247	0	-0.276	0.006

Variables	Percent of first 1,000 days households using a clean play space for children 6 to 24 months of age		Percent of first 1,000 days households practicing safe disposal of infant/young child feces		Percent of caregivers washing hands before preparing young child's food		Percent of caregivers washing hands after cleaning an infant's bottom and disposing of his/her child's feces	
	Coefficient	p value	Coefficient	p value	Coefficient	p value	Coefficient	p value
Endline Nurture	0.2865	0.17	0.4103	0.144	0.3129	0.203	0.5529	0.326
Number of household members	-0.0438	0.037	-0.107	0.002	-0.0904	0	-0.0595	0.193
Female household head	0.0202	0.874	0.5205	0.011	-0.0019	0.989	0.286	0.23
Age of household head	0.0049	0.12	0.0098	0.042	0.0056	0.116	0.0015	0.825
Low education of household head	-0.0477	0.6	-0.4816	0	-0.2692	0.004	-0.1148	0.465
Number of rooms in dwelling	0.023	0.598	0.1186	0.098	0.0879	0.062	-0.0594	0.495
Dwelling has electricity	0.4125	0.005	0.2305	0.443	0.0413	0.808	0.0175	0.96
Household member farms or gardens	-0.1955	0.082	-0.3791	0.021	-0.2174	0.041	-0.8349	0
Wealth (asset index)	-0.0037	0.911	0.2694	0	0.1819	0	0.233	0
Dwelling has improved roof	-0.074	0.782	-0.0111	0.98	0.1705	0.583	-0.4661	0.416
Province	-0.1114	0.191	0.016	0.917	-0.1722	0.093	-0.1159	0.512

Variables	Percent of women achieving MAD		Percent of women with a live birth who received at least 4 ANC visits		Percent of women with a live birth in who received ANC within the first 12 weeks of pregnancy		Percent of first 1,000 days households who can recall a nutrition related action	
	Coefficient	p value	Coefficient	p value	Coefficient	p value	Coefficient	p value
Endline Nurture	0.771	0.006	-0.1309	0.721	0.6059	0.027	0.2335	0.334
Number of household members	-0.0238	0.432	-0.1276	0	-0.0855	0	-0.0351	0.117
Female household head	0.1059	0.61	0.1665	0.248	0.137	0.305	0.2767	0.043
Age of household head	0.0045	0.392	0.0061	0.108	0.0033	0.339	-0.0028	0.415
Low education of household head	-0.2467	0.078	-0.6228	0	-0.3305	0	-0.3153	0.001
Number of rooms in dwelling	-0.048	0.445	0.0577	0.247	0.0323	0.526	0.0585	0.235
Dwelling has electricity	0.4487	0.183	-0.0309	0.852	0.1413	0.394	0.6885	0
Household member farms or gardens	-0.0704	0.657	-0.1538	0.192	-0.0849	0.48	0.4659	0
Wealth (asset index)	0.2789	0	0.4168	0	0.1961	0	0.0383	0.288
Dwelling has improved roof	-0.3739	0.44	-0.0539	0.831	0.8036	0.036	-0.1469	0.607
Province	0.4172	0.003	-0.5835	0	-0.7004	0	0.2189	0.058

Variables	Percent of mothers who reported receiving breastfeeding information during ANC, among those with at least 1 ANC visit		Percent of mothers who reported receiving iron and folic acid during ANC, among those with at least 1 ANC visit		Percent of mothers who reported receiving help with positioning and attachment from a health care provider post delivery		Mean number of food groups consumed by WRA	
	Coefficient	p value	Coefficient	p value	Coefficient	p value	Coefficient	p value
Endline Nurture	0.0077	0.982	0.6635	0.499	0.2671	0.331	0.1428	0.377
Number of household members	-0.0392	0.129	-0.1283	0.002	-0.0824	0.003	-0.0313	0.019
Female household head	0.1342	0.381	0.3069	0.371	0.0977	0.556	0.0251	0.74
Age of household head	0.0012	0.732	0.013	0.104	0.0134	0.001	0.0014	0.457
Low education of household head	-0.3206	0.001	-0.5774	0.01	-0.2913	0.006	-0.1777	0
Number of rooms in dwelling	-0.0232	0.657	-0.0937	0.347	0.051	0.368	0.0433	0.072
Dwelling has electricity	0.1883	0.241	0.0331	0.902	0.2705	0.168	0.0665	0.384
Household member farms or gardens	-0.2278	0.07	-0.4263	0.129	-0.2028	0.148	-0.0257	0.666
Wealth (asset index)	0.0704	0.072	0.3216	0	0.1526	0.001	0.1639	0
Dwelling has improved roof	0.6289	0.047	0.0752	0.876	0.6794	0.099	-0.1223	0.314
Province	-0.0124	0.904	-0.2083	0.311	-0.3969	0.001	0.2675	0

Variables	Percent of children 0 23 months with breastfeeding initiated in the first hour (colostrum)		Percent of children 12 15 months who are fed breastmilk		Percent of children 0 23 months who are fed breastmilk		Percent of children 0 23 months of age fed using a bottle or teat in the past 24 hours		Percent of children 6 23 months receiving an animal source protein in the past 24 hours	
	Coefficient	p value	Coefficient	p value	Coefficient	p value	Coefficient	p value	Coefficient	p value
Endline Nurture	-0.1849	0.638	0.194	0.839	0.845	0.085	-0.3367	0.476	-0.9829	0.062
Number of household members	-0.0092	0.673	0.1435	0.08	0.047	0.093	-0.0793	0.001	-0.1168	0
Female household head	-0.0782	0.531	-0.0197	0.96	-0.29	0.092	0.2606	0.068	-0.145	0.373
Age of household head	0.0043	0.215	0.0014	0.884	-0.0018	0.671	0.0116	0.001	0.0066	0.087
Low education of household head	-0.0856	0.333	0.1782	0.501	0.2063	0.069	-0.2449	0.01	-0.0882	0.421
Number of rooms in dwelling	-0.0013	0.978	-0.0302	0.845	0.0077	0.905	-0.0398	0.418	-0.0636	0.261
Dwelling has electricity	-0.2171	0.11	-0.2163	0.657	0.2483	0.178	0.5606	0.007	0.1561	0.388
Household member farms or gardens	0.052	0.638	0.7231	0.031	0.4359	0.001	-0.3343	0.004	0.0548	0.677
Wealth (asset index)	0.0501	0.141	-0.5224	0	-0.39	0	0.2766	0	0.1053	0.01
Dwelling has improved roof	0.3174	0.321	0.7025	0.469	-0.3752	0.501	0.6026	0.165	0.4283	0.334
Province	-0.0693	0.465	-0.5357	0.056	-0.1462	0.244	0.3643	0.002	0.0745	0.489
Age (in months)	0.0116	0.041	-0.4339	0	-0.1474	0	0.0214	0.001	0.1019	0

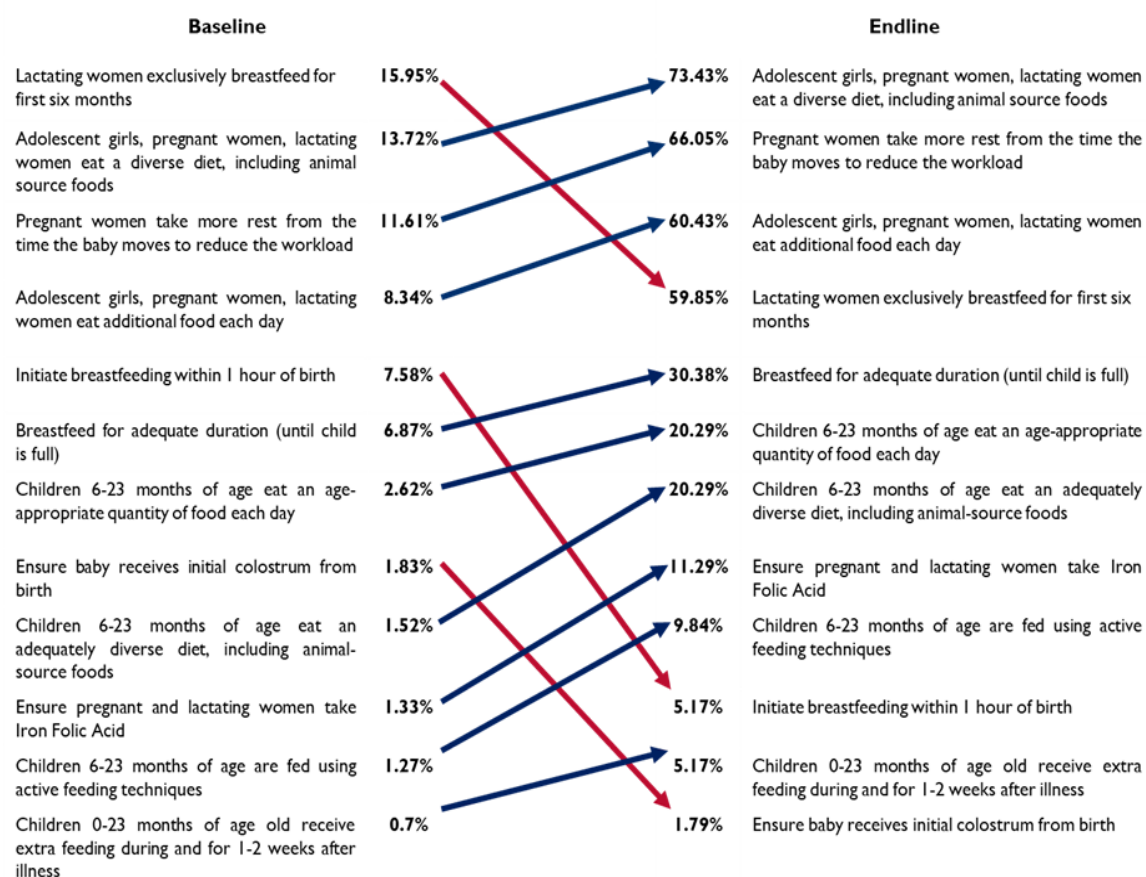
Variables	Percent of children 0-23 months actively fed in the last 24 hours ^a		Percent of children 6-23 months who achieve MMF		Percent of children 6-23 months who achieve MDD		Percent of children age 6-23 months of age who consume a minimum acceptable diet (MAD)		Percent of children 6-23 months of age who were fed one additional meal in the days following their last episode of fever or diarrhea	
	Coefficient	p value	Coefficient	p value	Coefficient	p value	Coefficient	p value	Coefficient	p value
Endline Nurture	0.4059	0.474	-0.2203	0.638	-0.0197	0.969	0.2192	0.685	-0.9103	0.492
Number of household members	0.0313	0.333	0.0197	0.458	0.0037	0.925	0.0531	0.238	-0.1967	0.15
Female household head	0.1457	0.488	0.004	0.979	0.0586	0.798	0.1551	0.587	0.4359	0.472
Age of household head	-0.0017	0.737	-0.0016	0.709	-0.0006	0.918	0.0029	0.714	-0.0185	0.225
Low education of household head	0.068	0.604	-0.2042	0.075	-0.3776	0.01	-0.5967	0.002	0.5676	0.206
Number of rooms in dwelling	-0.1661	0.006	-0.0184	0.749	-0.1085	0.229	-0.2805	0.006	0.0347	0.909
Dwelling has electricity	0.5266	0.013	0.235	0.216	0.5294	0.053	0.3183	0.39	0.1729	0.779
Household member farms or gardens	0.3088	0.015	0.1124	0.408	0.2797	0.148	0.6396	0.026	-0.4211	0.302
Wealth (asset index)	0.0013	0.977	0.0931	0.031	0.1756	0.002	0.2328	0.003	0.1872	0.241
Dwelling has improved roof	0.3719	0.498	0.0537	0.873	0.9035	0.392	0	0	0	0
Province	-0.7873	0	0.4561	0	0.0647	0.661	0.4904	0.011	-1.3961	0.003
Age (in months)	-0.0262	0.016	-0.0561	0	0.0939	0	0.0796	0	-0.0702	0.077

Variables	Percent of CU5 who received GMP services		Median duration of breastfeeding		Median duration of exclusive breastfeeding		Mothers Receiving Sick Child Feeding Advice During Sick Child Visits (n/s) ^a		Mothers Receiving WASH Information During Sick Child Visits (n/s) ^a	
	Coefficient	p value	Coefficient	p value	Coefficient	p value	Coefficient	p value	Coefficient	p value
Endline Nurture	-0.6913	0.3	0.2608	0.883	0.5689	0.397	-0.0077	0.984	0.1083	0.813
Number of household members	-0.0824	0.003	0.1093	0.303	-0.031	0.209	0.0356	0.194	0.0199	0.488
Female household head	0.2992	0.098	-0.7177	0.224	-0.1224	0.386	0.1068	0.53	0.0045	0.979
Age of household head	0.0044	0.318	-0.0199	0.259	0.0007	0.846	-0.0009	0.824	0.0083	0.033
Low education of household head	-0.3847	0.002	0.3103	0.474	-0.2576	0.012	-0.252	0.035	-0.239	0.049
Number of rooms in dwelling	0.0312	0.617	-0.2815	0.253	0.0218	0.669	0.0057	0.908	-0.0652	0.209
Dwelling has electricity	0.8684	0	-1.1461	0.301	-0.117	0.479	-0.5467	0.002	-0.968	0
Household member farms or gardens	0.4372	0.004	0.3599	0.501	-0.8205	0	0.1783	0.151	0.2229	0.055
Wealth (asset index)	0.1253	0.014	0.0021	0.99	0.138	0.001	0.0458	0.297	0.1018	0.026
Dwelling has improved roof	0.1553	0.678	-8.516	0.092	-0.3965	0.34	0.3299	0.346	-0.1535	0.687
Province	-0.5157	0	-1.8249	0	-0.3279	0.003	-0.2077	0.07	-0.3094	0.008
Age (in months)	-0.0063	0.495	0.5007	0	0.0406	0	0.0131	0.178	0.0228	0.024

^a Midline-Endline comparisons

ANNEX G: SUPPLEMENTAL DATA VISUALIZATION

Figure 24. Comparison of Message Recall Ranking, Baseline vs. Endline



ANNEX H: QUANTITATIVE INSTRUMENT (BASELINE/MIDLINE)

SECTION I. INTERVIEWER (ENUMERATOR) ADMINISTRATIVE IDENTIFICATION QUESTIONS

a. Household number: Please enter the household number (may be filled in from sampling assignment documents).		Enumerator's name and number: b. NUMBER: _____ c. NAME: _____
		Supervisor's name and number: d. NUMBER: _____ e. NAME: _____
f. Day / Month / Year of interview: ____ / ____ / 20____		
Location		
g. Province	☐ Khammouane Province (1)	☐ Savannakhet Province (2)
h/i. District	☐ Bualapha District (1206)	☐ Atsaphangthong District (1303)
	☐ Hinboon District (1204)	☐ Champhone (1306)
	☐ Mahaxay District (1202)	☐ Outhoumphone District (1302)
	☐ Nakai District (1207)	☐ Phine District (1304)
	☐ Nhommalath District (1205)	☐ Vilabuly District (1312)
	☐ Xaibouathong District (1203)	☐ Xonboully District (1314)
j-o. Village Name & ID	_____ []	_____ []
Enumerator introduction and reason for visit. Request to speak with an adult member of the household to ask introduction qualification questions.		

READ INFORMED CONSENT:

p. Consent: My name is _____ and I am here on behalf of Social Impact Inc., an evaluation company based out of the United States, and IndoChina Research, a data collection firm with a regional branch in Laos, to learn about the state of child nutrition, maternal nutrition, Water Sanitation and Hygiene (WASH) practices, and assets and credit in your household and community. Your household is one of 2,768 that was selected for participation in this research study because of your insight on these issues. By interviewing households like yours, we will better understand the barriers to improving nutrition and children's growth. Results will be reported to United States Agency for International Development (USAID), who funds the USAID Nurture program and may use the findings of this research to inform future programming.

Risk and benefits: Today I will ask some questions about your practices pertaining to USAID Nurture and WASH. Participation in this study will involve taking part in an hour-long interview. If you choose to participate in this study, I will be taking measurements from one child and one woman of reproductive age in your household. There are minimal risks to participating in this study, as children and women may experience mild, temporary discomfort when undergoing anthropometric measurements, and some questions related to income, assets, nutrition, and pregnancy may be considered emotionally distressing by some respondents. There are no direct benefits, though your participation may benefit other families like yours who participate in future programs. If, for any reason, the study is cancelled before its completion, IndoChina Research will call to inform you. We anticipate that each of these interviews will take approximately one hour.

Confidentiality: I want to assure you that all personally-identifying responses you provide during this interview will be kept confidential. Only a handful of researchers directly involved in this study will have access to your identifiable information. Your name, address and contact information will not be shared with anyone outside of the research team. Your personal information will be recorded electronically and will be stored securely.

Voluntary participation: Your participation in this study is completely voluntary and you are under no obligation to participate. If you start the interview and wish to stop at any time for any reason, or if you don't want to answer any questions, you may do so without penalty.

Do you have any questions about this interview?

If you have any questions in the future, please feel free to contact Vanxay Vang at 20-55219900 or Lisette Anzoategui with Social Impact at +1 703-465-1884 or lanzoategui@socialimpact.com or the Social Impact Institutional Review Board at irb@socialimpact.com with questions about the study or results.

Do you provide your consent to begin?

- ☐ 1 Yes
☐ 2 No ☐ Q118

q. Is this household eligible to complete the survey based on eligibility criteria?

- ☐ 1 Yes
☐ 2 No ☐ Q117

SECTION 2. HOUSEHOLD DEMOGRAPHIC DATA (HEAD OF HOUSEHOLD OR CAREGIVER)

TRANSITION WITH THE HEAD OF HOUSEHOLD/CAREGIVER AND SAY:

“Thank you for accepting to participate. I will now ask you some questions about the name and sex of the individuals who lives here, starting with the head of household.”

Section 2.1 Head of Household Data (Head of Household/Caregiver)

r. Please enter the respondent's phone number.	_____
s. What is the highest education level completed by the head of household?	1 Never went 2 Kindergarten/Preschool 3 Primary 4 Lower secondary 5 Upper secondary 6 Vocational school 7 College 8 University -97 Don't know
t. Including yourself, how many people are members of this household?	_____

Section 2.2 Household Demographic Data: Household Roster (u – ag)

TRANSITION WITH THE HEAD OF HOUSEHOLD/CAREGIVER AND SAY:

“I would like to ask a few questions about your household members”

List the head of the household in line 1. Then list the names of all household members (q2). Make a complete list of everyone by starting from the head of household and continuing with the spouse and other members, from oldest to youngest.

Then ask: “Does anyone else live here, even if they are not at home now? These may include children in school or household members at work.”

If yes, complete listing. Then collect information starting with q4 for each member, one person at a time. Enter all household members, even if more than 10.

Line #	First and Last Name	Is [NAME] male or female? 1 male 2 female	How old is [NAME] in years?*	Is [NAME] pregnant? 1 Yes 2 No	What is the relationship to the head of household? 1 Head Of Household 2 Spouse/Partner 3 Son/Daughter 4 Son/Daughter In Law 5 Father/Mother 6 Father/Mother In Law 7 Sister/Brother 8 Grandchild 9 Grandparent 10 Niece/Nephew 11 Other Relative 12 Unrelated	What is the marital status of [NAME]? 1 Married 2 Co Habitation (Living Together But Not Legally Married) 3 Divorced 4 Separated 5 Widow/Er 6 Single 98 Other, Specify	What is [NAME'S] mother tongue? 1 Laos 2 Khamou 3 Hmong 4 Leu 5 Tri 6 Phoutal 7 Makong 98 Other, specify 824F Cannot speak ²⁸	Does [NAME] have a mental or physical disability? 1 Yes 2 No 3 Don't know/ Refuse to respond
(l)	(u)	(v) M F	(w-y)	(z)	(aa-ae)	(ad-ag)	(ah-aj)	(ak)
1		1 2						
2		1 2						
3		1 2						
4		1 2						
5		1 2						
6		1 2						
7		1 2						
8		1 2						
9		1 2						
10		1 2						

²⁸ Code 8 is for child who cannot speak and household member who cannot speak

*To determine age, CAPI will ask:

w. How old is \${name} in years?	Any age
x. How old is \${name} in months (TOTAL)?	Less than 2 years old
y. How old is \${name} in days?	Less than 1 month old

PLEASE VERIFY THE CHILD'S AGE BY ASKING TO VIEW THE MOTHER AND CHILD MONITORING BOOK IF AVAILABLE.	
1. Does (Child's NAME) have a pink book "Mother and Child Health Monitoring Book" with the birth date recorded? IF NOT, PROBE THE MOTHER ABOUT THE DATE OF BIRTH.	☐ 1 Yes, we have the book. ☐ 2 No, we do not have the book but mother <u>remembers</u> the birth date ☐ 3 No, we do not have the book and <u>do not</u> remember the birth date ☐ Q5
DOCUMENT ONLY: IF THE PINK BOOK "MOTHER AND CHILD HEALTH MONITORING BOOK" IS SHOWN AND THE RESPONDANT CONFIRMS THE INFORMATION IS CORRECT, RECORD THE DATE AS DOCUMENTED ON THE CARD; OTHERWISE RECORD THE DATE THE MOTHER TELLS YOU.	1a. YEAR [][][][] 1b. MONTH [][] 1c. DAY [][]
2. What is the most recent HEIGHT recorded and the date?	2. Height [][].[] cm. Record "-97" if Not available 2a. YEAR [][][][] 2b. MONTH [][] 2c. DAY [][]
3. What is the most recent WEIGHT recorded and the date?	3. Weight [][].[] in kilograms. Record "-97" if not available 3a. YEAR [][][][] 3b. MONTH [][] 3c. DAY [][]
4. What is the birth weight listed on the third page under "Child Information"?	[][][].[]g. Record "-97" No birth weight available
5. Was [CHILDS NAME] born at home?	☐ 1 Yes ☐ 2 No ☐ -97. Don't know
6. Is [Name of youngest child under two years of age] available?	☐ 1 Yes ☐ 2 No
7. Is the primary care giver of [Name of youngest child under two years of age] available and of reproductive age (15-49)?	☐ 1 Yes ☐ 2 No

Section 2.3 HOUSEHOLD DEMOGRAPHIC DATA: HOUSEHOLD DATA

TRANSITION WITH THE CAREGIVER/MOTHER AND SAY:
 "Now, I would like to ask a few questions about your household"

8.a. What is the name of the primary caregiver for (CHILD's NAME)?
8.b. What is the primary caregiver's relationship to the youngest child? [SELECT ONE]
☐ 1 Mother
☐ 2 Grandmother
☐ 3 Aunt
☐ 4 Step mother
☐ 5 Mother's sister
☐ 6 Father's sister
☐ -98. Other _____
☐ -97. Don't Know
8.c. Which children are under the care of (PRIMARY CAREGIVER NAME) the majority of the time?
☐ Select multiple options with all children's names from roster under five years of age
8.d. Is [Name of youngest child under two years of age] under your care the majority of the time?
☐ 1 Yes
☐ 2 No
8.e. What is the education level of the primary caregiver for the youngest child?
☐ 1 Never went
☐ 2 Kindergarten/Preschool
☐ 3 Primary
☐ 4 Lower Secondary
☐ 5 Upper Secondary
☐ 6 Vocational School
☐ 7 College
☐ 8 University
☐ -97 Don't know
9. Which of the following livelihoods best represents the main income earner in the household?
☐ 1 Farmers (Agricultural)
☐ 2 Fisherman
☐ 3 Farmers (Livestock)
☐ 4 Agro-pastoralists
☐ 5 Agricultural Laborer
☐ 6 Non-agricultural Laborer [i.e., factory worker, construction worker, etc.]
☐ 7 Skilled and Salaried
☐ 8 Artisans with agriculture: handicrafts
☐ 9 Artisans with agriculture: brewers
☐ 10 Petty Traders
☐ 11 Remittances
☐ 12 Government Allowances

☐ 12 Big traders
☐ -98. Other activities

Section 2.4. Household Demographic Data: Household Asset Ownership²⁹

10. Does your household own the dwelling you are living in?	☐ 1 Yes	☐ 2 No	☐ -97 Don't Know
11. What type of household do you have?			
☐ 1 Private dwelling house			
☐ 2 A part of private dwelling house (renting)			
☐ 3 Hostel			
☐ -98 Other – Please specify the type of household			
12. How many rooms in this household are used for sleeping?			
No. of Rooms _____			
13. Does your house have electricity?	☐ 1 Yes	☐ 2 No	☐ -97 Don't Know
14. What is the household's main-primary source of energy for lighting? [SELECT ONE]			
☐ 1 Electricity from public network			
☐ 2 Electricity from generator			
☐ 3 Electricity from battery			
☐ 4 Kerosene lamp			
☐ 5 Candle			
☐ 6 Solar panel			
☐ -98 Other (specify)			
☐ 7 None			
15. What type of material does your household mainly (primarily) use for cooking? [SELECT ONE]			
☐ 1 Wood			
☐ 2 Electricity			
☐ 3 Liquid Propane Gas			
☐ 4 Charcoal			
☐ 5 Kerosene			
☐ -98 Other (specify)			
☐ 6 None			
16. Does your household legally own any land?	☐ 1 Yes ☐ 2 No ☐ Q18.b ☐ -97 Don't Know ☐ Q18.b		
17. What type of land title do you have?	☐ 1 Private land title (Golden Rim) ☐ 2 Communal land title (Golden Rim) ☐ 3 Government land title (Golden Rim)		

²⁹ In the Sustainable Livelihoods Framework, the term 'asset' is referring to 5 groups of assets: physical, natural, human, financial and social. ("Lao PDR: Comprehensive Food Security & Vulnerability Analysis (CFSVA)." World Food Programme, Vulnerability Analysis and Mapping Branch (ODAV), November 2006. <http://documents.wfp.org/stellent/groups/public/documents/vam/wfp178971.pdf>.)

