Terms of Reference

Consultant for Evaluation of Community Based Management of Acute Malnutrition (CMAM) Programme in Madhya Pradesh and Gujarat, India

(Closing Date: 10th December 2020)

Note: This is re-advertisement and applicants who applied earlier may apply again but along with detailed Technical Proposal.

1. Background/Rationale

Malnutrition is estimated to be the root cause of close to 50% of child mortality globally. Severe wasting is responsible for between 1 to 2 million of the 5.9 million deaths of children under five every year globally. Although children with acute malnutrition have an increased risk of mortality, between nine to eleven times higher than a well-nourished child, deaths from acute malnutrition are preventable.

Effective, evidence-based prevention and treatment approaches for wasting exist that can achieve high coverage and are currently implemented across multiple countries in Asia and sub-Saharan Africa, integrated into government systems. Evidence shows that about 85-90% of children with SAM who have been identified through active case finding can be treated at the community level under the CMAM model. However, due to the absence of such programmes, all children identified as SAM are either referred to Nutrition Rehabilitation Centres (NRCs) regardless of whether they require inpatient care or they do not receive any specific services.

Comprehensive community-based approaches to treat wasting do not yet exist at scale in India, reflecting the lack of national guidelines. Under POSHAN Abhiyaan, the Indian government has demonstrated its commitment to the large-scale implementation of treatment services for severely wasted children by including it as one of the high impact convergent nutrition indicators. CMAM guidelines have been in development since 2017, although they are not yet published. Meanwhile, states are moving ahead with the CMAM agenda.

Details are provided in Annexure 3.

2. Purpose of Assignment

The consultant is expected to undertake a comprehensive external evaluation of CMAM services provided through government systems in India. The CMAM model is designed to be adapted to the context in which it is implemented, which is particularly pertinent in India where there are highly developed health and nutrition infrastructures at the community-level into which services can be integrated. However, the ability of the resulting services to deliver a high quality of care at scale has not been evaluated in depth. With SAM prevalence ranging from 2.2% to 11.9%,[1] which are unusually high rates when compared with other countries implementing CMAM services and translate to a high caseload, assessment and course correction are essential to meet the need. Moreover, the complex policy environment and the limited evidence base for CMAM in India has led to the development of multiple treatment protocols which vary as to their adherence to the global protocols. Therefore, a better understanding of these revised models, which have a limited evidence base for effectiveness, is essential. The two states proposed for in-depth assessment as part of this evaluation (Gujarat and Madhya Pradesh) have adopted different treatment protocols, one which uses a therapeutic food that meets WHO standards and the second which uses a therapeutic food that does not meet WHO standards, which will be taken into account when considering programme performance.

[1] NFHS 4

3. Objectives

1. To evaluate CMAM programme in terms of both prevention and treatment activities using standard Development Assistance Committee (DAC) criteria. Specifically, assessment of relevance and appropriateness, effectiveness, coverage, efficiency and sustainability in two states, considering programme outcomes over the last one-year period.
2. To evaluate the effectiveness of cross-cutting issues, such as coordination and management, equity (specifically gender and caste), and information and data management on programme performance.
3. To document state specific key successes and gaps that need to be addressed, presenting the key learnings to guide development and implementation/scale up of CMAM services in other Indian states.
4. Provide recommendations for programme strengthening to overcome the constraints in the immediate and long term (6 months to one year). Cross-learning between the two states evaluated would be beneficial.

4. Scope of Activity

To ensure the evaluation focuses on specific aspects of the community-based approach, the following aspects of CMAM will be evaluated in terms of activities and outcomes:

1. Outpatient treatment for children suffering from SAM without medical complications at decentralized facilities;
2. Linkage with inpatient treatment, both to and from the community and outpatient components;
3. Linkage with the Integrated Child Development Services (ICDS) Supplementary Nutrition Programme and capacity of the programme to prevent relapse of cases post-discharge;
4. Community mobilization activities, both sensitization and screening.

It is expected that the Theory of Change for the program is developed so that design of the program is adequately captured, and it would be clear how the evaluation questions interrogate key aspects of the program design. Assessment of the quality of care delivered in inpatient facilities, which is well established across the states has been excluded to enable a focus on the community-based aspects which have been introduced more recently.

ICDS program includes following components – that can be linked to CMAM program services:

- Growth monitoring - which can be the platform for screening children for acute malnutrition
- Home visits to priority households – so appropriate individualized counseling can be provided
- Anganwadi Center serves as site for Village Health Nutrition Sanitation Days (monthly health days) when medical assessment, appetite test can be performed in presence of an Auxiliary Nurse Midwife (ANM – female health worker) instead of a typical OTP site.

The time period under assessment will be state-specific, considering the process from the beginning of service development (Gujarat from May 2016 and Madhya Pradesh from October 2017) to December 2021. The geographical scope would be limited to two states, Gujarat and Madhya Pradesh. While the evaluation findings will need to be representative of the state overall, a deep dive on implementation aspects of the program would be focused on two districts in each of the two states that are already identified for the CIFF Evaluation i.e. Hoshangabad and Khandwa district of Madhya Pradesh, and Valsaad and Narmada district of Gujarat. The four districts were chosen based on the priority given by respective state governments either

because they were part of Aspirational Districts or they were already part of focused attention due to prior engagement of UNICEF in the State.

While the CIFF led evaluation would focus on the Centers of Excellence and their roles in supporting the program implementation in two districts in each state, the present UNICEF led evaluation would focus on the broader picture in terms of the relevance, effectiveness, coverage, efficiency and sustainability of the CMAM program.

