HELLEN KELLER INTERNATIONAL/COMPANY PARTNER/COMPANY PARTNER PILOT

EVALUATION REPORT
EXTERNAL REPORT

Context

The Transforming Education in Cocoa Communities (TRECC) initiative aims at improving the living conditions of children and youth in Côte d'Ivoire by promoting quality education in cocoa-growing communities. Via its Grant Matching Mechanism round 2 (GMM2), 14 pilots-to-scale projects are being co-funded with 10 cocoa companies and implemented by 14 implementing organizations in the sectors of Early Childhood Development, Primary Education and Vocational Training.

The role of Innovations for Poverty Action (IPA) is to provide technical support to the companies and implementing agencies to design and implement sound monitoring systems to closely monitor and learn from these pilots. In parallel, IPA conducts its own independent and complementary data collection. IPA will use these two sources of information – the administrative data collected by the implementing organizations through their own M&E system and the independent data collection – to feed into an independent evaluation matrix to assess each pilot. The final scale up report will therefore be based on the evaluation matrix that was agreed upon all partners.

IPA has used this data to make recommendations on the potential scale-up of the HKI pilot to other relevant cocoa-growing communities. In addition, TRECC may consider whether certain pilots are feasible for future scale-up beyond such communities, for example to the regional or national level, though this has not been a central focus of this evaluation given the existing contractual arrangements on GMM2.

The report is divided into the following five sections: Relevance; Results (outputs and immediate outcomes); Costs & Operations management; Capacity to learn, improve and innovate; and Sustainability. For each section, we are describing the key findings based on quantitative and qualitative evidence.

Following the setup of the evaluation matrix, we are using a color system to provide an overall assessment against each of the 11 criteria: green means that the pilot is compliant with the criteria requirement for potential scale-up, red means that it is not, and orange means that it does partially comply and that eligibility for scale-up should be conditional on corrective measures to be taken in that area. As per the initial plan, our final overall recommendation is then decided as follows: pilots with green assessments on all 11 criteria receive an *unconditional* recommendation for eligibility for a scale-up proposal; pilots who have only green and orange criteria (no red), and among these a majority of green criteria, receive a *conditional* recommendation for scale-up – i.e. conditional on the various corrective measures being mentioned in the orange criteria. Pilots with any red criteria are not recommended for scale-up.

The Assessment signs used throughout the document are the following:

Executive Summary

1. General Appreciation and Recommendation

Overall, the HKI pilot has earned our conditional recommendation for scale-up. Seven criteria were rated as green and four as orange. Therefore, this recommendation comes with several important conditions that would have to be addressed for the program to be well positioned to go to scale:

> **1** Improvements should be made on the core ECD material. The messaging and implementation should be further refined and tested to better increase knowledge and ECD practices.

> **2** Considerable effort must be carried out to implement a sound monitoring strategy that collects credible data.

> **3** A more detailed vision of the scale up should be presented to have a better grasp of the cost structure of the program

> **4**. A more detailed planning of the supervision structure in the scale-up phase should be presented.

2. Specific assessment against each pre-defined evaluation criteria:

2.1. Relevance

Evidence shows that this project is targeting an important need in the population, both in terms of nutrition hygiene and ECD practices. The region is suffering from high rates - over 30 % - of stunting and malnutrition (Demographic Health Survey 2012), and in the 6 pilot communities, selected beneficiaries were slightly worse off than non-beneficiaries in terms of hygiene practices.

However, despite the preliminary work on the census to gather beneficiaries, we observe a high rate of households that have no children in their first 1000 days. We therefore recommend HKI to pay more attention during this first census step and better inform community workers on the eligibility criteria before launching the sessions.

The pilot as implemented seems fully aligned with the objectives of all stakeholders. This include both companies Company Partner and Company Partner, who have other long-term projects that include similar components.

2.2. Results outputs and direct outcomes

This evaluation relies on a before versus after comparison. Therefore, as per the initial plan, the focus of the analysis is on outputs and direct outcomes – on which improvements are more likely to accurately reflect program performance than improvements on more indirect downstream outcomes.

HKI was able to provide all key outputs described in the logframe in a timely manner. This includes the training of 10 master trainers and 100 community workers. One caveat on these results is that due to the opt-in nature of sessions, it appears to have been difficult to track individual attendance. In addition to this, concerning the knowledge of community workers, we notice an improvement in global knowledge as per our independently collected data. However, only 55% of community workers were reaching the expected knowledge score, falling short of the 85% target mentioned in the proposal. A recommendation is therefore to simplify the message delivered during the training.

Turning to beneficiaries, significant progress is observed on the number of mothers who could report the correct age for introduction of complementary food from 58 % to 72%. However, hygiene related knowledge indicators did not change. This might be attributed to the high level of pre-existing knowledge in the 6 communities on handwashing practices.

Results in terms of early childhood development have been more limited. We were not able to identify changes in early childhood knowledge and practices.

Generally, beneficiaries provided very positive feedbacks on the program, and high levels of satisfaction.

3. Cost and operations management

As far as we can tell, HKI seems to have made cost-efficient utilization of resources through the course of the project. We observe a small underspending of 11% of the planned budget of 233 885 CHF.

Based on the scale-up proposal submitted by X and HKI the vision for scale-up costing at this stage remains very incomplete. Except the fact that the scale-up will follow a more traditional health program approach - targeting all communities in one health district - the proposal is very elusive on the impact of such a change in scale on the cost structure. One key concern has been taken into consideration related to the fact that community workers were considered as volunteers: a substantial budget of 91 000 CHF is planned for "material and handout".

With regards to the monitoring system that will be in place for the scale up, HKI suggested to switch to an electronic model to increase efficiency and reduce costs. While this approach seems reasonable, we do not recommend implementing electronical data collection at this stage if it has not been thoroughly and planned. Especially in a low resources context, such as rural Ivory Coast, mismanagement with electronical data could quickly turn into data loss.

Despite the many challenges related to the multi-stakeholder nature of the project, the overall project management of HKI can be considered as quite successful. The project was implemented as planned. No significant deviations from the workplan have been observed other than changes that were motivated by challenges that were observed along the way. However, tensions between the different private partners on the projects had a negative impact on the speed of the decision process and the choice of scale up location. We do recommend open discussions before scale-up to align expectations and roles of the various stakeholders to avoid further challenges and inefficiencies.

4. Capacity to learn, improve and innovate.

HKI has collected a significant amount of data at each phase of the program to monitor the implementation. As an independent evaluator IPA was using the administrative data transmitted by HKI, which was partly verified through IPA's own independent data collection to monitor quality. Cooperation with HKI has been good and their staff always diligently transmitted the different documents and information IPA was asking for. Nevertheless, portions of the data collected by HKI on the field were not usable due to low quality: during IPA's three data verification spot-checks, large discrepancies were noticed between the data transmitted to us and what was observed on the field. For instance, during the month of June only 53% of community agents were reporting the same number of visits as we computed. This is a typical challenge of voluntary-based nutrition programs and we recommend HKI to strengthen their effort on the data collection tools and trainings, as accurate data will become even more critical at scale. We also recommend allocating a bigger amount of resources to the monitoring task in the scale up and to provide a solid management structure to community workers.

Despite the many caveats on the data collected, HKI has proved to be adaptive, and responded to a number of key implementation problems that arose, such as the low level of participation in the fathers' groups. During our different meetings on the quality of the data, HKI also acted and implemented some changes in the tools through which the information was collected.

5. Sustainability

Interviews with beneficiaries indicated enthusiasm for the project, but the limited local resources seem to indicate weak prospects for sustainability. The fact that those communities are also benefiting from the implementation of other NGO projects on a regular basis create certain types of expectations. Some community workers indicated that it seemed more reasonable to them to wait for another project to come than to continue one for which no further incentives would be provided. While the financial (and therefore sustainability) implications are complex, it is likely that a nutrition intervention of this kind would have to move beyond a purely voluntary-based approach in order to be sustained.

As for larger prospects for scale-up, the level of cooperation that is observed between HKI and the ministry of health is promising. The National Nutrition Program also expressed interest in

potentially using the open source documentation developed through this pilot for other projects and in other regions. Finally, bigger projects such as the World Bank Multi-Sectoral Nutrition Plan offer potential for future synergies.

Snapshot of specific assessment against each pre-defined evaluation criteria:

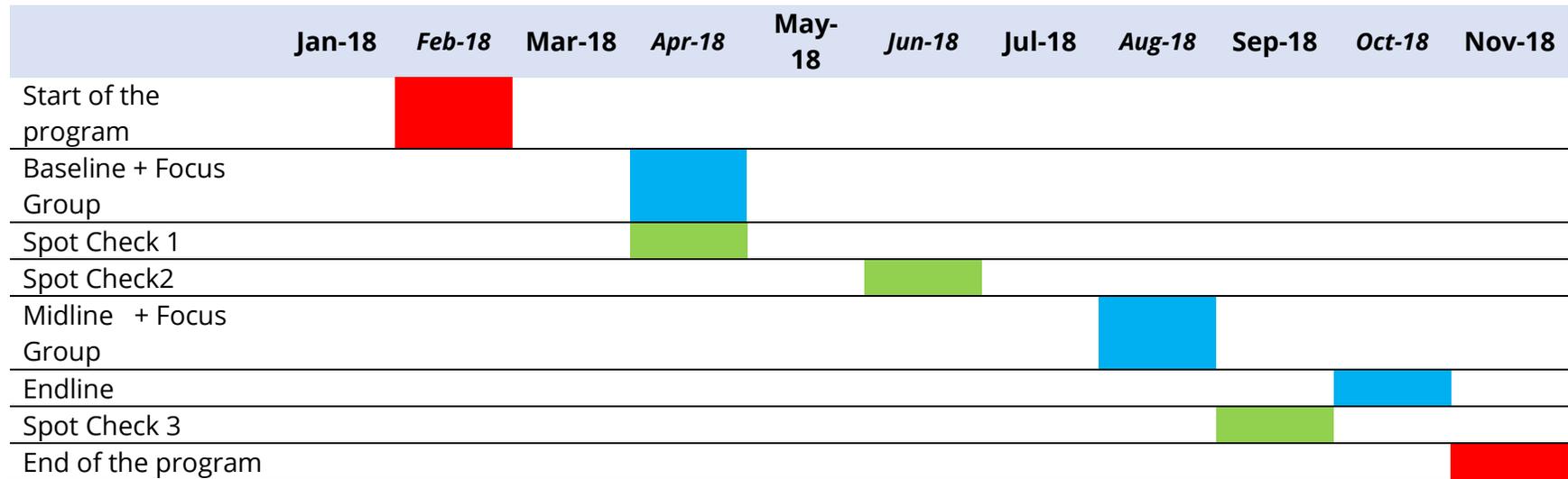| Evaluation Criteria	Assesment	Recommendations
1.Relevance		
1.1 Targets an important need in the community	✓	Improve targeting of mothers with children in their first 1000 days1.2
1.2 Aligns with the priorities of the donors	✓	
2.Results: outputs and direct outcomes		
2.1 Delivers outputs at high quality	✓	Less ambition targets for home visits and improve monitoring system to track individual participation rates
2.2 Achieves direct outcomes	✓	Simplify ECD message
2.3 Beneficiaries' feedback about the program is positive	✓	Take into account beneficiaries' constraints such as seasonal work
3.Costs and operations management		
3.1 Costs are well managed/cost scale-up vision	✓	Incomplete vision of cost at scale
3.2 Project management is successful	✓	Clearly define the specific role and input of each partner before scale-up
4.Capacity to learn, improve and innovate		
4.1 Project collects credible monitoring data	✓	Improve monitoring strategy, instruments to use and staff training on how to collect and analyze data
4.2 Monitoring is used to learn and improve	✓	Improve iteration and feedback loops to take corrective measures
5.Sustainability		
5.1 Provides sustained benefit to community	✓	Reduce project dependence on Blommer's field staff
5.2 There are prospects of scale-up beyond GMM2	✓	Strengthen organizational capacity through more project staff

Data collection timeline

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Start of the program		■									
Baseline + Focus Group				■							
Spot Check 1				■							
Spot Check2						■					
Midline + Focus Group								■			
Endline										■	
Spot Check 3									■		
End of the program											■

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Project summary

Helen Keller International (HKI) with technical support from PATH partnered with Company Partner Chocolate Company and The Company Partner Company through the Transforming Education in Cocoa Communities (TRECC) initiative to undertake an innovative, integrated approach to improving childhood development and nutritional outcomes during the first 1,000 days, a crucial period of life from the beginning of a woman's pregnancy until a child's second birthday. This 12-month pilot targets six villages in cocoa-farming communities in Western Côte d'Ivoire, reaching an estimated 22,136 direct and indirect beneficiaries.

The package of interventions proposed by this project focuses on three key interrelated factors documented and proven to underpin a successful start to life, including: 1) improved nutrition; 2) improved hygiene and sanitation; and 3) early childhood development achieved through appropriate play and communication. Training provided will support improved parenting skills that ensures children are clean, nutritiously fed, and nurtured during a critical window of their early development. The expected outcome is a cohort of children who are healthier, follow normal growth trajectories, and have improved brain development leading to enhanced cognitive, physical, social and emotional abilities. These skills will lead to future generations that are more prepared for lifelong health, success in school, and economic productivity.

