INDICATOR 1: Prevalence of stunting (height for age <-2 SD from the median of the WHO Child Growth Standards) among children under five years of age

Why this indicator? What will it measure and provide information for?

This is a globally used indicator applied to local and national levels. Reflects impact of chronic stunting "most often due to prolonged exposure to an inadequate diet and poor health." Reduction of stunting is a major objective in many countries; lifelong impacts on physical and mental capacity. (SDG Target 2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.)

What Sustainable Development Goal is the indicator connected to?

SDG Goal 2.2, indicator 2.2.1 (green list, Nov 2015): Prevalence of stunting (height for age under 2 SD from the median of the WHO Child Growth Standards) among children under five years of age.

Definitions and key terms

Stunting: having a height (or length)-for-age more than 2 SD below the median of the NCHS/WHO international reference.

Data and information required to calculate the indicator

- Numerator: Number of children U5 who are stunted, disaggregated by sex.
- Denominator: Total number of children aged U5 years screened, disaggregated by sex.

Suggested method for data collection

- Primary data collection: anthropometric measurements
- Secondary data analysis.
- For more information: http://www.who.int/ceh/indicators/0_4stunting.pdf
- Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of barriers and potential negative consequences of decreasing prevalence of stunting.

Possible data sources

- Primary data collection: anthropometric measurements
- Secondary data
- Local health care systems
- WHO Global Database on Child Growth and Nutrition (www.who.int/nutgrowthdb/)
- Demographic and Health Surveys (funded by USAID)
- Pan Arab Project for Child Development (PAPCHILD) survey (funded by Pan-Arab League and UNFPA)
- Living Standard Measurement Surveys (LSMS) and Social Dimensions of Adjustment (SDA) surveys in sub-Saharan Africa (funded by World Bank)

Resources needed for data collection

The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the monitoring and evaluation plan and budgeted for.

Reporting results for this indicator: number of people for which the change happened

- A change in the percentage of girls and boys U5 that are stunted.

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)

- Calculation: 100 * (Cstunt / Ctot) where: Cstunt is the number of children U5 who are stunted, and Ctot is the total number of U5 surveyed.
- This indicator provides a measure of success, or failure, of the actions taken to combat problems of undernutrition and impaired physical development of children.

Other considerations

- Reduced growth can also reflect problems of undernutrition, infection of other illnesses throughout the early years of life.
- Using stunting later in life as an indication of action also assumes that underweight children are surviving. Where rates of perinatal and infant mortality are high, this may not be the case, therefore the indicator needs to be applied and interpreted alongside other measures.
- Changing in stunting are long term; the likelihood is slim of seeing significant changes in the timeline of a project, so considerations must be made for long term measurement.

INDICATOR 2: Prevalence of population with moderate or severe food insecurity, based on the **Food Insecurity Experience Scale** (FIES)

Why this indicator? What will it measure and provide information for?
Developed by FAO from Voices of Hunger project, adopted by SDGs. Based on self-reporting, uses a continuum of food insecurity from worrying about access, to compromising quality, to reducing quantity / frequency, to experiencing hunger. Focus on access to food, collected at the household or individual level. Intended to complement (not to substitute) other measures of food insecurity. Metric for the severity of food insecurity with a focus on the access dimension.

What Sustainable Development Goal is the indicator connected to?
SDG Goal 2.2, indicator 2.1.2 (green list, Nov 2015): "Prevalence of population with moderate or severe food insecurity, based on the **Food Insecurity Experience Scale** (FIES)"

Definitions and key terms
Food (in) security: Access to food (men and women) because of financial resources; also includes negative coping strategies (skipping meals, going an entire day without food), lack of quality and variety.

Data and information required to calculate the indicator

- Survey modules are for households or individual level.