The target groups that would be included are stakeholders from state, district, block and community level who are involved with the CMAM program. The participants would be selected using purposive sampling using the principle of maximum diversity. Stakeholders involved in CMAM implementation from the service provision side include DWCD and DHFW at the state, district, block, health facility and community levels, and administrative staff. From the demand side, caregivers of beneficiaries (both those that have received treatment in the past and those currently receiving treatment), community members, religious and community leaders and other relevant community members would be included.

a. Evaluation Questions

The evaluation will provide the evidence base to answer the following questions:

1. Relevance/Appropriateness
   - How appropriate is the CMAM strategy adopted in each state and to what extent do the strategies and interventions respond to the state specific context (health system and nutrition context)?
   - How has the CMAM programme influenced (strengthened/weakened) existing health and nutrition services at the health center and community levels, from the perspective of both the provider and demand sides? How can any gaps or weaknesses be addressed? How synergistic are the services?

2. Effectiveness and quality of services
   - To what extent are programme outcomes acceptable as per international standards? How do outcomes vary across the state and why? Consider programme maturity.
   - What are the bottlenecks that limit programme performance and the boosters that facilitate good performance? Consider human resources, supplies and community mobilization.
   - How effective are outpatient services in ensuring the SAM child receives the correct nutrition component of treatment at the required time? Is the complete package of services delivered to each child as per protocol? If not, why not?
   - To what extent are services responding to seasonality in terms of wasting incidence and migration and how could the response be strengthened?
   - How effective have community mobilization strategies been in mobilizing the communities to continuously engage with services and why?
   - To what extent do CMAM services provide a complete continuum of care from screening to the transition to home foods on recovery?
   - To what extent is the programme able to achieve sustained recovery in children treated under the program till six months post-discharge?

3. Coverage
   - What is the estimated geographic and treatment coverage of CMAM services? How appropriate is the level of coverage?

- To what extent has the geographical expansion of services been accompanied by quality service provision?
- How does ICDS growth monitoring coverage affect CMAM inpatient and outpatient service coverage?
- What are the boosters that facilitate good coverage and the barriers that limit coverage?

4. Efficiency
- To what extent was the intervention efficient in making the best possible use of available resources to achieve its outcomes?
- What are the key inefficiencies at each level of implementation (community, AWC, block, district)?
- To what extent is the coordination between government departments strengthening or limiting efficiency?

5. Sustainability and opportunities for scale up
- Is the existing programme sustainable in terms of the national and state-level policy environments? If not, how can sustainability be improved?

6. Cross-cutting issues
- Does the programme effectively consider equity, especially gender and caste to ensure access to those that need services?
- How does the coordination and management of the programme by DWCD and DHFW affect service quality? How could it be strengthened?
- Are data management systems effective in enabling collection, management and use of data for timely corrective action?

Further, the evaluation would also answer questions around coherence. Coherence means assessing the compatibility of the intervention with other interventions in a country, sector or institution. It covers both internal and external coherence:

- **Internal**: addresses the synergies and interlinkages between the intervention and other interventions carried out by the same institution/government, as well as the consistency of the intervention with the relevant international norms and standards to which that institution/government adheres
- **External**: considers the consistency of the intervention with other actors' interventions in the same context. This includes complementarity, harmonisation and co-ordination with others, and the extent to which the intervention is adding value while avoiding duplication of effort.

Note that consultants are expected to validate, build on and further refine these evaluation questions in their proposal and propose additional questions around coherence, to demonstrate their understanding of the object under evaluation as well as their technical expertise in designing evaluations. This can be combined with the refinement of the Evaluation Matrix suggested in section 4 below.

5. Methodology

This evaluation is summative i.e. it collates the results of existing program experience, and also formative i.e. it will inform future program. Presented below is a proposed methodology and consultants are encouraged to demonstrate their technical skills by expanding it, or even proposing a more rigorous approach more suitable to the evaluation questions.

Approach or Design: The evaluation will use a mixed method design to answer the evaluation questions. For each state, the following activities are expected to be undertaken:

Phase 1: Desk review of relevant documents and data, discussions with CIFF-led evaluation team, review of CIFF-led evaluation methodology and tools and feedback for any further adjustments, development of theory of change for program, methodology and tools for any additional components, development of inception report, including the theory of change for the program.

Phase 2: Liaising with CIFF led evaluation team during data collection activities, field visits during the end-line data collection processes, additional data collection – qualitative.

Phase 3: Data analysis and interpretation, presentation of results to UNICEF, development of recommendations, final report draft and final version submission

Methodology and Data Collection:

This evaluation will use combination of existing data and information from documents, monitoring databases and the CIFF evaluation, as well as undertake additional primary data collection (qualitative) in the form of Key Informant Interviews (KIIs) with government officials, In-Depth Interviews (IDIs) and Focus Groups Discussions (FGDs) with frontline/community workers, supervisors and beneficiaries. It is also expected that field observations will be undertaken, as part of the evaluation.

The estimated number of KIIs, IDIs, FGDs and field visits are provided below:

Item	Description	Estimated Number
Key Informant Interviews	Interviews with beneficiaries – both present and past (16) Interviews with frontline workers – Anganwadi Workers (8), ANMs (8) and ASHA workers (8) Interviews with local elected representatives from the villages (4)	44
In-depth Interviews	At-least one senior official from both State Governments from Department of Health and Department of Women and Child Development (4) At least one District Level official from both Departments in two districts of each state (8) At least on Block level official from both Departments in one block each of the two districts of each state (8)	20
Focused Group Discussions	At least two FGDs in one block each of the two districts in both States – one with beneficiaries, frontline workers and community members; and one with specific vulnerable groups	8
Field Visits	At least four field visits covering one block each of the two districts in both States exclusively to observe program implementation in operation	4

The table in Annexure 4 presents a draft Evaluation Matrix, which should be supplemented and refined by consultants in their proposal.

Key tasks and activities:

1. Desk review of relevant documents, to provide the context of CMAM in India over the last 5 years as well as state-specific documents relating to the development, implementation and performance of services. Specifically:
    a. CMAM and SAM care programme reports from multiple states;
    b. CMAM routine monitoring data from Gujarat and Madhya Pradesh;
    c. CMAM program status publication 2019 across UNICEF supported states;
    d. Programme reports of CMAM assessments;
    e. Training guidelines and plans;
    f. State-specific CMAM guidelines and materials;
    g. State-level coordination meeting reports/minutes;
    h. Centre of Excellence Evaluation report for each state;
    i. CIFF led Evaluation findings – which were concluded earlier;
    j. Any other relevant documents.