Map1

Location of the HKI communities

1.Relevance

The relevance section will include the following two criteria:

✓ The program is targeting important needs in the community

✓ The program is aligned with donor's priorities

> ✓ 1.1 The program is targeting important needs in the community
>
> Through this project an important and specific need in terms of nutrition hygiene and ECD is targeted among the population. The pilot target population is appropriate in terms of hygiene but the targeting in terms

of percentage of households with children in their first 1000 days could be improved.

Recommendation for the scale-up: A special attention should be given to the methods used to construct lists of beneficiaries. Community workers should indeed be clearly aware of all key targeting criteria's before building the different lists.

✔ Criteria 1.1.1 Evidence of nutrition hygiene and ECD being an important need in the community

The current HKI project focuses on the Western region of Ivory Coast near the city of Man. The six-communities selected for the pilot are spread across two regions and three districts.

✔ Nutrition

HKI and Bloomer jointly chose these communities because of their high rates of malnutrition of over 30% (DHS, 2012) and given the existence of previous work relationship. According to our baseline carried out on a random sample of 322 beneficiaries and 69 non-beneficiaries, the food consumption of the beneficiaries is comparable to national averages, with around 90% having "acceptable" food consumption and 9% "borderline", and less than 1% "poor". Also, 86.2% of beneficiaries have a diversified diet (score above 4 based on food groups).

The qualitative data gathered from focus groups suggests some challenges related to neonatal nutrition and breastfeeding. It seems that some women may prevent their children's consumption of colostrum (the "yellow milk"), and that some may be introducing complementary foods before six months. This is mostly due to breastfeeding problems and a lack of knowledge. In terms of nutrition knowledge, only around 60% of both groups were able to name the correct age for introduction of complementary feeding (six months).

✔ Hygiene

As mentioned in the needs assessment, access to drinking water is a central problem for communities. They report periods of water shortage during February and March and very malfunctioning water pumps. According to our baseline, beneficiaries and non-beneficiaries have similar access to water with a third of households relying on unprotected wells as their main water source.

We observe in the baseline a poor access to sanitation with two third not having access to latrines.

✔ ECD

According to our baseline on knowledge about child stimulation and development methods, parents were asked to choose between two pictures, one showing a child stimulation practice (such as playing with a child) and one showing another action not related to child stimulation (such as giving the child a vaccination or punishing them). We found that participants' knowledge was not much better than a random guess (4.9/8), with neither group able to get more than 5 questions out of 8 correct in identifying stimulation methods. We suppose that by merely guessing participants would get 50 % right on average or a score of 4.

These indicators on knowledge are backed up by the outcomes about reported ECD practice. According to focus groups, amongst mothers, we observe a low level of engagement in child development activities.

Communication and play are the stimulation practices reported to be used by focus group participants. For instance, a participant reported "*we start talking to our children from the age of three months, six months and sometimes at one year. We talk to them about their families (fathers, brothers, sisters) while giving them affection. We also play with our children*".

According to Dr Biemi working at the National Nutrition Program, her team identified important socio-cultural barriers to child development in the targeted region. This includes the fact that fathers should not be present during their wives' pregnancy but also a limited communication between children and parents.

✅ Criteria 1.1.2 Beneficiaries' description of their needs include project related topics

During focus groups an open question was asking beneficiaries' needs to better take care of their children as parents. Respondents most often mentioned improved economic condition, but also regularly mentioned improved knowledge as to how to take care of children, alongside improved infrastructure for water, transport and healthcare. Interest in ECD coaching was relatively strong, and past exposure to such coaching limited among beneficiaries.

✅ Criteria 1.1.3 Those who received the intervention have a comparable or greater level of need compared with the rest of the community

✅ Nutrition

Regarding exclusive breastfeeding, we see that introduction of other foods and beverages before the age of six months is common among both groups (around 36% beneficiaries, and 46% among non-beneficiaries); while almost all mothers in both groups reported they were able to breastfeed and being the first to breastfeed their child.

Concerning nutrition knowledge, only around 60% of both groups were able to name the correct age for introduction of complementary food (six months).

✔ Hygiene

In terms of sanitation the beneficiaries have nearly twice the rate of reported open defecation, with 13.1% compared to 7.7%, though non-beneficiaries have a higher rate of use of unimproved facilities (a hole in the farm plot) at 69.2% compared with 53.1%. Finally, the beneficiary group has a far higher reported incidence of diarrhea than the non-beneficiaries, at 43.4% compared with 24.3%.

On hygiene knowledge, 79.3% of beneficiaries (compared with 89.7% of non-beneficiaries) were able to name at least three key occasions for handwashing.

✔ ECD

We found marginally statistically significant evidence that beneficiaries' knowledge is slightly stronger (by half a point) than non-beneficiaries. Performance was weak across all four domains of stimulation (cognitive, language, socio-emotional, and physical).

34.1% of beneficiaries (and 19.2% of non-beneficiaries) reported engaging in three or more learning-promoting activities with their child under two in the past three days (such as singing or playing with the child). The most common activities were singing, playing or taking the child outside, while telling stories and counting were less common. The reported proportion of those engaging in three or more learning activities among fathers was higher (at 63.7% for beneficiaries and 43.5% for non-beneficiaries) but that reflects the fact that fathers were asked about activities with all their children, not only those under the age of 2.

✔ Prevalence of households with a child under two

Prevalence of caregivers with a child in their first thousand days is smaller in the beneficiary group (71.1%) than in the non-beneficiary group (93.2 %). This suggests that some caregivers of older children have been included in the program. During our endline the rate of households taking care of a child younger than 2 years is falling to 63 %. The main reason for this discrepancy comes from the process of building list of beneficiaires. In fact, community agents were asked to construct the list before their own training. As a result, not fully aware of all criteria, they tended to select beneficiaries based on their social knowledge and preferences.

✔ 1.2 Aligns with donors' priorities

The intervention as implemented focuses on the objectives initially agreed and is fully aligned with the current priorities of donors.

The intervention was implemented according to plan and respected the calendar drafted in the proposal. No major changes were made to the initial plan. In this respect our interviews with the different stakeholders of the program management confirmed that the program was aligned with their priorities

✔ Criteria 1.2.1 Align with Company Partner's strategy:

Company Partner stated in the annual report that the current project and scale up is aligned with their global strategy. Indeed, Company Partner is also engaged in the Cocoa Action initiative that aims to improve learning abilities while improving nutrition and hygiene for young children.

According to Kip Walk The pilot with HKI provides the opportunity for X to address early childhood development. The business case for education is not purely about productivity increase for Company Partner. Market dynamics require for more resilient farmers via income diversification and quality education.

It is worth noting that Company Partner was recently sold to a Japanese ingredient company called Fuji Oil Holding. According to Frederic Dion, this new transition will not affect Xs' activities in terms of sustainability.

✔ Criteria 1.2.2 Align with Company Partner's strategy

Company Partner also clearly stated that the current project was fully in line with their global strategy. They launched in April 2018 a holistic cocoa sustainability approach called Cocoa for Good. One of the pillars of this approach is to increase family access to good nutrition**.** In this respect, this pilot and scale up proposal are fully aligned with Company Partner's long-term strategy that includes a half-a-billion-dollar commitment by 2030.

Company Partner's expressed an interest in the combined approach of ECD and child development. According to Beatrice Moulianitaki, Head of Sustainable Sourcing, the combined nutrition and child development package is typically something they would like to implement with other partners in other regions.

2.Results: outputs and direct outcomes

The Results section will include the following criteria:

✔ Delivers output at high quality

✔ Achieves direct outcomes

✔ Beneficiaries' feedback about the program is positive

✔ 2.1Delivers outputs at high quality

Most of the outputs were achieved with the expected quality.

Recommendation for scale-up: We recommend HKI to set less ambitious targets for home visits. In addition to this we recommend implementing a more rigorous monitoring strategy to better track individual participation rates.

✔ Criteria 2.1.1 Has the pilot produced measurable outputs with the required quality

✔Staff Training

The HKI model is relying on a cascading model. In fact, master trainers first followed a 5 days training that is paid via per diems and in a second stage trained 100 community workers in 6 communities. Crosschecking the annual report outputs and the administrative information we had access to, we find that all targets in terms of number of staffs trained were achieved.

Table 1: Key Outputs

Indicators	Target	Achieved	Difference	Data Source
HKI staff trained	3	3	0	Attendance list of training
Ministry of Health agents trained	3	3	0	Attendance list of training
Master trainers trained	10	10	0	Attendance list of training

Health agents trained	20	20	0	Attendance list of training
Total staff trained	**36**	**36**	**0**	Attendance list of training
Community workers	100	100	0	Attendance list of training

HKI trained 36 people to their core nutrition program in total. This included people from ministries and different stakeholders, but ultimately 12 health agents did all the trainings for community agents.

✓ Beneficiaries

To maximize the impact of their message, HKI decided to adopt a three-pronged approach. In fact, the key messages on how to support child development and nutrition was targeting three different groups. Mothers that were taking care of children under 2 years old, fathers that had a child under two and a group of grandmothers. The rationale behind it is that women's empowerment within their households and communities requires fostering the active engagement of men in childcare and nutrition tasks.

The output measure concerns the number of caregivers' groups created in the six communities. Typically, one community agent would oversee one mother, one father and one grandmother group. Given that we have 100 community workers overseeing three groups on average we have 300 groups. A group is composed of an average of 14 beneficiaries. Each group would on average meet every two weeks for a group session during a period of 7 months. In total 16 different modules were delivered and covered nutrition and child development subjects. At the end of the program **4538 beneficiaries** were trained

Table 2: Key outputs 2

Indicator	Targeted	Achieved	Data source
Caregiver groups created	302	311	HKI annual report
Caregivers who received counselling	4531	4538	HKI annual report
Home visit	21000	16251	HKI annual report & Admin data

HKI has set a target of 8 monthly sessions to be organized by each community worker. This includes the three types of groups, so it could be 3 mother sessions, 2 father sessions and 3 grandmother sessions.

Figure 1: Average sessions' completion by community workers

Average number of community workers that completed 8 sessions per month

■ Taux par mois
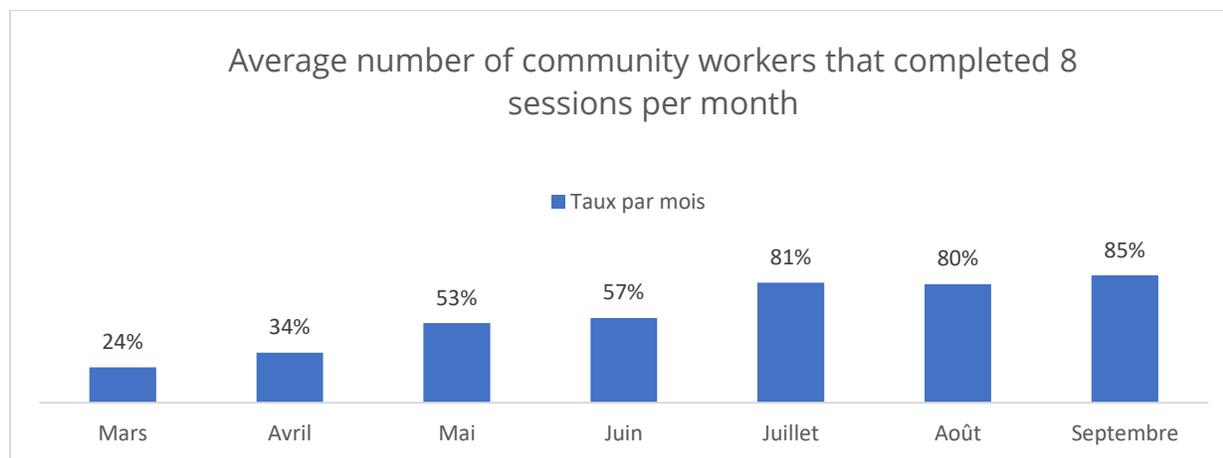
We used administrative data to map the evolution of the monthly session target to follow the roll-out of the program and the speed of implementation. In the graph1 we observe that for the first three months a small number of agents managed to organize 8 sessions. In August, the project achieved a good rate of 80 % of community agents organizing 8 or more session in their community. Despite the global positive trend, a strong heterogeneity among the different communities was observed with communities like Siambly having an average of only 40 % of community agents organizing at least 8 sessions per months across the 7 months of the project (see annex 4 for more details).

Recommendation: *Despite the positive trend during the roll-out of the program, we observe that 8 sessions per month is an ambitious target that could be reconsidered during the next phases of the project*

✔ Home visits

In addition to monthly sessions, community workers were conducting home visits in households to provide practical support on subjects covered during the group discussions. These home visits were mostly targeting mother's groups, so an average of 15 households per community agents. HKI has set a target of 2 monthly home visits. This requires 30 visits per month per agent. In total

17

16500 home visits were performed which results in an average of 1.5 home visit per community agent per month (16500/(100 (AC)*7 (months)*15 (beneficiaries))

> **Recommendation:** It seems that organizing two home visits for the 15 beneficiaries has been an ambitious target. In a context where beneficiaries can live far away from each other, doing 30 monthly visits can take a significant amount of time and create transportations costs. This is indeed one of the top expected improvement listed by community agents, providing transportation means.