		☐ 4 Land Use right certificate ☐ -97 Don't know
18.a. How much area of your total land does your household <u>own</u>? RECORD IN HECTARES.³⁰ OR Rai ☐ 1 0 ha/0 rai (None) ☐ 2 0-0.5 ha/0-3 rai ☐ 3 0.5-1 ha/3- 6 rai ☐ 4 1-1.5 ha/6-9 rai ☐ 5 1.5-3.0 ha/9-18 rai ☐ -98 Other (ha) ☐ -99 Other (rai) ☐ -100 Other (meters squared) ☐ -97 Don't Know		
18.b. How much area of your total land does your household <u>rent</u>? RECORD IN HECTARES.³¹ OR Rai ☐ 1 0 ha/0 rai (None) ☐ 2 0-0.5 ha/0-3 rai ☐ 3 0.5-1 ha/3- 6 rai ☐ 4 1-1.5 ha/6-9 rai ☐ 5 1.5-3.0 ha/9-18 rai ☐ -98 Other (ha) ☐ -99 Other (rai) ☐ -100 Other (meters squared) ☐ -97 Don't know		
19. In dry season of the most recent year, of the total land that your household uses for agriculture, how many hectares do you irrigate? RECORD IN HECTARES or Rai. (MUST NOT EXCEED PREVIOUS AREA) ☐ 1 0 ha/0 rai (None) ☐ 2 0-0.5 ha/0-3 rai ☐ 3 0.5-1 ha/3- 6 rai ☐ 4 1-1.5 ha/6-9 rai ☐ 5 1.5-3.0 ha/9-18 rai ☐ -98 Other (ha) ☐ -99 Other (rai) ☐ -100 Other (meters squared) ☐ -97 Don't know		
20. Do you or any members of your household participate in home gardening or farming?	☐ 1 Yes ☐ 2 No ☐ Q25 ☐ -97 Don't Know ☐ Q25	
20.a. Was most of your farming-your own land, rented land or someone else's land (for free)?	☐ 1 Own land ☐ 2 Rented Land ☐ 3 Someone else's Land	

³⁰ There are 0.16 hectares in 1 rai

³¹ There are 0.16 hectares in 1 rai

21. What does your household use to cultivate MOST of your farmland? [SELECT ONE]	
☐ 1 Hand tool	
☐ 2 Animal drawn plow	
☐ 3 Tractor drawn plow	
☐ -98 Other, specify _____	
22. Please estimate how much (total rainy and dry season) paddy land (both rent and owned land) you farmed this season.	☐ 1 0 ha/0 rai (None) ☐ 2 0-0.5 ha/0-3 rai ☐ 3 0.5-1 ha/3- 6 rai ☐ 4 1-1.5 ha/6-9 rai ☐ 5 1.5-3.0 ha/9-18 rai ☐ -98 Other (ha) ☐ -99 Other (rai) ☐ -100 Other (meters squared) ☐ -97 Don't know
22.a. Enumerator please note if land has been cleared for Lao National Unexploded Ordnance Program for development and safety.	☐ 1 Yes ☐ 2 No ☐ -97 Don't Know
23. Please estimate how much upland you farmed in the last 12 months	☐ 1 0 ha/0 rai (None) ☐ 2 0-0.5 ha/0-3 rai ☐ 3 0.5-1 ha/3- 6 rai ☐ 4 1-1.5 ha/6-9 rai ☐ 5 1.5-3.0 ha/9-18 rai ☐ -98 Other (ha) ☐ -99 Other (rai) ☐ -100 Other (meters squared) ☐ -97 Don't Know
24. Does your household have a home garden?	☐ 1 Yes ☐ 2 No ☐ Q25 ☐ -97 Don't Know ☐ Q25
24.a. What do you plant in your home garden? [SELECT MULTIPLE] [READ OUT]	
☐ 1 Banana	
☐ 2 Chilies	
☐ 3 Cucumbers	
☐ 4 Long beans	
☐ 5 Okra (Mak Buab)	
☐ 6 Sweet Potatoes (Man dang)	
☐ 7 Cassava (Man ton)	
☐ 8 Mango	
☐ 9 Other types of cabbages (Phak Kard)	
☐ 10 Papaya	
☐ 11 Other types of herbs (chives (hom bua), hom pin (coriander), etc.)	
☐ 12 Chinese broccoli (Phak kard na)	

☐ 13 Pumpkins	
☐ 14 Tomato	
☐ 15 Secondary crops: coconut, rice, sugar cane, rubber, tamarind or tobacco	
☐ -98 Other types of vegetables	
☐ 16 None	
25. Do you or your household own productive assets (used for agricultural production, rice processing, and transportation)? If yes, which ones? [SELECT MULTIPLE] [READ OUT]	
☐ 1 Shovel	
☐ 2 Sickle	
☐ 3 Plough	
☐ 4 Buffalo	
☐ 5 Tractor/Power Tiller (tock tock)	
☐ 6 Hand tools (spade/hoe)	
☐ 7 Pounding rice mills (activated by foot or hand)	
☐ 8 Pounding mills (electric) rice mill	
☐ 9 Fuel-powered rice mill	
☐ 10 Fish net	
☐ -98 Other, specify _____	
☐ 11 None	
26. Does your household own any animals, fish ponds or poultry?	☐ 1 Yes ☐ 2 No ☐ Q26b ☐ -97 Don't Know ☐ Q26b
26.a. How many of the following animals/ poultry/fish pond do your household own? [SELECT MULTIPLE] [READ OUT] if none write 0, for fish indicate the number of fish ponds	
	Estimated Number
☐ 1 Buffalo	_ _
☐ 2 Cattle	_ _
☐ 3 Chickens	_ _
☐ 4 Ducks	_ _
☐ 5 Goats	_ _
☐ 6 Fish	_ _
☐ 7 Rabbits	_ _
☐ 8 Pigs	_ _
☐ 9 Poultry	_ _
☐ 10 Sheep	_ _
☐ 11 Cats	_ _
☐ 12 Dogs	_ _
☐ 13 Frogs	_ _
☐ -98 Other Animals (include pets) _____	_ _

26.b-e. Do any of these animals: a) roam openly in the yard, b) sleep in the house, c) sleep under the house, d) Roam where the food is prepared or cooked? [SELECT MULTIPLE]	26.b. Roam openly in the yard	26.c. Sleep in the House	26d. Sleep under the house	26.e. Roam where the food is prepared or cooked?
1. Buffalo	☐ A	☐ B	☐ C	☐ D
2. Cattle	☐ A	☐ B	☐ C	☐ D
3. Chickens	☐ A	☐ B	☐ C	☐ D
4. Ducks	☐ A	☐ B	☐ C	☐ D
5. Goats	☐ A	☐ B	☐ C	☐ D
6. Pigs	☐ A	☐ B	☐ C	☐ D
7. Other poultry (apart from chickens or ducks)	☐ A	☐ B	☐ C	☐ D
8. Sheep	☐ A	☐ B	☐ C	☐ D
-98. Other (including other pets) _____	☐ A	☐ B	☐ C	☐ D
9. Don't have animal near home	☐ A	☐ B	☐ C	☐ D
27. Does any member of your household have: [SELECT MULTIPLE] [READ OUT]				
☐ 1 Air conditioner				
☐ 2 Animal drawn-cart				
☐ 3 Motorbike cart				
☐ 4 Bicycle				
☐ 5 Boat with motor (Mekong Heujak boat)				
☐ 6 Boat without motor				
☐ 7 Camera				
☐ 8 Car/Truck				
☐ 9 CD/DVD Player				
☐ 10 Clock				
☐ 11 Computer				
☐ 12 Electricity				
☐ 13 Fan				
☐ 14 Hand Tractor				
☐ 15 Mobile Phone				
☐ 16 Motorcycle/Scooter				
☐ 17 Non-Mobile Telephone				
☐ 18 Radio				
☐ 19 Refrigerator/Freezer				
☐ 20 Sewing Machine				
☐ 21 Sleeping Mat				
☐ 22 Sofa/wooden settee				
☐ 23 Television				

☐ 24 Tuk tuk
☐ 25 Vacuum Cleaner
☐ 26 Washing Machine
☐ 27 Watch
☐ 28 Water pump
☐ 29 None
28. Has your household ever received the following? [SELECT MULTIPLE] [READ OUT]
☐ 1 A loan either in credit (cash) from village head
☐ 2 A loan either in credit (cash) from middle man
☐ 3 Interest free borrowing from relatives or friends)
☐ 4 Remittances from relatives
☐ -98 Other
☐ 5 None
☐ -97 Don't know

SECTION 3. HEALTH/NUTRITION INDICATORS- (SELECT 1 HOUSEHOLD WOMEN OF REPRODUCTIVE AGE (15-49 YEARS OF AGE) WHO IS ALSO A PRIMARY CAREGIVER OF A CHILD UNDER 2 YEARS OF AGE)

VERIFY THAT YOU ARE SPEAKING WITH THE CORRECT RESPONDENT BY CHECKING THAT THE RESPONDENT IS THE PRIMARY CAREGIVER (WHICH IS USUALLY THE MOTHER) OF A CHILD UNDER 2 YEARS OF AGE (NAME). IF THE PERSON YOU ARE SPEAKING WITH IS NOT THAT INDIVIDUAL, ASK TO SPEAK WITH THE CORRECT RESPONDENT.

Section 3.1. Minimum Dietary Diversity For Women (M-DDW)

Women's Dietary Diversity (Minimum Dietary Diversity for Women 15-49 years)
29.a Are you the primary caregiver (SELECTED CHILD NAME) in this household? INSTRUCTIONS: VERIFY THAT YOU ARE SPEAKING WITH THE CORRECT RESPONDENT BY CHECKING THAT THE RESPONDENT IS THE PRIMARY CAREGIVER (A FAMILY MEMBER OR PAID HELPER WHO LOOKS AFTER A CHILD THE MAJORITY OF THE TIME) OF A CHILD UNDER 2 YEARS OF AGE (NAME). IF THE PERSON YOU ARE SPEAKING WITH IS NOT THAT INDIVIDUAL, ASK TO SPEAK WITH THE CORRECT RESPONDENT. ☐ 1 Yes ☐ 2 No
29.b Have you ever been pregnant? ☐ 1 Yes ☐ 2 No ☐ -97 Don't know
29.c Was yesterday a special day, like a celebration or feast day or a fast day where you ate special foods or where you ate more or less than usual or did not eat because you were fasting? NOTE TO ENUMERATOR: If yesterday was not a special day, then ask the respondent about the types of foods that the respondent ate yesterday during the day and at night. If yesterday was a special day, then ask the respondent to describe the foods (meals and snacks) consumed the day before yesterday (or the last normal day) during the day and night, whether at home or outside the home. ☐ 1 Yes ☐ 2 No If yes, specify _____
* FOR MOTHERS (PRIMARY CAREGIVER) OF CHILDREN UNDER FIVE YEARS OF AGE IN THE HOUSEHOLD 29.d Now I'd like to ask you to describe everything that you ate or drank, <u>starting with yesterday morning and ending with yesterday during the night</u>, whether you ate it at home or anywhere else (NOTE: Probe for consumption during the 24 hours period from midnight to midnight). Please include all foods and drinks, any snacks or small meals, as well as any main meals. Remember to include all foods you may have eaten while preparing meals or preparing food for others. Please also include food you ate even if it was eaten elsewhere, away from your home.

I am interested in whether you had the food items I will mention even if they were combined with other foods. For example, if you had a soup made with carrots, potatoes and meat, you should reply “yes” for each of these ingredients when I read you the list. However, if you consumed only the broth of a soup, but not the meat or vegetable, do not say “yes” for the meat or vegetable.

As I ask you about foods and drinks, please think of foods and drinks you had as snacks or small meals as well as during any main meals. Please also remember foods you may have eaten while preparing meals or preparing food for others.

Let’s start with the first food or drink consumed yesterday.

- 1) NOTE WHETHER YESTERDAY WAS A SPECIAL DAY (RELIGIOUS FESTIVAL OR CELEBRATION) WHEN UNUSUALLY VARIED OR LIMITED DIET WAS EATEN
- 2) LIST ALL MEALS, WHICH THE RESPONDENT ATE IN THE PREVIOUS DAY IN THE RECORDING MEALS FORM (SEE LINK BELOW). SEE ADULT DIET RECORDING FORM
- 3) DOUBLE CHECK THE MEALS COMPOSITION (E.G., PORRIDGE WITH OR WITHOUT EGG).
- 4) CHECK FOR ANY SNACKS (INCLUDING FRUITS) WHICH WERE NOT MENTIONED.
- 5) ONLY THEN RECORD IN THE QUESTIONNAIRE THAT FOOD GROUPS WERE EATEN. DOUBLE CHECK WITH THE RESPONDENT REGARDING FOODS EATEN FROM GROUPS THAT WERE NOT MENTIONED (FOR EXAMPLE: “DID YOU YESTERDAY EAT ANY EGGS?”)

Minimum serving size (in order to tick yes), is palm of the hand, except for the following categories:

- Dairy (1 cup)
- Insets (handful)
- Nuts (handful)
- Oil and fats (1-2 teaspoons)
- Fried snacks (any amount)
- Sweets (any amount)
- For fruit and veggies, if eating amount smaller than palm of hand, it is considered a condiment.

Food Categories		Consumed in the Last 24 hours?	
Instructions: Enumerator please complete for categories for food consumed by the respondent in the last 24 hours			
I	FOODS MADE FROM GRAINS, WHITE ROOTS AND TUBERS AND PLANTAINS (WHITE FLESH) ☐ Bread ☐ Cassava Root ☐ Corn ☐ Noodles ☐ Other foods made from grains ☐ Plantains ☐ Rice- Black rice	I Yes	2 No

	☐ Rice- Glutinous Rice ☐ Rice in bamboo leaves ☐ Rice porridge ☐ Rice-white ☐ Taro ☐ Wheat ☐ White Potatoes ☐ Yams ☐ Other: specify: _____		
2	PULSES (BEANS, PEAS AND LENTILS) Mature beans or peas (fresh or dried seed), lentils or soy products, including tofu or tempeh. ☐ Mature beans ☐ Mature peas ☐ Lentils ☐ Soy products-tofu ☐ Soy products-tempeh ☐ Soy Products-Soymilk ☐ Pigeon pea (mak baep) ☐ Other: Please specify: _____	I Yes	2 No
3	NUTS AND SEEDS Any tree nuts, groundnut/peanut or certain seeds, or nut/seed, or pastes including sesame. ☐ Cashew Nuts ☐ Peanuts ☐ Sesame Paste ☐ Tamarind Nuts ☐ Other _____	I Yes	2 No
4	DAIRY: MILK (NOT SOY) AND MILK PRODUCTS ☐ Cheese ☐ Milk ☐ Milk powder for pregnancy, (Annmum brand-Noom foun ka annmum) ☐ Milk UHT, (Thaidenmark brand) (dairy products, fluid or powdered milk (non-fortified) ☐ Milk, instant, Annum brand (Noom kong ka annmum) (dairy products, fluid or powdered milk (fortified) ☐ Yoghurt ☐ Yoghurt, drinking, foremost brand (Noom som ka foremost; no flavor or sugar) ☐ Other milk products but NOT including butter, dairy ice cream	I Yes	2 No
	MEAT, POULTRY AND FISH/SEAFOOD	I Yes	2 No

	Beef, pork, goat, rabbit, wild game meat, chicken, duck or other bird, liver, kidney, heart, etc., including blood-based food. 5 MEAT AND POULTRY: Beef, Other: ☐ Beef ball, blanched (Look sine ngoua) (Processed meat) ☐ Beef, blanched (Choum sine ngoua) (Red meat) ☐ Beef, dried, grilled (Ping sine ngoua hang) (Red meat) ☐ Beef, dry, fried (Cheun sine ngoua hang) (Red meat) ☐ Beef, grilled (Ping sine ngoua) (Red meat) ☐ Beef, raw (Sine ngoua dip) (Red meat) ☐ Beef, lab (lab ngoua) Chicken/Poultry, Other: ☐ Chicken, roasted (Ping kai) ☐ Chicken, boiled (Toom sine kai) ☐ Duck, roasted (Ping pet) ☐ Bird, lab (Lab nok) ☐ Bird, roasted (Ping Nok) Pork, Other: ☐ Pork sausage, grilled (Ping sai oua moo) (Processed meat) ☐ Pork fermented (Som Moo) ☐ Pork balls ☐ Pork or wild pork, boiled (Toom sine moo) ☐ Pork or wild pork, grilled (Ping sine moo) ☐ Pork or wild pork, raw (Sine moo soth) ☐ Pork, shredded, arvae style (Moo foi) (Processed meat) ☐ Pork or wild pork, skin, raw (Nang moo dip) (Other animal parts) ☐ Squirrels, grilled (Ping Kahok) Wild meat, Other ☐ Rat ☐ Cat ☐ Dog ☐ Other small wild (bush meat) or domesticated mammals ☐ Frogs and other amphibians ☐ Snakes, gecko, lizard, and other reptiles 6 ORGAN MEAT: Organ Meat: Liver, kidney, heart, or other organ meats (including blood-based food). Beef, Organ Meat: ☐ Beef internal organ barbecue (Ping kheuang nai ngoua) ☐ Beef, intestine, raw (Sai ngoua dip) ☐ Beef, liver, grilled (Ping tab ngoua) ☐ Beef, liver, raw (Tab ngoua dip)		
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	☐ Beef, lung, raw (Pod ngoua dip) ☐ Beef, spleen, raw (Mam ngoua dip) ☐ Beef, stomach, raw (Phoung ngoua dip) Chicken, Organ Meat: ☐ Chicken liver, boiled (Toom tab kai) ☐ Chicken, heart (Houa chay kai dip) ☐ Chicken, liver, grilled (Ping tab kai) ☐ Chicken, liver, raw (Tab kai dip) Pork, Organ Meat: ☐ Pork, liver, grilled (Ping tab moo) ☐ Pork, liver, raw (Tab moo dip) ☐ Pork, spleen, raw (Mam moo dip) ☐ Pork, blood, boiled (Toom leuad moo) (blood sausage) 7 FISH/SEAFOOD: Fish/Seafood: Fresh, frozen or dried fish, eels shellfish, or seafood. ☐ Eels ☐ Fermented fish, sour, fried (Cheun pa som) ☐ Fermented fish with bone (Pa deak niew) (Small, whole fish, with bones) ☐ Nile tilapia fish, raw (Pa nin dip) ☐ Nile tilapia, roasted (Ping pa nin) ☐ Short-bodied mackerel fried (Cheua pa tu) ☐ Short-bodied mackerel, roasted (Ping pa tu) ☐ Siamese mud carp, grilled (Ping pa khao) ☐ Seafood Other: Please specify		
8	EGGS ☐ Chicken Hen egg, fried (Cheuan khai dao) ☐ Chicken Hen Egg, whole (Khai kai dip) ☐ Chicken Hen Egg, whole, boiled (Khai kai toom) ☐ Chicken Omelet hen egg (Cheuan khai kai) ☐ Duck -Omelet duck egg (Cheuan khai pet) ☐ Duck Egg, whole, boiled (kai pet toom) ☐ Monitor Lizard Egg ☐ Other Birds Egg ☐ Quail Egg ☐ Snake Egg	I Yes	2 No
9	DARK GREEN LEAFY VEGETABLES (exclude herbs eaten in small amounts) ☐ Cassava leaves (Bai man ton) ☐ Cassava leaves, blanched (Bai mun ton Luak) ☐ Chinese cabbage, blanched (Pak kaad khao louak) ☐ Edible Bracken (Phak Kut)	I Yes	2 No

	☐ Eugenia Leaves (Phak Samek) ☐ Green amaranth, small, blanched (Pak huom louak) ☐ Green amaranth, small, fresh (Pak huom soth) ☐ Horse Tamarind, young leaves (Bai ka thin soth) ☐ Kale ☐ Melientha Suavis (Phak Kased) ☐ Morning Glory /swamp cabbage, blanched (pak bong louak) ☐ Morning Glory /swamp cabbage, fresh (pak bong soth) ☐ Mustard green, blanched (Phak kaad khiew louak) ☐ Mustard green, stem and leaves (Pak kaad khiew soth) ☐ Mustard, fresh (Phak kaad soum soth) ☐ Sweet potatoe leaves (Bai Man Dang) ☐ Tamarind, young leaf, fresh (bai maak kham onh) ☐ Wildbetal Leafbush (Pak e leuad) ☐ Other (Please Specify):__		
10	OTHER VITAMIN A-RICH FRUITS AND VEGETABLES. ³²	1 Yes	2 No
	6. Vitamin A-Rich Vegetables, Roots and Tubers ☐ Carrots ☐ Pumpkin, mature, fresh (Maak eu) ☐ Red Pepper ☐ Squash (orange or dark yellow-fleshed only) ☐ Sweet Potatoes (that are yellow, or orange inside)		
	6. Vitamin A-Rich Fruits ☐ Cantaloupe melon (Mark teang warn) ☐ GAC fruit ☐ Hog Plum ☐ Mango (ripe) ☐ Musk melon ☐ Papaya (ripe) (Maak hung sook) ☐ Passion Fruit (Maak nord) ☐ Peaches (Maak khaii) ☐ Persimmon ☐ Other (Please Specify):_____		
12	OTHER VEGETABLES ☐ Bamboo ☐ Bean sprouts, fresh (Thoua ngok soth) ☐ Bean, Yard long bean, green, fresh (Maak thoua ngao soth) ☐ Cabbage, blanched (Pak ka lam pe louak) ☐ Cabbage, common, fresh (Pak ka lam pe soth) ☐ Chayote, boiled (Maak sa ver louak) ☐ Chayote, fruit, fresh (Maak sa ver soth)	1 Yes	2 No

³² The next two groups (“Vitamin A-rich vegetables, roots and tubers” and “Vitamin A-rich fruits”) are separated into two rows on the questionnaire but are combined into one group for calculation of the MDD-W indicator.

