

Performance Evaluation of the Tuendele Pamoja II RFSa in the Democratic Republic of the Congo

Summary Brief



Photo Credit: Felly Muambayi, Kinshasa School of Public Health

INTRODUCTION

Overview

The Tuendele Pamoja II (TPII) Resilience Food Security Activity (RFSa) was launched in September 2016. The goal of TPII was “All members of households from all tribes in South Kivu and Tanganyika provinces of DRC live with social and economic well-being.”

The activity purposes supporting this goal were:

- Purpose 1: Households have food and income security.
- Purpose 2: Improved nutrition and health status of women of reproductive age, pregnant and lactating women, adolescent girls, and children under 5 years old.
- Purpose 3: Women, men, and youth of all tribes are social equals and feel safe in their homes and communities.

Prepared by Tulane University School of Public Health and Tropical Medicine, this brief summarizes the results of the performance evaluation published in 2022.¹

Methodology

The performance evaluation used a pre-/post-population-based survey evaluation design, with surveys representative of the RFSa area of implementation. The design allows for the statistical detection of changes in indicators between survey rounds. However, it does not allow statements to be made about attribution or causation relating to activity impact.

Baseline Round 1 (R1) data was collected in July–August 2017, with a sample of 1,300 households from 44 villages in the planned implementation area. After the R1 survey, the RFSa modified the coverage area, with some villages dropped and others added. The sample in the Round 2 (R2) survey was designed to be representative of the modified, current area of implementation. Data was collected July–August 2021, with

¹ [Performance Evaluation of the Tuendele Pamoja II Resilience Food Security Activity in the Democratic Republic of the Congo | Food Security and Nutrition Network \(fsnnetwork.org\)](#)

a total sample of 1,231 households from 47 villages. Forty of these villages were re-sampled from the R1 survey, and an additional seven villages were sampled.

The analysis of the change between survey rounds presented in this brief is based on data from the entire samples in both rounds. Analysis was also conducted comparing the data from the re-sampled villages only. The few instances where these findings differed from the analysis of the full datasets are highlighted.

Data on the same lower-level outcome indicators were collected in both survey rounds, although the R2 questionnaire excluded the poverty module (due to time and cost considerations) and the anthropometry modules (due to concerns about COVID-19 transmission). The R2 questionnaire also added a module on self-reported household-level participation in various RFSA interventions.

The quantitative findings were triangulated with findings from the mid-term qualitative evaluation,² activity annual reports, activity direct participant monitoring data, and other secondary data sources.

KEY FINDINGS

Intervention Exposure and Participation

The Round 2 (R2) survey shows that self-reported household participation was relatively low for most interventions, even though most were implemented in all the villages included in the R2 survey. Overall, 34% of households in the R2 survey reported participation in one or more of the surveyed RFSA interventions. The highest reported prevalence of household participation include agriculture trainings (16% of households), WASH trainings (14% of households), farmers' groups (13% of households), and activities focused on improved agricultural production (13%). Others had very low coverage.

For example, youth-related interventions had very low coverage despite being implemented in all surveyed villages. Youth leadership training participation was reported by 2% of households, and adolescent life skill trainings by 3%. The TPII mid-term evaluation conducted in 2019 found similar concerns. It highlighted that TPII had undertaken too many interventions and was behind on implementing several activities at that time. It noted that there was minimal direct targeting of youth for health- and nutrition-related messages. It

ABOUT TUENDELEE PAMOJA II

Primary Focus Areas: Interventions in agriculture, health, nutrition, water and sanitation, literacy, and conflict transformation.

Implementing Organizations: Food for the Hungry, Search for Common Ground, Consultative Group on International Agricultural Research, Institut Nationale d'Etude et Recherche Agronomique, Inspection Provinciale l'Agriculture, Pêche et Elevage, SENASEM, HarvestPlus, TearFund International, Union for the Emancipation of the Indigenous Woman, Ligue pour la Protection des Enfants et le Développement des Mamans, Tillers International, and Johns Hopkins University.

Intervention Period: Oct. 2016 – Sept. 2021

Funding: United States Agency for International Development (USAID) Bureau of Humanitarian Assistance (BHA). Total budget of USD \$71 million.

Intervention Areas: 715 villages, located in two territories of Tanganyika Province (Kalemie territory: Kalemie and Nyemba health zones and in Moba territory: Moba and Kansimba health zones) and one territory in South Kivu (Walungu territory: Walungu, Mubumbano, Kaziba health zones)

Targeting: 214,000 households, directly benefiting up to 1,427,487 individuals.

² <https://www.fsnnetwork.org/resource/mid-term-evaluation-tuendeleee-pamoja-ii-development-food-security-activity-drc>

also indicated they were reaching only a small segment of the adolescent population.

Direct participation estimates from the R2 survey were difficult to triangulate against activity-reported figures. The 2020 annual report stated there were 155,335 unique direct-participant households, which is 150% of the total households in the implementation area. Furthermore, the same report mentioned the RFSA target to reach 214,000 households, roughly the entire population of the territories where the RFSA was implemented.