✔ Criteria 2.1.2 Participation rate

Given that our preliminary indicator was the number of groups created, HKI was tracking the participation rate at the group level. The administrative data gives us detailed information on the number of sessions organized and the number of participants. In this respect HKI reported a participation rate of 80% for the mothers' group, 74 % for the father's group and 71% for the caretakers' group

Crosschecking data:

First it is important to keep in mind that if we want detailed information on participation rates we need to track each individual beneficiary and then aggregate the data. In this respect given that we received aggregated data at the group level from HKI, IPA is not able to compute a reliable participation rate throughout the program.

We however did spot-checks, meaning that we manually entered the data of each booklet in excel and did our own computation. This work seems to confirm HKI's results in the differential participation rates between fathers' and mothers' groups (see annex4).

Having a X number of people coming to each session is indeed a valuable information to compute participation rate but ultimately our goal is to have the same person come again and again to the different modules. Therefore, to achieve this we need precise disaggregated data. This would enable us to compute the number of caregivers that completed the 16 sessions. An extrapolation using the number of groups that benefited from at least 16 sessions indicates that 73 % fulfilled the training (see annex5). This is a very conservative estimation since some modules are taking more than 1 session to be completed. We therefore can question the results of the final report of HKI showing that 90% of all the groups completed all sessions.

A final challenge to compute participation rate at the individual level has been the turnover of beneficiaries within groups. Indeed, in their final report HKI reported a total of 335 people who entered the program (7 % attrition) and 235 who left it.

> *Recommendation: HKI chose to focus their monitoring strategy at the group level. This has the clear advantage of being easier to implement and aggregate but prevents us to really compute precise*

✓ 2.2 Achieves direct outcomes

Some of the key immediate outcomes have not been achieved. Despite successfully changing the knowledge on one of the key nutrition indicators we observe mixed results on ECD outcomes. Measuring reliable ECD indicators has proven to be challenging and more work should be carried out to refine instruments.

✓ Criteria 2.2.1. Change in knowledge of community workers

Quality of the training:

To assess how the training would impact the knowledge of master trainers and community workers HKI decided to carry out a test before and after the training. Our key measure to address the level of knowledge will be the percentage of people scoring above 75 on the training test. In this respect the goal was set at 85% and we observe in this table that right after the training only 48 % of community agents reached this score (table 3).

To reach the 85 % target we could argue that the theory must be anchored into the practice and that time will positively influence the global level of knowledge. To test this hypothesis, we carried out another post training test (using the same test HKI previously delivered) 4 months after the initial training, in August 2018. We observe that learning levels among community agents are lower than originally targeted, only 55% of the 100 community agents scored above 75. Supervision visits were then organized by HKI to address this knowledge gap.

Table 3: Agents' score

Indicators	Target	Post test score	IPA August test
Community agents who scored above 75 on the post-training knowledge test	85%	48%	55%

A deeper look at the test scores reveals that the average score is very similar in both ECD and Nutrition sections. Both sections are comprised of 25 questions. However, the lowest scores are observed in the ECD sections. A detailed analysis seems to indicate that the worse scores are related to questions that might not be the most critical. Questions such as "At what age a kid is starting to see? "scored poorly, 44% of good answers. The worse score is found in the following question, "Is a kid allowed to play with old pots?" Only 21 % of the respondents gave a correct answer. A limitation of this test could be that some questions scored poorly not because of the real level of trainers but because of the poor phrasing and difficult translation of those questions. In fact, pots in French refers to a wide variety of objects that could not be considered as dangerous.

To increase learning levels of community workers, different strategy could be adopted. A first solution could be to improve the training, this could include spending more time on specific modules, extending the training period, organizing refresher trainings. Another avenue for improvement could be related to the material itself. Simplicity and clarity of the message is a key factor to increase knowledge. Finally, stronger supervision of community workers could also have an impact on knowledge scores.

Recommendation: Increasing knowledge of community workers is a central piece of the theory of change. In this sense, IPA recommends spending more time simplifying and clarifying the material as this is the most cost-effective approach to increase knowledge. The test should also be reviewed to better reflect the key messages HKI wants to deliver.

✔ Criteria 2.2.2 Change in beneficiaries' knowledge

During our endline survey we managed to interview 270 beneficiaries out of the 320 initially interviewed during baseline. This leads us to an attrition rate of 15%. The attrition is mainly coming from beneficiaries that were travelling through the country as presented in the following table. Similar concerns have been raised by HKI that also suffered from beneficiary's turnover. We can mention that within country travels are specifically frequent during the cocoa harvest when farmers are travelling to sell their production. At the end of the section a more detailed attrition analysis will be provided.

Table 4: Reasons for non-surveyed

Village	Relocated	Travel in country	Not available	Travel outside Ivory Coast	Unknown	Total
X	0	2	1	1	0	4
X	0	3	0	1	0	6
X	0	2	2	2	0	6

X	1	10	3	5	1	20
X	1	6	2	1	0	10
X	2	1	0	0	3	6
Total	**4**	**24**	**8**	**10**	**4**	**50**

✔️ *Changes in direct outcomes*

As presented earlier HKI was working on three different targets, mother's fathers' and grandmothers' groups. The implementation revealed that each target group had specific characteristics requiring a different type of approach. On the learning side we could also consider that mothers and fathers have different learning curves. Therefore, we present the key learning outcomes for nutrition and hygiene knowledge in a disaggregated form for endline data.

Table 5: Overview of key direct outcomes baseline and endline for the mothers' group
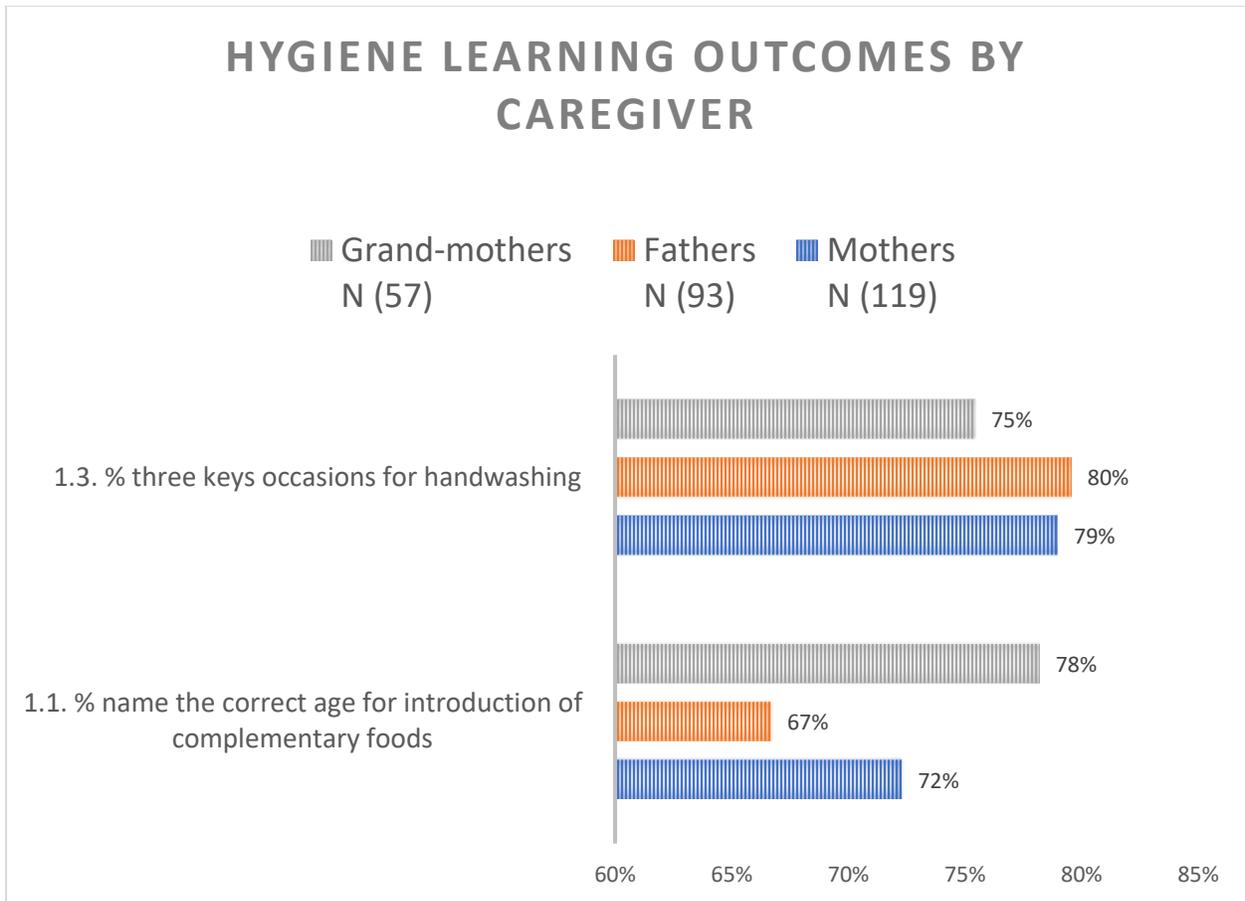
	Baseline	Endline	
1-Nutrition and Hygiene	Mothers N (145)	Mothers N (119)	Perc Point diff
1.1. % name the correct age for introduction of complementary foods	58%	72%	⬆️ 14%
1.3. % **three** keys occasions for handwashing	79%	79%	0%
2- ECD (knowledge)	Mothers N (145)	Mothers N (119)	Perc Point diff
2.1. % **name identify** at least two ways to stimulate the development of a young child	84%	83%	-1%
2.2. % of caregivers who can name 1 story they can tell their child.	N/A	26%	N/A
2- ECD (Practice)	Mothers N (145)	Mothers N (119)	Perc Point diff
2.3. % engaged in four or more activities to promote learning and school readiness in the past 3 days	34%	32%	-2%

This first overview indicates that we only observe a significant change in learnings for the nutrition component of the program. Results on ECD knowledge and practice are non-significant.

Nutrition hygiene knowledge: endline

We observe in the following graph 2 that learning levels achieved on the key outcomes stated in the log frame are different by groups. For the handwashing outcome we have similar scores, but we notice very big differences in knowledge related to the correct age for the introduction of complementary foods. These results are in line with the findings of the MICS 2016 where for the Western region, only 37 % of mothers exclusively breastfeed their children. Interestingly, we observe that grandmothers' score significantly better than the other groups. Current results on the very low score of fathers are supporting the three-pronged approach HKI is working on.

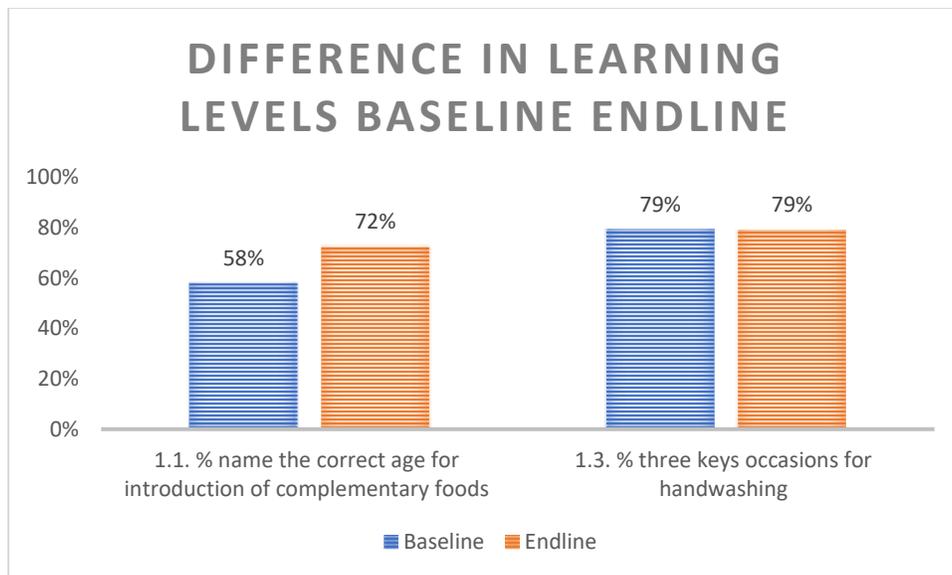*Figure 2: Hygiene and learning outcomes for caregivers*

Nutrition Hygiene Knowledge: baseline/endline

In the graph 3, we observe differences in knowledge for the mothers' group between endline and baseline.

Knowledge around handwashing didn't change on average. During the baseline we first computed an indicator on the two key occasions for handwashing but given the very high rate of correct answers, 98 %, we decided to have a more precise indicator and decided to compute the three key occasions for handwashing. For this indicator we don't observe a significant variation between baseline and endline. This is mostly because the level of knowledge on handwashing practices was already quite high among beneficiaries.

The key knowledge indicator for nutrition was the percentage of mothers that could name the correct age for introduction of complementary food. During our tests we considered only 6 months as a good answer. For this indicator we observe a significant change of 14 percentage point which is above the threshold set by HKI (10%). This is an encouraging result and changing knowledge on how to feed children seem to be a core priority to improve nutrition status of children. Especially in a context where beneficiaries declared in focus group giving water and other types of food to their children under 6 months.

Graph3: Difference in Learning levels baseline end line for the mother group

DIFFERENCE IN LEARNING LEVELS BASELINE ENDLINE

- 1.1. % name the correct age for introduction of complementary foods: Baseline 58%, Endline 72%
- 1.3. % three keys occasions for handwashing: Baseline 79%, Endline 79%

Early childhood development knowledge endline:

To investigate the level of knowledge achieved for ECD at endline in agreement with project stakeholders, we chose to focus our attention on two key indicators. The first one focused on the interaction caregivers have with their children and ask the respondent the name of a story they tell their children. For this indicator we had a quite comprehensive approach considering all types of story as valid. We observe a significant difference between fathers' and mothers' group. This supports the rationale that all caregiver's groups should be included in the ECD practice.