	☐ Chayote young leaves (Yod maak sa ver) ☐ Cucumber, fresh (Maak teng soth) ☐ Eggplant (Mark kheua hum ma) ☐ Eggplant/brinjal, green, fresh (Maak kheua soth) ☐ Horse Tamarins (Maak Ka Thin Soth), ☐ Mushrooms ☐ Onion ☐ Sponge gourd (mak buap) ☐ Tomato, fresh (Maak len) ☐ Other (Please Specify):_____		
13	OTHER FRUITS ☐ Apple, pink, fresh (Maak apple) ☐ Banana (unripened, grilled) ☐ Banana, ripe, yellow (Maak kouy nam souk) ☐ Banana, ripe, yellow, boiled (Maak kouy nam souk toom) ☐ Coconut Flesh ☐ Durian Fruit ☐ Fig ☐ Guava ☐ Green Plum (same as Hog Plum) ☐ Jackfruit ☐ Jujubes ☐ Litchee Fruit ☐ Longan ☐ Mangosteen ☐ Orange, sweet, fresh (Maak kieng sang) ☐ Pear ☐ Pineapple ☐ Rumbutam, fresh (Maak ngor) ☐ Sweetsop ☐ Star Fruit ☐ Tamarind ☐ Tangerine (not the same as oranges) ☐ Watermelon ☐ Other (Please Specify):_____	I Yes	2 No
14	INSECTS AND OTHER SMALL PROTEINS ☐ Bamboo caterpillar ☐ Butterfly ☐ Cicadas ☐ Cockchafer beetles ☐ Green weevil (Meang xang) ☐ Dragonflies ☐ Fish roe	I Yes	2 No

	☐ Giant water bugs ☐ Grasshoppers ☐ Horned beetle ☐ Insect eggs ☐ Insect larvae/grubs ☐ Insects ☐ Mole cricket ☐ Scarab beetle (Duang Peek Khaeng) ☐ Short-tailed cricket ☐ Snails ☐ Spiders ☐ Sting bug ☐ Termites ☐ Wasps ☐ Wasps arvae (Duang to tor) ☐ Weaver ant larvae (Khai mod som) ☐ Any other small invertebrates ☐ Other (Please Specify):_____		
15	CONDIMENTS AND SEASONINGS ☐ Chili pepper, hot, red, fresh ☐ Ginger ☐ Garlic ☐ Fermented fish, liquid ☐ Fish sauce ☐ Lemon grass, fresh ☐ Lime-in 12 other condiments ☐ Lemon – in 12 other condiments ☐ Monosodium glutamate (MSG) ☐ Onion ☐ Oyster sauce ☐ Salt ☐ Shallot, bulb ☐ Tiliacora triandra diels (bai gna nang) Condiment Vegetables ☐ Coriander, fresh (Pak hom pome) ☐ Dill, fresh (Pak ce soth) ☐ Hairy basil, fresh (Pak e tu) ☐ Fennel common leaves (Pak hom Pea) ☐ Mint, leaf (Pak houm lab soth) ☐ Pak kha yeng	I Yes	2 No
16	OTHER OILS AND FATS ☐ Butter ☐ Chicken Fat/Lard ☐ Margarine	I Yes	2 No

	☐ Palm Oil ☐ Pork Fat/Lard ☐ Soybean Oil ☐ Sunflower Oil		
17	OTHER BEVERAGES AND FOODS ☐ Coffee ☐ Coconut Water ☐ Coke ☐ Coffee with sugar ☐ Energy Drinks ☐ FANTA ☐ Nescafe instant coffee ☐ Ovaltine ☐ Pickles ☐ Mustard green, fermented, sour (Som pak kaad) ☐ Pepsi ☐ Tea ☐ Tea with sugar ☐ Soda ☐ Any other drink with sugar	I Yes	2 No
18	SAVORY AND FRIED SNACKS ☐ Banana Chips ☐ Cassava chips ☐ Fried donuts ☐ Pork Cracklings ☐ Potato Chips ☐ Corn Chips ☐ Local fried snacks—name here ☐ Sweet potatoe chips ☐ Taro Chips ☐ Other (Please Specify): _____	I Yes	2 No
19	SWEETS ☐ Candy ☐ Cakes ☐ Cookies ☐ Honey ☐ Ice cream ☐ Pastries (sweet, fried or baked) ☐ Peanut candies ☐ Sesame Candies ☐ Sugar Cane ☐ Sweetened condensed milk ☐ Other (Please Specify): _____	I Yes	2 No
20	Nothing eaten or drank at all	I Yes	2 No

	-98. Other Any other solid or semi-solid food? SPECIFY HERE _____	1 Yes	2 No
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Section 3.2. Infant & Young Child Feeding Behaviors

Infant and Young Child Feeding Behaviors (Children 0-59 months of age CU5)	
30. Was (CHILD'S NAME) ever breastfed?	☐ 1 Yes ☐ 2 No ☐ Q37 ☐ -97 Don't Know ☐ Q37
31. Did you practice active feeding when breastfeeding (CHILD'S NAME)? Active feeding is defined as the practice where the caregiver is responsive to the child's clues for hunger and also encourages the child to eat.	
☐ 1 Yes ☐ 2 No ☐ -97 Don't Know	
Continued: Breastfeeding (CU5 of age)	
32a. How long after birth did you first put (CHILD'S NAME) to the breast?	☐ 1 Immediately ☐ Q33 ☐ 2 Within hours ☐ Q32b ☐ 3 Within days ☐ Q32C ☐ -97 Don't Know ☐ -98 Other ☐ Q32D
32b. How many hours passed until you put (CHILD'S NAME) to the breast?	_____ hours
32c. How many days passed until you put (CHILD'S NAME) to the breast?	_____ days
32d. If other, how long after birth did you first put (CHILD'S NAME) to the breast?	_____
33. Are you still breastfeeding (CHILD'S NAME)?	☐ 1 Yes ☐ 2 No ☐ Q35 ☐ -97 Don't Know ☐ Q35
34. Was (CHILD'S NAME) breastfed yesterday during the day or at night?	☐ 1 Day ☐ 2 Night ☐ 3 Both day and night ☐ 4 Did not feed yesterday ☐ -97 Don't Know

35. For how long (TOTAL) did you breastfeed (CHILD'S NAME)? Breastfeeding refers to an infant receiving breast milk (including expressed breast milk or milk from a wet nurse)	Select unit: ☐ 1 Months ☐ 2 Years
THESE QUESTIONS ARE FOR CHILDREN UNDER TWO.	
Continuing Breastfeeding at One Year	
36. Did you breastfed (by either breast or hand-pumped breast milk (or both) for your child (CHILD'S NAME)?	☐ 1 Breast ☐ 2 Hand pump ☐ 3 Both ☐ 4 None ☐ -97 Don't Know
37. In the first three days after delivery, was (CHILD'S NAME) given anything to drink other than breast milk?	☐ 1 Yes ☐ 2 No ☐ -97 Don't Know
Complementary Feeding	
38.a Does (CHILD'S NAME) consume foods or drinks other than breast milk?	☐ 1 Yes ☐ 2 No ☐ Q39 ☐ -97 Don't Know ☐ Q39
38.b What age did you first give (CHILD'S NAME) something (liquid or food) other than breast milk?	Enter integer: _____ Select unit: ☐ 1 Months ☐ 2 Years
Feeding Breast Milk by Spoon, Cup or Bottle	
TALK TO THE MOTHER. Sometimes babies are fed breast milk in different ways, for example by spoon, cup or bottle . This can happen when the mother cannot always be with her baby. Sometimes babies are breastfed by another woman, or given breast milk from another woman by spoon, cup or bottle or some other way. This can happen if a mother cannot breastfeed her own baby.	
39. Did (CHILD'S NAME) drink anything from a bottle with a nipple or teat yesterday or last night?	☐ 1 Yes ☐ 2 No ☐ -97 Don't Know
40. Did (CHILD'S NAME) consume breast milk in any of these ways yesterday during the day or at night? [SELECT MULTIPLE] [READ OUT]	☐ 1 Spoon ☐ 2 Cup ☐ 3 Bottle ☐ 4 Straws

	☐ 5 None ☐ -98 Don't Know
41.a. Did you give your child anything other than breast milk, ORS (ORS: Nam Tha Lay Pon or OLALID), Vitamins/minerals/medicines, including water, other liquids or other foods in the first six months?	☐ 1 Yes ☐ 2 No ☐ Q44 ☐ -97 Don't Know/Recall ☐ Q44
41.b. What did you give your child?	☐ 1 Mashed bananas or papaya ☐ 2 Boiled pumpkin puree ☐ 3 Chewed sticky rice ☐ 4 Rice broth & sugar ☐ 5 Slowed cooked Rice in banana leaf ☐ 6 Boiled potato puree ☐ 7 Water ☐ 8 Sugar and honey with warm water ☐ -98 Other
42. 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?	☐ 1 Yes ☐ 2 No ☐ -97 Don't Know/Recall
43. Was (CHILD'S NAME) given Oral Rehydration Salt solution (ORS) (ORS: Nam Tha Lay Pon or OLALID) yesterday during the day or at night?	☐ 1 Yes ☐ 2 No ☐ -97 Don't Know/Recall
Complementary Feeding (Children 6-23 months of age)	
Introduction of Solid, Semi-solid or Soft Foods	
44. Now I would like to ask you about liquids or foods (NAME) had yesterday during the day or at night (in the last 24 hours). Did (CHILD'S NAME) drink/eat: READ THE LIST OF LIQUIDS STARTING WITH PLAIN WATER, HOW MANY TIMES YESTERDAY DURING THE DAY OR AT NIGHT DID (NAME) CONSUME ANY (ITEM FROM LIST) IN THE LAST 24 HOURS?	

	Child 1	Child 2	Child 3	Child 4	Child 5
1. Plain water?					
2. Infant formula, such as Cerelac?					
3. Milk such as tinned, powdered, carton, or fresh animal milk?					
4. Juice or juice drinks?					
5. Clear broth?					
6. Yogurt?					
7. Soy milk					
8. Thin porridge					
9. None					
-98 Any other liquids? If yes, what liquid? Other liquids may include: Local products: Pepsi, Mirinda, Coke, Sprite, fresh coconut water Imported product: fruit juices, Oishi tea Milk or food-based liquid: Local product: Soy milk, Taro milk, corn milk					
Complementary Feeding Practices (Children 6-23 months of age)					
Minimum Meal Frequency					
45. Did (CHILD'S NAME) eat any solid, semi-solid, or soft foods yesterday during the day or at night?	☐ 1 Yes ☐ 2 No ☐ Q48 ☐ -97 Don't Know ☐ Q48	☐ 1 Yes ☐ 2 No ☐ Q48 ☐ -97 Don't Know ☐ Q48	☐ 1 Yes ☐ 2 No ☐ Q48 ☐ -97 Don't Know ☐ Q48	☐ 1 Yes ☐ 2 No ☐ Q48 ☐ -97 Don't Know ☐ Q48	☐ 1 Yes ☐ 2 No ☐ Q48 ☐ -97 Don't Know ☐ Q48

46. How many times did (CHILD NAME) eat solid, semi-solid, or soft foods other than liquids yesterday?	☐ 1 1 time ☐ 2 2 times ☐ 3 3 times ☐ 4 4 times ☐ 5 more than 4 times ☐ -97 Don't Know	☐ 1 1 time ☐ 2 2 times ☐ 3 3 times ☐ 4 4 times ☐ 5 more than 4 times ☐ -97 Don't Know	☐ 1 1 time ☐ 2 2 times ☐ 3 3 times ☐ 4 4 times ☐ 5 more than 4 times ☐ -97 Don't Know	☐ 1 1 time ☐ 2 2 times ☐ 3 3 times ☐ 4 4 times ☐ 5 more than 4 times ☐ -97 Don't Know	☐ 1 1 time ☐ 2 2 times ☐ 3 3 times ☐ 4 4 times ☐ 5 more than 4 times ☐ -97 Don't Know
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Minimum Acceptable Diet (MAD) (6-23 months of age)

47. Was yesterday a special day, like a celebration or feast day or a fast day where your child ate special foods or where they ate more or less than usual or did not eat because they were fasting?

NOTE TO ENUMERATOR: If yesterday was not a special day, then ask the respondent about the types of foods that the child ate yesterday during the day and at night. If yesterday was a special day, then ask the respondent to describe the foods (meals and snacks) that the child consumed the day before yesterday (or the last normal day) during the day and night, whether at home or outside the home.

☐ 1 Yes

☐ 2 No

If yes, please specify _____

48. Please describe everything that (NAME) ate yesterday ate or drank, starting with yesterday morning and ending with yesterday during the night, whether (NAME) ate it at home or anywhere else (NOTE: Probe for consumption during the 24 hours period from midnight to midnight).

READ THE LIST OF FOODS BELOW

82. FOODS MADE FROM GRAINS, WHITE ROOTS AND TUBERS AND PLANTAINS (WHITE FLESH) Food made from grains, white roots, tubers, and plantains (white flesh) including porridge. White potatoes, white yams, manioc, cassava, or any other foods made from roots	☐ 1 Yes ☐ 2 No
82. PULSES (BEANS, PEAS AND LENTILS) Mature beans or peas (fresh or dried seed), lentils or soy products, including tofu or tempeh. • Mature beans • Mature peas • Lentils • Soy products-tofu • Soy products-tempeh • Soy Products-Soy milk • Pigeon pea (mak baep) • Other: Please specify: _____	☐ 1 Yes ☐ 2 No
82. NUTS AND SEEDS • Cashew Nuts • Peanuts • Sesame Paste • Tamarind Nuts • Other: Please specify: _____	☐ 1 Yes ☐ 2 No
4. MILK (NOT SOY) AND MILK PRODUCTS: Cheese, yogurt, or other milk products	☐ 1 Yes ☐ 2 No
82. FLESH MEATS: beef, pork, duck, chicken, birds, frogs, wild game? Beef, Other: • Beef ball, blanched (Look sine ngoua) (Processed meat) • Beef, blanched (Choum sine ngoua) (Red meat)	☐ 1 Yes ☐ 2 No

Minimum Acceptable Diet (MAD) (6 23 months of age)	
• Beef, dried, grilled (Ping sine ngoua hang) (Red meat) • Beef, dry, fried (Cheun sine ngoua hang) (Red meat) • Beef, grilled (Ping sine ngoua) (Red meat) • Beef, raw (Sine ngoua dip) (Red meat) Chicken/Poultry, Other: • Chicken, roasted (Ping kai) • Chicken, boiled (Toom sine kai) • Chicken, raw (Sine kai dip) • Duck, roasted (Ping pet) Pork, Other: • Pork sausage, grilled (Ping sai oua moo) (Processed meat) • Pork, boiled (Toom sine moo) • Pork, grilled (Ping sine moo) • Pork, raw (Sine moo soth) • Pork, shredded, arvae style (Moo foi) (Processed meat) • Pork, skin, raw (Nang moo dip) (Other animal parts)	
82. ORGAN MEAT Liver, kidney, heart, or other organ meats (including blood-based food). Beef, Organ Meat: • Beef internal organ barbecue (Sieb khuang nai ngoua) • Beef, intestine, raw (Sai ngoua dip) • Beef, liver, grilled (Ping tab ngoua) • Beef, liver, raw (Tab ngoua dip) • Beef, lung, raw (Pod ngoua dip) • Beef, spleen, raw (Mam ngoua dip) • Beef, stomach, raw (Phoung ngoua dip) Chicken, Organ Meat: • Chicken liver, boiled (Toom tab kai) • Chicken, gizzard, raw (Tai kai dip) • Chicken, heart (Houa chay kai dip) • Chicken, liver, grilled (Ping tab kai) • Chicken, liver, raw (Tab kai dip) Pork, Organ Meat: • Pork, liver, grilled (Ping tab moo) • Pork, liver, raw (Tab moo dip) • Pork, spleen, raw (Mam moo dip) • Pork, blood, boiled (Toom leuad moo) (blood sausage)	☐ 1 Yes ☐ 2 No
82. FISH/SEAFOOD: Fresh, frozen or dried fish, eels shellfish, or seafood. • Eels • Fermented fish, sour, fried (Cheun pa som) • Fermented fish with bone (Pa deak niew) (Small,whole fish,with bones) • Nile tilapia fish, raw (Pa nin dip) • Nile tilapia, roasted (Ping pa nin) • Short-bodied mackerel fried (Cheua pa tu) • Short-bodied mackerel, roasted (Ping pa tu)	☐ 1 Yes ☐ 2 No

Minimum Acceptable Diet (MAD) (6-23 months of age)	
• Siamese mud carp, grilled (Ping pa khao) • Fish powder • Seafood Other: Please specify	
82. EGGS: • Chicken Hen egg, fried (Cheuan khai dao) • Chicken Hen Egg, whole (Khai kai dip) • Chicken Hen Egg, whole, boiled (Khai kai toom) • Chicken Omelet hen egg (Cheuan khai kai) • Duck -Omelet duck egg (Cheuan khai pet) • Duck Egg, whole, boiled (kai pet toom) • Monitor Lizard Egg • Other Birds Egg • Quail Egg • Snake Egg	☐ 1 Yes ☐ 2 No
82. DARK GREEN LEAFY VEGETABLES (Exclude herbs eaten in small amounts) • Cassava leaves (Bai man ton) • Chinese cabbage, blanched (Pak kaad khao louak) • Edible Bracken (Phak Kut) • Eugenia Leaves (Phak Samek) • Green amaranth, small, blanched (Pak huom louak) • Green amaranth, small, fresh (Pak huom soth) • Horse Tamarind, young leaves (Bai ka thin soth) • Kale • Melientha Suavis (Phak kased) • Morning Glory /swamp cabbage, blanched (pak bong louak) • Morning Glory /swamp cabbage, fresh (pak bong soth) • Mustard green, blanched (Pak kaad some louak) • Mustard green, stem and leaves (Pak kaad khiew soth) • Mustard, fresh (Pak kaad soum soth) • Sweet potatoe leaves (Bai Man Dang) • Tamarind, young leaf, fresh (bai maak kham onh) • Wildbetal Leafbush (Pak e leuad) • Other (Please Specify): _____	☐ 1 Yes ☐ 2 No
82. VITAMIN A-RICH VEGETABLES, ROOTS AND TUBERS • Carrots • Pumpkin, mature, fresh (Maak eu) • Red Pepper • Squash (orange or dark yellow-fleshed only) • Sweet Potatoes (that are yellow, or orange inside)	☐ 1 Yes ☐ 2 No
82. VITAMIN A-RICH FRUITS • Cantaloupe melon (Mark teang warn) • GAC fruit • Hog Plum • Mango (ripe) • Musk melon • Papaya (ripe) (Maak hung sook)	☐ 1 Yes ☐ 2 No

Minimum Acceptable Diet (MAD) (6 23 months of age)	
● Passion Fruit (Maak nord) ● Peaches (Maak khaii) ● Persimmon ● Other (Please Specify):_____	
82. OTHER VEGETABLES ● Bamboo ● Bean sprouts, fresh (Thoua ngok soth) ● Bean, Yard long bean, green, fresh (Maak thoua ngao soth) ● Cabbage, blanched (Pak ka lam pe louak) ● Cabbage, common, fresh (Pak ka lam pe soth) ● Chayote, boiled (Maak sa ver louak) ● Chayote, fruit, fresh (Maak sa ver soth) ● Chayote young leaves (Yod maak sa ver) ● Cucumber, fresh (Maak teng soth) ● Eggplant (Mark kheua hum ma) ● Eggplant/brinjal, green, fresh (Maak kheua soth) ● Mushrooms ● Onion ● Sponge gourd (mak buap) ● Tomato, fresh (Maak len) ● Other (Please Specify):_____	☐ 1 Yes ☐ 2 No
13. OTHER FRUITS ● Apple, prink, fresh (Maak apple) ● Banana (unripened, grilled) ● Banana, ripe, yellow (Maak kouy nam souk) ● Banana, ripe, yellow, boiled (Maak kouy nam souk toom) ● Coconut Flesh ● Durian Fruit ● Fig ● Guava ● Green Plum (same as Hog Plum) ● Jackfruit ● Jujubes ● Lime ● Lemon (Nam maak nao) ● Litchee Fruit ● Longan ● Mangosteen ● Orange, sweet, fresh (Maak kieng) ● Pear ● Pineapple ● Rumbutam, fresh (Maak ngor) ● Sweetsop ● Star Fruit ● Tamarind ● Tangerine (not the same as oranges) ● Watermelon	☐ 1 Yes ☐ 2 No

Minimum Acceptable Diet (MAD) (6-23 months of age)	
Other (Please Specify): _____	
14. INSECTS AND OTHER SMALL PROTEINS - Bamboo caterpillar - Cicadas - Cockchafer beetles - Green weevil (Meang xang) - Dragonflies - Fish roe - Giant water bugs - Grasshoppers - Horned beetle - Insect eggs - Insect larvae/grubs - Insects - Mole cricket - Scarab beetle (Meang chinoun) - Short-tailed cricket - Snails - Spiders - Sting bug - Termites - Wasps - Wasps arvae (Duang to tor) - Weaver ant larvae (Khai mod som) - Any other small invertebrates - Other (Please Specify): _____	☐ 1 Yes ☐ 2 No
15. CONDIMENTS AND SEASONINGS - Chili pepper, hot, red, fresh - Ginger - Garlic - Fermented fish, liquid - Fish sauce - Lemon grass, fresh - Lime-in 12 other condiments - Lemon – in 12 other condiments - Monosodium glutamate (MSG) - Onion - Oyster sauce - Salt - Shallot, bulb - Tiliacora triandra diels (bai gna nang) Condiment Vegetables - Coriander, fresh (Pak hom pome) - Dill, fresh (Pak ce soth)	☐ 1 Yes ☐ 2 No

Minimum Acceptable Diet (MAD) (6-23 months of age)	
• Hairy basil, fresh (Pak e tu) • Fennel common leaves (Pak hom Pea) • Mint, leaf (Pak houn lab soth) • Pak kha yeng	
16. OTHER OILS AND FATS ☐ Butter ☐ Chicken Fat/Lard ☐ Margarine ☐ Palm Oil ☐ Pork Fat/Lard ☐ Soybean Oil ☐ Sunflower Oil	☐ 1 Yes ☐ 2 No
17. OTHER BEVERAGES AND FOODS ☐ Coffee ☐ Coconut Water ☐ Coke ☐ Coffee with sugar ☐ Energy Drinks ☐ FANTA ☐ Nescafe instant coffee ☐ Ovaltine ☐ Pickles ☐ Mustard green, fermented, sour (Som pak kaad) ☐ Pepsi ☐ Tea ☐ Tea with sugar ☐ Soda ☐ Any other drink with sugar	☐ 1 Yes ☐ 2 No
18. SAVORY AND FRIED SNACKS ☐ Banana Chips ☐ Cassava chips ☐ Fried donuts ☐ Pork Cracklings ☐ Potato Chips ☐ Corn Chips ☐ Local fried snacks—name here ☐ Sweet potatoe chips ☐ Taro Chips ☐ Other (Please Specify): _____	☐ 1 Yes ☐ 2 No
19. SWEETS Cakes, sweets, (kanom), etc. • Candy • Cakes	☐ 1 Yes ☐ 2 No

Minimum Acceptable Diet (MAD) (6 23 months of age)	
• Cookies • Honey • Ice cream • Pastries (sweet, fried or baked) • Peanut candies • Sesame Candies • Sugar Cane • Sweetened condensed milk • Other (Please Specify): _____	
20. BABY/INFANT FORMULA • Baby milk powder, dumex Hi Q brand (Noom foun ka Dumex hi q) • Baby milk powder, lactogen brand (Noom foun ka lactogen) • Infant formula (fortified)	☐ 1 Yes ☐ 2 No
21. PALM OIL Foods made with red palm oil, red palm nut, red palm nut pulp sauce?	☐ 1 Yes ☐ 2 No
-98. OTHER Any other solid or semi-solid food? SPECIFY HERE _____	☐ 1 Yes ☐ 2 No
22. NOTHING EATEN OR DRANK AT ALL	☐ 1 Yes ☐ 2 No

Feeding During Illness (6 23 months of age)	
3.2.s. When (NAME) is ill/sick, how much <u>drink</u> including breast milk is given? [READ OUT LIST]	☐ 1 Nothing to drink ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional Liquids ☐ -97 Don't know
3.2.t. When (NAME) is ill/sick, how much <u>food</u> is given? [READ OUT LIST]	☐ 1 Nothing to eat ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional foods ☐ -97 Don't know
3.2.u. When (Name) is ill/sick and you take them to the doctor or health clinic for a visit, do you receive advice from a doctor about how to feed your sick child?	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor of health clinic ☐ -97 Don't know

Feeding During Illness (6 23 months of age)	
3.2.v. When (Name) is ill/sick and you take them to the doctor or health clinic for a visit, do you receive advice from a doctor about how to change your sanitation and hygiene practices?	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor of health clinic ☐ -97 Don't know

Minimum Acceptable Diet (MAD) (6 23 months of age)	
47. Was yesterday a special day, like a celebration or feast day or a fast day where your child ate special foods or where they ate more or less than usual or did not eat because they were fasting?	
NOTE TO ENUMERATOR: If yesterday was not a special day, then ask the respondent about the types of foods that the child ate yesterday during the day and at night. If yesterday was a special day, then ask the respondent to describe the foods (meals and snacks) that the child consumed the day before yesterday (or the last normal day) during the day and night, whether at home or outside the home. ☐ 1 Yes ☐ 2 No If yes, please specify _____	
48.-Please describe everything that (NAME) ate yesterday ate or drank, starting with yesterday morning and ending with yesterday during the night, whether (NAME) ate it at home or anywhere else (NOTE: Probe for consumption during the 24 hours period from midnight to midnight).	
READ THE LIST OF FOODS BELOW	
82. FOODS MADE FROM GRAINS, WHITE ROOTS AND TUBERS AND PLANTAINS (WHITE FLESH) Food made from grains, white roots, tubers, and plantains (white flesh) including porridge. White potatoes, white yams, manioc, cassava, or any other foods made from roots	☐ 1 Yes ☐ 2 No
82. PULSES (BEANS, PEAS AND LENTILS) Mature beans or peas (fresh or dried seed), lentils or soy products, including tofu or tempeh. • Mature beans • Mature peas • Lentils • Soy products-tofu • Soy products-tempeh • Soy Products-Soymilk • Pigeon pea (mak baep) • Other: Please specify: _____	☐ 1 Yes ☐ 2 No
82. NUTS AND SEEDS • Cashew Nuts • Peanuts • Sesame Paste • Tamarind Nuts	☐ 1 Yes ☐ 2 No

Minimum Acceptable Diet (MAD) (6 23 months of age)	
Other: Please specify: _____	
4. MILK (NOT SOY) AND MILK PRODUCTS: Cheese, yogurt, or other milk products	☐ 1 Yes ☐ 2 No
82. FLESH MEATS: beef, pork, duck, chicken, birds, frogs, wild game? Beef, Other: - Beef ball, blanched (Look sine ngoua) (Processed meat) - Beef, blanched (Choum sine ngoua) (Red meat) - Beef, dried, grilled (Ping sine ngoua hang) (Red meat) - Beef, dry, fried (Cheun sine ngoua hang) (Red meat) - Beef, grilled (Ping sine ngoua) (Red meat) - Beef, raw (Sine ngoua dip) (Red meat) Chicken/Poultry, Other: - Chicken, roasted (Ping kai) - Chicken, boiled (Toom sine kai) - Chicken, raw (Sine kai dip) - Duck, roasted (Ping pet) Pork, Other: - Pork sausage, grilled (Ping sai oua moo) (Processed meat) - Pork, boiled (Toom sine moo) - Pork, grilled (Ping sine moo) - Pork, raw (Sine moo soth) - Pork, shredded, arvae style (Moo foi) (Processed meat) - Pork, skin, raw (Nang moo dip) (Other animal parts)	☐ 1 Yes ☐ 2 No
82. ORGAN MEAT Liver, kidney, heart, or other organ meats (including blood-based food). Beef, Organ Meat: - Beef internal organ barbecue (Sieb kheuang nai ngoua) - Beef, intestine, raw (Sai ngoua dip) - Beef, liver, grilled (Ping tab ngoua) - Beef, liver, raw (Tab ngoua dip) - Beef, lung, raw (Pod ngoua dip) - Beef, spleen, raw (Mam ngoua dip) - Beef, stomach, raw (Phoung ngoua dip) Chicken, Organ Meat: - Chicken liver, boiled (Toom tab kai) - Chicken, gizzard, raw (Tai kai dip) - Chicken, heart (Houa chay kai dip) - Chicken, liver, grilled (Ping tab kai) - Chicken, liver, raw (Tab kai dip) Pork, Organ Meat: - Pork, liver, grilled (Ping tab moo) - Pork, liver, raw (Tab moo dip)	☐ 1 Yes ☐ 2 No