Although TPII RFSA achieved wide coverage of its interventions, this did not result in high levels of reported household participation. Additionally, any spillover of the impacts from the RFSA interventions to indirect participants may be less than hoped. As such, impacts may be diluted at the population level. Therefore, more programmatic intensity and focus may be required to positively impact the lower-level outcome indicators and ultimately improve food security and resilience at the population level.

It is important for BHA and Food for the Hungry to consider, in general, the cost of implementation of an activity and its interventions relative to the saturation that the activity may be expected to reach to determine if it is worth running an intervention that is “a mile wide and an inch deep.” The diversity of interventions in future activities may need to be reduced, selecting for the highest and most sustainable impact. This study only begins to scratch at the surface of these issues.

Food Security and Resilience

Food security, as measured by the Household Dietary Diversity Score (HDDS) and the Food Insecurity Experience Scale (FIES), showed a small, marginally significant decrease. The prevalence of moderate and severe food insecurity was very high in R1 (93%) and R2 (90%). However, stable household dietary diversity could be interpreted as a positive outcome, considering the volatile food security situation in the DRC potentially compounded by the COVID-19 pandemic in the year before the survey.

All three resilience capacity indices (absorptive, adaptive, and transformative) increased significantly between survey rounds. However, changes in the indices were largely driven by only one (or a few) of their component indicators.

The increase in absorptive capacity was primarily due to a significantly increased presence of humanitarian assistance. This increase in reported humanitarian assistance may be due to additional humanitarian and development assistance. This additional assistance may include certain types of services or other assistance provided through TPII, although it is important to note that this cannot be confirmed by available data. There was also a small but significant improvement in the availability of informal safety nets, cash savings, and productive assets, offset by a sizable decline in access to remittances.

The adaptive capacity index increased significantly, but the change was small. The improvement was driven by positive changes in social safety nets and productive assets but lessened by decreases in education/training, livelihood diversity (primarily due to the reduction of “livelihood sources,” such as remittances and gifts), and improved agricultural practices. These are all sub-components of the index.

Transformative capacity experienced a small but significant increase. This improvement was driven by improvements in formal safety nets, access to natural resources, and collective action (all sub-components of the index).

There is a positive association between the HDDS and the resilience indices in the R2 data, particularly the absorptive and adaptive indices. However, the transformative capacity index is largely defined by community-level indicators rather than household-level indicators, so the associations between that index and the HDDS are less likely to be observed.

Water, Sanitation, and Hygiene

Drinking water access improved significantly between survey rounds. For example, the percentage of households that can obtain drinking water in under 30 minutes increased from 57% to 78%. Additionally, access to improved drinking water improved from 38% at baseline to 51% at R2, although the change was not significant. However, no significant changes in the use of water treatment technologies were observed.

Although the use of basic (improved) sanitation did not change significantly between surveys, the percentage of households practicing open defecation decreased from 8% to 3%. Toilet-building interventions were only implemented in villages representing 6% of households and did not show a significant relationship to sanitation. However, households that had participated in water, sanitation, and hygiene (WASH) training interventions had significantly higher use of basic (improved) sanitation facilities (15%) than non-participation households (5%). It is important to note that WASH training participation was reported by only 13% of households.

Agriculture

Among the agriculture indicators, only the percentage of farmers using improved storage practices increased from 27% to 38% between rounds. No significant change was seen in the percentage of farmers using financial services, nor in the practice of value chain activities promoted by the activity. Significant decreases in the use of sustainable crop practices and sustainable livestock practices were observed. However, it is challenging to assess whether these negative changes between rounds are methodology/collection issues, or if they accurately reflect changes.

There was little to no association between household participation in any of the surveyed interventions and the agricultural outcomes measured. Village Savings and Loan Association (VSLA) participation was the one exception, associated with a significantly higher rate of access to financial services. However, only 7% of households reported participating in VSLAs despite VSLA interventions in 100% of the villages surveyed.

Women's Health and Nutrition

A small but significant improvement was observed in women's consumption of a diet of minimum diversity (18% at baseline to 20% at R2). However, women's consumption of targeted nutrient-rich commodities did not change significantly, and only small changes were seen in the various specific commodities assessed. In addition, no significant change was observed in contraceptive use.

Household participation in nutrition training was associated with a better Minimum Dietary Diversity (MDD) for women (30% among participants vs. 18% among non-participants). However, only 7% of households reported participating in this type of training.

The percentage of women who reported contraceptive use was also positively associated with participation in mothers' groups for the small numbers of households who engaged in these activities.

Child Health and Nutrition

Significant improvements were observed in diarrhea prevalence (23% at baseline to 17% at R2) and the prevalence of exclusive breast-feeding of children under 6 months old (44% to 72%). However, no significant change was seen in Oral Rehydration Therapy (ORT) treatment, children consuming a minimum acceptable diet, or children consuming targeted nutrient-rich foods.

Although mothers' groups, nutrition training, and home health visits were implemented in all communities surveyed at R2, the participation rates were low. Only about 7% of households reported participation in each of these interventions. Among the few (26) children in the surveyed households benefited from household participation in nutrition training, the prevalence of a minimum acceptable diet was 23%, compared to 7% for the non-participating.