As for the knowledge about child stimulation and development methods, parents were asked to choose between three pictures, one showing a child stimulation practice (such as playing with a child) and two others showing another action not related to child stimulation (such as giving the child a vaccination or punishing them). We aggregated these four dimensions, cognitive stimulation, language, socio-emotional stimulation and physical stimulation. As listed above those four dimensions have quite precise definitions and many activities can overlap. For instance, an activity that supports physical skills could also be beneficial for the language. We will discuss the implication of such a test in the next section. In the current graph we don't observe significant differences between the mothers' and fathers' groups.

ECD KNOWLEDGE INDICATORS ENDLINE

Grand-mothers N (57) Fathers N (93) Mothers N (119)

2.2. % of caregivers who can name 1 story they can tell their child.
- Grand-mothers: 45%
- Fathers: 44%
- Mothers: 26%

2.1. % name identify at least two ways to stimulate the development of a young child
- Grand-mothers: 75%
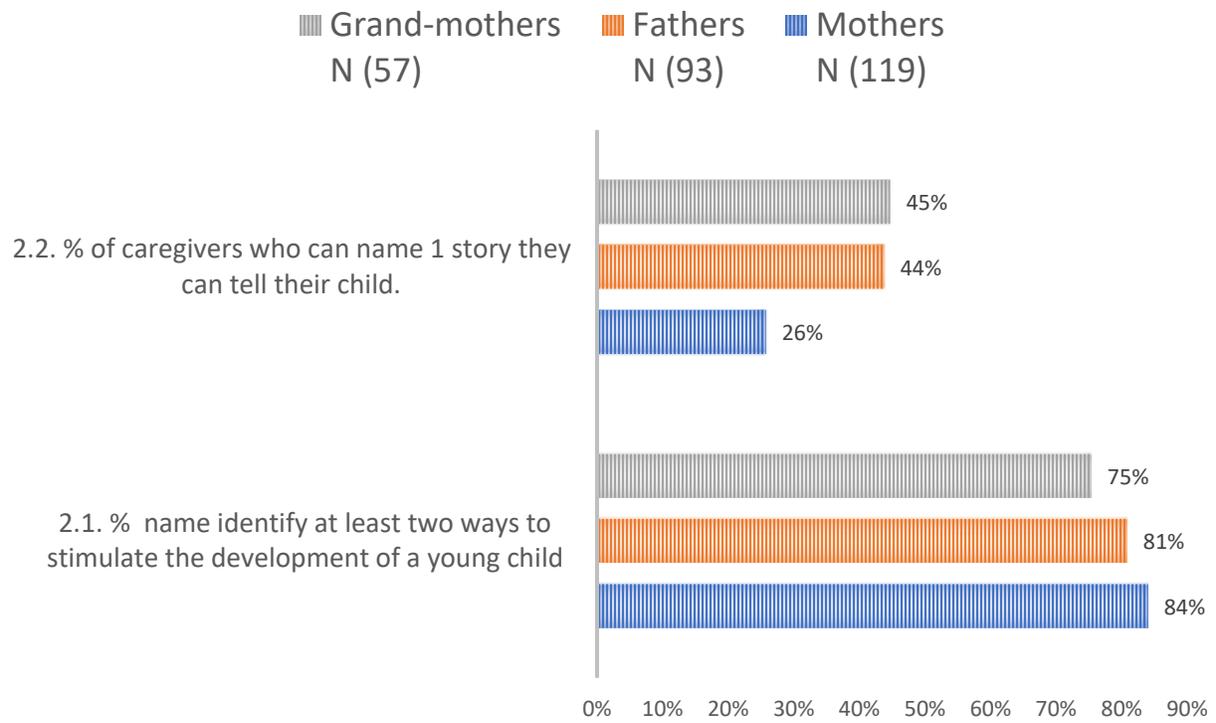- Fathers: 81%
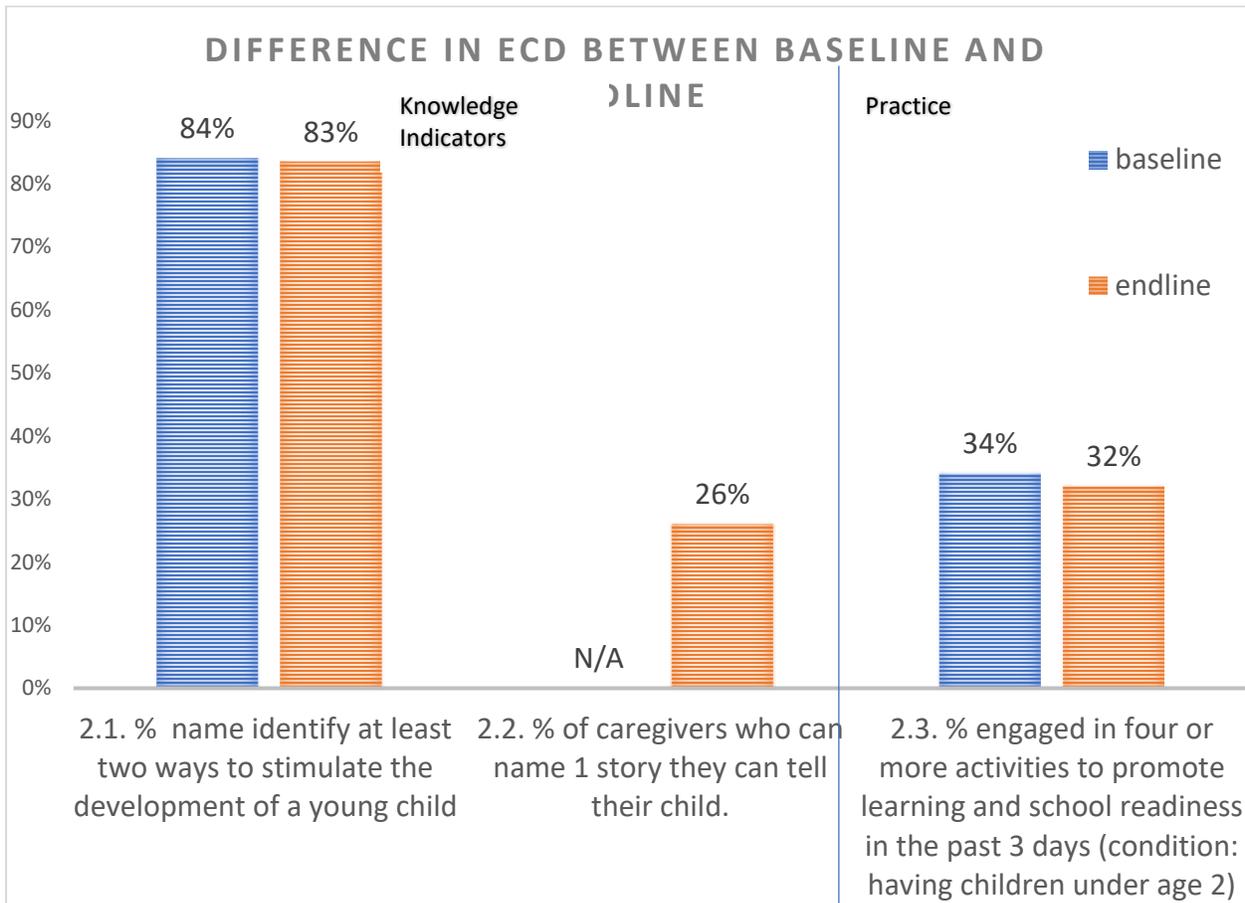- Mothers: 84%

Figure 3: ECD knowledge indicators

Figure 4: ECD practice baseline/Endline for mothers

Looking at the differences between baseline and endline (Graph 4.2) we don't find any significant evolution on ECD knowledge for the mothers' group that is our primary target. As explained earlier this indicator was based on an image test. We constructed this test using HKI's training images. Despite any clear average effect on knowledge a more detailed analysis seems to indicate that parents have a broader idea of the different types of benefits a stimulation activity could provide. This means that for an image showing for instance a father playing with his child, this could be beneficial for the language but also for the cognitive skills.

As for the heterogeneity of the impact, the following graph 4.3 gives us a better idea of the evolution of the different types of scores between endline and baseline.
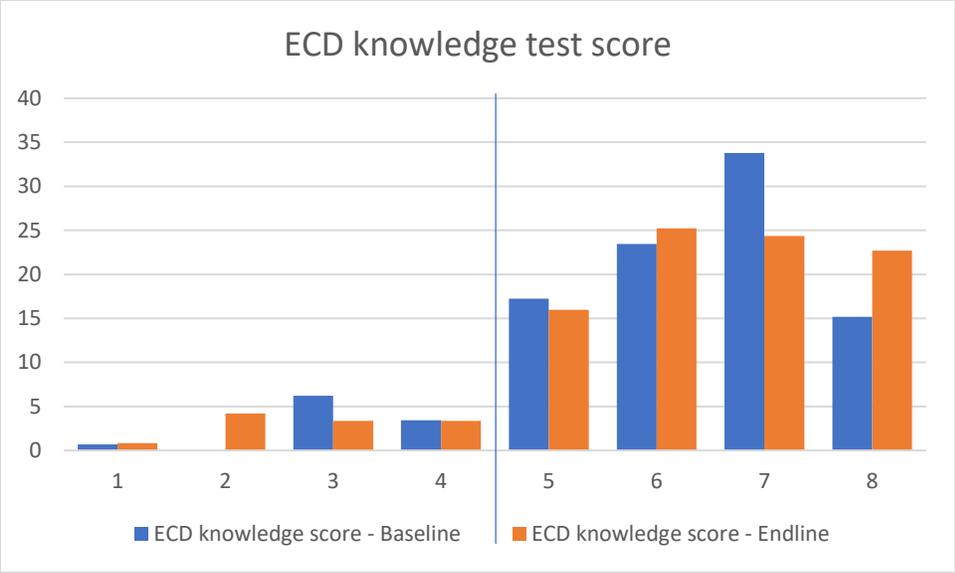
Figure 5: ECD knowledge score on 8 for mothers

As described earlier, the goal of the program is to increase knowledge and therefore to increase the amount of people that are scoring above 4 (better than a random guess). For both endline and baseline we have the same amount of people scoring above 4 (83% can name at least two activities to stimulate the development of a young child). However, looking at the graph 4.3, we can see a significant increase of people on the higher end, scoring a perfect score of 8. Hence, despite a non-significant effect on average we might observe that the program changed knowledge for a subsegment of the population. This will be an interesting avenue for research in the next phases of the program. How the program heterogeneously impacts beneficiaries and what are the main drivers of these differences.

As expected, since knowledge didn't significantly change, we don't observe any impact on ECD self-reported practices (6 types of activities that promote learning[1].) between baseline and endline. It is important to mention that given the focus on the first 1000 days of the program we only looked at self-reported practices for children between 0 and 2 years old. This is turn had a significant impact on our sample of study since only 70 % of beneficiaries during endline had a child under 2. Looking at the MICS 2016, we observe that for the western region, only 10.8 % of children between 36 and 59 months are engaged in four or more activities with their mother. It seems to indicate that ECD practices are more widespread for children in their first 1000 days.

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[1] The activities refer to reading a book with, tell a story to, singing to, going outside with, playing with and drawing/counting with as in UNICEF-MICS.

Threats to validity

Attrition analysis

As described in the methodological section (annex A) , IPA applies a strict protocol to reduce attrition rates and maintain high quality standards. This includes that all missing households are visited at least three times. However, despite our many efforts, we reached a level of 15 % of attrition. Attrition is a threat to internal validity and can introduce a bias in the analysis. Our main concern is the selection effect. This means that results are driven by the sample we selected during endline.

To address this issue one strategy is to study the pattern of attrition. If both the attritors and the surveyed groups are similar there is a priori no real reason to think that the results are driven by a selection effect. Observational evidence didn't seem to suggest that attritors were different from people remaining in the program. As for the quantitative side, table 4.1 shows the differences between key outcomes for attritors and baseline population. Preliminary analysis suggests that along the observational characteristics both populations have the same outcomes. This is indeed a strong argument towards the random nature of attrition that should not impact our results.

Table 6: Attrition table

1- Nutrition and Hygiene	Baseline group (145)	Attrition group (26)	Difference
1.1. % name the correct age for introduction of complementary foods	58%	54%	4%
1.3. % three keys occasions for handwashing	80%	85%	5%
2- ECD (knowledge)	Baseline group (145)	Attrition group (26)	Difference
2.1. % name at least two ways to stimulate the development of a young child	83%	85%	1%
2- ECD (knowledge)	Baseline group (145)	Attrition group (26)	Difference
2.2. % engaged in four or more activities to promote learning and school readiness in the past 3 days (condition: having children under age 2)	34%	33%	1%

Indicator Construction:

Measuring ECD learning has proven to be a challenge in a context with low literacy. In addition to this the translation of words such as cognitive development of socio-emotional skills in local language has also proven to be a challenge and in the process part of the profound meaning was diluted. Therefore, our first intuition was to use images to simplify the testing process. However, we discovered that most images had a broader definition than what we initially though and planned in turn affecting the precision of our measure.