2. Development of Theory of Change for the program

3. Liaison with CIFF led Evaluation team for quantitative and qualitative data collection:
    a. Discussion with CIFF-led evaluation team regarding the overall methodology and tools being used for the Evaluation. The Consultant is expected to review the same and provide feedback so that the key questions for the evaluation are captured through these tools. Note that the CIFF-led evaluation team would be undertaking the primary data collection – and the Consultant may consider visiting the field when the end-line data collection activities are on-going.
    b. The Consultant would need to propose additional qualitative assessments for field observations of clinical practices in health centers (CHCs), village health and nutrition days (VHNDs) and Anganwadi centers for examination of clinical registers for outpatient services, and while services are being delivered.
    c. The Consultant would undertake additional key informant interviews with government staff from DHFW and DWCD at state, district and block levels, Auxiliary Nurse Midwives and community members, non-governmental organizations, civil society organizations and UNICEF – however, for government stakeholders, it may be best to combine the visits with the CIFF-led Evaluation teams when possible so that the additional burden for the Government stakeholders as well as overlap and repetition can be avoided.
    d. The Consultant would need to undertake focus group discussions with a range of informal groups including beneficiaries, community members, Accredited Social Health Activist (ASHA) and Anganwadi Workers, as appropriate.

    Field implementation issues would be explored in greater detail in the two identified districts in each of the two States where CIFF-led Evaluation focuses on. For the qualitative assessments, the consultant would be supported through partner organizations already working in the respective geographies for scheduling and coordinating for field visits and meetings, facilitating communication in local language as well as for translating and transcribing under the guidance of the consultant. The

consultant would be overall responsible for the qualitative data collection, cleaning, analyzing, reporting, etc. themselves.

4. Community-based evaluation of coverage to determine treatment coverage of services. The methodology and findings from the CIFF-led evaluation would serve the purpose of determining the coverage of services. The Consultant will have an opportunity to interact and understand from the CIFF-led evaluation team the methodology that is followed for this assessment and may also suggest areas for strengthening the same.

Equity focus: As is clear from the objectives, the evaluation will have a core focus on equity. There are multifaceted intersections of especially caste and gender on nutritional outcomes/indicators. Furthermore, the CMAM program itself has gender and equity at the heart of its core model: it focusses on engagement with primary care givers, who are usually female members of the household in which a child lives, and it leverages female community workers for most of the community mobilization activities. As such, the evaluation will need to not only consider these contextual dimensions, but also critically examine whether the design and implementation of the CMAM program is appropriate and effective with respect to these dimensions. Some suggested ways in which the evaluation can do so include looking at admissions and outcomes disaggregated by sex, age and vulnerable groups (e.g. tribal); ensuring the participation of affected vulnerable groups in primary data collection, so that their views, experience and voices are considered. It is expected that consultants further outline how equity will be explicitly focused on in this evaluation, in their proposals.

Quality assurance: Triangulation of data from multiple sources and collected by a range of methods will be essential to eliminate bias as much as possible. The evaluation will undergo an extensive peer review process by internal specialists, including the Regional Evaluation Adviser and an external QA mechanism. Each also has an Evaluation Reference Group (ERG) who review key deliverables and steer the technical quality. The Consultant is expected to respond to the queries or clarifications that are sought from members of the Evaluation Advisory Group and to address the issues raised.

6. **Risks and Limitations:**

In India the CMAM policy environment is complex. It is possible that if the objectives of the evaluation are not clearly communicated to interviewees, they will not participate as fully as desired which will limit the depth and utility of the findings. The Consultant will require a complete understanding of the context in India before starting.

Anganwadi Centers maintain child wise records of growth monitoring every month in the form of hard copy registers and growth charts. If ICDS-CAS is rolled out, then information would be available on a smart phone. The Integrated Child Development Services – Common Application Software is a technological system that was designed to strengthen the supply chain and service delivery of ICDS services. It was created and launched by the Ministry of Women and Child Development in order to ensure better delivery as well as implement data-based decision making. The ICDS-CAS is used by a variety of stakeholders including state officials as well as AWWs. Further, where CMAM programs are operational, additional registers and apps are being used for recording the information of targeted children. While the compiled reports from the Blocks and District do not provide disaggregated data for sex, caste groups, etc. the information maintained at AWCs in the form of registers collect such data.

Data quality of routine services may limit the analysis that can be undertaken for the entire state. Consultant will need to ensure that mitigation measures are put in place if required, such as the

collection of data from a sample of outpatient centers (e.g. Anganwadi centers) which can indicate programme outcomes if required.

As the CMAM Evaluation will liaise closely with the CIFF led Evaluation and the Evaluation teams, the Consultant is expected to work closely and collaboratively with the CIFF led Evaluation team so that the relevant findings from the CIFF led Evaluation help answer the key evaluation questions. In order to facilitate this, joint meeting between UNICEF, CIFF, CIFF-Evaluation Team and the Consultant would be held at the beginning of the assignment to clearly define the roles and responsibilities, including modalities of communication and working together. Clear terms regarding sharing of evaluation data between the CIFF-led team and the Consultant. The existing documents related to the CIFF-led Evaluation – such as Centers of Excellence performance standards, baseline reports, tools for assessments, and other relevant data would be shared after initial joint discussions. If any conflict arises between the Consultant and the CIFF-led evaluation team, the same would be amicably resolved through joint discussions involving UNICEF and CIFF.

In addition, the Consultant would also be expected to provide guidance to the CIFF led Evaluation team where this helps strengthen their evaluation activities. This collaboration will be facilitated through UNICEF. This mechanism may also entail that the consultant has lesser control over when and how data collection is executed. Further, when the consultant may suggest additional questions to be covered, this may result is longer interview times, that may result in fatigued participants. These factors will need to be considered by the consultant while working collaboratively with the CIFF led Evaluation team.