Minimum Acceptable Diet (MAD) (6 23 months of age)	
• Pork, spleen, raw (Mam moo dip) • Pork, blood, boiled (Toom leuad moo) (blood sausage)	
82. FISH/SEAFOOD: • Fresh, frozen or dried fish, eels shellfish, or seafood. • Eels • Fermented fish, sour, fried (Cheun pa som) • Fermented fish with bone (Pa deak niew) (Small,whole fish,with bones) • Nile tilapia fish, raw (Pa nin dip) • Nile tilapia, roasted (Ping pa nin) • Short-bodied mackerel fried (Cheua pa tu) • Short-bodied mackerel, roasted (Ping pa tu) • Siamese mud carp, grilled (Ping pa khao) • Fish powder • Seafood Other: Please specify	☐ 1 Yes ☐ 2 No
82. Eggs: • Chicken Hen egg, fried (Cheuan khai dao) • Chicken Hen Egg, whole (Khai kai dip) • Chicken Hen Egg, whole, boiled (Khai kai toom) • Chicken Omelet hen egg (Cheuan khai kai) • Duck -Omelet duck egg (Cheuan khai pet) • Duck Egg, whole, boiled (kai pet toom) • Monitor Lizard Egg • Other Birds Egg • Quail Egg • Snake Egg	☐ 1 Yes ☐ 2 No
82. DARK GREEN LEAFY VEGETABLES • (Exclude herbs eaten in small amounts) • Cassava leaves (Bai man ton) • Chinese cabbage, blanched (Pak kaad khao louak) • Edible Bracken (Phak Kut) • Eugenia Leaves (Phak Samek) • Green amaranth, small, blanched (Pak huom louak) • Green amaranth, small, fresh (Pak huom soth) • Horse Tamarind, young leaves (Bai ka thin soth) • Kale • Melientha Suavis (Phak kased) • Morning Glory /swamp cabbage, blanched (pak bong louak) • Morning Glory /swamp cabbage, fresh (pak bong soth) • Mustard green, blanched (Pak kaad some louak) • Mustard green, stem and leaves (Pak kaad khiew soth) • Mustard, fresh (Pak kaad soum soth) • Sweet potatoe leaves (Bai Man Dang) • Tamarind, young leaf, fresh (bai maak kham onh) • Wildbetal Leafbush (Pak e leuad)	☐ 1 Yes ☐ 2 No

Minimum Acceptable Diet (MAD) (6-23 months of age)	
Other (Please Specify): _____	
82. VITAMIN A-RICH VEGETABLES, ROOTS AND TUBERS - Carrots - Pumpkin, mature, fresh (Maak eu) - Red Pepper - Squash (orange or dark yellow-fleshed only) - Sweet Potatoes (that are yellow, or orange inside)	☐ 1 Yes ☐ 2 No
82. VITAMIN A-RICH FRUITS - Cantaloupe melon (Mark teang warn) - GAC fruit - Hog Plum - Mango (ripe) - Musk melon - Papaya (ripe) (Maak hung sook) - Passion Fruit (Maak nord) - Peaches (Maak khaii) - Persimmon - Other (Please Specify): _____	☐ 1 Yes ☐ 2 No
82. OTHER VEGETABLES - Bamboo - Bean sprouts, fresh (Thoua ngok soth) - Bean, Yard long bean, green, fresh (Maak thoua ngao soth) - Cabbage, blanched (Pak ka lam pe louak) - Cabbage, common, fresh (Pak ka lam pe soth) - Chayote, boiled (Maak sa ver louak) - Chayote, fruit, fresh (Maak sa ver soth) - Chayote young leaves (Yod maak sa ver) - Cucumber, fresh (Maak teng soth) - Eggplant (Mark kheua hum ma) - Eggplant/brinjal, green, fresh (Maak kheua soth) - Mushrooms - Onion - Sponge gourd (mak buap) - Tomato, fresh (Maak len) - Other (Please Specify): _____	☐ 1 Yes ☐ 2 No
13. OTHER FRUITS - Apple, pink, fresh (Maak apple) - Banana (unripened, grilled) - Banana, ripe, yellow (Maak kouy nam souk) - Banana, ripe, yellow, boiled (Maak kouy nam souk toom) - Coconut Flesh - Durian Fruit - Fig - Guava	☐ 1 Yes ☐ 2 No

Minimum Acceptable Diet (MAD) (6-23 months of age)	
• Green Plum (same as Hog Plum) • Jackfruit • Jujubes • Lime • Lemon (Nam maak nao) • Litchee Fruit • Longan • Mangosteen • Orange, sweet, fresh (Maak kieng) • Pear • Pineapple • Rumbutam, fresh (Maak ngor) • Sweetsop • Star Fruit • Tamarind • Tangerine (not the same as oranges) • Watermelon • Other (Please Specify): _____	
14. INSECTS AND OTHER SMALL PROTEINS • Bamboo caterpillar • Cicadas • Cockchafer beetles • Green weevil (Meang xang) • Dragonflies • Fish roe • Giant water bugs • Grasshoppers • Horned beetle • Insect eggs • Insect larvae/grubs • Insects • Mole cricket • Scarab beetle (Meang chinoun) • Short-tailed cricket • Snails • Spiders • Sting bug • Termites • Wasps • Wasps larva (Duang to tor) • Weaver ant larvae (Khai mod som) • Any other small invertebrates • Other (Please Specify): _____	☐ 1 Yes ☐ 2 No
15. CONDIMENTS AND SEASONINGS • Chili pepper, hot, red, fresh • Ginger • Garlic	☐ 1 Yes ☐ 2 No

Minimum Acceptable Diet (MAD) (6-23 months of age)	
• Fermented fish, liquid • Fish sauce • Lemon grass, fresh • Lime-in 12 other condiments • Lemon – in 12 other condiments • Monosodium glutamate (MSG) • Onion • Oyster sauce • Salt • Shallot, bulb • Tiliacora triandra diels (bai gna nang) Condiment Vegetables • Coriander, fresh (Pak hom pome) • Dill, fresh (Pak ce soth) • Hairy basil, fresh (Pak e tu) • Fennel common leaves (Pak hom Pea) • Mint, leaf (Pak houm lab soth) • Pak kha yeng	
16. OTHER OILS AND FATS ☐ Butter ☐ Chicken Fat/Lard ☐ Margarine ☐ Palm Oil ☐ Pork Fat/Lard ☐ Soybean Oil ☐ Sunflower Oil	☐ 1 Yes ☐ 2 No
17. OTHER BEVERAGES AND FOODS ☐ Coffee ☐ Coconut Water ☐ Coke ☐ Coffee with sugar ☐ Energy Drinks ☐ FANTA ☐ Nescafe instant coffee ☐ Ovaltine ☐ Pickles ☐ Mustard green, fermented, sour (Som pak kaad) ☐ Pepsi ☐ Tea ☐ Tea with sugar ☐ Soda ☐ Any other drink with sugar	☐ 1 Yes ☐ 2 No

Minimum Acceptable Diet (MAD) (6-23 months of age)	
18. SAVORY AND FRIED SNACKS ☐ Banana Chips ☐ Cassava chips ☐ Fried donuts ☐ Pork Cracklings ☐ Potato Chips ☐ Corn Chips ☐ Local fried snacks—name here ☐ Sweet potatoe chips ☐ Taro Chips ☐ Other (Please Specify): _____	☐ 1 Yes ☐ 2 No
19. SWEETS Cakes, sweets, (kanom), etc. • Candy • Cakes • Cookies • Honey • Ice cream • Pastries (sweet, fried or baked) • Peanut candies • Sesame Candies • Sugar Cane • Sweetened condensed milk • Other (Please Specify): _____	☐ 1 Yes ☐ 2 No
20. BABY/INFANT FORMULA • Baby milk powder, dumex Hi Q brand (Noom foun ka Dumex hi q) • Baby milk powder, lactogen brand (Noom foun ka lactogen) • Infant formula (fortified)	☐ 1 Yes ☐ 2 No
21. PALM OIL Foods made with red palm oil, red palm nut, red palm nut pulp sauce?	☐ 1 Yes ☐ 2 No
-98. OTHER Any other solid or semi-solid food? SPECIFY HERE _____	☐ 1 Yes ☐ 2 No
22. NOTHING EATEN OR DRANK AT ALL	☐ 1 Yes ☐ 2 No

	Child 1	Child 2	Child 3	Child 4	Child 5
Breastfeeding During Illness (6-23 months of age)					
49. When you are breastfeeding and <u>you</u> are sick or ill (with diarrhea or fever), how do you change the way you feed your child?	☐ 1 Continue breastfeeding when possible and feed more fluid/foods ☐ 2 Reduce breastfeeding ☐ 3 Stop breastfeeding ☐ -97 Don't know ☐ 4 Do not change behavior ☐ -98 Other	☐ 1 Continue breastfeeding when possible and feed more fluid/foods ☐ 2 Reduce breastfeeding ☐ 3 Stop breastfeeding ☐ -97 Don't know ☐ 4 Do not change behavior ☐ -98 Other	☐ 1 Continue breastfeeding when possible and feed more fluid/foods ☐ 2 Reduce breastfeeding ☐ 3 Stop breastfeeding ☐ -97 Don't know ☐ 4 Do not change behavior ☐ -98 Other	☐ 1 Continue breastfeeding when possible and feed more fluid/foods ☐ 2 Reduce breastfeeding ☐ 3 Stop breastfeeding ☐ -97 Don't know ☐ 4 Do not change behavior ☐ -98 Other	☐ 1 Continue breastfeeding when possible and feed more fluid/foods ☐ 2 Reduce breastfeeding ☐ 3 Stop breastfeeding ☐ -97 Don't know ☐ 4 Do not change behavior ☐ -98 Other
50. When you are breastfeeding and <u>your child</u> is sick or ill (with diarrhea or fever), how do you change the way you feed your child?	☐ 1 Continue breastfeeding when possible and feed more fluid/foods ☐ 2 Reduce breastfeeding ☐ -97 Don't know ☐ 4 Do not change behavior ☐ -98 Other	☐ 1 Continue breastfeeding when possible and feed more fluid/foods ☐ 2 Reduce breastfeeding ☐ -97 Don't know ☐ 4 Do not change behavior ☐ -98 Other	☐ 1 Continue breastfeeding when possible and feed more fluid/foods ☐ 2 Reduce breastfeeding ☐ -97 Don't know ☐ 4 Do not change behavior ☐ -98 Other	☐ 1 Continue breastfeeding when possible and feed more fluid/foods ☐ 2 Reduce breastfeeding ☐ -97 Don't know ☐ 4 Do not change behavior ☐ -98 Other	☐ 1 Continue breastfeeding when possible and feed more fluid/foods ☐ 2 Reduce breastfeeding ☐ -97 Don't know ☐ 4 Do not change behavior ☐ -98 Other

	Child 1	Child 2	Child 3	Child 4	Child 5
Feeding During Illness (6-23 months of age)					
51. When (NAME) is ill/sick, how much <u>drink</u> including breast milk is given? [READ OUT LIST]	☐ 1 Nothing to drink ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional liquids ☐ -97 Don't know	☐ 1 Nothing to drink ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional liquids ☐ -97 Don't know	☐ 1 Nothing to drink ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional liquids ☐ -97 Don't know	☐ 1 Nothing to drink ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional liquids ☐ -97 Don't know	☐ 1 Nothing to drink ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional liquids ☐ -97 Don't know
52. When (NAME) is ill/sick, how much <u>food</u> is given? [READ OUT LIST]	☐ 1 Nothing to eat ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional foods ☐ -97-Don't know	☐ 1 Nothing to eat ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional foods ☐ -97-Don't know	☐ 1 Nothing to eat ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional foods ☐ -97-Don't know	☐ 1 Nothing to eat ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional foods ☐ -97-Don't know	☐ 1 Nothing to eat ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional foods ☐ -97-Don't know
53. When (Name) is ill/sick and you take them to the doctor or health clinic for a visit, do you receive advice from a doctor about how to feed your sick child?	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor or health clinic ☐ -97 Don't know	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor or health clinic ☐ -97 Don't know	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor or health clinic ☐ -97 Don't know	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor or health clinic ☐ -97 Don't know	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor or health clinic ☐ -97 Don't know

	Child 1	Child 2	Child 3	Child 4	Child 5
Feeding During Illness (6-23 months of age)					
54. When (Name) is ill/sick and you take them to the doctor or health clinic for a visit, do you receive advice from a doctor about how to change your sanitation and hygiene practices?	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor or health clinic ☐ -97 Don't know	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor or health clinic ☐ -97 Don't know	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor or health clinic ☐ -97 Don't know	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor or health clinic ☐ -97 Don't know	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor or health clinic ☐ -97 Don't know

Section 3.3. Use of Quality Nutrition/Health Services

TRANSITION WITH THE CAREGIVER/MOTHER AND SAY:

“Now I would like to ask you about some of the health and nutrition services that you and your CU5 years of age may or may not receive”

Growth Monitoring and Promotion (GMP)	
THESE QUESTIONS INCLUDE ALL CHILDREN UNDER 5 YEARS OF AGE	
55. Have you with your child (0-59 months of age) participated in monthly community growth monitoring and promotion (along with immunizations)? [ASK TO SEE THE GROWTH BOOK MONITORING CHART]	☐ 1 Yes ☐ 2 No
56. Do you have pink book “Mother and Child Health Monitoring Book” for (CHILD’S NAME)?	☐ 1 Yes, book is available (seen by enumerator) ☐ 2 No, book is not available ☐ 3 Do not have the book ☐ Q59
[RECORD OBSERVATION ONLY] 57a. Does the child have an up-to-date growth chart? Note: “Up-to-date” means most recent recording has been taken.	☐ 1 Yes ☐ 2 No ☐ -97 Don’t know
[RECORD OBSERVATION ONLY] 57b. Is the growth chart completed to date? Note: “Completed to date” means completed every time a child gets a vaccination, the child should also have their height and weight recorded	☐ 1 Yes ☐ 2 No ☐ -97 Do Not know
58. Is the child fully immunized according to the pink book “Mother and Child Health Monitoring Book”? Note: Fully immunize means having complete vaccinations based on the age. A CU5 should be vaccinated five times. The first four times is done when they are 4-5 months old.	☐ 1 Yes ☐ 2 No ☐ -97 Don’t Know
Women’s Access to Health Care	
59. Have you experienced any concern accessing health care? [DO NOT READ OUT LIST]	
☐ 1 Knowing where to go for treatment	
☐ 2 Getting permission to go for treatment	
☐ 3 Getting money for treatment	
☐ 4 Distance to health facility	
☐ 5 Having to take transportation	
☐ 6 Not wanting to go alone	
☐ 7 Concern there may not be a female provider	
☐ 8 None	
☐ -98 Other (Please specify) _____	
☐ -97 Don’t know	
ANC	

60. Did you see anyone for ANC during your pregnancy with your most recent child?	☐ 1 Yes	☐ 2 No ☐ Q64 ☐ -97 Don't Know ☐ Q64
60.a. Whom did you see?		
☐ 1 Doctor		
☐ 2 Nurse/midwife		
☐ 3 Health Center Nurse		
☐ 4 Nutrition Facilitator		
☐ 5 Community Health Volunteer		
☐ 6 Traditional Birth Attendant		
☐ -98 Other: (specify) _____		
60.b. How many times during your pregnancy did you attend ANC? [PROBE TO IDENTIFY THE NUMBER OF TIMES ANC WAS RECEIVED. IF A RANGE IS GIVEN, RECORD THE MINIMUM NUMBER OF TIMES ANC RECEIVED.]		
☐ 1 Once ☐ Q60d		
☐ 2 Twice ☐ Q60d		
☐ 3 Three times ☐ 60d		
☐ 4 Four times ☐ 60d		
☐ 5 More than four times		
☐ -97 Don't know ☐ 60d		
60.c. If more than four times, how many times?		
60d. How many months pregnant were you when you first received ANC for this pregnancy? [If '9 Months' or later, record 9. Enter -97 for don't know]		
Breastfeeding during ANC		
61. Did you receive breastfeeding information during your ANC visit?	☐ 1 Yes ☐ 2 No ☐ Q63 ☐ -97 I Know ☐ Q63	
62. What breastfeeding information was shared? [SELECT MULTIPLE]		
☐ 1 Immediate Breastfeeding – baby should be put upon the breast immediately after birth		
☐ 2 Exclusive breastfeeding – breastfeed exclusively with breast milk, no other food or liquids (e.g., cerealac/rice), for six months		
☐ 3. Avoid water or rice until child is six months because breast milk is adequate food		
☐ 4 Initiate breastfeeding within one hour of birth		
☐ 5 Breastfeed for adequate duration (until child is full)		
☐ 6 Dietary counseling		
☐ 7 Direct Maternal and Infant and Young Child Feeding counseling		
☐ -98 Other (specify) _____		
☐ -97 Don't know/No response		
Iron and Folic Acid (IFA) during ANC		
63. During your most recent pregnancy, were you given or did you buy any iron and folic acid (IFA) tablets during ANC?	☐ 1 Yes ☐ 2 No ☐ Q64 ☐ Don't know ☐ Q64	

63.a. During the whole pregnancy, for how many days did you take iron and folic acid (IFA) tablets? Enter integer: _____ [If answer is not numeric, probe for approximate number of days. Enter '0' if no tablets were consumed.]		
63.b. From where did you receive iron and folic acid (IFA) tablets?		
☐ 1 Private clinic		
☐ 2 Local pharmacy		
☐ 3 Community Health Worker		
☐ 4 Nurse/midwife		
☐ 5 Health Center Nurse		
☐ 6 Nutrition Facilitator		
☐ 7 Community Health Volunteer		
☐ 8 Hospital		
☐ -98 Other, specify		
63.c. After receiving the tablets, did you take them?		
☐ 1 Yes, took all		
☐ 3 Yes, but only took some of them		
☐ 2 No, took none		
☐ 4 No-threw them ALL away		
☐ -97 Don't know		
Pregnancy and PNC		
64. When you became pregnant with your most recent child, did you change your habits?	☐ I-Yes	☐ 2 No ☐ Q66 ☐ Don't Know ☐ Q66
65. How did you change your habits? [MULTIPLE ANSWERS ALLOWED] [DO NO READ RESPONSES. THIS SHOULD BE PROBING ONLY]		
☐ 1 Ate locally available vegetables (cabbage, arvae cabbage, koli flower, morning glory, lettuce, arvae mustard, eggplant, pumpkin, taro, sweet potato, corn, coriander, green onion, mints, garlic, onion, ginger)		
☐ 2 Ate locally available fruits		
☐ 3 Eat an additional 400-500 kcal each day i.e., ate one extra meal a day during pregnancy in addition to regular meals, and two extra meals during breastfeeding		
☐ 4 Eat a diverse diet, including animal source foods		
☐ 5 Collect extra fish, frogs, eggs and vegetables each day		
☐ 6 Set aside food during preparation to eat between meals		
☐ 7 Preserve and store food to eat during pregnancy		
☐ 8 Let food settle for some time after eating		
☐ 9 Seek ANC early – as soon as pregnancy starts		
☐ 10 Take rest during the second and third trimesters		
☐ -98 Other (specify)		
☐ -97 Don't know/no response		
Food Taboos		

66. Did you avoid any foods while you were pregnant with your most recent child?	☐ Yes	☐ No ☐ Q68 ☐ Don't Know ☐ Q68
67. What foods did you avoid? [MULTIPLE ANSWERS ALLOWED]		
☐ 1 Chicken		
☐ 2 Beef		
☐ 3 White Buffalo		
☐ 4 Fish/Seafood		
☐ 5 Eggs		
☐ 6 Pickled Foods		
☐ 7 Fruits		
☐ 8 Vegetables		
☐ 9 Spicy foods		
☐ -98 Other (specify) _____		
☐ -97 Don't know/No response		
After Delivery: Care		
68. During the first two days after (CHILD's NAME) birth, did any health care provider (at the health facility or after a home delivery) do the following: [READ OUT]		
68.a. Examine the cord?	☐ 1 Yes ☐ 2 No ☐ -97 Don't Know	
68.b. Measure (CHILD's NAME) temperature?	☐ 1 Yes ☐ 2 No ☐ -97 Don't Know	
68.c. Counsel you on danger signs for newborns?	☐ 1 Yes ☐ 2 No ☐ -97 Don't Know	
68.d. Counsel you on breastfeeding?	☐ 1 Yes ☐ 2 No ☐ -97 Don't Know	
68.e. Observe (CHILD's NAME) breastfeeding?	☐ 1 Yes ☐ 2 No ☐ -97 Don't Know	
68.f. Counsel you on what to do and how to feed your child when he/she is sick	☐ 1 Yes ☐ 2 No ☐ -97 Don't Know	
After Delivery: Attachment		
69. After delivery, did a health care provider show you how to position and attach your baby to your breast?	☐ 1 Yes ☐ 2 No ☐ Q70 ☐ -97 Don't Know ☐ Q70	
69.a. What did you learn? [MULTIPLE ANSWERS ALLOWED] [DO NOT READ ANSWERS, PROBING ONLY]		
☐ 1 Cradle position (most commonly used)		
☐ 2 Sideline, side-lying position (can be used right after delivery, to rest while breastfeeding or at night)		
☐ 3 Cross cradle position (good for small babies)		

☐ 4 Under-arm position (use after caesarean section, if your nipples are painful or if mother is breastfeeding twins or a small baby).
☐ -97 Don't know/no response
Nutrition-Related Actions
70. Can you recall any nutrition-related actions that you heard from a health center, community health worker, or peer group that are intended to improve the health or nutrition of pregnant women or children? [MULTIPLE ANSWERS ALLOWED, NO PROBES, DO NOT READ OUT LIST]
☐ 1 Adolescent girls, pregnant women, lactating women eat additional food each day
☐ 2 Adolescent girls, pregnant women, lactating women eat a diverse diet, including animal source foods
☐ 3 Pregnant women take more rest from the time the baby moves to reduce the workload
☐ 4 Ensure Pregnant and lactating women take Iron Folic Acid
☐ 5 Initiate breastfeeding within one hour of birth
☐ 6 Lactating Women exclusively breastfeed for first six months
☐ 7 Breastfeed for adequate duration (until child is full)
☐ 8 Ensure baby receives initial colostrum from birth
☐ 9 Children 6-23 months of age are fed using active feeding techniques
☐ 10 Children 6-23 months of age eat an age-appropriate quantity of food each day
☐ 11 Children 6-23 months of age eat an adequately diverse diet, including animal-source foods
☐ 12 Children 0-23 months of age olds receive extra feeding during and for 1-2 weeks after illness
☐ 13 None
☐ -97 Don't know/Can't recall

SECTION 4. WATER, SANITATION AND HYGIENE (WASH) BEHAVIORS

TRANSITION WITH THE CAREGIVER/MOTHER AND SAY:

“Now I would like to ask you about water, sanitation and hygiene in your household and community”

Basic (Improved) Sanitation (used UNICEF/WHO Joint Monitoring Standards Improved Sanitation vs. basic)			
71. Are there households in this community that do not use latrines (including adults and children)?		☐ 1 Yes ☐ 2 No ☐ -97 Don't know	
72. In the past, did the community have projects (funded by the government or others) for households to get latrines?		☐ 1 Yes ☐ 2 No ☐ -97 Don't know	
Safe Water			
73./74. What is the <u>main</u> source of water for members of your household?			
RAINY SEASON		DRY SEASON	
<i>Improved facilities</i>			
☐	1 Piped supplies: Tap water in the dwelling, yard or plot	☐	1 Piped supplies: Tap water in the dwelling, yard or plot
☐	2 Piped supplies: Public stand posts	☐	2 Piped supplies: Public stand posts
☐	3 Non-piped supplies: Boreholes/tube wells	☐	3 Non-piped supplies: Boreholes/tube wells
☐	4 Non-piped supplies: Protected wells and springs	☐	4 Non-piped supplies: Protected wells and springs
☐	5 Non-piped supplies: Rainwater	☐	5 Non-piped supplies: Rainwater
☐	6 Non-piped supplies: Packaged water, including bottled water and sachet water	☐	6 Non-piped supplies: Packaged water, including bottled water and sachet water
☐	7 Non-piped supplies: Delivered water, including tanker trucks and small carts	☐	7 Non-piped supplies: Delivered water, including tanker trucks and small carts
<i>Unimproved Facilities</i>			
☐	8 Unimproved Facilities: Non-piped supplies: unprotected wells and springs	☐	8 Unimproved Facilities: Non-piped supplies: unprotected wells and springs
<i>No Facilities: Surface Water</i>			
☐	9 No facilities: surface water	☐	9 No facilities: surface water
☐	-97. Don't know/no response	☐	-97 Don't know/no response
75. Do members in your household go to the water source to fetch water? ☐ 1 Yes ☐ 2 No ☐ Q79 ☐ 8 Don't know ☐ Q79			
76. How many minutes does it take for members of your household to collect water in the rainy season? _____			
77. How many minutes does it take for members of your household to collect water in the dry season? _____			
78. Who usually goes to the water source to collect the water for your household? <i>PROBE: IS THIS PERSON UNDER AGE 15? [SELECT ONE]</i>			
☐	1 Adult woman		
☐	2 Adult man		
☐	3 Female child (under 15 years of age)		
☐	4 Male child (under 15 years of age)		
☐	-97 Don't Know		