Target Population

HKI's program is specifically targeting children in their first 1000 years. As a result, we chose to focus our attention on children under two years old. This in turn is affecting our results reducing our sample size. We recommend for the next phases of the project to be less restrictive on this dimension and consider all children for the ECD practices.

Despite the many challenges and caveats related of the analysis, IPA is confident with the fact that if there would have been a big impact of the program on people's knowledge and practices our current analysis and testing process would have been able to detect it.

Supportive supervision

Supportive supervisions have been implemented by HKI, PNN agents (master trainers), health agents and the primary teachers. A first dimension of the supervision was done locally, and a second one involved staff based in Abidjan. This second type of supervision consisted of a first observation phase where community agents were observed during a group session. The supervisor then filled in an observation questionnaire that computed a performance score. 200 supportive supervisions have been carried out in two waves of 100. The first wave was done by HKI and the PNN master trainer. During this first visit only 41 % of the community agents had a score superior to 75. During the second visit the proportion of community agents that scored above 75 increased up to 86 %. We had no access to this data, consequently we are not able to crosscheck these findings.

Recommendation: *Supervisions visits have been implemented by staff based in Abidjan. This had a big impact on the cost of the project. We therefore believe that creating a supervision scheme through local staff would be more cost efficient.*

✔ 2.3 Beneficiary feedback about the program is positive

A high participation rate was recorded among beneficiaries, who provided positive feedbacks on most of the outputs. Qualitative evidence suggests strong impact concerning the nutrition aspect.

✔ Criteria 2.3.1 Beneficiaries provide positive feedback on the delivery of outputs

Through our quantitative questionnaire we observe a large buy-in of the program. Nearly all participants reported being satisfied with the way coaching sessions were conducted. Interestingly, the satisfaction rate appears to be higher among the fathers' group.
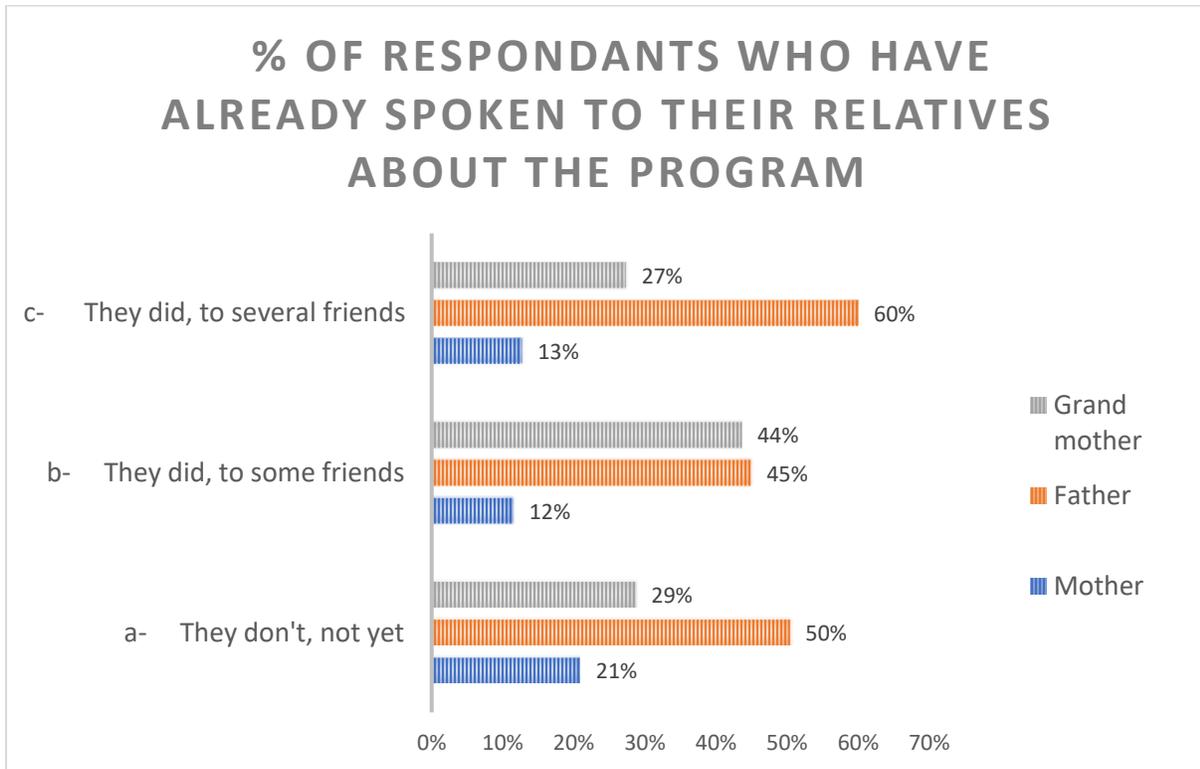
Figure 6: Satisfaction
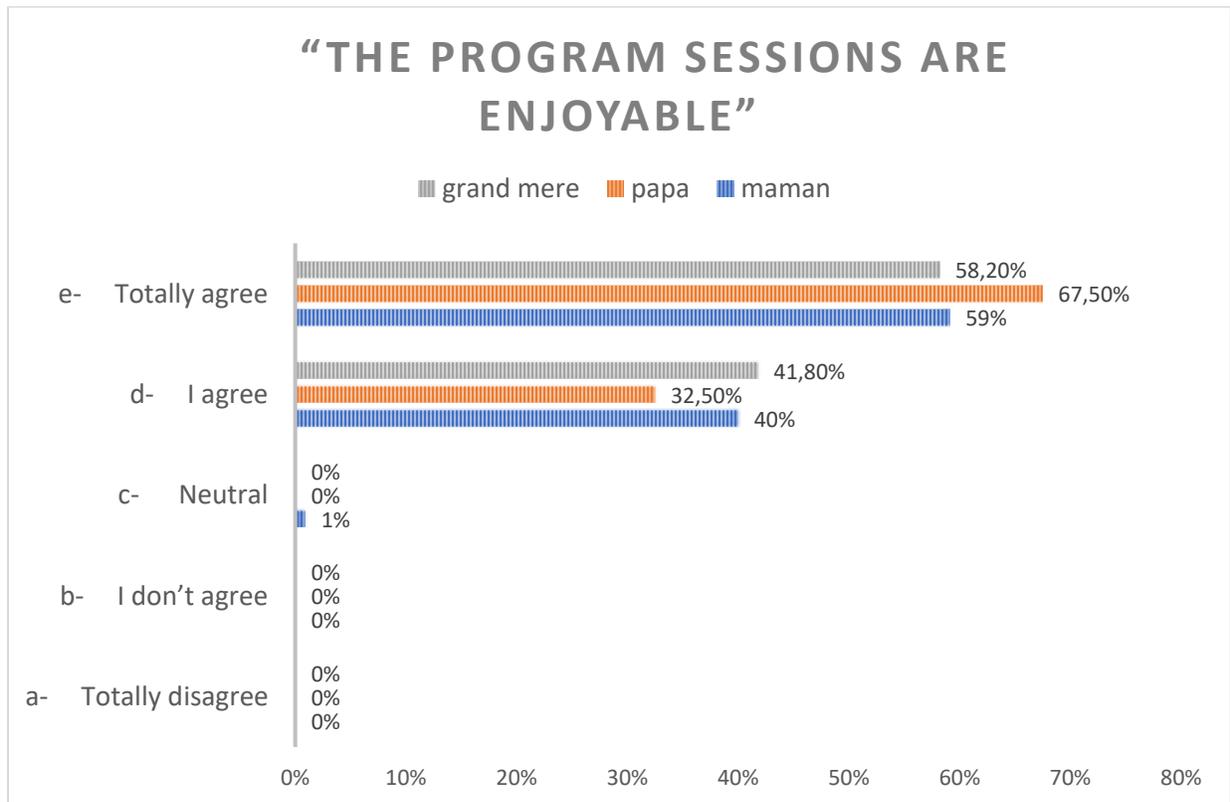
In line with the above results we find that more than 90 % of the beneficiaries would be willing to recommend the program to some relatives. In terms of effective transmission of the information, father groups seem to disseminate their experience of the program much more than the other.

This could be due to the fact that they are not used beinge a target for those types of programs or that in those communities men are spreading new information more than females on average.

Figure 7: Respondents who have spoken about the program

% OF RESPONDANTS WHO HAVE ALREADY SPOKEN TO THEIR RELATIVES ABOUT THE PROGRAM

c- They did, to several friends
- Grand mother: 27%
- Father: 60%
- Mother: 13%

b- They did, to some friends
- Grand mother: 44%
- Father: 45%
- Mother: 12%

a- They don't, not yet
- Grand mother: 29%
- Father: 50%
- Mother: 21%

According to information provided by focus group participants, the major barrier to participation is the occupation of the parents with the farm work. Coaching sessions were held in a period that coincides with farm work and for this reason it is difficult for parents to come to group sessions. As a result, community workers conducted home visits to deliver sessions. Some participants reported, for example, that they would like coaching sessions to be held in January or February when they are less busy with the farm work. A participant in a group discussion reported that "*We would prefer coaching sessions in January and February because we are free during this period*". Note that responses provided by participants differ from a group to another. The frequency of the training was also raised as a constraint to participation. This quote from a focus group participant summarizes the fact that coaching sessions frequency negatively impacts participation: "*We would prefer that the coaching sessions be held once or twice a month and we would like it to be held on Friday, Saturday or Sunday so that everyone can participate. Currently it is conducted weekly and we don't have enough time for that*".

The way the training session is planned impacts negatively the participation. According to the feedback collected in some focus groups, the sessions were not always planned in collaboration

with beneficiaries to consider their constraints. For example, a focus group participant raised the following concern: *"We would prefer to have a planning for sessions. Usually, we don't have a planning, it's when she (community agent) comes that she calls us for the session, we don't like this way of doing, but as we want to learn we just come"*

✔ Criteria 2.3.2 Beneficiaries provide positive feedback on the main immediate outcomes