This evaluation does not aim to compare the effectiveness of the specific treatment protocols adopted in the two states under assessment as it is not a research activity. The consultant must ensure that care is taken when presenting results to ensure the limitations of the findings are made clear. Additionally, on any publication of the report, UNICEF must emphasize this limitation to stakeholders.

As COVID-19 situation evolves, we assume that field visit would be possible by mid-2021 for the evaluation related field activities. However, there is a possibility that the COVID situation poses constraints for travel to the field. In such a scenario – alternate modalities for interviews with key stakeholders will need to be explored. Further, the field assessment may have to be adjusted to an alternative best possible modality. The cost related to field travel would not be payable in such an eventuality.

7. Ethical Considerations

The Consultant is expected to follow the ethical principles and considerations outlined in the United Nations Evaluation Group (UNEG) Ethical Guidelines for Evaluation and the UNICEF Procedure for Ethical Standards in Research, Evaluation and Data Collection and Analysis. In addition, the UNEG norms and standards will be observed. As per UNICEF standards for ethical research, the evaluation/research agency must give special attention to ethical considerations and should put in place adequate measures for ethical oversight throughout the study period.

IRB approval is mandatory for this evaluation, given it involves data collection with vulnerable populations. The consultant will be required to indicate his/her ability to obtain necessary IRB approvals for the protocol and other relevant components of the evaluation and, if possible, then should factor in the IRB process, from both financial and timeline perspectives. The proposal and implementation should be informed and guided by *UNICEF's Ethical Guidelines*.

The Consultant is expected to comply with the COVID related Infection Prevention and Control procedures that are deemed necessary for ensuring that the evaluation related activities do not pose an additional risk to the consultant, the communities as well as other stakeholders. The Consultant is expected to comply with the necessary local host government norms and provisions that would be operational during the time when field visits are planned.

Consultants are required to ensure there is no conflict of interest associated with their undertaking of the evaluation in the bid. Equally, to ensure that any risk of bias is considered in the bid process with steps that will be taken to overcome any such bias clear stated.

8. Schedule of Tasks & Timeline

S. No.	Major Task	Specific delivery date/deadline for completion of deliverable (please mention as date/no. of days/month)	Estimated travel required for completion of deliverable (please mention destination/ number of days)
	In 2021 (Phase 1 duration – January to February 2021)		
1	Desk review and initial discussions with evaluation reference group	Week* 1	Nil
2	Development of theory of change for the program	Week 2	Nil
3	Development of evaluation methodology, tools and workplan	Week 3-4	Nil
4	Submission of draft Inception report (including evaluation workplan and timeline, theory of change for the program, presentation of methodological approach, instruments to be used, annotated outline of final report), to be approved by UNICEF and two participating states. Draft outline of contents provided in Annexure 1.	Week 5-6	Nil
5	Incorporating feedback from R&E Specialist, program team, external review agency and ERG – and submission of the final Inception Report	Week 7-8	Nil
	In 2021 (Phase 2 duration - August-December 2021 - tentative)		
4	Field testing and finalization of tools	Week 9	Selected districts – one week
5	Data collection: Qualitative.	Week 10-17	Selected districts and State HQ of both States – 8 weeks

	Quantitative Data through liaison with CIFF-led evaluation team		
6	Presentation of initial findings to evaluation team	Week 18	Nil
7	Report preparation. Draft outline of contents provided in Annexure 2.	Week 19-21	Nil
8	Feedback and comments from evaluation reference group	Week 22-25	Nil
9	Incorporation of comments	Week 26-27	Nil
10	Presentation and two-page summary outlining the evaluation's key findings. Submission of final version of the report.	Week 28	Nil
11	Dissemination of the report	Week 29	Nil

*The number of weeks indicate time envisaged for undertaking the relevant task and does not indicate the week of the year when the task has to be completed. These are numbered from the start of the assignment across the two phases.

9. Estimated duration of contract

The evaluation will take place over a total period of 29 weeks; with expected involvement of 8 weeks (January - February 2021); when the baseline assessment by CIFF-led evaluation team is planned and likely to be ongoing) and field activities and reporting for 21 weeks (in second half of 2021 (tentatively August – December 2021, possibly extending into early 2022).

10. Deliverables

Deliverables and deadlines

- Submission of final, approved inception report outlining theory of change for program, evaluation methodology and study protocol, study tools, instruments and workplan – end of week 8 (in February 2021).
- Two presentations outlining initial findings of the evaluation (one per state) – end of week 21
- Submission of final, approved report (content outlined in annex 3) and accompanying presentation – end of week 28
- Dissemination materials (two x two-page summary of the report and presentation (one per state)) – end of week 28 (state-wise detailed reports are not required).

11. Use of Findings

The primary audience for this evaluation is UNICEF team at National Level and Government of India – Ministry of Women and Child Development.

Internally, the evaluation will help UNICEF to re-strategize support for CMAM programming in India at two levels. First at the national level in terms of ensuring support for CMAM guideline development and advocacy is informed by recent evidence and India-specific experience. Second at the state level for advocacy, policy development and programming purposes. The findings would also be shared with the Regional Office where

they would be of particular use in guiding CMAM development in other countries in the region, particularly those that have not made progress due to a lack of agreement on the most appropriate treatment strategy. Results would also be shared with UNICEF headquarters to provide an in-depth update on CMAM in India, the country with the largest SAM burden globally. Progress in addressing the burden in India through both preventative and treatment approaches is closely monitored at the global level as its ability to find a sustainable solution to the challenge of wasting has a large impact on global progress.