79. Do you use any methods to treat your household drinking water for children 6-23 months of age?	
☐	1 Boil the water
☐	2. Filter the water
☐	3 Purchase water
☐	4 Treatment with Chlorine
☐	5 Treatment with Alum (Aluminum Sulfate)
☐	-98 Other (SPECIFY): _____
☐	6 Do nothing
☐	-97 Don't Know
80. Do you use any methods to treat your household drinking water for adults?	
☐	1 Boil the water
☐	2. Filter the water
☐	3 Purchase water
☐	4 Treatment with Chlorine
☐	5 Treatment with Alum (Aluminum Sulfate)
☐	-98 Other (SPECIFY): _____
☐	6 Do nothing
☐	-97 Don't Know
Safe Water Storage	
81. Which of the following storage methods do you use to store drinking water? [MULTIPLE ANSWERS ALLOWED] [READ OUT]	
☐	1 Plastic jug
☐	2 Ceramic or metal containers
☐	3 Bucket with lid
☐	4 Rainwater collection and storage system
☐	-98 Other (SPECIFY): _____
☐	-97 Don't Know ☐ Q84
☐	9 None ☐ Q84
Household Water Treatment	
82. Does your drinking water storage container have a small/narrow or large spout? (i.e., can you put your hand in the container or are you forced to pour the water from the container?)	
☐	1 Small/narrow spout
☐	2 Large spout
83. Does your drinking water storage method have lids or fitted covers?	
☐	1 Yes
☐	2 No
84. Does your household use any drinking water treatment methods? [DO NOT READ OUT]	
☐	1 Water filtration (physical removal)
☐	2 Solar disinfection (ultraviolet/heat disinfection)
☐	3 Boiling (disinfection via heat)
☐	4 No treatment

☐	-98 Other (SPECIFY): _____	
☐	-97 Don't Know	
Household Hand Washing Station		
85. Does your household have a special place for hand washing at a toilet facility?		☐ 1 Yes ☐ 2 No ☐ -97 Don't know
86. Does your household have a special place for hand washing near the house's cooking/eating area?		☐ 1 Yes ☐ 2 No ☐ -97 Don't know
87. Are household washing locations used for purposes other than hand washing? If other, specify: _____		☐ 1 No, not used for other purposes ☐ 2 Yes, to clean nappies ☐ 3 Yes, to wash clothes ☐ 4 Yes, to clean dishes ☐ 5 Yes, to shower ☐ 6 Yes, to cook ☐ 7 There is no handwashing station at this household ☐ -98 Other
Hand washing with Soap		
88. Normally, when do you wash your hands with soap/ash? (When else?) [MULTIPLE ANSWERS ALLOWED] PROBE WHEN THE CAREGIVER WASHES THEIR HANDS AND <u>DO</u> NOT OFFER THE ANSWER].		
☐	1 Never	
☐	2 Before preparing food	
☐	3 Before eating	
☐	4 Before feeding children	
☐	5 After defecating	
☐	6 After attending to a child who has defecated (changing a baby's bottoms)	
☐	-98 Other (specify)	
☐	-97 Don't know/No response	
89. When do you wash your child's hands (children under 2) with soap/ash? (When else?) [MULTIPLE ANSWERS ALLOWED] PROBE WHEN THE CAREGIVER WASHES THEIR CHILD'S HANDS AND <u>DO NOT OFFER THE ANSWER</u>].		
☐	1 Never	
☐	2 Before preparing food	
☐	3 Before eating	
☐	4 Before feeding children	
☐	5 After defecating	
☐	6 After attending to a child who has defecated (changing a baby's bottoms)	
☐	-98 Other (specify)	
☐	-97 Don't know/No response	
Safe Disposal of Feces (Human)		
90. The last time the youngest child passed stools, what was done to dispose of the stools? [PROBE]		
Safe Disposal		
☐	1 Child used toilet/latrine	
☐	2 Put/rinsed into toilet or latrine	

Unsafe Disposal			
☐	3 Put/rinsed into drain or ditch		
☐	4 Thrown into garbage (solid waste)		
☐	5 Buried		
☐	6 Left in the open		
☐	-98 Other		
☐	-97 Don't know		
Clean Play Space for Children			
91. When you can't carry the child, where do mainly you put them?			
☐	1 On the ground floor (with no flooring)		
☐	2 On the wood floor		
☐	3 On the cement floor		
☐	4 On some protective layer-mat, blanket, etc.		
☐	5 Hammock		
☐	6 Basket		
☐	7 Playpen		
☐	8 Baby bed		
☐	-98 Other (SPECIFY): _____		
☐	-97 Don't know		
92. Where does the child mainly sleep during the night or day? PROBE FOR THE MOST COMMON AREA (should be one choice for each day and night)			
92a. Day		92b. Night	
☐	1 On the ground floor (with no flooring)	☐	1 On the ground floor (with no flooring)
☐	2 On the wood floor	☐	2 On the wood floor
☐	3 On the cement floor	☐	3 On the cement floor
☐	4 On some protective layer-mat, blanket, etc.	☐	4 On some protective layer-mat, blanket, etc.
☐	5 Hammock	☐	5 Hammock
☐	6 Basket	☐	6 Basket
☐	7 Playpen	☐	7 Playpen
☐	8 Baby bed	☐	8 Baby bed
☐	-98 Other (SPECIFY): _____	☐	-98 Other (SPECIFY): _____
☐	-97 Don't know	☐	-97 Don't know
WASH Information			
93. Did anyone ever talk to you about household water, sanitation and hygiene (WASH)?		☐ I Yes	☐ 2 No ☐ -97 Don't Know ☐ Q95
94. What did you learn? [MULTIPLE ANSWERS ALLOWED-DO NOT READ OUT LOUD ANSWERS]			
☐	1 Hand washing with soap at critical times for yourself		
☐	2 Hand washing with soap at critical times for your child		
☐	3 How to treat drinking water (boil, filter, other)		
☐	4 How to store treated drinking water safely		
☐	5 How to construct a toilet/latrine		

☐	6 How to use a toilet/latrine
☐	7 How to safely dispose of child feces/stools in the toilet/latrine
☐	8 Keep children areas clean (free of human and animal feces)
☐	-98 Other (SPECIFY): _____
☐	-97 Don't know
95. Ask "How do you dispose of exposed animal feces?" [MULTIPLE ANSWERS ALLOWED]	
☐	1 Dumped into a place designated by village authority
☐	2 Dumped into an open space or forest
☐	3 Dumped into a river
☐	4 Make it into compost
☐	5 Burned
☐	6 Buried underground
☐	7 Trash Truck
☐	8 Leave on the ground
☐	9 Collected it into a container or bag
☐	-98 Other (SPECIFY): _____
☐	-97 Don't know

SECTION 5. GENDER EQUITY AND WOMEN'S EMPOWERMENT

TRANSITION WITH THE CAREGIVER/MOTHER AND SAY:

“Now I would like to ask you about gender equality in your household and community”

96. Leadership/Group Member: Are you a member of any microfinance, women's, production or other groups?	☐ 1 Yes	☐ 2 No ☐ -97 Don't Know
97. Leadership/Speaking in Public: Do you feel comfortable speaking up in public:		
☐ 1 Yes, very comfortable	☐ 3 No, not at all comfortable	
☐ 2 Yes, somewhat comfortable	☐ -97 Don't know/Refused	

SECTION 6. OBSERVATIONS

OBSERVATION ONLY	Record observation only
HOME MATERIALS	
98. What are the main materials of the household dwelling roof?	
☐	1 Tile/sipax
☐	2 Zinc/metal
☐	3 Rudimentary Roofing: Wood Planks
☐	4 Rudimentary Roofing: Grass
☐	5 Finished roofing: Wood
☐	6 Finished roofing: Ceramic tiles
☐	-98 Other (specify)
☐	7 None
OBSERVATION ONLY	Record observation only
99. What are the main materials of the dwelling floor of the household?	
☐	1 Natural Floor: Earth/Sand
☐	2 Natural Floor: Dung
☐	3 Rudimentary floor-wood planks
☐	4 Rudimentary floor-Palm/Bamboo
☐	5 Finished floor-parquet or polished wood
☐	6 Finished floor-Vinyl or asphalt strips
☐	7 Finished floor-Ceramic tiles
☐	8 Finished floor-Cement
☐	9 Finished floor-carpet
☐	-98 Other (specify)
100. What are the main materials of the walls of the household?	
☐	1 Finished walls-Bricks
☐	2 Finished walls-Cement Blocks
☐	3 Finished walls-Wood planks/shingles
☐	4 Finished walls-Wall panel
☐	5 Finished walls-Concrete (reinforced concrete)
☐	-98 Other (specify)
☐	6 None
OBSERVATION ONLY	Record observation only
101. KITCHEN OBSERVATION	
In the household's kitchen, is food cooked on an open fire, an open stove or a closed stove?	
☐	1 Open fire
☐	2 Open stove
☐	3 Closed stove
☐	-98 Other (specify)
☐	4 None
HOMESTEAD OBSERVATION ONLY Look at household surrounding area.	

102. Are there animals in the household yard? (Do not include inside the house).	☐ 1 Yes, and at least some wandering freely ☐ 2 Yes, but all penned ☐ 3 No ☐ -97 Don't Know/No response
TOILET/LATRINE OBSERVATION ONLY <i>Look at toilet/latrine area</i>	
103. What kind of toilet facility does the household have? IF "FLUSH" OR "POUR FLUSH", PROBE: WHERE DOES IT FLUSH TO? IF NOT POSSIBLE TO DETERMINE, ASK PERMISSION TO OBSERVE THE FACILITY.	
<i>Improved facilities</i>	
☐	1 Networked Sanitation: Flush and pour flush toilets connected to sewers (if none ignore)
☐	2 On-site sanitation: Flush and pour flush toilets or latrines connected to septic tanks or pits
☐	3 On-site sanitation: Pit latrines with slabs
☐	4 On-site sanitation: Composting toilets, including twin pit latrines and container-based systems
<i>Unimproved Facilities</i>	
☐	5 On-Site sanitation: Pit latrines without slabs
☐	6 On-Site sanitation: Hanging latrines
☐	7 On-Site sanitation: Bucket latrines
<i>Open Defecation</i>	
☐	8 No facilities: open defecation
104. OBSERVATION ONLY: OBSERVE THE PRESENCE OF WATER AT THE PLACE FOR HAND WASHING. IN SOME CASES, WHERE HAND WASHING AREAS ARE MULTI-USE, WE SEE HIGHER CONTAMINATION. WHEN YOU OBSERVE THE HAND WASHING STATION, IS IT ALSO USED FOR OTHER PURPOSES (CLEANING NAPPIES, WASHING CLOTHES, CLEANING DISHES, ETC.). WHEN YOU OBSERVE IT, YOU CAN NOTE WHETHER THE GROUND IS VISIBLY DAMP (AND THEREBY A LIKELY SOURCE OF HIGH CONTAMINATION).	
105. Is water available?	
☐	1 Yes
☐	2 No
106. Hand washing station is visibly used for other uses:	
☐	1 No, not used for other purposes
☐	2 Yes, to clean nappies
☐	3 Yes, to wash clothes
☐	4 Yes, to clean dishes
☐	5 Yes, to shower
☐	6 Yes, for cooking
☐	7 There is no handwashing station at this household
☐	-98 Other (SPECIFY): _____
107. Is the Ground Visibly Damp?	
☐	1 Yes, it is visibly damp
☐	2 No, it is not visibly damp
108. OBSERVATION ONLY: OBSERVE PRESENCE OF SOAP, DETERGENT OR OTHER CLEANSING AGENT NEXT TO THE HAND WASHING STATION (Not Any Other Place)	
☐	1 Soap is available (detergent, bar, liquid, powder, paste) next to the hand washing station
☐	2 Ash, mud or sand is available next to the hand washing station

☐	3 There is NO soap or ash, mud, sand available next to the hand washing station	
Household Hand Washing Station		
I 09. Does the household have a special place for hand washing at a toilet facility? (ASK CAREGIVER TO SHOW YOU AREA) or PLEASE SHOW ME WHERE MEMBERS OF YOUR HOUSEHOLD MOST OFTEN WASH THEIR HANDS.	☐ 1 Yes	☐ 2 No ☐ -97 Don't know
I 10. Does the household have a special place for hand washing near the house's cooking/eating area? (ASK CAREGIVER TO SHOW YOU AREA) or PLEASE SHOW ME WHERE MEMBERS OF YOUR HOUSEHOLD MOST OFTEN WASH THEIR HANDS.	☐ 1 Yes	☐ 2 No ☐ -97 Don't know
Clean Play Space for Children (OBSERVE)		
Ask to see the play space. Do you observe an area free of human and chicken feces?	☐ 1 Yes	☐ 2 No
I 11. Is there a clean play space for the household children (6 to 24 months of age) free of human and chicken feces?		
Interviewers Observation Notes		

SECTION 7. ANTHROPOMETRIC DATA

Section 7.1. Anthropometric Data –Children under 5 Years of Age

ANTHROPOMETRY (Children 0-59 months of age [CU5])

TRANSITION WITH THE CAREGIVER/MOTHER AND SAY: “I WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT THE HEIGHT AND WEIGHT OF CHILDREN IN THIS HOUSEHOLD.”

I 12. Is (Name) available to be measured?		☐ 1 Yes <i>Q114</i>	☐ 2 No <i>Q117</i>
I 13. Why is (Name) not available to be measured?			
☐	1 Child is too ill to be measured		
☐	2 Child is too distressed to be measured		
☐	-98 Other (SPECIFY): _____		

Height (cm.)																																																											
I 14. MEASURE THE CHILDS HEIGHT																																																											
Children under 24 months of age should be measured lying down																																																											
Children 24 months or older should be measured standing up.																																																											
Measure height in centimeters to the nearest 0.1 cm: measure the child																																																											
Child 1				Child 2				Child 3				Child 4				Child 5																																											
Weight (kg)																																																											
I 15. MEASURE THE CHILDS WEIGHT																																																											
Weight in kgs to nearest 0.1 KG																																																											
Child 1				Child 2				Child 3				Child 4				Child 5																																											
I 16. Does (child's name) have bilateral pitting edema? <table border="1"> <tr> <td colspan="4">Child 1</td> <td colspan="4">Child 2</td> <td colspan="4">Child 3</td> <td colspan="4">Child 4</td> <td colspan="4">Child 5</td> </tr> <tr> <td>☐</td><td>Yes</td><td>☐</td><td>No</td><td>☐</td> <td>☐</td><td>Yes</td><td>☐</td><td>No</td><td>☐</td> <td>☐</td><td>Yes</td><td>☐</td><td>No</td><td>☐</td> <td>☐</td><td>Yes</td><td>☐</td><td>No</td><td>☐</td> </tr> </table>																				Child 1				Child 2				Child 3				Child 4				Child 5				☐	Yes	☐	No	☐	☐	Yes	☐	No	☐	☐	Yes	☐	No	☐	☐	Yes	☐	No	☐
Child 1				Child 2				Child 3				Child 4				Child 5																																											
☐	Yes	☐	No	☐	☐	Yes	☐	No	☐	☐	Yes	☐	No	☐	☐	Yes	☐	No	☐																																								

I 17. Questionnaire Status	
☐ 1 Survey Completed <i>Q end</i>	☐ 4 Refused <i>Q 118</i>
☐ 2 Partially completed <i>Q end</i>	☐ 5 Ineligible <i>Q end</i>
☐ 3 Vacant <i>Q end</i>	☐ 6 No one home <i>Q end</i>
I 18. Reason for Refusal	
☐ 1 I am unable to spare the time	☐ 4 I am concerned about privacy
☐ 2 I do not want to spare the time	☐ 5 I am concerned about safety
☐ 3 I am not interested in the topic of this survey	☐ -98 Other (specify) _____

ANNEX I: QUANTITATIVE INSTRUMENT (ENDLINE)

SECTION I. INTERVIEWER (ENUMERATOR) ADMINISTRATIVE IDENTIFICATION QUESTIONS & INFORMED CONSENT

Household Information	
6. Household number: Please enter the household number (may be filled in from sampling assignment documents).	Enumerator's name: b. NAME: _____
Supervisor's name: c. NAME: _____	d. Day / Month / Year of interview: ____ / ____ / 20 ____
Informed Consent	
6. Consent: My name is _____ and I am calling on behalf of Social Impact Inc., an evaluation company based out of the United States, and IndoChina Research, a data collection firm with a regional branch in Laos. We are conducting research for the United States Agency for International Development – or USAID – on the state of child nutrition, maternal nutrition, Water Sanitation and Hygiene – or WASH – practices, and assets and credit in your household and community. You may remember us visiting your household a few years ago for a similar survey. We are now following up with about 630 households we spoke to before to understand how things have changed for you in the past few years. If your household still meets our criteria, we would like to invite you to participate in a brief follow-up survey over the phone. E1. Do you have a few minutes for me to ask you a few qualifying questions? ☐ 1 Yes ☐ 2 No → End E2. Is there anyone who you would consider a member of your household who is currently pregnant? ☐ 1 Yes ☐ 2 No ☐ -88 Prefer not to respond E3. Are there any children between six and 23 months old in your household? ☐ 1 Yes → h5 ☐ 2 No ☐ -88 Prefer not to respond E4. Are there any CU5 in your household? ☐ 1 Yes ☐ 2 No ☐ -88 Prefer not to respond	

Enumerator: work with the household to determine the target respondent based on the inclusion criteria and respondent guidance.

E5. Is the target respondent available to speak with us?

☐ 1 Yes

☐ 2 No

If e2, e3 or e4 = “Yes,” and h5 = “Yes,” proceed with consent with the target respondent. If e2, e3 and e4 = “No” or “Prefer not to respond,” and/or e5 = “No,” thank respondent and end interview.

Introduction: Thank you for answering these questions. You do qualify to complete the interview.

Risk and benefits: Participation in this study will involve an interview over the phone that will take us about 30 minutes. I will ask some questions related to income, assets, nutrition, and pregnancy; other than these sensitive questions, there are no risks to your participation. While there are no direct benefits to you, your participation may benefit other families like yours who participate in future programs.

Confidentiality: I want to assure you that all personally-identifying information you provide during this interview, such as your name and address, will be kept confidential. Only a handful of researchers directly involved in this study will have access to this information.

Recording: With your permission, we would like to record this interview so we can return to it later to check our notes. Only our research team will have access to the recording. After our report is approved, the recording will be deleted.

Data sharing: After removing any information that could identify you, the “de-identified” data may be shared publicly for future research purposes. If you have any questions or concerns about the survey or your rights as a participant, you may contact [IRL contact] at [contact information]. You may also contact Social Impact’s institutional review board at irb@socialimpact.com.

Voluntary participation: Your participation in this study is completely voluntary and you are under no obligation to participate. You may also stop the interview at any time for any reason or skip questions without penalty.

E6. Do you have any questions about this interview?

E7. Do you provide your consent to begin?

☐ 1 Yes

☐ 2 No → End

E8. We would like to record this conversation for quality control purposes. Do you consent to us recording this interview?

☐ 1 Yes

☐ 2 No

Location

f. Province	☐ Khammouane Province (1)	☐ Savannakhet Province (2)
g. District	☐ Bualapha District (1206)	☐ Atsaphangthong District (1303)
	☐ Hinboon District (1204)	☐ Champhone (1306)
	☐ Mahaxay District (1202)	☐ Outhoumphone District (1302)
	☐ Nakai District (1207)	☐ hone District (1304)
	☐ Nhommalath District (1205)	☐ Vilabuly District (1312)
	☐ Xaibouathong District (1203)	☐ Xonbouly District (1314)
h. Village Name & ID	_____ []	_____ []

SECTION 2. HOUSEHOLD DEMOGRAPHIC DATA

TRANSITION WITH THE HEAD OF HOUSEHOLD/CAREGIVER AND SAY:

“Thank you for accepting to participate. I will now ask you some questions about the individuals who live in your household.”

Section 2.1 Household Demographic Data: Head of Household Data

2.1.a. What is your name?	_____
2.1.b. How old are you in years?	_____
2.1.c. What is the highest education level completed by the head of household?	1 Never went 2) Kindergarden/preschool 3) Primary 4) Lower secondary 5 Upper secondary 6 Vocational school 7 College 8 University -97 Don't know
2.1.d. How old is the head of household in years?	_____
2.1.e. Is the head of household male or female?	1 Male 2 Female
2.1.f. Including yourself, how many people are members of this household?	_____
2.1.g. How many women in this household are currently pregnant?	_____

Section 2.2 Household Demographic Data: Household Roster

SECTION TO BE COMPLETED ONLY IF HOUSEHOLD HAS AT LEAST ONE CHILD BETWEEN 6 AND 23 MONTHS OLD. IF NO CHILD BETWEEN 6 AND 23 MONTHS, SKIP TO SECTION 2.3.

Modified Child Roster

WORK WITH THE RESPONDENT TO SELECT A CHILD 6-23 MONTHS OF AGE TO COMPLETE THESE QUESTIONS. THE RESPONDENT SHOULD BE THE PRIMARY CAREGIVER FOR THE SELECTED CHILD.

2.2.a. What is the child's first name?	_____
2.2.b. How old is the child? (In months)	_____
2.2.c. Is (Child's NAME) male or female?	1 Male 2 Female

Section 2.3 Household Demographic Data: Household Data

TRANSITION WITH THE RESPONDENT AND SAY:

“Now, I would like to ask a few more questions about you.”

Primary Caregivers
2.3.a. What is your relationship to (Child's NAME)? [SELECT ONE]
☐ 1 Mother
☐ 2 Grandmother
☐ 3 Aunt
☐ 4 Step-mother
☐ 5 Mother's sister
☐ 6 Father's sister
☐ 7 Paid helper
☐ -98 Other
☐ -97 Don't Know
2.3.b. What is your level of education?
☐ 1 Never went
☐ 2 Kindergarden/Preschool
☐ 3 Primary
☐ 4 Lower Secondary
☐ 5 Upper Secondary
☐ 6 Vocational School
☐ 7 College
☐ 8 University
☐ -97 Don't know

Section 2.4. Household Demographic Data: Household Asset Ownership³³

Household Asset Ownership Non Productive Assets
2.4.a. How many rooms in this household are used for sleeping?
No. of Rooms _____

Household Asset Ownership Land Use, Land Ownership or Entitlement			
2.4.b. Do you or any members of your household participate in home gardening or farming?	☐ 1 Yes	☐ 2 No	☐ -97 Don't Know

Household Asset Ownership Productive Assets	
2.4.c. Do you or your household own productive assets (used for agricultural production, rice processing, and transportation)? If yes, which ones? [SELECT MULTIPLE] [READ OUT]	
☐ 1 Sickle	
☐ 2 Plough	
☐ 3 Fish net	
☐ 4 None	
2.4.d. How many of the following animals does your household own? [SELECT MULTIPLE] [READ OUT] if none write 0.	
	Estimated Number
☐ 1 Chickens	_ _ _
☐ 2 Pigs	_ _ _

Household Asset Ownership Non Productive Assets
2.4.e. Does any member of your household have: [SELECT MULTIPLE] [READ OUT]
☐ 1 Electricity
☐ 2 Mobile Phone
☐ 3 Motorcycle/scooter
☐ 4 Sofa/wooden settee
☐ 5 Washing Machine
☐ 6 Water pump
☐ 7 None

³³ In the Sustainable Livelihoods Framework, the term “asset” is referring to five groups of assets: physical, natural, human, financial and social. “Lao PDR: Comprehensive Food Security & Vulnerability Analysis (CFSVA).” World Food Programme, Vulnerability Analysis and Mapping Branch, November 2006.
<http://documents.wfp.org/stellent/groups/public/documents/vam/wfp178971.pdf>.

SECTION 3. HEALTH/NUTRITION INDICATORS

SECTION TO BE COMPLETED ONLY IF CURRENT RESPONDENT IS A WRA (15-49 YEARS OF AGE). IF NOT, SKIP TO SECTION 3.2.

Section 3.1. Minimum Dietary Diversity for Women (M-DDW)

Women's Dietary Diversity (Minimum Dietary Diversity for Women 15-49 years)

3.1.a. Was yesterday a special day, like a celebration or feast day or a fast day where you ate special foods or where you ate more or less than usual or did not eat because you were fasting?

NOTE TO ENUMERATOR: If yesterday was not a special day, then ask the respondent about the types of foods that the respondent ate yesterday during the day and at night. If yesterday was a special day, then ask the respondent to describe the foods (meals and snacks) consumed the day before yesterday (or the last normal day) during the day and night, whether at home or outside the home.

☐ 1 Yes

☐ 2 No

If yes, specify _____

3.1.b. Now I'd like to ask you to describe everything that you ate or drank, starting with yesterday morning and ending with yesterday during the night, whether you ate it at home or anywhere else (NOTE: Probe for consumption during the 24 hours period from midnight to midnight). Please include all foods and drinks, any snacks or small meals, as well as any main meals. Remember to include all foods you may have eaten while preparing meals or preparing food for others. Please also include food you ate even if it was eaten elsewhere, away from your home.

As I ask you about foods and drinks, please think of foods and drinks you had as snacks or small meals as well as during any main meals. Please also remember foods you may have eaten while preparing meals or preparing food for others.

Let's start with the first food or drink consumed yesterday.

1) NOTE WHETHER YESTERDAY WAS A SPECIAL DAY (RELIGIOUS FESTIVAL OR CELEBRATION) WHEN UNUSUALLY VARIED OR LIMITED DIET WAS EATEN

2) LIST ALL MEALS, WHICH THE RESPONDENT ATE IN THE PREVIOUS DAY IN THE RECORDING MEALS FORM (SEE LINK BELOW). SEE ADULT DIET RECORDING FORM

3) DOUBLE CHECK THE MEALS COMPOSITION (E.G., PORRIDGE WITH OR WITHOUT EGG).