Through the endline questionnaire (graph 7) we observe that nearly all beneficiaries 98% reported that the program changed the way they were taking care of children. Again, we found that the fathers' groups reported more changes than the mothers' groups. A follow-up question in the endline indicated that 100% of these changes were positive. For these types of questions with very high scores it is important to keep in mind the possibility of a Hawthorne effect. Meaning that individuals will modify their answers because they know they are part of an evaluation. Therefore, quantitative data should be thoroughly backed-up with qualitative research.
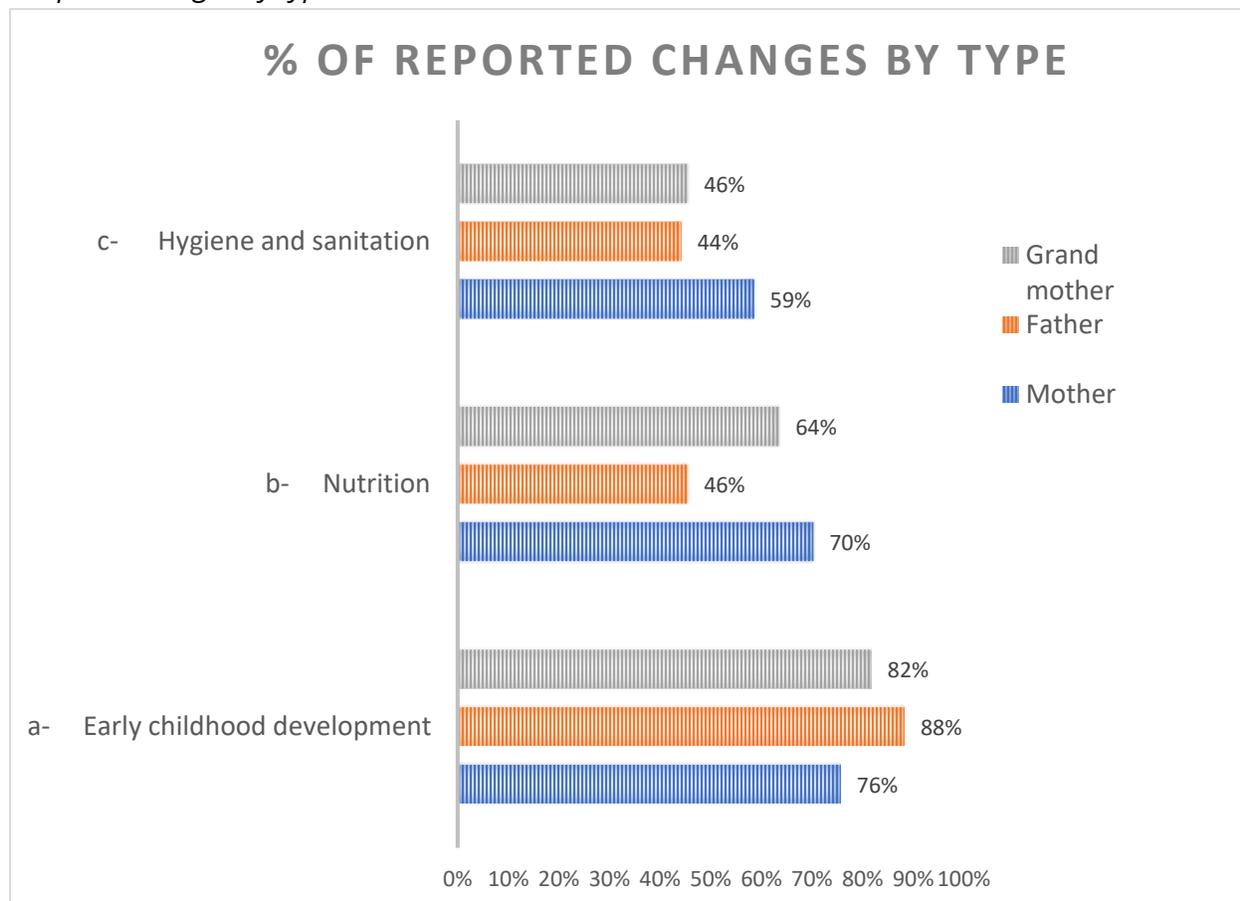
Figure 8: Respondents who report change in the way they take care of their children
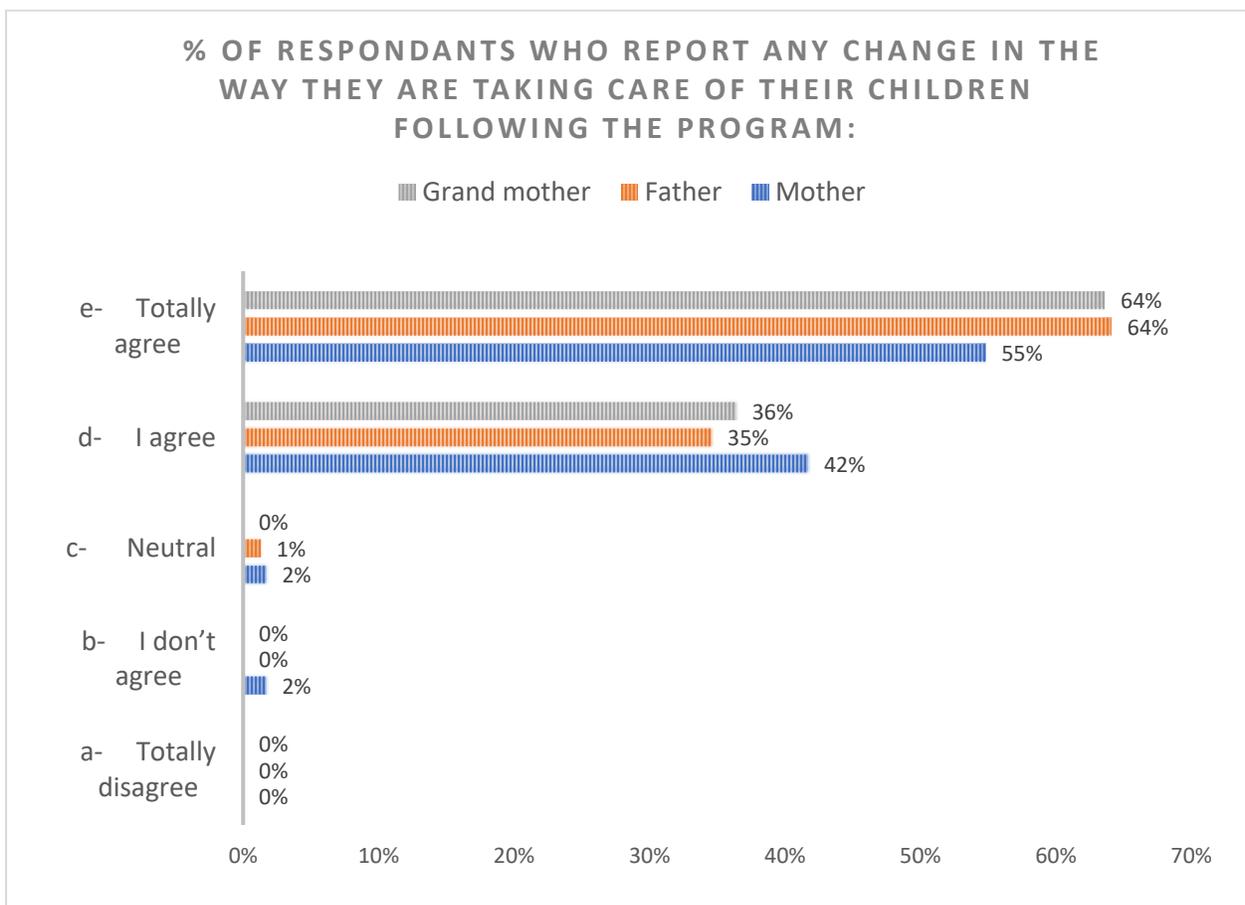
To know where changes happened, we asked beneficiaries to report them by type. The results presented in Graph 8 show that the most significative reported changes are coming from the ECD program. This might be because the ECD component was new to these populations. A

possible explanation for the ECD results could be that the notion of change respondents' are implicitly referring to is different than the one we measure.

Graph 8: changes by type

% OF REPORTED CHANGES BY TYPE

c- Hygiene and sanitation
- Grand mother: 46%
- Father: 44%
- Mother: 59%

b- Nutrition
- Grand mother: 64%
- Father: 46%
- Mother: 70%

a- Early childhood development
- Grand mother: 82%
- Father: 88%
- Mother: 76%

Legend: Grand mother, Father, Mother

✔ Criteria 2.3.3 Beneficiaries describe positive experiences with the program

Based on focus groups, the beneficiaries think the coaching sessions were useful to them as it allowed them to gain knowledge on how to feed and stimulate their children (from 0 to 6 years and plus) when they are healthy and when they are sick. They also reported that they gained useful knowledge on child care, child nutrition, what a pregnant woman should eat and how to behave with a child to support his or her development. Moreover, they reported having gained knowledge on the importance of handwashing and how to keep a clean environment.

Feedback from teachers and local health agents is also positive and reveals the focus on the nutrition and hygiene dimensions that are well understood by communities.

✅ Criteria 2.3.4 Beneficiaries report that the pilot was meaningful for them

Breastfeeding:

During baseline focus groups it clearly came out that parents give honey and lemon juice to newborns before giving them breast milk; "*The lemon juice is used to clean the throats of newborns*". The parents do not give the colostrum to newborns: "*We press the breast to evacuate the yellowish milk and we give the milk once it become clear to the baby* ". However, some women have reported that others give colostrum to their children. Most beneficiaries breastfeed from birth without pouring the first milk (yellow milk). "*I give water to my child from birth because I pour the yellow milk. I wait until the color is white before giving it to suck*.

During our midline focus groups women started to declare that they exclusively breast feed their children until the age of six months because they know now that it's good for their baby. For instance, a focus group participant reported that *"since the coaching session, I only give breast milk to my baby because when I followed the advice, they taught us, I noticed that my child does not get sick*".

At the same time, many participants still acknowledged giving water or other liquids to their children since birth. When women do not have enough breast milk, they give other artificial milks *"when I do not have enough milk, I give him artificial milk"*

Nutrition

Some participants in the focus group discussion reported that they start introducing complementary food at 6 months. *"In our community now, from six months we start giving some porridge to our babies"*. Other participants reported that they start introducing complementary food from 3 months, with some porridge; from 6 months they give to the child what the others family members eat like potato leaf, yam and rice.

ECD

Focus group participants reported that they can identify what their children need. In general, it is when the child cries that parents know exactly what he wants. *"When my child cries, I know that he wants something, then I can buy for example candy or something else for him"*.

In the grandmother's groups beneficiaries reported more responsive care actions. In fact a beneficiary declared "When a child is grabbing something on the ground, for a girl this means that she wants to play so I bring her toys " (Blepleu FG1)

In their majority, focus group participants reported singing and dancing with their children.

Main barriers to knowledge application

Through our different focus groups key feedback from the beneficiaries was collected. The most important barrier to knowledge application for this program is the lack of resources. In fact, some women declared that they had no financial means to buy iron rich food. Some others mentioned that they had no money to buy soap.

A second important barrier that was expressed was the limited time mothers had to offer for child development during certain period of the year due to farming activities.

Recommendations for scale-up: Recommendations for scale up: We recommend placing a special emphasis on the global logistics of sessions. In fact, it is important to take into account seasonal constraints of beneficiaries to maximize their buy in.

3.Costs and operations management

The costs and operations section will include the following criteria:

- ✔ Costs are well managed
- ✔ Project management is successful

✔ 3.1 Costs are well managed

Good cost management of the pilot in line with proposal. However, at this stage the partners' vision of scaling is still very incomplete.

[Details removed]

✔ 3.2. Project management is successful:

Good project management in line with the proposal

[Details removed]

4.Capacity to learn, Improve and innovate

The capacity to learn section will include the following criteria:

✔ Project collects credible monitoring data

✔ Monitoring is used to learn and improve

✔ 4.1 Project collects credible monitoring data

Signs that data was not always credible and reliable. This is specifically true for data collected on implemented activities

✔ Criteria 4.1.1 Routine monitoring data are collected and shared on time with stakeholders

As developed in the Logical framework, HKI was implementing 7 types of activities. For the last three detailed monitoring data was collected and shared with IPA for independent evaluation.

Activity 5: trainings:

A first wave of trainings of master trainers was organized by PATH in Abidjan. This training was first focusing on the Hygiene and Nutrition approach with the intervention of the National Nutrition Program. In a second part of the training, the Care for Child development approach was presented. During the three days training 19 people were present. A person from IPA assisted to the training and the attendance list was shared with us.

A second wave of training targeted regional and departmental trainers during a period of four days. The attendance list was also shared with IPA.

Following training provided at the departmental level, six distinct training sessions were held in each of the six villages covered by the project. The training sessions were led by a training team composed of a national expert trainer, a health worker, a teacher, and a X community agent and/or a X supervisor who had been trained in advance at the departmental level trainings held prior.   One hundred participants were trained in each of the following communities: X (30 trained), X (16 trained), X (10 trained), X (15 trained), X (16 trained), and X (13 trained).   Most trainees were either cocoa farmers (37), housewives (33), or people working in other sectors (merchants, mechanics, etc.). HKI shared with IPA pre and post-test results of these training. It is based on these tests that we programmed our midline test.

Activity 6: Participatory mother's, grandmother's and father's group meetings

According to the first monitoring plan, administrative data was supposed to be shared with IPA on a monthly basis. Given the implementation hurdles and the low level of literacy of community agents, data was shared every three months. Each community agent would fill in a special booklet with the name of beneficiaries attending sessions. This data was then collected by a HKI agent and aggregated at the group level. This is the data IPA received. Focusing the attention at the group level had the advantage of simplifying the aggregation process and information flow but would not give us a clear picture of the attendance rate.

Activity 7: Supportive supervision

According to the Annual report, HKI implemented 381 supportive supervisions. The supportive supervision's main purpose was to evaluate how interventions were being implemented by community workers, and to provide personalized coaching sessions to each community worker. HKI shared a document summarizing the two rounds of supervision and the associated scores with us. According to their document, we can count 246 supervision visits.

✅ Criteria 4.1.2 IPA spot check confirms the quality and accuracy of the data shared with partners

Three rounds of spot-checks were organized by IPA to support HKI in their monitoring and learning endeavor. Given the low level of literacy among community workers, HKI had to ask for external support and more particularly the help of local teachers to fill in the booklets.

Spot-check 1: March 2018
During this first field visit, IPA noticed very incomplete attendance lists and low participation rates. A recommendation to update beneficiary lists and building more capacities was made.

Spot-check 2: June 2018

During the second round of spot-check, the goal was to monitor the participation rate. We double checked 70 % of all booklets to compute participation rates and compared them to the data we received from HKI. We noticed a general improvement on participation rates. However, the quality of the reporting was still problematic.

This was mostly due to a growing confusion around the different types of activities community workers were supposed to organize. The confusion between group sessions and a home visits was blatant and leading to very high discrepancy rate between data transmitted and our own computations of attendance rates. For the mother groups, in April 2 out of 6 communities had more than 10 % discrepancy (annex 5). These results are worse for the grandmother groups were 5 communities out of 6 have a discrepancy superior to 10% for the month of March and April.

Spot-check 3: September 2018

For our last spot-checks, we focused our effort on comparing the number of session declared with what was actually organized by each community agent. In this respect, IPA took pictures of each pages of the different booklets and crosschecked the information.

On average we observe that a bit more than 50% of the community agents managed to report the correct number of sessions (annex 6). We also observe a high heterogeneity within the communities.

We first wanted to compute the participation rates for each module, but we discovered that the actual date when the session was organized was not available.

✓ Criteria 4.1.3 Monitoring data is actionable and aligned with program management

To assess the credibility of data collected we will use three key concepts

Validity: Valid data accurately captures the core concept one is seeking to measure

Reliability: implies that the same data collection procedure will produce the same data repeatedly.

Unbiased: Measurement bias refers to the systematic difference between how someone responds to a question and the true answer to that question.

Activity 5: Training

Credible Data Criteria	Valid	Reliable	Unbiased
Activitiy 5: Trainings	✓	✓	✓

Valid: The data collected on the trainings through the presence list accurately captured the concept. Using a test before and after the training also enabled us to measure the knowledge transmission during the training.

Reliable: The data was reliable

Unbiased: The data was unbiased

Activity 6: Participatory mother's, grandmother's and father's group meetings

Credible Data Criteria	Valid	Reliable	Unbiased
Activity 6: Participatory mother's , grandmother's and father's group meetings	✓	✗	✓

Valid: Despite improvements in the way data was collected we cannot say that the data captures the core concept of what we wanted to measure. We observed a lot of confusions around the concept of group session and home visits. This really needs to be clarify in advance. We think this confusion came from the fact that HKI asked to do some individualized sessions during home visits.