Externally, the findings from the evaluation will be used to draw lessons learned that can inform other stakeholders, mainly Government of India – Ministry of Women and Child Development and Ministry of Health and Family Welfare as well as development partners who are active in supporting the Government. The dissemination of the findings that are relevant for the Government would be done through a workshop that closely planned and coordinated with the Ministry of Health and Family Welfare and the Ministry of Women and Child Development. A separate meeting for dissemination of the findings would be organized for the development partners through the platform of the national-level IM-SAM group, a group of non-governmental partners that work on wasting in India. If appropriate, the results would be further shared with the regional No Wasted Lives initiative.[2]

The evaluation manager from UNICEF will keep a formal track of all dissemination approaches/activities.

12. Publication Plan

The findings will be made publicly available, as per UNICEF's Evaluation Policy, and published on UNICEF's Evaluation & research Database (EISI). At this stage there is no intention to publish the results academically since the results are meant primarily for programmatic purposes. However, a final decision around this will be taken during the Inception phase of the evaluation.

Any publication will follow UNICEF's guidelines. For academic publishing, UNICEF's Guidance on External Publishing would be followed.

13. Qualifications & Experience required

The Consultant, who will undertake the evaluation, will have experience of evaluating CMAM programmes and with an advanced understanding of acute malnutrition. The Consultant will work independently and will liaise with the CIFF-led evaluation team, facilitated by UNICEF. The details of the CIFF-led evaluation team are here - http://www.impactpartner.org.in/index.html

- High-quality project proposal as per the requirements of the ToR, including methodological aspects (compliance with the ToR).
- Advanced university degree in nutrition and/or public health.
- Proven expertise and experience of the consultant in carrying out evaluations and/or assessment of CMAM programmes, with specific experience in coverage methodologies (7-10 years);
- General experience in the Nutrition sector (10-15 years), including in the area of programme and strategy design and assessment, including demonstrable specific knowledge of UNICEF Nutrition programming, with specific experience in CMAM;
- Excellent knowledge of monitoring and evaluation methodologies (demonstrated by previous evaluations carried out by the consultant; a sample final report to be enclosed);

[2] nowastedlives.org

- Good understanding on the issues of equity – such as gender, caste, class, etc.
- Excellent analytical report writing skills (demonstrated through 1 sample report provided);
- Excellent written and spoken English required (demonstrated through sample report provided);
- Good communication and presentation skills;
- Familiarity with UNICEF programming processes is an asset;
- Knowledge of the country context and Nutrition programmes in India is an asset;
- Language: English, Hindi an asset.

14. Duty Station

Can work remotely through any duty-station. Visit to Gujarat and Madhya Pradesh states in 2021 during week 9 to week 17 would be necessary.

15. Management and Supervision

The Consultant will lead the evaluation process at all stages and coordinate with stakeholders as required. The Consultant would report to the Evaluation Manager (usually the Research & Evaluation Specialist) and would liaise with the Nutrition Specialist who is functioning as the program manager for the Acute Malnutrition portfolio. The Nutrition Specialist will be supported by Nutrition Specialists from each of the sampled states (Madhya Pradesh and Gujarat); the Chief of Nutrition will provide overall oversight and leadership support. The Consultant would be responsible for providing all deliverables on time and to a high quality. He/she will not be permitted to share any information regarding evaluation data or findings with any external stakeholders.

Reference Group - An Evaluation Reference Group (ERG) will be formed to oversee the evaluation process and ensure compliance to United Nations Evaluation Group (UNEG) Norms and Standards. It is an independent group of UNICEF and non-UNICEF experts (consisting of technical experts, government representatives) constituted for a specific evaluation by UNICEF India.

a. Coordinator: UNICEF Regional Advisor, ROSA
b. Representative from CIFF India
c. Government representative Madhya Pradesh
d. Government representative Gujarat
e. External nutrition evaluation expert e.g. IFPRI representative, SAS program representative, etc.

The Reference group will provide timely feedback to queries and reports from the Consultant.

16. Official travel involved

As part of the assignment, travel is expected during phase 2 of the assignment i.e. Week 6 to week 14 i.e. total 9 weeks. The travel would largely involve visits to State HQs of Madhya Pradesh and Gujarat and the two districts of each state that are proposed as part of evaluation – i.e. Hoshangabad and Khandwa districts in Madhya Pradesh, and Valsaad and Narmada districts in Gujarat.

Consultant shall be required to include the estimated cost of travel & per diem in the financial proposal. The travel cost shall be calculated based on economy class travel, regardless of the length of travel.

17. Payment Schedule

Payments will be made against the submission and acceptance of each of the below mentioned milestones and deliverables.

Milestone/Deliverable	Payment (%)
Submission of Approved Inception Report (with Methodology and Study Design, Workplan, Study Tools)	15%
Finalization of the tools after field testing	20%
Presentation of the initial findings of the evaluation and submission of draft report	25%
Submission of Approved Final Evaluation Report	25%
Dissemination materials (two x two-page summary of the report and presentation	15%

17. Technical Evaluation Criteria

- ***Weightage 70:30***

CATEGORY	MAX. POINTS	MIN. POINTS
1. SPECIFIC EXPERIENCE OF THE CONSULTANT RELEVANT TO THE ASSIGNMENT ▪ Professional expertise, knowledge and experience as outlined above (25)	**25**	**20**
2. METHODOLOGY ▪ Detailed technical proposal that details how the key questions related to the evaluation would be answered; the quality of the sample report (5) ▪ How effective is the proposed approach and methodology; is it sufficiently detailed/elaborated to meet the objectives of the terms of reference; has a robust sampling strategy been proposed with an adequate sample size; are adequate linkages with the CIFF led Evaluation team envisaged; any innovative techniques; (10) ▪ How is the quality of proposed implementation plan, i.e. how the consultant will undertake each task, appropriate number of input days, quality assurance mechanisms for the assignment, attention to issue of equity – especially gender and caste, attention to ethics, and time-schedules for implementation (5); ▪ Risk assessment and mitigation measures- recognition of the risks/peripheral problems and methods to prevent and manage risks/peripheral problems. (5)	**25**	**20**
3. INTERVIEW ▪ The candidate is able to defend the submitted technical proposal and demonstrates in-depth	**20**	**16**