Suggested method for data collection

- Manual available at: http://www.fao.org/3/a-as583e.pdf
- Survey module available at: http://www.fao.org/economic/ess/ess-fs/voices/fiesscale/en/
- Qualitative methods like focus group discussions and key informants interviews should

supplement the quantitative data collection to provide a better understanding of barriers and potential negative consequences of access to food.
Possible data sources Primary data collection using the above survey modules.
Resources needed for data collection The quantitative and qualitative data collection, storage, analysis will be responsibility of CARE and partners. It needs to be included in the monitoring and evaluation plan and budgeted for.
Reporting results for this indicator: number of people for which the change happened
Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change)   - What have been the main changes in people's experience of food insecurity over life of this project? Were there important differences in how different types of people (by gender, age, social or economic status etc) experienced food insecurity?   - How has CARE contributed to the change? What were CARE's main strategies for contributing to this change?   - Have there been any changes in legislation or practice that have influenced the results?   - What are the types of household decision making around food consumption that have seen a noticeable increase or decrease in the involvement of women?   - If the following information is available from quantitative or qualitative sources it would help the analysis of the data: - How are women concretely benefitting from the change? How has the gender based division of labor inside the household changed? Have men contributed to the change and how? Has the level of conflict inside the household increased or decreased?   - How have women changed? What strategies did they use to gain more power in decision making? How have men changed? What attitudes and behaviours did they change to share decision making more with women?   - How do women and men know that their decision making is "more equal"? What behavior proves this?   - How have any changes in these gender relations strengthened women's ability to participate in, sustain and grow their economic activities/businesses? How has this change in dynamic contributed to women's access to and control over financial assets and benefits?
Other considerations   - Care needs to be taken when planning and conducting data collection (quantitative and qualitative) to avoid leading questions.   - Establishing validity of results implies finding agreement on a definition of this food insecurity construct that can be measured along a scale of severity. In other words, it requires being able to speak legitimately of subjects to only in term of being food insecure of not, but also as being more or less food insecurity than others.

INDICATOR 3: Numbers of people better able to build resilience to the effects of climate change and variability

Why this indicator? What will it measure and provide information for?
This indicator measures reductions in vulnerability and increases in adaptive capacity at community, household or individual levels. Interventions to be based on a climate vulnerability assessment (such as CVCA) of underlying causes that make people vulnerable to climate change and variability. It has been developed by DFID and IIED.

What Sustainable Development Goal is the indicator connected to?
SDG Goal 13 "Combat climate change" has no relevant indicator in Nov 2015 green list. All of this goal's indicators are macro indicators that don't target directly community-based or households' resilience capacities; rather they target institutional, casualties and financial aspects related to climate change impacts and mitigation/adaptation initiatives.

Definitions and key terms
Tracking Adaptation and Measuring Development (TAMD) is a 'twin track' framework that evaluates adaptation success as a combination of how:
-   Widely and how well countries or institutions manage climate risks (Track 1), and
-   Successful adaptation interventions are in reducing climate vulnerability and in keeping development on course (Track 2).
TAMD allows a) assessing the adaptation process at multiple scales – from multiple-country initiatives to local projects; and b) linking Climate Risk Management (CRM), vulnerability and resilience, and broader human wellbeing.

Data and information required to calculate the indicator
*   Numerator: Numbers of people (by gender) better able to build resilience to the effects of climate change and variability
*   Denominator: Total number of people (by gender) affected by climate change and variability effects

Suggested method for data collection
*   Primary data collection: household survey
*   Secondary data analysis
*   For more information: http://pubs.iied.org/pdfs/10100IIED.pdf
*   Qualitative methods like focus group discussions and key informants interviews should supplement the quantitative data collection to provide a better understanding of Climate Risk Management activities, resilience initiatives; affected people's perception of wellbeing in the face of climate change and variability.

Possible data sources
-   Primary data collection: project household surveys
-   Secondary data
-   Local/national/regional weather information systems

Resources needed for data collection
The quantitative and qualitative data collection, storage and analysis will have to be conducted by CARE and partners (potentially including research / university partners). It needs to be included in the

monitoring and evaluation plan and budgeted for.

Reporting results for this indicator: number of people for which the change happened • A change in the percentage/number of people who are better able to build resilience to the effects of climate change and variability

Questions for guiding the analysis and interpretation of data (explaining the how and why the change happened, and how CARE contributed to the change) • This indicator provides a measure of changes in household and people resilience (in different geographical/administrative areas) and contributes to documenting the success or failure of the actions taken to build people's resilience to climate change and variability effects.

Other considerations • This indicator should be applied at several levels: institutional, community and people's scales to allow a comprehensive analysis of the scope of observed resilience • It should also apply to physical (infrastructures) and soft (committees, EWS, preparedness plans/strategies) measures adopted for building resilience.