Reliable: Due to the confusion around the definition of what was a session and the difficulty of community workers to collect data in the booklets, we cannot say that data is reliable. This lake of reliability was confirmed by the spot-check that revealed significant discrepancy in the data collected.

Unbiased: Given the ambitious objectives set by HKI and the clear incentive of community workers to overreport the number of sessions we cannot consider this measure as unbiased

Activity 7: Supportive supervision

Credible Data Criteria	Valid	Reliable	Unbiased
Activity 7: Supportive supervision	✓	✓	✓

Valid: The concept of a supportive supervision visit was clearly defined by HKI. Each visit would also follow a special procedure with a grading scheme.

Reliable: Through the analysis of the administrative documents HKI transferred to us we couldn't find the same number of supervision visits. We found 246 supervision visits when HKI declared 381.

Unbiased: We can consider that supervision visits data are unbiased

> **Recommendation for scale-up:** We advise HKI to work on the tools they are using to collect data in the field. Namely draft new booklets with the possibility to enter the date of session. A clear training should also be provided to the staff to explain how we fill in a booklet and the key definitions of the project activities. To improve the data flow, we also encourage HKI to think about all the required different steps needed to draft the final tables and aggregate data.

✔ 4.2. Monitoring is used to learn and improve

Data were analyzed and used to learn and take corrective measures to improve implementation.

✔ Criteria 4.2.1 HKI demonstrated willingness to learn innovate and incorporate feedback

Given the cascading model HKI chose for their project implementation, they naturally had a limited direct influence on voluntary community workers. Managing community agents and ensuring they would deliver the different sessions to an appropriate audience has proven to be one of the core challenges of the program.

Spot-check feedback:

After each spot-check, IPA was organizing a session with HKI to discuss the different results and challenges. After the first spot-check we noticed a very low participation rate, especially among the fathers' groups. In reaction to this, HKI took corrective measures and demonstrated a clear willingness to find solutions.

During the second spot-check IPA insisted a bit more on the need to clarify the definition of a session with community agents. In this respect HKI also took corrective measures. Despite sustained efforts these corrective measures didn't translate into significant improvement in terms of data reliability. We therefore think that the monitoring strategy should be revised.

Group discussion approach:

One major change that resulted from monitoring data was how the program was delivered. During the first months HKI observed a very low participation rate for the men groups. As a result, they decided to focus their attention on home visits instead of groups sessions for men.

Message Clarity:

Through the results of the pre and post-tests, HKI discovered that some of the messages provided in the modules were not easily understood by community agents. This partly explains the low score of community agents. In response to this, HKI will work on simplifying the message as explained in the scale-up proposal.

Recommendation for scale-up: Improve iteration and feedback loops to take corrective measures.

5.Sustainability

The sustainability section will include the following two criteria:

✔ Provides sustained benefits for community

✔ There are prospects of scale up beyond GMM2

✔ 5.1 Provides sustained benefit to community

Some signs of sustained benefits in the community and ways of improvement identified. However the fact that HKI's staff is not part of the project anymore threatens the sustainability of the project.

✔ Criteria 5.1.1. Signs that the intervention from the pilot will continue to benefit the beneficiaries/community members over time?

HKI provided anecdotal evidence about communities taking ownership of the program. The final wrap up meeting of the project was organized in Man with all community workers and local officials. According to HKI this event was a success and enabled community workers to receive recognition for their work which will be a key driver to sustain their work in the community.

HKI suggested that program could continue with a minimum of supervision using the partnership with the National Nutrition Program. However, no clear follow-up project or agreement seem to exist at this stage.

One clear threat to sustainability that is not mentioned in the different documents is the large array of NGO and programs that have already been implemented in the region. In fact, given that NGOs are coming with new projects every year in villages, community workers might be better off waiting for a new program being implemented than continuing an old one.

The involvement of X through their paid field staff has proven to be critical in providing a sound management structure. The local X's staff was specifically involved in the global coordination of the project and the logistics. Replacing these agents by a community of practice would certainly impact the global efficiency of the project.

Recommendation for scale-up: A special attention should be given to the replacement of X's staff with the community of practice. These communities will have to be implemented before the full launch of the project

5.2. There are prospects for scale-up beyond GMM2

There are promising prospects for scale-up beyond company funding.

Criteria 5.2.1 Evidence of government/partners buy-in

The National Nutrition Program's (PNN) mandate, as a program of the Ministry of Health, is to improve the nutritional status of Ivoirians. They provide a governmental institutional support to the program, and seek to co-develop a model with HKI that can be scaled beyond the framework of this project

HKI has many years' experience collaborating with the PNN. They have been working on different project for the last 10 years in Ivory Coast and HKI seem to have a deep knowledge of the PNN structure and model.

According to the interviews we carried out, both parties were satisfied with the level of collaboration. In this context the National Nutrition Program offered 99 bicycles and HKI increased this number by 20 bicycles in order to be able to give one to each community workers and supervisors (119 in total).

For the scale up of the project, other key partners, such as the National Ministry of Education and the Ministry of Solidarity, Women and Child Protection will be able to take an active role as members of the technical team established for implementation

5.2.2 Enabling and financing environment

National environment is suitable for further scale up given the new investment of the World Bank on a Multi-sectoral Nutrition Plan (USD 60 million). The first Strategic Objective is the following:

"Good nutritional practices and preventive measures are promoted". This objective aims to promote and support good nutritional practices and preventive measures with a focus on promoting key Essential Nutrition Actions (ENA +). One of the outputs of this strategy is the promotion of ENA + to be delivered by community workers, and this overlaps perfectly with our program's interventions to date.

According to the different rounds of discussions, UNICEF will also be consulted to explore potential synergies and overlap as they are a key nutrition player and could support the scale-up within an entire health district.

✔ 5.2.3 Organizational capacity to implement at scale

HKI benefits from a strong presence in Ivory Coast with very good institutional anchoring. They have been working in most of the Ivoirian regions and have a local knowledgeable staff able to travel frequently in the field.

However, during the pilot, it was clear that the local coordinator in Man was overwhelmed by the amount of work to carry on. As a result, we strongly suggest investing more in human resources to provide better field supervision and monitoring.

Recommendation for scale-up: HKI has revealed to be a strong partner and is certainly able to implement large scale projects. However, we do consider that for the scale-up phase, they should allocate more human resources to field management and monitoring

Brookings input

Given the time available between availability of the scale up proposal and report submission deadline, we were not able to have back-and-forth and/or integration of these comments into the report. They are provided as they are

Project Workplan

- Very exciting to read about the progress of the pilot, important lessons learned to date and implications for scale. There appear to be a number of strengths in regard to scale up, including but not limited to:
    - Initiative responds to a deeply felt need by local community;
    - clear alignment with national priorities;
    - identification of strategic opportunities with PNN and Multisectoral Nutrition and ECD Plan;
    - clear scale up goal to integrate within government system and already working with/through government infrastructure;

- o core aspects of the model have been identified and attempting to further simplify for scale;
- o recognition and plan to strengthen role of M&E and in particular for ongoing learning and adjustments, etc etc.

Rather than highlight all of the strengths of the proposal, given our limited time, we have focused below on areas where additional information or thinking could be useful.

- **Volunteer-led model:** Appears to be mixed assessments of viability of sustaining a volunteer-led model, especially at larger scale. Some previous HKI-Bloomer reports/meeting notes highlight challenges to maintaining engagement and motivation of volunteers. However, the workplan at times identifies the volunteer-led delivery model as a success with plans to continue as piloted; while at the same time there is also the recognition that in the long term it is not sustainable. All of this is to say that it may warrant a more robust discussion about a volunteer-dependent delivery model's potential, limitations and if there are any plans to address/adjust in this next phase. A frank examination of a volunteer-led delivery at scale would be an enormous contribution to the broader field, beyond CDI.
- **Current discussion of champions and opponents** is limited to those currently involved in implementation and beneficiaries – would be helpful to have more information on national and regional champions and opponents, who would be important to consider when planning for national scale. For example, don't recall any mention of plans to engage UNICEF, yet this is a KPI for Bloomer – integration into their work, as well as mentioned in previous meeting notes the potential to work with UNICEF and MEN. Good to mention if any plans to further engage them and/or others beyond health system.
- **Resources section is weak**. From what we have seen, there is no information about additional costs at scale, potential economies of scale, additional human resources needed, etc. This is included in their annual report, so not sure why it was not included in the scaling plan. Understand they submitted a separate scaling budget (which we hadn't received at time of reviewing these documents), but still think this narrative section needs more detail.
- **No information about the enabling environment**, potential constraints to scaling, etc. Think this could use a lot more thought, as difficult to imagine that there aren't any potential scaling constraints to consider (or unintended consequences to be aware of). Maybe the question is unclear or too broad to respond to? Good for us to get this feedback if it is the case.
- **Mentions communication between all partners has been excellent**—although some indication in the annual report that some important lessons have been learned to date where communication might have broken down. Good to identify any constructive lessons for going forward.
- **Section on sustainability could use some more thought and articulation**– think that a case can be made, just need to bring together, such as: partners have identified a cost-effective, simple model for improving children's nutrition and cognitive development that can be integrated into existing government policies and plans, as evidenced by

work already taking place through partnership with PNN and opportunity to further integrate key learnings within the Multisectoral Nutrition and Early Childhood Development Project, etc etc (not this word for word but the idea)...... Could also discuss if there are any plans to make strong case of clear link in supply chain for cocoa companies in order to sustain their engagement and investment. Annual report also mentioned some economies of scale which aren't included here. Additionally, it would be good if proposal could address plans post-Bloomers Activities through CocoaAction as understand these are only for the next three years? (unless I am mistaken). Given reliance on Bloomer in-kind contributions, what transition plans are in place post-Bloomer engagement?

- **Great to see beefed up M&E plans and intentions to experiment with online platforms** to address some of the quality and efficiency challenges with collecting monitoring data at scale. It would be helpful to see a bit more analysis/lessons learned from online data collection platforms as they propose (via tablets, smart phones etc) – what are the plans for testing this –or perhaps already being used as wasn't clear (tablets and smart phones mentioned)? Budget implications? Have any of the other TRECC pilots (or other related projects in CDI) experimented with tech-enabled data collection and any relevant lessons to consider?

- **Areas for further consideration:**
  o Reaching fathers – acknowledgement that men were difficult to reach and would be more effective to engage them individually/through home visits. Is this scalable/sustainable? Also acknowledges that to achieve cost efficiencies at scale will reduce the home visits. Therefore, might need to re-think this strategy - starting with ensuring an accurate diagnosis of that the root cause of men's lack of engagement (is it in fact group meetings versus other aspect that could be addressed more cost-effectively). And if there might be other approaches to consider rather than additional home visits.
  o Locations: Mentioned in previous reports/meeting notes challenges with pilots spread across districts and desire to consolidate during scale up to cover one health district. Seems like this is intention with vast majority (82 communities) in one district but still left with 14 communities in another district. Should this be re-considered given lessons learned to date and potential for scale?
  o Family planning: It was noted in the annual report during the community meeting a request for more information on healthy cooking and family planning. Noted that healthy cooking was mentioned as a potential adaptation in scale up phase but not family planning. Just flagging if has been considered

Overall lessons/thoughts not HKI-specific:

- **Important for all TRECC pilots/partners to consider and plan for transition period between pilot and scale up phase if not already**. HKI mentions challenge to retain groups and activities with limited supervision during this period and imagine won't be

unique to their project. Something that should be carefully considered, planned for and managed.
- **Costs continue to be elusive**—how numbers are calculated, what are anticipated costs for scale up, etc. TRECC might consider providing pilots some external costing support/technical assistance during this scale up phase. Given how challenging it is to get costing data in global education projects (let alone cost efficiency or effectiveness analyses) yet how critical for considerations for scale, could be great contribution not only to these individual pilots but to the broader field on simple, cost-effective ways to collect, analyze and document this data.
- It would have been good--and perhaps not too late—to include a question somewhere in the workplan about **opportunities to collaborate with other related TRECC pilots** to date, any lessons learned/knowledge shared and any plans to collaborate in the next phase. For example, potential to deliver the intervention through existing community groups such as VSLAs - which aligns well with ICS-SP/CARE pilot that is delivering parenting training through VSLAs. Our bad for not considering this question sooner.

Annex 1 : Baseline nutrition outcomes

Indicators	Beneficiaries	Non-beneficiaries	Difference
Household food consumption			
Average household food consumption score (out of 126) as reported by mothers[2]	61.7	54.4	7.3*
% of household with poor Food Consumption Score	0.7	0	0.7
% of household with borderline Food Consumption Score	9.0	23.1	-14.1*
% of household with acceptable Food Consumption Score	90.3	76.9	13.4*
Average household food diversification score as reported by mothers (out of 6)[3]	4.7	4.1	.6**
% of household with food consumption above 4	86.2	69.2	17.0**
Household practices about exclusive breastfeeding			
% of mothers who reported having at least one child under 6 months taking some food or beverage other than maternal milk	35.9	46.1	-10.2
% of mothers who reported having at least one child not benefit from maternal breastfeeding at all	.7	0	.7

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[2] The Average Food Consumption score is from the World Food Program. We use the modified version of the *Action Against Hunger* questionnaire. From their classification, we say denote by insufficient food score = [0,28], limited food score = [28.5,42] and acceptable food score > 42.