CATEGORY	MAX. POINTS	MIN. POINTS
understanding of the program related issues as well as Indian context (20)		
Sub Total	**70**	**56**
4. FINANCIAL PROPOSAL – PRICE ▪ 30 points is allocated to the lowest priced proposal. The financial scores of the other proposals will be in inverse proportion to the lowest price.	**30**	**NA**
	100	**NA**

Weightage of technical and price proposal will be in the ratio of 70 and 30 respectively. *Passing marks for technical would be 56/70. (The candidate should pass in each of the minimum score and the overall score of 56)*

HOW TO APPLY: Your online application should contain four separate attachments:

i) Curriculum Vitae (CV) **(to be uploaded online)**

ii) High-quality technical proposal as per the requirements of the ToR **(to be uploaded online against bid folder - "Other – Applicant")**, consisting the following:

a. Detailed technical proposal that details how the key questions related to the evaluation would be answered;
b. How effective is the proposed approach and methodology; is it sufficiently detailed/elaborated to meet the objectives of the terms of reference; has a robust sampling strategy been proposed with an adequate sample size; are adequate linkages with the CIFF led Evaluation team envisaged; any innovative techniques;
c. How is the quality of proposed implementation plan, i.e. how the consultant will undertake each task, appropriate number of input days, quality assurance mechanisms for the assignment, attention to issue of equity – especially gender and caste, attention to ethics, and time-schedules for implementation;
d. Risk assessment and mitigation measures- recognition of the risks/peripheral problems and methods to prevent and manage risks/peripheral problems.

iii) Quality sample report of previous Evaluation conducted **(to be uploaded online)**

iv) Financial Proposal indicating deliverable-based lumpsum fee as per template attached. Please do not forget to specify your name in the file and include your signature, while saving. **(to be uploaded under financial proposal section).**

IMPORTANT: Without the technical and financial proposal and the sample report your application will be considered incomplete.

- Any attempt to unduly influence UNICEF's selection process will lead to automatic disqualification of the applicant.
- Joint applications of two or more individuals and sub-contracting are not accepted.
- Please note, UNICEF does not charge any fee during any stage of the process.
- Attached are General Terms and Conditions for the Consultancy Contracts for your reference.

Annexure 1: Sample Table of Contents for an Inception Report (no more than 30 pages, plus annexes)

CONTENTS

5. Interview checklists/protocols*

6. Draft Study Tools*

7. Theory of change / outcome model*

8. Detailed work plan*

9. Detailed responsibilities of evaluation team members

10. Reference documents

11. Document map

12. Project list

13. Project mapping

*The structure of inception reports may be adjusted depending on the scope of the evaluation. Chapters and sections with an asterisk should be included by default.

Annexure 2: Sample Table of Contents for an Evaluation Report (not more than 60 pages, plus annexes)

CONTENTS

2. List of meetings attended*

3. List of persons interviewed*

4. List of documents reviewed*

5. Interview checklists/protocols

6. Study Tools

7. Any other relevant materials

*The structure of evaluation reports may be adjusted depending on the scope of the evaluation. Chapters and sections with an asterisk should be included by default.

Annexure 3: Background of CMAM Program in India and two states

Introduction

Malnutrition is estimated to be the root cause of close to 50% of child mortality globally. Severe wasting is responsible for between 1 to 2 million of the 5.9 million deaths of children under five every year globally. Although children with acute malnutrition have an increased risk of mortality, between nine to eleven times higher than a well-nourished child, deaths from acute malnutrition are preventable.

Globally, there are close to 47 million children wasted at any one time, with an estimated 14.3 million severely wasted. 69% of the global burden lies in Asia. South Asia is the sub-region with the highest wasting prevalence in the world, with India accounting for 4 out of 5 such children in the region. Under the Sustainable Development Goal (SDG) 2 - 'End Hunger, achieve food security and improved nutrition and promote sustainable agriculture' - countries have committed to reducing wasting to below 5% by 2025. In 2015-16, wasting prevalence in India was estimated at 21.0%, a significant increase of 1.2% from 2005-06, while rates of stunting and underweight reduced. An estimated 22 million children are wasted and 8 million severely wasted. If India is to achieve the SDG, there needs to be a reduction of 16 percentage points in six years in wasting prevalence.

Wasting levels as per NFHS-4 were higher amongst males (21.9% vs 20.1%), in rural areas (21.4% vs 19.9%), and in scheduled tribes (27.4% vs 21.2% - scheduled caste, 20.5% - other backward class, 19.0% other). Similar issues of inequity were seen in levels of severe wasting as well. Though India is infamous for gender discrimination, child nutrition is a typical variable in which a stark sex gap is absent. However, certain studies have found significant sex gap among certain social groups such as upper caste Hindus. Thus, multifaceted intersections of caste and gender are acknowledged in shaping inequalities in many indicators, including in nutrition indicators.

Programming to address wasting

Effective, evidence-based prevention and treatment approaches for wasting exist that can achieve high coverage and are currently implemented across multiple countries in Asia and sub-Saharan Africa, integrated into government systems. The community-based management of acute malnutrition (CMAM) model, developed in Malawi and Ethiopia in the early 2000s, was endorsed by UNICEF, the WHO and the UN Standing Committee on Nutrition in 2007. This model comprises of four components: inpatient treatment for children with medical complications, outpatient treatment for children with SAM without medical complications, supplementary nutrition component for children with moderate acute malnutrition (MAM) and community mobilisation. Early detection of cases and referral to appropriate services are the essential components of the model which ensure its success. The model requires adaptation and contextualisation at the country-level to ensure it fits into existing health and nutrition platforms.

Existing services in India

Primary Health Care services are delivered through a network of Subcenters and Primary Health Care centers run by the Ministry of Health and Family Welfare, and network of Anganwadi Centers under the Integrated Child Development Services program run by Ministry of Women and Child Development. Anganwadi Centers are childcare centers that are established at approximately a 1000 population. ICDS is a government program which provides health, nutrition and education services for children as well as pregnant and lactating women. It was launched in 1975 with the presently adjusted goal of impacting the first 1,000 days of life.