4) CHECK FOR ANY SNACKS (INCLUDING FRUITS) WHICH WERE NOT MENTIONED. 5) ONLY THEN RECORD IN THE QUESTIONNAIRE THAT FOOD GROUPS WERE EATEN. Minimum serving size (in order to tick yes), is palm of the hand, except for the following categories: • Dairy (1 cup) • Insets (handful) • Nuts (handful) • Oil and fats (1-2 teaspoons) • Fried snacks (any amount) • Sweets (any amount) • For fruit and veggies, if eating amount smaller than palm of hand, it is considered a condiment.				
Enumerators – Record responses on paper for the following questions: • What did you eat and drink before breakfast? • What did you eat and drink for breakfast? • What did you eat and drink between breakfast and lunch? • What did you eat and drink for lunch? • What did you eat and drink between lunch and dinner? • What did you eat and drink after dinner? • During the last day or night, did you eat any fruit, vegetables or snacks which you did not mention?				
Instructions: Enumerator please complete for categories for food consumed by the respondent in the last 24 hours				
Food Categories		Consumed in the Last 24 hours?		
I. FOODS MADE FROM GRAINS, WHITE ROOTS AND TUBERS AND PLANTAINS (WHITE FLESH) ☐ Bread ☐ Cassava Root ☐ Corn ☐ Noodles ☐ Other foods made from grains ☐ Plantains ☐ Rice- Black rice		<table border="1"> <tr> <td>1 Yes</td> <td>2 No</td> </tr> </table>	1 Yes	2 No
1 Yes	2 No			

☐ Rice- Glutinous Rice ☐ Rice in bamboo leaves ☐ Rice porridge ☐ Rice-white ☐ Taro ☐ Wheat ☐ White Potatoes ☐ Yams ☐ Other: specify:_____		
2. PULSES (BEANS, PEAS AND LENTILS) Mature beans or peas (fresh or dried seed), lentils or soy products, including tofu or tempeh. ☐ Mature beans ☐ Mature peas ☐ Lentils ☐ Soy products-tofu ☐ Soy products-tempeh ☐ Soy Products-Soymilk ☐ Pigeon pea (mak baep) ☐ Other: Please specify:_____	1 Yes	2 No
3. NUTS AND SEEDS Any tree nuts, groundnut/peanut or certain seeds, or nut/seed, or pastes including sesame. ☐ Cashew Nuts ☐ Peanuts ☐ Sesame Paste ☐ Tamarind Nuts ☐ Other_____	1 Yes	2 No
4. DAIRY: MILK (NOT SOY) AND MILK PRODUCTS ☐ Cheese	1 Yes	2 No

☐ Milk ☐ Milk powder for pregnancy, (Annum brand-Noom foun ka annum) ☐ Milk UHT, (Thaidenmark brand) (dairy products, fluid or powdered milk (non-fortified) ☐ Milk, instant, Annum brand (Noom kong ka annum) (dairy products, fluid or powdered milk (fortified) ☐ Yoghurt ☐ Yoghurt, drinking, foremost brand (Noom som ka foremost; no flavor or sugar) ☐ Other milk products but NOT including butter, dairy ice cream		
MEAT, POULTRY AND FISH/SEAFOOD Beef, pork, goat, rabbit, wild game meat, chicken, duck or other bird, liver, kidney, heat, etc., including blood-based food. 5. MEAT AND POULTRY: Beef, Other: ☐ Beef ball, blanched (Look sine ngoua) (Processed meat) ☐ Beef, blanched (Choum sine ngoua) (Red meat) ☐ Beef, dried, grilled (Ping sine ngoua hang) (Red meat) ☐ Beef, dry, fried (Cheun sine ngoua hang) (Red meat) ☐ Beef, grilled (Ping sine ngoua) (Red meat) ☐ Beef, raw (Sine ngoua dip) (Red meat) ☐ Beef, lab (lab ngoua) Chicken/Poultry, Other: ☐ Chicken, roasted (Ping kai) ☐ Chicken, boiled (Toom sine kai) ☐ Duck, roasted (Ping pet) ☐ Bird, lab (Lab nok) ☐ Bird, roasted (Ping Nok) Pork, Other: ☐ Pork sausage, grilled (Ping sai oua moo) (Processed meat)	I Yes	

☐ Pork fermented (Som Moo) ☐ Pork balls ☐ Pork or wild pork, boiled (Toom sine moo) ☐ Pork or wild pork, grilled (Ping sine moo) ☐ Pork or wild pork, raw (Sine moo soth) ☐ Pork, shredded, arvae style (Moo foi) (Processed meat) ☐ Pork or wild pork, skin, raw (Nang moo dip) (Other animal parts) ☐ Squirrels, grilled (Ping Kahok) Wild meat, Other ☐ Rat ☐ Cat ☐ Dog ☐ Other small wild (bush meat) or domesticated mammals ☐ Frogs and other amphibians ☐ Snakes, gecko, lizard, and other reptiles 6. ORGAN MEAT: Organ Meat: Liver, kidney, heart, or other organ meats (including blood-based food). Beef, Organ Meat: ☐ Beef internal organ barbecue (Ping kheuang nai ngoua) ☐ Beef, intestine, raw (Sai ngoua dip) ☐ Beef, liver, grilled (Ping tab ngoua) ☐ Beef, liver, raw (Tab ngoua dip) ☐ Beef, lung, raw (Pod ngoua dip) ☐ Beef, spleen, raw (Mam ngoua dip) ☐ Beef, stomach, raw (Phoung ngoua dip) Chicken, Organ Meat: ☐ Chicken liver, boiled (Toom tab kai) ☐ Chicken, heart (Houa chay kai dip)		
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☐ Chicken, liver, grilled (Ping tab kai) ☐ Chicken, liver, raw (Tab kai dip) Pork, Organ Meat: ☐ Pork, liver, grilled (Ping tab moo) ☐ Pork, liver, raw (Tab moo dip) ☐ Pork, spleen, raw (Mam moo dip) ☐ Pork, blood, boiled (Toom leuad moo) (blood sausage) 7. FISH/SEAFOOD: Fresh, frozen or dried fish, eels shellfish, or seafood. • Eels • Fermented fish, sour, fried (Cheun pa som) • Fermented fish with bone (Pa deak niew) (Small,whole fish,with bones) • Nile tilapia fish, raw (Pa nin dip) • Nile tilapia, roasted (Ping pa nin) • Short-bodied mackerel fried (Cheua pa tu) • Short-bodied mackerel, roasted (Ping pa tu) • Siamese mud carp, grilled (Ping pa khao) • Fish powder • Seafood Other: Please specify		
8. EGGS ☐ Chicken Hen egg, fried (Cheuan khai dao) ☐ Chicken Hen Egg, whole (Khai kai dip) ☐ Chicken Hen Egg, whole, boiled (Khai kai toom) ☐ Chicken Omelet hen egg (Cheuan khai kai) ☐ Duck -Omelet duck egg (Cheuan khai pet) ☐ Duck Egg, whole, boiled (kai pet toom) ☐ Monitor Lizard Egg ☐ Other Birds Egg ☐ Quail Egg	1 Yes	2 No

☐ Snake Egg		
9. DARK GREEN LEAFY VEGETABLES (exclude herbs eaten in small amounts) ☐ Cassava leaves (Bai man ton) ☐ Cassava leaves, blanched (Bai mun ton Luak) ☐ Chinese cabbage, blanched (Pak kaad khao louak) ☐ Edible Bracken (Phak Kut) ☐ Eugenia Leaves (Phak Samek) ☐ Green amaranth, small, blanched (Pak huom louak) ☐ Green amaranth, small, fresh (Pak huom soth) ☐ Horse Tamarind, young leaves (Bai ka thin soth) ☐ Kale ☐ Melientha Suavis (Phak Kased) ☐ Morning Glory /swamp cabbage, blanched (pak bong louak) ☐ Morning Glory /swamp cabbage, fresh (pak bong soth) ☐ Mustard green, blanched (Phak kaad khiew louak) ☐ Mustard green, stem and leaves (Pak kaad khiew soth) ☐ Mustard, fresh (Phak kaad soum soth) ☐ Sweet potatoe leaves (Bai Man Dang) ☐ Tamarind, young leaf, fresh (bai maak kham onh) ☐ Wildbetal Leafbush (Pak e leuad) ☐ Other (Please Specify):__	I Yes	2 No
OTHER VITAMIN A-RICH FRUITS AND VEGETABLES. ³⁴	I Yes	2 No
10. VITAMIN A-RICH VEGETABLES, ROOTS AND TUBERS ☐ Carrots ☐ Pumpkin, mature, fresh (Maak eu) ☐ Red Pepper ☐ Squash (orange or dark yellow-fleshed only)		

³⁴ The next two groups (“Vitamin A-rich vegetables, roots and tubers” and “Vitamin A-rich fruits”) are separated into two rows on the questionnaire but are combined into one group for calculation of the MDD-W indicator.

☐ Sweet Potatoes (that are yellow, or orange inside)		
11. VITAMIN A-RICH FRUITS ☐ Cantaloupe melon (Mark teang warn) ☐ GAC fruit ☐ Hog Plum ☐ Mango (ripe) ☐ Musk melon ☐ Papaya (ripe) (Maak hung sook) ☐ Passion Fruit (Maak nord) ☐ Peaches (Maak khaii) ☐ Persimmon ☐ Other (Please Specify): _____		
12. OTHER VEGETABLES ☐ Bamboo ☐ Bean sprouts, fresh (Thoua ngok soth) ☐ Bean, Yard long bean, green, fresh (Maak thoua ngao soth) ☐ Cabbage, blanched (Pak ka lam pe louak) ☐ Cabbage, common, fresh (Pak ka lam pe soth) ☐ Chayote, boiled (Maak sa ver louak) ☐ Chayote, fruit, fresh (Maak sa ver soth) ☐ Chayote young leaves (Yod maak sa ver) ☐ Cucumber, fresh (Maak teng soth) ☐ Eggplant (Mark kheua hum ma) ☐ Eggplant/brinjal, green, fresh (Maak kheua soth) ☐ Horse Tamarins (Maak Ka Thin Soth), ☐ Mushrooms ☐ Onion ☐ Sponge gourd (mak buap) ☐ Tomato, fresh (Maak len)	I Yes	2 No

☐ Other (Please Specify):_____		
13. OTHER FRUITS ☐ Apple, pink, fresh (Maak apple) ☐ Banana (unripened, grilled) ☐ Banana, ripe, yellow (Maak kouy nam souk) ☐ Banana, ripe, yellow, boiled (Maak kouy nam souk toom) ☐ Coconut Flesh ☐ Durian Fruit ☐ Fig ☐ Guava ☐ Green Plum (same as Hog Plum) ☐ Jackfruit ☐ Jujubes ☐ Litchee Fruit ☐ Longan ☐ Mangosteen ☐ Orange, sweet, fresh (Maak kieng sang) ☐ Pear ☐ Pineapple ☐ Rumbutam, fresh (Maak ngor) ☐ Sweetsop ☐ Star Fruit ☐ Tamarind ☐ Tangerine (not the same as oranges) ☐ Watermelon ☐ Other (Please Specify):_____	1 Yes	2 No
14. INSECTS AND OTHER SMALL PROTEINS ☐ Bamboo caterpillar	1 Yes	2 No

☐ Butterfly ☐ Cicadas ☐ Cockchafer beetles ☐ Green weevil (Meang xang) ☐ Dragonflies ☐ Fish roe ☐ Giant water bugs ☐ Grasshoppers ☐ Horned beetle ☐ Insect eggs ☐ Insect larvae/grubs ☐ Insects ☐ Mole cricket ☐ Scarab beetle (Duang Peek Khaeng) ☐ Short-tailed cricket ☐ Snails ☐ Spiders ☐ Sting bug ☐ Termites ☐ Wasps ☐ Wasps larvae (Duang to tor) ☐ Weaver ant larvae (Khai mod som) ☐ Any other small invertebrates ☐ Other (Please Specify):_____		
15. CONDIMENTS AND SEASONINGS ☐ Chili pepper, hot, red, fresh ☐ Ginger ☐ Garlic ☐ Fermented fish, liquid	1 Yes	2 No

☐ Fish sauce ☐ Lemon grass, fresh ☐ Lime-in 12 other condiments ☐ Lemon – in 12 other condiments ☐ Monosodium glutamate (MSG) ☐ Onion ☐ Oyster sauce ☐ Salt ☐ Shallot, bulb ☐ Tiliacora triandra diels (bai gna nang) Condiment Vegetables ☐ Coriander, fresh (Pak hom pome) ☐ Dill, fresh (Pak ce soth) ☐ Hairy basil, fresh (Pak e tu) ☐ Fennel common leaves (Pak hom Pea) ☐ Mint, leaf (Pak houm lab soth) ☐ Pak kha yeng		
16. OTHER OILS AND FATS ☐ Butter ☐ Chicken Fat/Lard ☐ Margarine ☐ Palm Oil ☐ Pork Fat/Lard ☐ Soybean Oil ☐ Sunflower Oil	I Yes	2 No
17. OTHER BEVERAGES AND FOODS ☐ Coffee ☐ Coconut Water	I Yes	2 No

☐ Coke ☐ Coffee with sugar ☐ Energy Drinks ☐ FANTA ☐ Nescafe instant coffee ☐ Ovaltine ☐ Pickles ☐ Mustard green, fermented, sour (Som pak kaad) ☐ Pepsi ☐ Tea ☐ Tea with sugar ☐ Soda ☐ Any other drink with sugar		
18. SAVORY AND FRIED SNACKS ☐ Banana Chips ☐ Cassava chips ☐ Fried doughnuts ☐ Pork Cracklings ☐ Potato Chips ☐ Corn Chips ☐ Local fried snacks—name here ☐ Sweet potatoe chips ☐ Taro Chips ☐ Other (Please Specify):_____	1 Yes	2 No
19. SWEETS ☐ Candy ☐ Cakes ☐ Cookies ☐ Honey	1 Yes	2 No

☐ Ice cream ☐ Pastries (sweet, fried or baked) ☐ Peanut candies ☐ Sesame Candies ☐ Sugar Cane ☐ Sweetened condensed milk ☐ Other (Please Specify): _____		
20. NOTHING EATEN OR DRANK AT ALL	1 Yes	2 No
-98. OTHER Any other solid or semi-solid food? SPECIFY HERE	1 Yes	2 No

Section 3.2. Infant and Young Child Feeding Behaviors

IF THE HOUSEHOLD HAS A CHILD 6-23 MONTHS OF AGE, PROCEED WITH THIS CHILD.

IF NO CHILD 6-23 MONTHS OF AGE BUT THERE IS A CHILD UNDER 5, WORK WITH THE RESPONDENT TO SELECT A CHILD UNDER 5 YEARS OF AGE TO COMPLETE THESE QUESTIONS. THE RESPONDENT SHOULD BE THE PRIMARY CAREGIVER FOR THE SELECTED CHILD.

IF NO CHILD UNDER 5, SKIP TO SECTION 4.

Section 3.2. Infant and Young Child Feeding Behaviors	
Infant and Young Child Feeding Behaviors (Children 0-59 months of age Children under 5)	
If no child between 6-23 months: What is the child's first name?	
If no child between 6-23 months: How old is the child? (In months)	
If no child between 6-23 months: Is (Child's NAME) male or female?	☐ 1 Male ☐ 2 Female
3.2.a. Was (CHILD'S NAME) ever breastfed?	☐ 1 Yes ☐ 2 No → 3.2.j ☐ -97 Don't Know → 3.2.j
3.2.b. Did you practice active feeding when breastfeeding (CHILD'S NAME)? Active feeding is defined as the practice where the caregiver is responsive to the child's clues for hunger and also encourages the child to eat. ☐ 1 Yes ☐ 2 No ☐ -97 Don't Know	
Continued: Breastfeeding (Children under 5 of age)	
3.2.c. How long after birth did you first put (CHILD'S NAME) to the breast?	☐ 1 Immediately → 3.2.g ☐ 2 Within hours → 3.2.d ☐ 3 Within days → 3.2.e ☐ -97 Don't Know ☐ -98 Other → 3.2.f
3.2.d. How many hours passed until you put (CHILD'S NAME) to the breast?	_____ hours
3.2.e. How many days passed until you put (CHILD'S NAME) to the breast?	_____ days
3.2.f. If other, how long after birth did you first put (CHILD'S NAME) to the breast?	_____
3.2.g. Are you still breastfeeding (CHILD'S NAME)?	☐ 1 Yes ☐ 2 No → 3.2.i ☐ -97 Don't Know → 3.2.j
3.2.h. Was (CHILD'S NAME) breastfed yesterday during the day or at night?	☐ 1 Day ☐ 2 Night ☐ 3 Both day and night ☐ 4 Did not feed yesterday ☐ -97 Don't Know

3.2.i. For how long (TOTAL) did you breastfeed (CHILD'S NAME)? Breastfeeding refers to an infant receiving breast milk (including expressed breast milk or milk from a wet nurse)		Select unit: ☐ 1 Months ☐ 2 Years
THESE QUESTIONS ARE FOR CHILDREN UNDER 2 ONLY.		
Continuing Breastfeeding at 1 Year		
Complementary Feeding		
3.2.j. Does (CHILD'S NAME) consume foods or drinks other than breast milk?		☐ 1 Yes ☐ 2 No → 3.2.l ☐ -97 Don't Know → 3.2.l
3.2.k. What age did you first give (CHILD'S NAME) something (liquid or food) other than breast milk?		Enter integer: _____ Select unit: ☐ 1 Months ☐ 2 Years
Feeding Breast Milk by Spoon, Cup or Bottle		
TALK TO THE MOTHER. Sometimes babies are fed breast milk in different ways, for example by spoon, cup, or bottle . This can happen when the mother cannot always be with her baby. Sometimes babies are breastfed by another woman, or given breast milk from another woman by spoon, cup or bottle or some other way. This can happen if a mother cannot breastfeed her own baby.		
3.2.l. Did (CHILD'S NAME) drink anything from a bottle with a nipple or teat yesterday or last night?		☐ 1 Yes ☐ 2 No ☐ -97 Don't Know
3.2.m. Did (CHILD'S NAME) consume breast milk in any of these ways yesterday during the day or at night? [SELECT MULTIPLE] [READ OUT]		☐ 1 Spoon ☐ 2 Cup ☐ 3 Bottle ☐ 4 Straws ☐ 5 None ☐ -98 Don't Know
Complementary Feeding (Children 6-23 months of age)		
Introduction of Solid, Semi-solid, or Soft Foods		
3.2.n. Now I would like to ask you about liquids or foods (NAME) had yesterday during the day or at night (in the last 24 hours). Did (CHILD'S NAME) drink/eat: READ THE LIST OF LIQUIDS STARTING WITH PLAIN WATER, HOW MANY TIMES YESTERDAY DURING THE DAY OR AT NIGHT DID (NAME) CONSUME ANY (ITEM FROM LIST) IN THE LAST 24 HOURS?		
☐ 1 Plain water?		
☐ 2 Infant formula, such as Cerelac?		
☐ 3 Milk such as tinned, powdered, carton, or fresh animal milk?		
☐ 4 Juice or juice drinks?		
☐ 5 Clear broth?		
☐ 6 Yogurt?		
☐ 7 Soy milk?		
☐ 8 Thin porridge?		
☐ 9 None		

☐ -98 Any other liquids? Other liquids may include: Local products: Pepsi, Mirinda, Coke, Sprite, fresh coconut water Imported product: fruit juices, Oishi tea Milk or food-based liquid: Local product: Soy milk, Taro milk, corn milk	
Complementary Feeding Practices (Children 6 23 months of age)	
Minimum Meal Frequency	
3.2.o. Did (CHILD'S NAME) eat any solid, semi-solid, or soft foods yesterday during the day or at night? (For example, mashed bananas or papaya, chewed sticky rice, boiled potato puree, etc.)	☐ 1 Yes ☐ 2 No → 3.2.q ☐ -97 Don't Know → 3.2.q
3.2.p. How many times did (CHILD NAME) eat solid, semi-solid, or soft foods other than liquids yesterday?	☐ 1 1 time ☐ 2 2 times ☐ 3 3 times ☐ 4 4 times ☐ 5 more than 4 times ☐ -97 Don't Know
Minimum Acceptable Diet (MAD) (6 23 months of age)	
3.2.q. Was yesterday a special day, like a celebration or feast day or a fast day where your child ate special foods or where they ate more or less than usual or did not eat because they were fasting? NOTE TO ENUMERATOR: If yesterday was not a special day, then ask the respondent about the types of foods that the child ate yesterday during the day and at night. If yesterday was a special day, then ask the respondent to describe the foods (meals and snacks) that the child consumed the day before yesterday (or the last normal day) during the day and night, whether at home or outside the home. ☐ 1 Yes ☐ 2 No	
3.2.r. Please describe everything that (NAME) ate yesterday ate or drank, starting with yesterday morning and ending with yesterday during the night, whether (NAME) ate it at home or anywhere else (NOTE: Probe for consumption during the 24 hours period from midnight to midnight). FOLLOW SAME PROCESS AS DETAILED IN SECTION 3.I.	
1. FOODS MADE FROM GRAINS, WHITE ROOTS AND TUBERS AND PLANTAINS (WHITE FLESH) Food made from grains, white roots, tubers, and plantains (white flesh) including porridge. White potatoes, white yams, manioc, cassava, or any other foods made from roots	☐ 1 Yes ☐ 2 No
2. PULSES (BEANS, PEAS AND LENTILS) Mature beans or peas (fresh or dried seed), lentils or soy products, including tofu or tempeh. • Mature beans • Mature peas • Lentils	☐ 1 Yes ☐ 2 No

• Soy products-tofu • Soy products-tempeh • Soy Products-Soymilk • Pigeon pea (mak baep) Other: Please specify:_____	
3. NUTS AND SEEDS • Cashew Nuts • Peanuts • Sesame Paste • Tamarind Nuts Other: Please specify:_____	☐ 1 Yes ☐ 2 No
4. MILK (NOT SOY) AND MILK PRODUCTS: Cheese, yogurt, or other milk products	☐ 1 Yes ☐ 2 No
5. FLESH MEATS: beef, pork, duck, chicken, birds, frogs, wild game? Beef, Other: • Beef ball, blanched (Look sine ngoua) (Processed meat) • Beef, blanched (Choum sine ngoua) (Red meat) • Beef, dried, grilled (Ping sine ngoua hang) (Red meat) • Beef, dry, fried (Cheun sine ngoua hang) (Red meat) • Beef, grilled (Ping sine ngoua) (Red meat) • Beef, raw (Sine ngoua dip) (Red meat) Chicken/Poultry, Other: • Chicken, roasted (Ping kai) • Chicken, boiled (Toom sine kai) • Chicken, raw (Sine kai dip) • Duck, roasted (Ping pet) Pork, Other: • Pork sausage, grilled (Ping sai oua moo) (Processed meat) • Pork, boiled (Toom sine moo) • Pork, grilled (Ping sine moo) • Pork, raw (Sine moo soth) • Pork, shredded, chinese style (Moo foi) (Processed meat) • Pork, skin, raw (Nang moo dip) (Other animal parts)	☐ 1 Yes ☐ 2 No
6. ORGAN MEAT Liver, kidney, heart, or other organ meats (including blood-based food). Beef, Organ Meat: • Beef internal organ barbecue (Sieb khuang nai ngoua) • Beef, intestine, raw (Sai ngoua dip) • Beef, liver, grilled (Ping tab ngoua) • Beef, liver, raw (Tab ngoua dip) • Beef, lung, raw (Pod ngoua dip) • Beef, spleen, raw (Mam ngoua dip) • Beef, stomach, raw (Phoung ngoua dip) Chicken, Organ Meat:	☐ 1 Yes ☐ 2 No

● Chicken liver, boiled (Toom tab kai) ● Chicken, gizzard, raw (Tai kai dip) ● Chicken, heart (Houa chay kai dip) ● Chicken, liver, grilled (Ping tab kai) ● Chicken, liver, raw (Tab kai dip) Pork, Organ Meat: ● Pork, liver, grilled (Ping tab moo) ● Pork, liver, raw (Tab moo dip) ● Pork, spleen, raw (Mam moo dip) ● Pork, blood, boiled (Toom leuad moo) (blood sausage)	
7. FISH/SEAFOOD: Fresh, frozen or dried fish, eels shellfish, or seafood. ● Eels ● Fermented fish, sour, fried (Cheun pa som) ● Fermented fish with bone (Pa deak niew) (Small,whole fish,with bones) ● Nile tilapia fish, raw (Pa nin dip) ● Nile tilapia, roasted (Ping pa nin) ● Short-bodied mackerel fried (Cheua pa tu) ● Short-bodied mackerel, roasted (Ping pa tu) ● Siamese mud carp, grilled (Ping pa khao) ● Fish powder ● Seafood Other: Please specify	☐ 1 Yes ☐ 2 No
8. EGGS: ● Chicken Hen egg, fried (Cheuan khai dao) ● Chicken Hen Egg, whole (Khai kai dip) ● Chicken Hen Egg, whole, boiled (Khai kai toom) ● Chicken Omelet hen egg (Cheuan khai kai) ● Duck -Omelet duck egg (Cheuan khai pet) ● Duck Egg, whole, boiled (kai pet toom) ● Monitor Lizard Egg ● Other Birds Egg ● Quail Egg ● Snake Egg	☐ 1 Yes ☐ 2 No
9. DARK GREEN LEAFY VEGETABLES (Exclude herbs eaten in small amounts) ● Cassava leaves (Bai man ton) ● Chinese cabbage, blanched (Pak kaad khao louak) ● Edible Bracken (Phak Kut) ● Eugenia Leaves (Phak Samek) ● Green amaranth, small, blanched (Pak huom louak) ● Green amaranth, small, fresh (Pak huom soth) ● Horse Tamarind, young leaves (Bai ka thin soth) ● Kale ● Melientha Suavis (Phak kased) ● Morning Glory /swamp cabbage, blanched (pak bong louak) ● Morning Glory /swamp cabbage, fresh (pak bong soth) ● Mustard green, blanched (Pak kaad some louak) ● Mustard green, stem and leaves (Pak kaad khiew soth)	☐ 1 Yes ☐ 2 No