[3] Food groups are: Cereals and tubers, legumes, Vegetables and leaves, Fruits, Animal protein, Dairy products, Sugar, Oil.
Diversified food consumption is considered to be a score greater or equal to 4.

% of targeted mothers who reported that they were not the first to breastfeed their child[4]	.7	2.6	-1.9

Annex 2: Baseline Hygiene and sanitation outcomes

Indicators	Beneficiaries	Non-beneficiaries	Difference
% of households with at least one household member suffering from diarrhea during the last 30 days as reported by mothers	43.4	24.3	19.1**
Main water source for the household as reported by mothers (%):			
Running water for the household	0.7	2.6	
Running water outside or in another household	0.0	2.6	
Public fountain[5]	16.6	12.8	
Well (protected)	44.1	48.7	
Well (unprotected)	38.6	33.3	
Toilet facilities for household, as reported by mothers (%):			
Interior, exclusive use, without flush	1.4	0.0	
Common, without flush	13.8	10.3	
Improved latrines	14.5	10.3	
Hole in the plot	53.1	69.2	

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[4] 100% of those who were not the first to breastfeed their child said that it was in order to avoid giving the child colostrum ("yellow milk").
[5] E.g. water pump.

Open defecation (bush)	13.1	7.7	
Other	4.1	2.6	

Annex 3: Baseline ECD outcomes

Indicators	Beneficiaries	Non-beneficiaries	Difference
1- Outcome in the log frame: ECD *outcomes*			
Knowledge indicators			
1.1. Average score (out of 8) of caregivers on test to recognize at ways to stimulate the development of a young child[6]	4.9	4.4	.5*
1.1.1. Average caregiver score (out of two) on subsection of test about <u>cognitive stimulation</u> (average score out of 2)	1.3	1.2	.1
1.1.2. Average caregiver score (out of two) on subsection of test about <u>language stimulation</u> (average score out of 2)	1.2	1.0	.2*
1.1.3. Average caregiver score (out of two) on subsection of test about	1.3	1.1	.2

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[6] HKI's logframe specifies that caregivers be able to recognize at least two ways to stimulate development. It may be more appropriate to specify an improvement on this test score. Note that by merely guessing, participants would get 50% right on average, or a score of 4.0.

	socio-emotional stimulation (average score out of 2)			
1.1.4.	Average caregiver score (out of two) on subsection of test about *physical stimulation* (average score out of 2)	1.1	1.0	.1
Practice indicators				
1.2.	% mothers who report having engaged in four or more activities[7] to promote learning and school readiness in the past 3 days	34.1	19.2	14.9
1.3.	% fathers who report having engaged in four or more activities to promote learning and school readiness in the past 3 days with at least one child (of any age) he is taking care of[8]	63.7	43.5	20.2*

Annex 4: Participation rate of the spot-checks in percentage for the mother groups by community

Community	March	April	May
Béon Gohouo	70.33	70.47	75.66
Kahen	84.88	69.5	83.61
Banguéhi	70.74	70.46	65.72
Pinhou	61.85	63.7	67
Blepleu	78.01	71.82	73.6
Siambly	63.86	62.31	63.88

[7] The list of relevant activities includes commonly accepted child stimulation activities such as playing or singing with the child.
[8] This indicator have been computed only for fathers reporting taking care of at least one child under two

Average	**71.61**	**68.04**	**71.58**

Annex 5: Participation rate spot-check

Communauté	Mars (taux de participation avec les données spot check)	Mars (taux de participation avec les données admin)	Ecarts observé en Mars	Avril (taux de participation avec les données spot check)	Avril (taux de participation avec les données admin)	Ecarts observé en Avril
Béon Gohouo	70,33	75,63	7%	70,47	85,64	<u>18%</u>
Kahen	84,88	75,05	<u>-13%</u>	69,50	72,80	5%
Banguéhi	70,74	70,24	-1%	70,46	45,38	<u>-55%</u>
Pinhou	61,85	60,34	-3%	63,70	67,54	6%
Blepleu	78,01	77,92	0%	71,82	67,18	-7%
Siambly	63,86	63,64	0%	62,31	65,06	4%

Annex 6: Number of sessions correctly reported in comparison with spot-check

% of sessions corectly reported for the mother groups

Community	June	July	August
Banguéhi	71%	57%	57%
Béon Gohouo	78%	78%	89%
Blepleu	56%	0%	56%
Kahen	41%	45%	41%
Pinhou	57%	71%	57%
Siambly	14%	14%	14%
Average	53%	44%	52%

Annex 7: % of community agents that performed at least 8 monthly sessions per month

Mois	X	X	X	X	X	X	Taux Moyen par mois
Mars	40%	30%	15%	50%	6%	31%	**24%**
Avril	60%	0%	8%	67%	75%	19%	**34%**
Mai	40%	60%	85%	53%	69%	31%	**53%**
Juin	67%	60%	92%	60%	81%	19%	**57%**
Juillet	60%	90%	92%	73%	100%	75%	**81%**
Août	80%	90%	85%	83%	100%	50%	**80%**
Septembre	80%	80%	85%	77%	94%	100%	**85%**
Taux par village	**59%**	**64%**	**48%**	**65%**	**59%**	**39%**	**55%**

Annex 8: Number of sessions completed by groups

	Nb of groups	Nb of groups that did 16 sessions	% of froups that completed 16 sessions
Mother	128	94	73%
Father	98	72	73%
Grand mother	85	62	73%
Total	**311**	**228**	**73%**

Annex A: IPA General methodology

1. Introduction

The Independent Data Collection (IDC) is led by IPA in the context of the TRECC-GMM2 project in order to inform the Evaluation Matrix. This comes in complement to the administrative data collected by the respective M&E team of each pilot. The objective is to better understand the context in which the pilots are being implemented, learn and provide feedback and recommendations to TRECC, implementers and companies.

This document presents the protocol guiding our independent data collection. It is organized in two main parts: first, the methodology (this document) and second, its application to the specifics of each pilot. The methodology part includes 5 main sections about: i) the different waves of data collection; ii) the data collection methods; iii) the sampling strategy; iv) data quality; and v) the regulatory requirements. The part on the pilots includes as many sections as the number of pilots.

2. Waves of data collection

There will be three to four data collection rounds per pilot. Ideally, we will run one before the beginning of the intervention (baseline), one or two during the implementation (follow-up) and one at the end of the pilot (end-line).

In each round, the type of information collected, and interviews conducted may change. For instance, it may be relevant to look at the beneficiary selection criteria into the program at the baseline but not during the follow-up or the end-line.

In general, the baseline survey will analyze the situation before the intervention starts and how the selection criteria into the program affect the overall profile of the beneficiaries. The follow-up surveys will focus on tracking the activities, outputs and learning process during implementation. The end-line survey will focus on beneficiaries and contribute to understand whether and how the intervention affected them.

3. Data collection methods

We will combine quantitative and qualitative data collection through individual surveys, focus groups, Key Informant Interviews and direct observations.

Individual quantitative survey (IQS)

Design

The 30-45 minute individual survey collects quantitative data (list of short open-ended questions) and targets direct beneficiaries, indirect beneficiaries and non-beneficiaries at the unit level (i.e. at the individual level or the household level) of the intervention. The three main goals of the IQS are to provide data to assess programs against the evaluation matrix, validate the administrative

data collected by the implementer and give a general idea of the local context. Survey questions are designed based on the Theory of Change and the log frame.

Implementation

Staffing (Other than the permanent staff) per wave of data collection

- Enumerators (probably 4-5)
- Team Leader (probably 1)
- Back-checker (probably 1)

Staff will be selected from the IPA database to meet the criteria specific to each position and trained.

- Number of interviews

The sample size of the IQS will depend on the number of beneficiaries and the size of the population in the village/ community selected.

4. **Sampling for quantitative survey**

Sampling method

Sampling of beneficiaries

The beneficiaries are the principal source of information which will be used during each round of IDC. They will be selected from a list provided by the implementer, using a sampling method specific to each pilot, detailed in the separate sections for each pilot.

Sampling of non-beneficiaries

In addition of the beneficiaries, we may need to interview non-beneficiaries at baseline if the targeting of the program to a specific segment of the population is an important part of the program. In those cases, non-beneficiaries (similar to the beneficiaries except that they are not taking part to the program) will be selected using a systematic choice from a listing done with village chief, Community agent etc. In most cases it won't be necessary to survey non-beneficiaries during follow-up or end-line surveys, because baseline data will be sufficient to assess the program's success in targeting the beneficiaries most in need.

Sample size

Determining a sample size to have credible and reliable results is very important. Thus, the main criteria to determine our sample size will be to achieve a representative sample within the budget, and ensure that we have adequate statistical power to detect target changes on key indicators between baseline and end-line for immediate outcomes. The default parameters for our sample size calculations are:

- Margin of error: We will use the standard margin of error of 10% percent, where the budget allows.
- Confidence interval: we will use the standard rate of 95%.

This means that we will be able to say with 95% confidence that the true value of variable of interest is within 5 percentage points of our sample estimate.

The general formula we use in our Sample size calculator is:

$$n \geq \frac{\alpha * N}{N + \alpha - 1} \; avec \; \alpha = \left(\frac{Z}{\varepsilon}\right)^2 * p * (1 - p) \quad (E.1)$$

n : The sample size
N : The population size
ε : The margin error
p : The estimated proportion of people having the studied characteristic.
Z : z score with 95% confidence

5. Data Quality

IPA has strong requirements regarding high data quality and will implement a <u>Data quality insurance plan</u>.

The plan defines all data quality protocols and steps in processing the data that should be done during the data's lifetime.

Focus group discussion

<u>Design</u>

This survey will be done at the village/community level with a group of 8-12 people. Depending on the data collection wave to be conducted, the FG could be direct/indirect beneficiaries/non-beneficiaries.

The goal will be to get qualitative data on:

- Perceptions of the community members regarding the problem the pilot is seeking to address,
- Community members' current practice as compared to what the intervention is seeking to bring

– Beneficiaries' description of their needs links to the outcomes delivered by the pilot
– Beneficiaries describe positive experiences with the program
– Indications that the community are likely to continue with the practices or program activities
– General feedback about interventions (current and past/future);
– General ideas on local behaviors and beliefs.

Implementation

Staffing

– A focus group moderator (1)
– A focus group moderator-assistant (1-2)

Focus groups moderators (and assistants) will be selected from the IPA database or from a recruitment process. We will require previous experiences in focus group and Key Informant Interviews, with focus on strong qualitative data collection experiences. Once selected, they will be trained to use the research instruments of this project.

Number and composition of focus group discussions

The number of discussion sessions will depend on the characteristics of the pilot (number of village, size of the population, number of community/ethnic group etc.). Depending on the local culture and in order to increase interactions / discussions, it may be possible to re-organize people in order to have a homogenous discussion group.

Key informant interviews

Design

We will run key informant interviews in other to complete the evaluation matrix regarding questions like alignment with priorities, sustainability and operations. It will consist of individual structured interviews with key people for each pilot.

According the matrix the keys informants are:

– Partners program management team
– TRECC staff
– Brooking Institution staff
– Government relevant staff
– Community leaders

Implementation

Staffing:

Those interviews will be led by the facilitators, the Field managers or the M&E staff depending on the level of the people to be interviewed.

Language concerns/accommodations

There are many local languages and not one main language in Cote d'Ivoire. Therefore, it may be useful for the team to have guides/translators. Together, team leaders / enumerator who speak the language and the guides will agree translations of questions. In addition, some regularly used words / expressions in some local languages could be added in the electronic form.

Regarding the focus group, teams could take translators (who are not participants) to help them during the interview if needed.

Confidentiality and privacy

We strongly care about the privacy and the confidentiality. The name of the companies associated with the implementers and other details from other pilots should not be mentioned during interviews or any other moment outside IPA office.

Information from interviews should not be discuss outside / after interviews even in another village or location. We remind that all interviews are strictly confidential.

Consent

As this project is a M&E project, we are not required to submit for approval by an Institutional Review Board (IRB). However, we still ask consent from respondents to whatever survey they are taking part in.

To be able to interview children aged under 18 involved in an intervention (for example, primary school students), consent from their parents/ legal guardian is needed as well as consent (verbal or written) from the child and youth themselves.

For the specific case of the focus group, they should be done whenever the minimum number is achieved and people consent to be part of it. However, this should be done with sensitivity to cultural expectations – for example, we will notify the relevant community or group leader about the focus group if appropriate.

Personal data protection

Collecting and/or sharing personal data (personal data are those that can allow to identify an individual; this includes name, first name, phone number, GPS coordinates, etc.) in Côte-D'Ivoire is regulated by the recently created Autorité de Régulation des Télécommunication en Côte-D'Ivoire (ARTCI). Although the regulation is quite new and its application still has some ambiguities, it appears that in order to collect and share such data in conformity with national rules and regulations, an organization needs to comply with the Law No. 2013-450 of 19 June 2013 regarding the protection of personal data of ARTCI. Since companies, implementing

agencies and IPA will be collecting and sharing personal data, it is important that each partner investigates whether it needs to comply with ARTCI.

IPA has submitted a request to ARTCI for an authorization and has designated its M&E coordinator as "ARTCI data protection correspondent". The process is still ongoing and we are waiting for ARTCI approval. As far as the process is ongoing IPA can legally start the data collection.