The Ministry of Health and Family Welfare (MoHFW), Government of India has established 1,151 Nutrition Rehabilitation Centres (NRCs) across the country to provide clinical management and reduce mortality

among children with SAM and medical complications. The national operational guidelines on facility-based management of children with SAM were released in 2011. In 2018, a total of 152,312 children with SAM were admitted to the NRCs with a reported 71% recovery rate.

However, facility-based treatment at NRCs are required for usually 10-15% of children with SAM, those that have medical complications. Evidence shows that about 85-90% of children with SAM who have been identified through active case finding can be treated at the community level under the CMAM model. However, due to the absence of such programmes, all children identified as SAM are either referred to NRCs regardless of whether they require inpatient care or they do not receive any specific services. As observed in other contexts, caregivers are reluctant to attend inpatient services due to the high opportunity cost of doing so, specifically due to wage loss, the need to care for other children in the family and the cost and time required to travel the often-long distance between the NRC and their home. It is also costly for the treatment provider to admit children without complications into inpatient care, which has been estimated to be 1344 USD per disability-adjusted life year (DALY) compared to 26 USD for outpatient care in other contexts[3]. Data on the cost-effectiveness of treatment in India is limited.

Comprehensive community-based approaches to treat wasting do not yet exist at scale in India, reflecting the lack of national guidelines. Under POSHAN Abhiyaan, the Indian government has demonstrated its commitment to the large-scale implementation of treatment services for severely wasted children by including it as one of the high impact convergent nutrition indicators.

History of CMAM in India and the present status

Prior to 2015, CMAM implementation experiences in India were limited to small scale interventions by a variety of actors in multiple states. Initially implemented in Bihar in 2011 by a non-governmental organization (NGOs) in emergency response mode, it has subsequently been implemented in some form in multiple states largely been led by NGOs.

In 2015, a lack of evidence as to the effectiveness of the model in India[4] led to the Ministry of Health and Family Welfare (MoHFW) to commission pilots in one block of each of the 13 states with UNICEF presence. However, the roll out of a CMAM program which incorporates the use of commercially developed ready-to-use therapeutic foods (RUTF) has been opposed by a group of academics and activists. In January 2018, this culminated in the release of a circular by the Ministry of Women and Child Development (MoWCD) stating that for the management of children with SAM, the decision to use RUTF may be left to the discretion of the individual states in consultation with National Technical Advisory Board (NTBN). The board was constituted in January 2018.

CMAM guidelines have been in development since 2017, although they are not yet published.

Meanwhile, states are moving ahead with the CMAM agenda. Some states went ahead with the original plans of CMAM implementation as pilots – Kerala, Jharkhand, Bihar, Uttar Pradesh and Telangana. Some states are rolling out CMAM programs – Rajasthan, Gujarat, Maharashtra and Madhya Pradesh. Some states had planned to implement CMAM pilot programmes which are now on hold following the communication from MWCD regarding use of RUTF which requires states to take an approval from the NTBN before initiating

[3] Puett C. Sadler K, Alderman H et al., (2013) Cost-effectiveness of the community-based management of severe acute malnutrition by community health workers in Southern Bangladesh, Health Policy Plan, 28(4); 386-99.

[4] Evidence on the effectiveness of community-based protocols that existed in 2015: Aguayo et al., Integrated program achieves good survival but moderate recovery rates among children with severe acute malnutrition in India, Am J Clin Nutr 2013;98:1335–42; Burza et al., Community-based management of severe acute malnutrition in India: new evidence from Bihar, Am J Clin Nutr 2015;101:847–59.

the CMAM program on field – Odisha. These states remain prepared and are ready to roll out CMAM programs once the bottleneck is addressed. More states are in the stage of planning CMAM roll out – Assam and Chhattisgarh. UNICEF has documented the programmatic experience, challenges, opportunities and learnings from 12 states and can be found here. Since COVID-19, the CMAM programs have been largely put on hold across the country, while the services for facility-based management of children with SAM continue to be provided.

POSHAN Abhiyaan (National Nutrition Mission) Prime Minister's Overarching Scheme for Holistic Nourishment was launched by Hon'ble Prime Minister on 8th March 2018. POSHAN Abhiyaan is an overarching umbrella scheme to improve the nutritional outcomes for children, pregnant women and lactating mothers by holistically addressing the multiple determinants of malnutrition and attempts to prioritize the efforts of all stakeholders on a comprehensive package of intervention and services targeted on the first 1000 days of a child's life. It seeks to do so through an appropriate governance structure by leveraging and intensifying the implementation of existing programs across multiple Ministries while at the same time trying to rope in the expertise and energies of a whole range of other stakeholders – State Governments, Communities, Think tanks, Philanthropic Foundations and other Civil Society Actors. It aims to reduce child stunting, underweight and low birth weight by 2 percentage points per annum and anemia among children (and young females) by 3 percentage points per annum. It is based on 4 pillars:

- **Ensuring access to quality services across the continuum of care** to every woman and child; particularly during the first 1000 days of the child's life.
- **Ensuring convergence of multiple programs and schemes:** ICDS, PMMVY, NHM (with its sub-components such as JSY, MCP card, Anemia Mukt Bharat, RBSK, IDCF, HBNC, HBYC, Take Home Rations), Swachh Bharat Mission, National Drinking water Mission, NRLM etc.
- **Leveraging technology (ICDS-CAS)** to empower the frontline worker with near real time information to ensure prompt and preventive action; rather than reactive one.
- **Jan Andolan:** Engaging the community in this Mission to ensure that it transcends the contours of being a mere Government programme into a peoples' movement inducing large scale behavior change with the ownership of the efforts being vested in the community rather than government delivery mechanisms.

Further, the country celebrates Poshan Maah (Nutrition Month) in September and Poshan Pakhwada (Nutrition Fortnight) in March every year to accelerate various activities under POSHAN Abhiyaan. In September 2020, The Poshan Maah has prioritized early identification and management of children with Acute Malnutrition.