• Mustard, fresh (Pak kaad soum soth) • Sweet potatoe leaves (Bai Man Dang) • Tamarind, young leaf, fresh (bai maak kham onh) • Wildbetal Leafbush (Pak e leuad) • Other (Please Specify):_____	
10. VITAMIN A-RICH VEGETABLES, ROOTS AND TUBERS • Carrots • Pumpkin, mature, fresh (Maak eu) • Red Pepper • Squash (orange or dark yellow-fleshed only) • Sweet Potatoes (that are yellow, or orange inside)	☐ 1 Yes ☐ 2 No
11. VITAMIN A-RICH FRUITS • Cantaloupe melon (Mark teang warn) • GAC fruit • Hog Plum • Mango (ripe) • Musk melon • Papaya (ripe) (Maak hung sook) • Passion Fruit (Maak nord) • Peaches (Maak khaii) • Persimmon • Other (Please Specify):_____	☐ 1 Yes ☐ 2 No
12. OTHER VEGETABLES • Bamboo • Bean sprouts, fresh (Thoua ngok soth) • Bean, Yard long bean, green, fresh (Maak thoua ngao soth) • Cabbage, blanched (Pak ka lam pe louak) • Cabbage, common, fresh (Pak ka lam pe soth) • Chayote, boiled (Maak sa ver louak) • Chayote, fruit, fresh (Maak sa ver soth) • Chayote young leaves (Yod maak sa ver) • Cucumber, fresh (Maak teng soth) • Eggplant (Mark kheua hum ma) • Eggplant/brinjal, green, fresh (Maak kheua soth) • Mushrooms • Onion • Sponge gourd (mak buap) • Tomato, fresh (Maak len) • Other (Please Specify):_____	☐ 1 Yes ☐ 2 No
13. OTHER FRUITS • Apple, prink, fresh (Maak apple) • Banana (unripened, grilled) • Banana, ripe, yellow (Maak kouy nam souk) • Banana, ripe, yellow, boiled (Maak kouy nam souk toom) • Coconut Flesh • Durian Fruit • Fig • Guava	☐ 1 Yes ☐ 2 No

● Green Plum (same as Hog Plum) ● Jackfruit ● Jujubes ● Lime ● Lemon (Nam maak nao) ● Litchee Fruit ● Longan ● Mangosteen ● Orange, sweet, fresh (Maak kieng) ● Pear ● Pineapple ● Rumbutam, fresh (Maak ngor) ● Sweetsop ● Star Fruit ● Tamarind ● Tangerine (not the same as oranges) ● Watermelon ● Other (Please Specify): _____	
14. INSECTS AND OTHER SMALL PROTEINS ● Bamboo caterpillar ● Cicadas ● Cockchafer beetles ● Green weevil (Meang xang) ● Dragonflies ● Fish roe ● Giant water bugs ● Grasshoppers ● Horned beetle ● Insect eggs ● Insect larvae/grubs ● Insects ● Mole cricket ● Scarab beetle (Meang chinoun) ● Short-tailed cricket ● Snails ● Spiders ● Sting bug ● Termites ● Wasps ● Wasps arvae (Duang to tor) ● Weaver ant larvae (Khai mod som) ● Any other small invertebrates ● Other (Please Specify): _____	☐ 1 Yes ☐ 2 No
15. CONDIMENTS AND SEASONINGS ● Chili pepper, hot, red, fresh ● Ginger ● Garlic ● Fermented fish, liquid	☐ 1 Yes ☐ 2 No

• Fish sauce • Lemon grass, fresh • Lime-in 12 other condiments • Lemon - in 12 other condiments • Monosodium glutamate (MSG) • Onion • Oyster sauce • Salt • Shallot, bulb • Tiliacora triandra diels (bai gna nang) Condiment Vegetables • Coriander, fresh (Pak hom pome) • Dill, fresh (Pak ce soth) • Hairy basil, fresh (Pak e tu) • Fennel common leaves (Pak hom Pea) • Mint, leaf (Pak houm lab soth) • Pak kha yeng	
16. OTHER OILS AND FATS ☐ Butter ☐ Chicken Fat/Lard ☐ Margarine ☐ Palm Oil ☐ Pork Fat/Lard ☐ Soybean Oil ☐ Sunflower Oil	☐ 1 Yes ☐ 2 No
17. OTHER BEVERAGES AND FOODS ☐ Coffee ☐ Coconut Water ☐ Coke ☐ Coffee with sugar ☐ Energy Drinks ☐ FANTA ☐ Nescafe instant coffee ☐ Ovaltine ☐ Pickles ☐ Mustard green, fermented, sour (Som pak kaad) ☐ Pepsi ☐ Tea ☐ Tea with sugar ☐ Soda ☐ Any other drink with sugar	☐ 1 Yes ☐ 2 No
18. SAVORY AND FRIED SNACKS ☐ Banana Chips ☐ Cassava chips ☐ Fried donuts	☐ 1 Yes ☐ 2 No

☐ Pork Cracklings ☐ Potato Chips ☐ Corn Chips ☐ Local fried snacks—name here ☐ Sweet potatoe chips ☐ Taro Chips ☐ Other (Please Specify): _____	
19. SWEETS Cakes, sweets, (kanom), etc. • Candy • Cakes • Cookies • Honey • Ice cream • Pastries (sweet, fried or baked) • Peanut candies • Sesame Candies • Sugar Cane • Sweetened condensed milk • Other (Please Specify): _____	☐ 1 Yes ☐ 2 No
20. BABY/INFANT FORMULA • Baby milk powder, dumex Hi Q brand (Noom foun ka Dumex hi q) • Baby milk powder, lactogen brand (Noom foun ka lactogen) • Infant formula (fortified)	☐ 1 Yes ☐ 2 No
21. Palm Oil Foods made with red palm oil, red palm nut, red palm nut pulp sauce?	☐ 1 Yes ☐ 2 No
-98. OTHER Any other solid or semi-solid food? SPECIFY HERE _____	☐ 1 Yes ☐ 2 No
22. NOTHING EATEN OR DRANK AT ALL	☐ 1 Yes ☐ 2 No
Feeding During Illness (6 23 months of age)	
3.2.s. When (NAME) is ill/sick, how much <u>drink</u> including breast milk is given? [READ OUT LIST]	☐ 1 Nothing to drink ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional Liquids ☐ -97 Don't Know

3.2.t. When (NAME) is ill/sick, how much <u>food</u> is given? [READ OUT LIST]	☐ 1 Nothing to eat ☐ 2 Much less ☐ 3 Somewhat less ☐ 4 About the same ☐ 5 Additional foods ☐ -97 Don't Know
3.2.u. When (Name) is ill/sick and you take them to the doctor or health clinic for a visit, do you receive advice from a doctor about how to feed your sick child?	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor of health clinic ☐ -97- Don't Know
3.2.v. When (Name) is ill/sick and you take them to the doctor or health clinic for a visit, do you receive advice from a doctor about how to change your sanitation and hygiene practices?	☐ 1 Yes ☐ 2 No ☐ 3 Did not take child to doctor of health clinic ☐ -97 Don't Know

Section 3.3. Use of Quality Nutrition/Health Services

SECTION TO BE COMPLETED ONLY IF HOUSEHOLD HAS AT LEAST ONE CHILD UNDER 5. IF NO CHILD UNDER 5, SKIP TO SECTION 4.

TRANSITION WITH THE RESPONDENT AND SAY:

“Now I would like to ask you about some of the health and nutrition services that you and your CU5 years of age may or may not receive”

Growth Monitoring and Promotion (GMP)	
THESE QUESTIONS INCLUDE ALL CHILDREN UNDER 5 YEARS OF AGE	
3.3.a. Have you with your child (0-59 months of age) participated in monthly community GMP (along with immunizations)?	☐ 1 Yes ☐ 2 No
Women's Access to Health Care	
ANC	
BEFORE ASKING THESE QUESTIONS, PLEASE ASK THE MOTHER IF SHE HAS A MATERNAL HEALTH CARD. IT IS OK TO PROCEED IF THE MOTHER DOES NOT HAVE THE CARD.	
3.3.b. Did you see anyone for ANC during your pregnancy with your most recent child?	☐ 1 Yes ☐ 2 No → 3.3i ☐ -97 Don't Know → 3.3i
3.3.c. How many times during your pregnancy did you attend antenatal care? [PROBE TO IDENTIFY THE NUMBER OF TIMES ANC WAS RECEIVED. IF A RANGE IS GIVEN, RECORD THE MINIMUM NUMBER OF TIMES ANC RECEIVED.]	
☐	1 Once → 3.3h
☐	2 Twice → 3.3h
☐	3 Three times → 3.3h
☐	4 Four times → 3.3h
☐	5 More than four times
☐	-97 Don't know → 3.3h
3.3.d. If more than four times, how many times?	
3.3.e. How many months pregnant were you when you first received ANC for this pregnancy? [If '9 Months' or later, record 9. Enter -97 for don't know]	
Breastfeeding during ANC	
3.3.f. Did you receive breastfeeding information during your ANC visit?	☐ 1 Yes ☐ 2 No ☐ -97 Don't Know
IFA during ANC	
3.3.g. During your most recent pregnancy, were you given or did you buy any (IFA tablets during ANC?	☐ 1 Yes ☐ 2 No → 3.3i ☐ -97 Don't know → 3.3i
3.3.h. During the whole pregnancy, for how many days did you take IFA tablets? Enter integer: _____ [If answer is not numeric, probe for approximate number of days. Enter '0' if no tablets were consumed.]	
3.3.i. From where did you receive iron and folic acid (IFA) tablets?	
☐	1 Private clinic

☐	2 Local pharmacy
☐	3 Community Health Worker
☐	4 Nurse/midwife
☐	5 Health Center Nurse
☐	6 Nutrition Facilitator
☐	7 Community Health Volunteer
☐	8 Hospital
☐	-98 Other, specify
Pregnancy and Postnatal Care	
After Delivery: Attachment	
3.3.i. After delivery, did a health care provider show you how to position and attach your baby to your breast?	
☐ 1 Yes ☐ 2 No ☐ -97 Don't Know	
Nutrition Related Actions	
3.3.j. Can you recall any nutrition-related actions that you heard from a health center, community health worker, or peer group that are intended to improve the health or nutrition of pregnant women or children? [MULTIPLE ANSWERS ALLOWED, NO PROBES, DO NOT READ OUT LIST]	
☐	1 Adolescent girls, pregnant women, lactating women eat additional food each day
☐	2 Adolescent girls, pregnant women, lactating women eat a diverse diet, including animal source foods
☐	3 Pregnant women take more rest from the time the baby moves to reduce the workload
☐	4 Ensure Pregnant and lactating women take IFA
☐	5 Initiate breastfeeding within one hour of birth
☐	6 Lactating Women exclusively breastfeed for first six months
☐	7 Breastfeed for adequate duration (until child is full)
☐	8 Ensure baby receives initial colostrum from birth
☐	9 Children 6-23 months of age are fed using active feeding techniques
☐	10 Children 6-23 months of age eat an age-appropriate quantity of food each day
☐	11 Children 6-23 months of age eat an adequately diverse diet, including animal-source foods
☐	12 Children 0-23 months of age olds receive extra feeding during and for 1-2 weeks after illness
☐	13 None
☐	-97 Don't know/Can't recall

SECTION 4. WATER, SANITATION AND HYGIENE (WASH) BEHAVIORS

TRANSITION WITH THE RESPONDENT AND SAY:

“Now I would like to ask you about water, sanitation and hygiene in your household and community”

Basic (Improved) Sanitation (used UNICEF/WHO Joint Monitoring Standards Improved Sanitation vs. basic)	
Safe Water	
4.a. What is the <u>main</u> source of water for members of your household?	
<i>Improved facilities</i>	
☐	1 Piped supplies: Tap water in the dwelling, yard or plot
☐	2 Piped supplies: Public stand posts
☐	3 Non-piped supplies: Boreholes/tube wells
☐	4 Non-piped supplies: Protected wells and springs
☐	5 Non-piped supplies: Rainwater
☐	6 Non-piped supplies: Packaged water, including bottled water and sachet water
☐	7 Non-piped supplies: Delivered water, including tanker trucks and small carts
<i>Unimproved facilities</i>	
☐	8 Unimproved Facilities: Non-piped supplies: unprotected wells and springs
<i>No Facilities: Surface Water</i>	
☐	9 No facilities: surface water
☐	-97. Don't know/no response
4.b. Do you use any methods to treat your household drinking water for children 6-23 months of age?	
☐	1 Boil the water
☐	2 Filter the water
☐	3 Purchase water
☐	4 Treatment with Chlorine
☐	5 Treatment with Aluminum Sulfate
☐	-98 Other
☐	6 Do nothing
☐	-97 Don't Know
4.c. Do you use any methods to treat your household drinking water for adults?	
☐	1 Boil the water
☐	2 Filter the water
☐	3 Purchase water
☐	4 Treatment with Chlorine
☐	5 Treatment with Aluminum Sulfate
☐	-98 Other
☐	6 Do nothing
☐	-97 Don't Know
Household Water Treatment	
4.d. Does your household use any drinking water treatment methods? [DO NOT READ OUT]	

☐	1 Water filtration (physical removal)	
☐	2 Solar disinfection (UV/heat disinfection)	
☐	3 Boiling (disinfection via heat)	
☐	4 No treatment	
☐	-98 Other	
☐	-97 Don't Know	
Household Hygiene		
Household Hand Washing Station		
4.e. Does your household have a special place for hand washing at a toilet facility?		☐ 1 Yes ☐ 2 No ☐ -97 Don't Know
4.f. Does your household have a special place for hand washing near the house's cooking/eating area?		☐ 1 Yes ☐ 2 No ☐ -97 Don't Know
4.g. Are household washing locations used for purposes other than hand washing? [MULTIPLE ANSWERS ALLOWED]	☐ 1 No, not used for other purposes ☐ 2 Yes, to clean nappies ☐ 3 Yes, to wash clothes ☐ 4 Yes, to clean dishes ☐ 5 Yes, to shower ☐ 6 Yes, to cook ☐ 7 There is no handwashing station at this household ☐ -98 Other	
Hand Washing with Soap		
4.h. Normally, when do you wash your hands with soap? (When else?) [MULTIPLE ANSWERS ALLOWED] PROBE WHEN THE CAREGIVER WASHES THEIR HANDS AND <u>DO NOT OFFER THE ANSWER.</u>		
☐	1 Never	
☐	2 Before preparing food	
☐	3 Before eating	
☐	4 Before feeding children	
☐	5 After defecating	
☐	6 After attending to a child who has defecated (changing a baby's bottoms)	
☐	-98 Other	
☐	-97 Don't know/No response	
4.i. When do you wash your child's hands (children under 2) with soap? (When else?) [MULTIPLE ANSWERS ALLOWED] PROBE WHEN THE CAREGIVER WASHES THEIR CHILD'S HANDS AND <u>DO NOT OFFER THE ANSWER.</u>		
☐	1 Never	
☐	2 Before preparing food	
☐	3 Before eating	
☐	4 Before feeding children	
☐	5 After defecating	
☐	6 After attending to a child who has defecated (changing a baby's bottoms)	
☐	-98 Other	
☐	-97 Don't know/No response	
Safe Disposal of Feces (Human)		

4.j. The last time the youngest child passed stools, what was done to dispose of the stools? [PROBE]	
<i>Safe Disposal</i>	
☐	1 Child used toilet/latrine
☐	2 Put/rinsed into toilet or latrine
<i>Unsafe Disposal</i>	
☐	3 Put/insed into drain or ditch
☐	4 Thrown into garbage (solid waste)
☐	5 Buried
☐	6 Left in the open
☐	-98 Other
☐	-97 Don't know

SECTION 5: GENDER EQUITY AND WOMEN'S EMPOWERMENT

TRANSITION WITH THE RESPONDENT AND SAY:

“Now I would like to ask you about gender equality in your household and community”

Section 5. Gender Equity and Women's Empowerment		
5.a. Leadership/Group Member: Are you a member of any microfinance, women's, production or other groups?	☐ 1 Yes	☐ 2 No ☐ -97 Don't Know
5.b. Leadership/Speaking in Public: Do you feel comfortable speaking up in public:		
☐ 1 Yes, very comfortable	☐ 3 No, not at all comfortable	
☐ 2 Yes, somewhat comfortable	☐ -97 Don't know/Refused	

SECTION 6. HOME MATERIALS

Section 6. Home Materials	
Home Materials	
6.a. What are the main materials of the household dwelling roof?	
☐	1 Tile/sipax
☐	2 Zinc/metal
☐	3 Rudimentary Roofing: Wood Planks
☐	4 Rudimentary Roofing: Grass
☐	5 Finished roofing: Wood
☐	6 Finished roofing: Ceramic tiles
☐	-98 Other (specify)
☐	7 None
6.b. What are the main materials of the dwelling floor of the household?	
☐	1 Natural Floor: Earth/Sand
☐	2 Natural Floor: Dung
☐	3 Rudimentary floor-wood planks
☐	4 Rudimentary floor-Palm/Bamboo
☐	5 Finished floor-parquet or polished wood
☐	6 Finished floor-Vinyl or asphalt strips
☐	7 Finished floor-Ceramic tiles
☐	8 Finished floor-Cement
☐	9 Finished floor-carpet
☐	-98 Other (specify)
Toilet/Latrine	
6.c. What kind of toilet facility does the household have?	
IF "FLUSH" OR "POUR FLUSH", PROBE: WHERE DOES IT FLUSH TO?	
<i>Improved facilities</i>	
☐	1 Networked Sanitation: Flush and pour flush toilets connected to sewers (if none ignore)
☐	2 On-site sanitation: Flush and pour flush toilets or latrines connected to septic tanks or pits
☐	3 On-site sanitation: Pit latrines with slabs
☐	4 On-site sanitation: Composting toilets, including twin pit latrines and container-based systems
<i>Unimproved Facilities</i>	
☐	5 On-Site sanitation: Pit latrines without slabs
☐	6 On-Site sanitation: Hanging latrines
☐	7 On-Site sanitation: Bucket latrines
<i>Open Defecation</i>	
☐	8 No facilities: open defecation
6.d. Is water available at the place where you wash your hands?	
☐	1 Yes
☐	2 No
6.e. Do you use the same water for other purposes?	
☐	1 No, not used for other purposes

☐	2 Yes, to clean nappies
☐	3 Yes, to wash clothes
☐	4 Yes, to clean dishes
☐	5 Yes, to shower
☐	6 Yes, for cooking
☐	7 There is no handwashing station at this household
☐	-98 Other
6.f. Do you have soap or another cleansing agent available at the place where you wash your hands?	
☐	1 Soap is available (detergent, bar, liquid, powder, paste) next to the hand washing station
☐	2 Ash, mud or sand is available next to the hand washing station
☐	3 There is NO soap or ash, mud, sand available next to the hand washing station
Household Hand Washing Station	
6.g. Does your household have a special place for hand washing at your toilet facility?	☐ 1 Yes ☐ 2 No ☐ -97 Don't know
6.h. Does your household have a special place for hand washing near your cooking/eating area?	☐ 1 Yes ☐ 2 No ☐ -97 Don't know
Clean Play Space for Children	
6.i. Is there a clean play space for the household children (six to 24 months of age) free of human and chicken feces?	☐ 1 Yes ☐ 2 No
Interviewers Observation Notes	

ANNEX J: ENDLINE QUALITATIVE INSTRUMENTS

INFORMED CONSENT SCRIPT

Introduction: Thank you for taking the time to meet with us today. We are researchers from IRL and Social Impact (SI), and we have been contracted by the U.S. Agency for International Development (USAID) to conduct an evaluation of the USAID Nurture program. The USAID Nurture program, led by Save the Children and implemented in partnership with the Government of Lao PDR, aimed to contribute to a reduction in young child stunting in two target provinces of Lao PDR by improving infant and young child feeding (IYCF) and water, sanitation, and hygiene (WASH) practices.

Request: We would like to invite you to participate in an interview about nutrition and WASH in your area and your opinion on the USAID Nurture program. You were selected for this interview due to your connection and previous involvement with the USAID Nurture program. We are conducting these interviews with about 80 people in total including National, Provincial, District and Village level officials and technical staff, health center staff, vendors, community members who may have interacted with Nurture, and other donors. This discussion should take about 1 hour. *[For limited in-person interactions only: plus about ____ minutes to get to ____ and back.]*

Risks and benefits: There are no direct benefits to you if you participate, other than knowing you are helping to generate knowledge about a program that aims to help children and their families. We do not anticipate that you will incur any risk from participating in this discussion.

For limited in-person interactions only: Given the COVID-19 pandemic there are several reasons you may choose not to participate in the study. If you or someone in your household or workplace has been feeling sick including having a cough or high temperature in the past two weeks, we ask you not to participate for your safety and the safety of others. If you would like to participate, I will wear a mask while we are relocating to another area to complete the survey and will remain distanced from you during your interview.

Voluntary participation: Your participation is voluntary. If you do not want to participate or to answer specific questions you do not have to. You may also cease to participate at any time. There are no consequences for not participating.

Confidentiality: Your responses in this discussion will be kept in confidence by the evaluation team. Only the evaluation team will have access to notes and transcripts.

Recording: With your permission, we would like to record this interview so we can return to it later to check our notes. Only our research team will have access to the recording and it will be destroyed after our report is approved.

Public report & data: The information that you and others provide will be used to write an evaluation report on the status of the USAID Nurture program, which will be shared with USAID for comment, and then made publicly available. As noted above, no identifying information or potentially identifying information will be included in the report. After removing any information that could identify you, the data we collect may be combined with other study participants' data and shared publicly or with USAID for future research purposes.

Contacts: If you have any questions or concerns you may contact the Social Impact Program Manager Alison Smith at asmith@socialimpact.com, Social Impact's Institutional Review Board at irb@socialimpact.com, or IRL's Field Manager at _____.

Informed consent questions:

- Do you have any questions for us before we get started?
- Would you like me to repeat the contact information so you can write it down?
- Are you willing to participate in this interview? Yes/No
- Are you willing to be recorded Yes / No

GUIDE A: SAVE THE CHILDREN

OBJECTIVES

- Get a better understanding of the program from the implementer's point of view.
- Hear about challenges they faced.
- Discuss recommended changes moving forward in potential future programming.

QUESTIONS

1. Can you please tell me about your role with Save the Children and your involvement with the USAID Nurture program?
2. How would you describe the main components of the USAID Nurture approach?
 - 1 – capacity, enabling environment central level
 - 2 – capacity at health facility level
 - 3 – WASH marketing and engagement of private sector
 - 4 – community mobilization/demand creation
3. To what extent would you say USAID Nurture was effective in improving the nutritional status of children under two?
 - Probe on indicator types: stunting/wasting/underweight, maternal (growth monitoring, receiving information during ANC and sick child visits), IYCF (breastfeeding, minimum acceptable diet, dietary diversity), WASH (ODF, sanitation facilities, water treatment, handwashing)
4. Do you think all families are benefiting equally from the program? If not, why not?
 - Probe on gender, age, geographic area (province)
5. Which program components do you think were the most successful? Why?
 - Probe on three components from evaluation questions: Maternal, IYCF, WASH
 - Probe on four components in midline report: Improved community nutrition/health and WASH services; Capacity building to improve quality service delivery; Demand creation for use of nutrition/health/WASH services and products; and Supportive enabling environment
 - Probe on programmatic aspects (if relevant): Activity protocols; Time and duration of activities; Targeting of activities; Frequencies of the visits; Project team outreach: Communication skills pre-arrangement and informed notice, any issues with team composition i.e., gender; Language used during the outreach/visits; IEC Materials: relevant, comprehensible, and comprehensive?
6. Which program components were the least successful? Why? How could these components have been improved in retrospect?
7. Of the program components we've discussed, which components or activities do you think are most likely to be sustained post-implementation? Why? How will they be sustained?
 - Probe on government buy-in at different levels
8. Which behaviors or outcomes will be sustained? Why?
9. What challenges has USAID Nurture faced with implementing this program?
 - Probe on challenges mentioned in annual reports: staff turnover, partnerships, GOL restrictions, MOU process, flooding, literacy, local capacity constraints, working around other nutrition programs, COVID-19
10. What are the key implementation successes over the course of the activity?
11. How has Save used the monitoring data over the course of the activity?

12. Do you have any other observations you would like to share about your experience with the USAID Nurture program?

Thank you for taking the time to speak with me today.

GUIDE B: NATIONAL LEVEL OFFICIALS AND TECHNICAL STAFF

OBJECTIVES

- Understand each respondent's relationship to the Nurture activity
- Hear the GOL perspective on overarching activity results
- Discuss challenges and successes
- Understand GOL commitment to sustaining Nurture interventions post-implementation
- Gather recommendations on future nutrition programming

QUESTIONS

1. Can you please tell us about your involvement with the USAID Nurture program?
 - Nurture had four components:
 - 1 – capacity, enabling environment central level
 - 2 – capacity at health facility level
 - 3 – WASH marketing and engagement of private sector
 - 4 – community mobilization/demand creation
 - Which of these components did you interact with the most?
 - Who else did you interact with, and how did you interact with them? (Save the Children staff, other National Level Officials, Province Level Officials, District Level Officials, health center staff, Vendors, Village Level Officials, other Donors)
2. In the adoption of optimal nutrition and WASH practices, what do you think are the main challenges faced by pregnant and lactating women and caregivers of children under two?
 - How effective was Nurture in addressing these challenges?
3. How effective was USAID Nurture in improving the nutritional status of children under two?
 - Based on answer, follow-up with any of the questions below.