Gender

Little change was noted across the gender indicators. Gender norms are deeply entrenched and will likely take years or even decades to change.

The percentage of women who earned cash in the previous year decreased significantly, from 36% to 20% at R2. Other indicators showed no significant change, including the percentage of men and of women who say it's ok for a man to batter his wife for any reason, the percentage of women participating in decision-making bodies, and the percentage of men or women who have knowledge of maternal and child health and nutrition (MCHN) practices. However, households that received home visits (8% of all households) were significantly associated with better knowledge of MCHN practices.

Methodological Challenges

This evaluation had some methodological challenges that should be considered in future evaluations, most importantly those related to the limitations in the pre-/post-PBS design and the utility and function of certain outcome indicators.

Modifying areas of implementation after the baseline PBS is common across RFSA. Therefore, pre-/ post-PBS methodology may not be well suited to adapt to changes in where interventions are implemented.

Sampling frame data in the DRC often has large inaccuracies. This results in highly variable probability and population weights, and a loss of statistical power. Alternative PBS sampling strategies should be considered to reduce the loss of statistical power with similar sample sizes and budgets.

There is a desire to have evaluation data that can show the impact of interventions on the various outcomes. However, PBSs do not readily allow this level of analysis. Population-level changes in many of the low-level indicators have a low likelihood of occurring with the given intensity of certain interventions.

The utility of certain food security indicators (such as the FIES) should be re-evaluated, including an assessment of their functionality in specific locations and contexts. The prevalence of moderate and severe food insecurity (as measured by the FIES) was very high at baseline (95%) and the interim (96%). This homogeneity of the food security status as measured by this indicator renders a more detailed analysis less useful in assessing change. The FIES has other statistical limitations in the populations surveyed. It may not adequately describe the food security situation in the populations surveyed.

The resilience capacity indices are less useful as composite indicators. The sub-components of the indices tend to reveal more useful information. For example, three of the adaptive capacity component indicators are related to agriculture, so households that did not engage in agriculture tend to have lower scores on this index even if they are highly resilient. This indicates that the adaptive capacity index in the aggregate may be of limited use for households not engaged in agriculture. Therefore, it may benefit from adaptation to reflect adaptability as a function of livelihood.

SCORECARD

The table below outlines the lower-level outcome indicators collected in both rounds and highlights where there are significant changes (analysis restricted to the areas surveyed in both survey rounds). The indicator values, sample sizes, full names, and other information can be found in the full evaluation report.³ The complexity of the gender indicators related to decision-making does not lend themselves to this scorecard presentation and so are excluded (see gender section above for those key findings).

³ <https://www.fsnnetwork.org/resource/performance-evaluation-tuendeleee-pamoja-ii-resilience-food-security-activity-democratic>

TUENDELEE PAMOJA II Indicator Scorecard

| Significantly worse > 10 percentage points | Significantly worse < 10 percentage points | No significant change | Significant improvement < 10 percentage points | Significant Improvement > 10 percentage points |
|---|---|---|--|---|
| Food Security, Resilience | | | | |
| | | 1. Household Dietary Diversity Score 2. Food Insecurity Experiential Scale | 40. Shock exposure index 43. Adaptive capacity index 44. Transformative capacity index | 41. Severity weighted shock exposure index 42. Absorptive capacity index |
| Water, Sanitation, and Hygiene | | | | |
| | | 6. Improved drinking water source 7. Correct use of water treatment 9. Basic sanitation facility 11. Hand washing 46. Disposal of child feces | 10. Open defecation | 8. Water access in < 30 min |
| Agriculture | | | | |
| 13. Farmers practicing value chain activities 14. Farmers using ≥ 3 sust. ag. technologies 15. Farmers using ≥ 3 sust. crop technologies 16. Farmers using ≥ 3 sust. livestock technologies | | 12. Farmers using financial services 17. Farmers using ≥ 3 sust. NRM practices/tech | | 18. Improved storage |
| Women's Health and Nutrition | | | | |
| | | 20. Minimum dietary diversity (women) 22. Contraception prevalence rate 23. Consumption of nutrient rich foods (women) | | |
| Child Health and Nutrition | | | | |
| | | 28. Diarrhea treated with ORT (< 5 years) 30. Minimum acceptable diet (6–23 months) 31. Cons. of nutrient rich foods (6–23 months) | 27. Prevalence of diarrhea (< 5 years) | 29. Exclusive breastfeeding (< 6 months) |

| Significantly worse > 10 percentage points | Significantly worse < 10 percentage points | No significant change | Significant improvement < 10 percentage points | Significant Improvement > 10 percentage points |
|---|---|--|---|---|
| Gender | | | | |
| | 32b. Earned cash in past year (women) | 32a. Earned cash in past 35a. Knowledge of MCHN (men) 35b. Knowledge of MCHN (women)year (men) 47b. OK to batter wife (women) 48. Women in comm. decision making bodies 47a. OK to batter wife (men) | | |



This brief is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the Implementer-Led Evaluation & Learning (IMPEL) award and do not necessarily reflect the views of USAID or the United States Government.