For example,

 - How did Nurture affect stunting, wasting or underweight in children?
 - How did Nurture affect nutrition practices among pregnant women? Refers to the two behavior change messages promoted by Nurture: eating extra food at every meal, going for ANC services as soon as pregnant
 - How did Nurture affect IYCF practices? Refers to the five behavior change messages promoted by Nurture: breastfeeding within first hour of birth, keeping baby with mother to continue breastfeeding, breastfeeding consistently in the first six months, feeding family food with meat and vegetables (that are blended or minced so that your child can eat it), and continue breastfeeding until two years old
 - How did USAID Nurture affect WASH practices of mothers, parents, and other caregivers? Refers to the six behavior change messages promoted by Nurture: washing hands with soap and water before cooking and eating, washing your hands and children hands, disposing of baby stool safely, being open defecation-free, sanitation facilities, and water treatment
4. What were the most and least successful aspects of the program? Why?
 - How could the least successful components have been improved in retrospect?
5. What is the government's general impression of the USAID Nurture program?
 - How did the USAID Nurture program align with national policies on nutrition? (e.g., National Nutrition Strategy 2016-25 and National Plan of Action for Nutrition 2016-21, the National Social and Behavior Change Communication (SBCC) Strategy, National RMNCAH Strategy)?

- How was the government's relationship with Save? Were there any challenges?
6. Which aspects of the USAID Nurture program were sustained now that the program has ended? Why? By Whom?
 7. Which aspects of the program were not sustained? Why?
 8. How did the Nurture program adapt to the challenges of COVID-19? Please explain/please give examples.
 9. What recommendations would you have for future programming in this area?
 10. Do you have any other observations you would like to share about your experience with the USAID Nurture program?

Thank you for taking the time to speak with me today.

GUIDE C: PROVINCIAL AND DISTRICT LEVEL OFFICIALS AND TECHNICAL STAFF (PROVINCIAL NURTURE COORDINATOR, FIRST 1,000 DAYS COUNSELING TRAINER, SUPPORTIVE SUPERVISION TEAM LEAD, DISTRICT NUTRITION COORDINATOR)

OBJECTIVES

- Understand each respondent's relationship to the Nurture activity
- Hear provincial and district level perspectives on overarching activity results
- Discuss challenges and successes, probing on specific missed targets as relevant
- Understand GOL commitment to sustaining Nurture interventions post-implementation
- Gather recommendations on future nutrition programming

QUESTIONS

1. Can you please tell us about your involvement with the USAID Nurture program? Which of these components did you interact with the most?
 - Nurture had four components:
 - 1 – capacity, enabling environment central level
 - 2 – capacity at health facility level
 - 3 – WASH marketing and engagement of private sector
 - 4 – community mobilization/demand creation
 - Who else did you interact with, and how did you interact with them? (Save the Children staff, other National Level Officials, Province Level Officials, District Level Officials, health center staff, Vendors, Village Level Officials, other Donors)
2. In the adoption of optimal nutrition and WASH practices, what do you think are the main challenges faced by pregnant and lactating women and caregivers of children under two?
 - How effective was the USAID Nurture in addressing these challenges?
3. How effective was USAID Nurture in improving the nutritional status of children under two?
 - Based on answer, follow-up with any of the questions below:
 - How did Nurture affect stunting, wasting or underweight in children?
 - How did Nurture affect nutrition practices among pregnant women? Refers to two behavior change messages promoted by Nurture: eating extra food at every meal, going for ANC services as soon as pregnant
 - How did Nurture affect IYCF practices? Refers to the five behavior change messages promoted by Nurture: breastfeeding within first hour of birth, keeping baby with mother to continue breastfeeding, breastfeeding consistently in the first six months, feeding family food with meat and vegetables (that are blended or minced so that your child can eat it), and continue breastfeeding until two years old
 - How did USAID Nurture affect WASH practices of mothers, parents and other caregivers? Refers to the six behavior change messages promoted by Nurture: washing hands with soap and water before cooking and eating, washing your hands and children hands, disposing of baby stool safely, being open defecation-free, sanitation facilities, and water treatment
 - Were these changes consistent across age, gender, geographic location?
4. What were the most and least successful aspects of Nurture? Why?
 - How could the least successful components have been improved in retrospect?
 - Based on the least successful components mentioned, probe related IPTT indicators that missed targets, then probe on all below:

- **IPTT probe:** Few adolescents (10-19 years) joined NURTURE activities (about 64 percent overall – 52 percent in Savannakhet, 83 percent in Khammouane). What do you think is the reason?
- If answer is insufficient, follow-up:
 - During the quarterly community awareness, please tell us how adolescent girls participated in this event?
 - During home visits by CFs, please describe how parents discussed with their adolescent daughter their nutrition needs. How did the girls participate in this conversation?
 - **IPTT probe:** There were still some villages where households defecated outside (15 percent), what do you think are the reasons for this? (85 percent of target reached)
 - **IPTT probe:** The sales agents sold very few latrines (30 percent) and even less water filters (nine percent). Why do you think so?
 - **IPTT probe:** A majority of the sales agents recruited were men (93 percent, 59 percent were women). What do you think is the reason? (If answer is insufficient follow-up) Can you tell us how they were recruited and trained?
 - **IPTT probe:** There were less women healthcare staff (61 percent) who were trained on first 1,000 days counseling, compared to men (197 percent). What do you think is the reason?
- 5. **(Only for Nurture Project Coordinator, District Nutrition Committee Focal Point):** Tell us about the multi-sectoral plan for nutrition services developed by District Nutrition Committees:
 - How was the plan used to coordinate in your district the nutrition actions in WASH, agriculture, and health across the different sectors?
- 6. What is the government's general impression of the USAID Nurture program?
 - How was the government's relationship with the implementer? Were there any challenges with working with Save?
- 7. Which aspects of the USAID Nurture program were as sustained now that the program has ended? Why? By Whom?
- 8. Which aspects of program were not sustained? Why?
- 9. How did the Nurture program adapt to the challenges of COVID-19? Please explain/please give examples
- 10. What recommendations would you have for future programming in this area?
- 11. Is there anything else you would like to share about your experience with the USAID Nurture program?

Thank you for taking the time to speak with me today.

GUIDE D: HEALTH CENTERS

OBJECTIVES

- Understand each respondent's relationship to the Nurture activity
- Hear health center staff perspectives on overarching activity results
- Discuss challenges and successes, probing on specific missed targets as relevant
- Gather recommendations on future nutrition programming

QUESTIONS

1. Can you please tell us about your involvement with the USAID Nurture program? Which of these components did you interact with the most?
 - Nurture had four components (note that Components 2 and 4 will likely be most relevant to health center staff)
 - 1 – capacity, enabling environment central level
 - 2 – capacity at health facility level
 - 3 – WASH marketing and engagement of private sector
 - 4 – community mobilization/demand creation
 - Who else did you interact with, and how did you interact with them? (Save the Children staff, National Level Officials, Province/District level Officials, other health center staff, Vendors, Village Level Officials, other donors)
2. What kind of training or resources did you receive from the Nurture program?
3. Let's talk about the trainings and resources (IEC materials, gas allowance, DSA, etc.) you received about counseling.
 - How did they change your ability to...
 - Provide ANC and PNC?
 - Support successful breastfeeding?
 - Support optimal complimentary feeding of children after the first 6 months of life?
 - Monitor and support optimal care of children from birth until two years?
 - Support the nutritional needs of adolescents (who are not married)?
4. When adopting optimal nutrition and WASH practices, what do you think are the main challenges faced by pregnant and lactating women and caregivers of children under two?
 - How effective was the USAID Nurture in addressing these challenges?
5. Do you think USAID Nurture has improved the nutritional status of children under two?
 - Based on the response, follow-up with any of the questions below:

For example,

 - How did Nurture affect stunting, wasting or underweight in children?
 - How did Nurture affect nutrition practices among pregnant women? Refers to two behavior change messages promoted by Nurture: eating extra food at every meal, going for ANC services as soon as pregnant
 - How did Nurture affect feeding and care of young children? Refers to the five behavior change messages promoted by Nurture: breastfeeding within first hour of birth, keeping baby with mother to continue breastfeeding, breastfeeding consistently in the first six months, feeding family food with meat and vegetables (that are blended or minced so that your child can eat it), and continue breastfeeding until two years old
 - How did USAID Nurture affect WASH practices of mothers, parents and other caregivers? Refers to the six behavior change messages promoted by Nurture: washing hands with soap and water before cooking and eating, washing your hands and children

hands, disposing of baby stool safely, using sanitation facilities regularly or being open defecation-free, and water treatment

6. Do you think all first 1,000 days families benefited equally from the program? If not, why not?

- Based on answers, follow-up with any of the following questions.

For example,

- Did you see the same benefits in male and female children?
- How, if at all, did adolescent girls benefit from the program compared to adult women?
- Did pregnant women and mothers from remote villages come to use the services?

7. What were the most and least successful aspects of the program? Why?

- How could the least successful components have been improved in retrospect?
- Based on the least successful components mentioned, probe related IPTT indicators that missed targets, and probe on all below:
 - **IPTT probe:** Few adolescents (10-19 years) joined NURTURE activities (about 64 percent overall – 52 percent in Savannakhet, 83 percent in Khammouane). What do you think is the reason?

If answer is insufficient, follow up:

- During the quarterly community awareness, please tell us how adolescent girls participated in this event.
- During home visits by CFs, please describe how parents discussed with their adolescent daughter their nutrition needs. How did the girls participate in this conversation?
- **IPTT probe:** There were still some villages where households defecated outside (15 percent), what do you think are the reasons for this? (85 percent of target reached)
- **IPTT probe:** The sales agents sold very few latrines (30 percent) and even less water filters (nine percent). Why do you think so?
- **IPTT probe:** A majority of the sales agents recruited were men (93 percent, 59 percent were women). What do you think is the reason?

If answer is insufficient follow up:

- Can you tell us how they were recruited and trained?
- **IPTT probe:** There were less women health center staff (61 percent) were trained on first 1,000 days counseling, compared to 197 percent male. Please tell us why less women were trained?

8. What was your health center's perception of the USAID Nurture program in general?

9. Which aspects of the USAID Nurture program was sustained now that the program has ended? Why? By Whom?

10. Which aspects of program was not sustained? Why?

11. How did the Nurture program adapt to the challenges of COVID-19? Please explain/please give examples

12. What recommendations would you have for future programming in this area?

13. Is there anything else on your experience with the USAID Nurture program that you would like to share?

Thank you for taking the time to speak with me today.

GUIDE E: VENDORS

OBJECTIVES

- Gain a basic understanding of the business and interaction with the Nurture activity
- Discuss the relative success of the products suggested by Nurture and effects on the business
- Hear vendor perspectives on the sustainability of products suggested
- Explore gender differences in training provided to vendors
- Gather recommendations on future nutrition programming

QUESTIONS

1. Are you aware of the USAID Nurture project that was implemented in this community?
2. Please tell us about your business. What do you normally sell and to whom?
 - Tell us about your distribution and marketing channels. How do you reach rural and poor populations? If no, then what are the main barriers for you as a business in reaching rural areas?
3. What was your business involved with in the USAID Nurture program?
 - Who from the Nurture program did you interact with? How often?
 - Did they encourage you to sell certain products? Which ones?
4. Did you try to sell all of the products that Nurture suggested? Why or why not?
 - Of these items that Nurture suggested, which products sold the best? Why?
 - Which products did not sell well? Why?
5. Can you describe the families that purchased the Nurture products?
 - Were your customers usually men or women?
 - How old were they?
 - Were the families coming from villages far from here, and from nearby?
6. When you added the products that Nurture suggested, was it useful to your business or not? Why?
7. Do you still sell the products that Nurture encouraged you to sell? Why or why not?
8. Can you tell us about the role of sales agents:
 - What did they do? (For example, did they interact most closely with community members?)
 - Can you tell us about their selection and training?
 - Were the sales agents mostly men or mostly women?
 - Why were there more men/more women?
9. If USAID or another donor were to implement a similar program in the future, would you/your business participate? What are your suggestions for similar programs?
 - What suggestions do you have on...
 - the use of sales agents, advertising?
 - public-private partnerships?
 - working with NGOs and projects?
10. Is there anything else you would like to share about your experience with the USAID Nurture program?

Thank you for taking the time to speak with me today.

GUIDE F: VILLAGE LEVEL OFFICIALS (VILLAGE HEAD, VIC MEMBERS), VILLAGE BENEFICIARIES (CFS, VHVS, SALES AGENTS)

OBJECTIVES

- Get a better understanding of the program from the local stakeholder's point of view.
- Investigate outcomes in the areas of IYCF, WASH, and maternal interventions.
- Understand sustainability of interventions and recommendations for future programming from the Village level perspective.

QUESTIONS

USAID Nurture Program

1. **(All):** Can you please tell us about your involvement with the USAID Nurture program?
 - Nurture had four components
 - 1 – capacity, enabling environment central level
 - 2 – capacity at health facility level
 - 3 – WASH marketing and engagement of private sector
 - 4 – community mobilization/demand creation
 - Who else did you interact with and how? (Save the Children staff, National Level Officials, Province/District level Officials, health center staff, Vendors, other Village Level Officials, other Donors)
2. What kind of training or resources did you receive from the Nurture program?
3. How did the trainings and training materials/resources change your ability to...

CF/VHV – How did the trainings and materials change your ability to do home visits to first 1,000 days families, and conduct nutrition education to primary care givers (parents, grandparents, other relatives), and pregnant women. Probe the role of the CF/VHVs below depending on the answer:

 - promote the ten small doable actions
 - promote eating a variety of vegetables and other sources of nutrients, and growing home gardens
 - promote other sanitation and hygiene practices such as use of latrines, having clean play spaces, waste disposal
 - promote using income to meet nutritional needs
 - improve knowledge as related to cultural practices and taboos
 - influence decision making within the household on what they will grow in their home garden

Village Heads/VIC – How did the trainings and materials change your ability to do village community awareness events and conduct nutrition education. Probe the role of VHV/VIC below depending on the answer:

- promote the 10 small doable actions
- conduct community-led total sanitation activities
- promote use of latrines, and the sale of latrines by sales agents
- promote other sanitation and hygiene practices such as use of latrines, having clean play spaces, waste disposal

Select from the following IYCF, Maternal, and WASH sections based on respondent's role and involvement with USAID Nurture.

(CF/VHV): Infant and Young Child Feeding Practices

4. What activities were successful in improving breastfeeding, and in improving complementary feeding for children from six months by primary caregivers? Please explain.
- What activities were unsuccessful? What are your suggestions for improving them?
 - Have there been any changes with regards to...
 - ... Who makes decisions about breastfeeding the baby right after birth, and consistently in the first six months?
 - ... Who makes decisions about feeding a child starting from six months (by giving family food with meat and vegetables that are blended or minced)?

Please explain or give examples.

5. What breastfeeding practices did Nurture promote from the time a baby is born until 2 years of age in your community?

Example for Interviewer: breastfeeding within first hour of birth, keeping baby with mother to continue breastfeeding, breastfeeding consistently in the first six months

- Have you observed any changes in breastfeeding practices after the program started?
 - Is this your observation in all of the households you visited?
 - Is this your observation in the opinion among men and women in the households you visited?
 - Is this your observation in the opinion by grandmothers or older carers?
6. Tell us about any traditional cultural practices related to men's roles, about breastfeeding and feeding children over six months.
- Please explain/give examples
7. Do you see noticeable changes in height/weight among children after 24 months?
- If so, why do you think that is?
 - Probe:
 - In your village, is this the case among baby girls or baby boys?
 - Is this the case in all of the households you visited?

(CF/VHV): Maternal Care and Nutrition Practices

8. What nutrition and care practices were promoted by Nurture during pregnancy, and after giving birth?

Example for Interviewer: Go for ANC as soon as you are pregnant; go for PNC after delivery – if delivery was at home

- Have you observed any changes in...
 - ... The quantity or type of food that pregnant women ate?
 - ... Pregnant women's visits to the health center or nearest hospital?
 - ... The workload of pregnant women at home or in the rice field?
 - ... Mothers taking their newborn children to the health center or to nearest hospitals for growth monitoring (height, weight measurements), vaccinations and when children are ill?
 - ... Mothers taking their young children to the health center or to nearest hospitals for growth monitoring (height, weight measurements), vaccinations and when they are ill?

Please explain or give examples.

9. What activities were successful in improving these care and eating behaviors among pregnant women? Please explain or give examples.
- What activities were unsuccessful? What are your recommendations for improving them?

Based on the answer, follow up with:

- Have there been any changes with regards to... (see below)
 - ... What food pregnant women eat?
 - ... What food women eat after giving birth?
 - ... Getting ANC during pregnancy?
 - ... Who decides regarding what food a pregnant woman should eat? (gender)
 - ... Who decides regarding what food women should eat after giving birth? (gender)
 - ... A woman's workload at home or in the field when she is pregnant? Or after she has just delivered a child? (gender)
 - ... Who decides taking infants or young children to the health center or hospital for needed vaccination, or when they are ill? (gender)

Please explain or give examples.

10. Can you describe the most significant change you've seen among men in the household and in community with regards to...
- ... Doing household chores when the wives are pregnant? Or after their wives have just given birth?
 - Refers to behavior change messages promoted by Nurture to support pregnant women: helping with household chores, i.e., carrying firewood/water, taking care of animals, collecting manure, agricultural work, going to the market to sell/purchase foods
 - ... Going with their wives to the health centers for her ANC during pregnancy, or for giving birth? For PNC after giving birth?
 - Refers to behavior change message promoted by Nurture for pregnant women: going for ANC services as soon as pregnant; go for PNC after delivery – if delivery was at home
 - ... Encouraging their pregnant wife to eat more?
 - Refers to behavior change messages promoted by Nurture for pregnant women: eating extra food at every meal
 - What do you think caused the change? /Why is there no change?

11. Have you seen any changes with regards to clinical services (in health centers) ...

- ... For pregnant women?
- ... For lactating women?
- ... On feeding and care for newborn until two years?

Please explain or give examples

(For CF/VHV): Adolescent (10-19 years) Nutrition Practices

12. What activities were successful in improving adolescent nutrition? Please explain or give examples
- What activities were unsuccessful? What are your ideas for improving them?

13. Have there been any changes with regards to amount and quality of food that adolescents eat in your community? Please explain or give examples.

14. What changes do you see among parents that has affected the nutrition behavior of adolescent girls, after Nurture started? Please explain or give examples.

(All): WASH

15. Please tell us about the water, sanitation and hygiene activities conducted in your village.

Examples for interviewer: CLTS including village awareness events; sales of latrines and water filters; CF home visits and discussion with parents and child caregivers about handwashing, disposal of stools, and clean spaces for playing

- What were the most successful? Please explain or give examples.
- What were the least successful activities? What are your suggestions for improving them?
- What do you think of CLTS approach?

Based on answers, follow-up:

- There were still some villages where households defecated outside (15% villages), what do you think are the reasons for this?

16. Have you seen any behavior changes with regards to...

- Open defecation in the village?
- Sale or marketing of latrines and water filters in the village?
- Latrine construction and use by household?
- Use of clean water, with use of water filters in household?
- Waste disposal in the village?

Probe: Did you see these improvements in behavior in both fathers and mothers? In both men and women in the family?

Please explain or give examples.

17. Did you notice any changes about the occurrence of diarrhea or other illness in your children, and in the community?

- Did you see these same improvements in all of the families you visited?
- Is this the case among both boys and girls in your village?
- Is this the case among newborn and young children?

18. What have you learned and adopted from Nurture about water, sanitation and hygiene in your household, for yourself, for your baby, and for your community?

- What triggered this change?

19. Can you tell us about the work of the WASH Sales Agent in the village?

- Was there a demand from the community for the WASH products being promoted? Please explain why or why not?
 - Was this the case for both men and women (or husband and wife)?
 - Was this the case in all villages covered by the Sales Agent?
- What were the challenges by Sales Agents in selling the latrines and water filters?
- Possible follow-ups depending on answers to above:
 - Are community members able to pay the price?
 - Are the products always available?
 - What is the quality of the products?
 - Is it convenient to access them? To use them?
- How do households (and who in the household) make the decision whether or not to spend money on these products?

Closing

20. Which aspects of the USAID Nurture program has been sustained now that the program has ended? Why? By Whom?
21. Which aspects of the program were not sustained? Why?
22. Is there anything else you would like to share about your experience with the USAID Nurture program?

Thank you for taking the time to speak with me today.

GUIDE G: OTHER DONORS/MULTI-LATERALS

OBJECTIVES

- Understand each respondent's relationship to the Nurture activity
- Hear the donor's perspective on overarching activity results
- Discuss challenges and successes
- Understand donor commitment to supporting similar interventions in the future
- Gather recommendations on future nutrition programming

QUESTIONS

WHO and UNICEF

Possible answers: they were involved in RMNCAH Strategy assessment and reorganization with Save the Children as lead of formation of Well Child Technical Working Group who developed WC Guide for health centers (under Strategy Sub-Objective 4); updating of Mother's Book (pink book) and sub-national roll out; development of first 1,000 days counseling guide; with UNICEF, development of IMAM Guideline

World Vision and Health Poverty Action

1. Can you please tell us about your role in your organization?
2. How did you interact with the Nurture program between 2016 and 2021?
 - Nurture had four components:
 - 1 – capacity, enabling environment central level
 - 2 – capacity at health facility level
 - 3 – WASH marketing and engagement of private sector
 - 4 – community mobilization/demand creation
 - Which of these components did you interact with the most?
 - What was the nature of your interaction?
 - Did your organization/activity partner with Nurture in some way? In which areas?
 - What did the partnership look like? How were the roles of your organization versus Nurture defined?
 - Who did you interact with, and how did you interact with them? (Save the Children staff, national level officials, province level officials, district level officials, health center staff, vendors, village level officials, other donors, direct beneficiaries, community members)
3. What would you say are the main changes you've seen in communities in the past few years related to *[COMPONENT/TOPIC RESPONDENT IS MOST FAMILIAR WITH]*?
 - Are these changes consistent across age/gender/geographic location?
 - What are the remaining barriers to be improved *[COMPONENT/TOPIC RESPONDENT IS MOST FAMILIAR WITH]*? Please cite examples.
4. How would you describe the sustainability of *[COMPONENT/TOPIC RESPONDENT IS MOST FAMILIAR WITH]* in the absence of funding from your organization and/or USAID?
 - Probe on indicator areas of Maternal, IYCF, WASH
 - Will these services/reforms continue? Why or why not?
 - Who will be responsible for sustaining these services/reforms?
 - Probe on ongoing efforts by the respondent's organization, other organizations, or the government
 - What are the challenges to sustaining these services/reforms? How might these challenges be addressed?

5. What recommendations do you have for future programming in this area?
6. Do you have any other observations you would like to share about your experience with the USAID Nurture program?

Thank you for taking the time to speak with me today.

ANNEX K: USAID NURTURE PROGRAM LOGIC EXPECTED OUTCOMES AND ASSUMPTIONS

OUTCOMES	ASSUMPTIONS	INTERMEDIATE IMPACT	ASSUMPTIONS	GOAL IMPACT
Pregnant women attend ANC for at least 4 visits and ensure they take their iron folic acid (IFA) supplements Pregnant and lactating women improve optimal infant and young child feeding practices (measured by IYCF indicators) Community members develop CLTS competencies after trained/sensitized on CLTS approach Community members are trained and therefore develop competencies about hygiene and sanitation behaviors (handwashing) WASH-related products are made available in local markets Households improve their dietary diversification through consumption of additional food groups and diversifying local agriculture and livestock production	Beneficiaries absorb and retain messaging from training and/or materials Beneficiaries adhere to IFA dosage requirements/supplement schedule Beneficiaries have the resources, time, desire, and motivation to implement optimal IYCF practices Target beneficiaries have the autonomy and/or decision-making power to implement optimal IYCF practices Beneficiaries are not already aware of and/or employing IYCF optimal practices Optimal nutrient-dense food products, IFA supplements, and WASH products are locally available and beneficiaries know where to find them Dietary preferences / customs do not inhibit the consumption of new food groups	Improved dietary diversification of pregnant women's diets Increased use of IFA supplements among pregnant women Increased exclusive and continued breastfeeding and timely complementary feeding Improved dietary diversification of children's diets Improved feeding practices for children who are ill Increased use of safe water sources Increased handwashing with soap Increased community use of appropriate improved sanitation facilities, disposal of human and animal feces and decreased open defecation Improved dietary diversity	Behavioral change is significant and sustained enough to lead to long-term health impacts Other factors that contribute to child stunting do not undermine program impacts Sufficient critical mass coverage is achieved to result in community-level change where appropriate (e.g., open defecation); we define saturation as achieving 90 percent coverage of prevention or treatment services in those defined population groups.³⁵	Reduced stunting in CU2 Reduced underweight in CU2

³⁵ Bhutta ZA, Das JK, Rizvi A, et al, The Lancet Nutrition Interventions Review Group, and the Maternal and Child Nutrition Study Group. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? Lancet 2013; published online June 6. [http://dx.doi.org/10.1016/S0140-6736\(13\)60996-4](http://dx.doi.org/10.1016/S0140-6736(13)60996-4).