CMAM protocol

There are two key approaches to programming for the management of acute malnutrition – prevention and treatment. Under the comprehensive CMAM programme, both these approaches are undertaken simultaneously for achieving a sustainable solution to the problem of acute malnutrition. This means that existing evidence-based, high-priority interventions delivered through nutrition promotion programmes being implemented by Government of India that are preventative of acute malnutrition in nature are being strengthened as part of the CMAM implementation. However, prevention under the CMAM programme is defined more specifically for the purpose of assessing the quality of services. The nutrition status of children discharged as 'normal' from the programme should be able to maintain that status and it is the programmes responsibility to ensure that they do not relapse as defined by deterioration to moderate or severe acute malnutrition.

Due to the delay in the publication of national guidelines and the directive concerning the use of RUTF, the nutrition component of the treatment protocol varies by state. Some states are providing commercially produced ready-to-use therapeutic food that meet World Health Organization standards, while others offer augmented home-based diverse food. In households of such children, frontline workers promote dietary diversity and minimum meal frequency for children as provided in the IYCF guidelines through an existing nutrition promotion programme. In addition, mothers/caregivers of households of such children will be taught how to make multiple recipes with the required amount of energy, protein, micro and macro nutrients as well as receiving counselling on the importance of providing such food to the children for their successful treatment.

Rationale for the assignment

The consultant is expected to undertake a comprehensive external evaluation of CMAM services provided through government systems in India. The CMAM model is designed to be adapted to the context in which it is implemented, which is particularly pertinent in India where there are highly developed health and nutrition infrastructures at the community-level into which services can be integrated. However, the ability of the resulting services to deliver a high quality of care at scale has not been evaluated in depth. With SAM prevalence ranging from 2.2% to 11.9%,[5] which are unusually high rates when compared with other countries implementing CMAM services and translate to a high caseload, assessment and course correction are essential to meet the need. Moreover, the complex policy environment and the limited evidence base for CMAM in India has led to the development of multiple treatment protocols which vary as to their adherence to the global protocols. Therefore, a better understanding of these revised models, which have a limited evidence base for effectiveness, is essential. The two states proposed for in-depth assessment as part of this evaluation (Gujarat and Madhya Pradesh) have adopted different treatment protocols, one which uses a therapeutic food that meets WHO standards and the second which uses a therapeutic food that does not meet WHO standards, which will be taken into account when considering programme performance.

Brief details of program in states:

Gujarat: Department of Health and Family Welfare, Government of Gujarat launched the CMAM (Community based Management of Severe Acute Malnutrition) in May 2016 in 13 districts. The program was gradually scaled up and is presently operational across the state, led by the Department of Health and Family Welfare, Government of Gujarat. State Government funds are used for implementing all the components of the CMAM programme. For extending technical support to the Government of Gujarat to strengthen SAM management (both CMAM and F-SAM) programme across the state, a Centre of Excellence (CoE) was established in GMERS Medical College and Hospital Valsad, Gujarat. The CoE is involved in capacity building, monitoring, strengthening supportive supervision and validation activities to CMAM programme. In concurrence with the Department of Health and Family Welfare and State Centre of Excellence, Dharampur block of Valsad district has been selected for intensive monitoring, documentation of CMAM implementation processes, identification of good practices and evaluation of CMAM. Since COVID-19 the program has been presently on hold.

Madhya Pradesh: The pilot program for CMAM was first initiated in Madhya Pradesh in late 2017. Presently a community-based care for children with SAM programme is implemented by Department of Women and Child Development in nine districts, where training of field functionaries has been completed. Two districts have initiated enrollment of identified children with SAM in CMAM programme and reporting on their progress. The state has a Centre of Excellence in AIIMS, Bhopal. Departments of Pediatrics and Community

[5] NFHS 4

and Family Medicine are involved in strengthening the facility and community based programme for management of SAM respectively. The CoE is involved in providing technical support to the State Government on the SAM management issues, capacity building of field level functionaries, monitoring, supportive supervision and validation activities to strengthen SAM management programme. In concurrence with the Department of Women and Child Development and State Centre of Excellence (AIIMS Bhopal), Babai block of Hoshangabad has been selected for intensive monitoring, documentation of CMAM implementation processes, identification of good practices and evaluation of CMAM. AIIMS, Bhopal also facilitated development of a CMAM mobile application for capturing real time data. The application is integrated with state ICDS supportive supervision app- 'SAMPARK' and is hosted on ICDS MIS website / database. The progress of the programme is being reviewed to improve coverage, strengthen implementation and quality. Since COVID-19 the program was on hold. A guideline on re-initiation of the CMAM program has been recently issued by the State Government.

The models used in Gujarat and Madhya Pradesh are both used in other states therefore the findings from this evaluation will be applicable elsewhere. Both states have a considerable tribal population and tribal areas, thus – the findings from this evaluation will guide on specific strategies that work for such vulnerable population groups. Furthermore, the evaluation is expected to provide cross-learning between districts and states on all aspects of implementation, an exercise which is essential as states scale up services. The relevance and appropriateness, effectiveness and coverage, efficiency and sustainability of the CMAM programme will be assessed, with the documentation of best practices to inform implementation in subsequent states.

A comprehensive evaluation of the role of Centers of Excellence (CoE) in developing appropriate capacity of the health system to deliver community-based care in Gujarat and Madhya Pradesh, and status of program implementation in two districts each of the two states, commissioned by the Children's Investment Fund Foundation (CIFF), is simultaneously on-going and will be completed in December 2021. The evaluation assesses the CoEs directly but also the impact of the work, thus looking at the capacity of frontline workers to deliver services. It uses qualitative and quantitative methods, engaging with a range of stakeholders from the CoE to the community.

Linkages with CIFF-supported evaluation

The CIFF led evaluation is being implemented through a third-party agency. This evaluation would focus on the role played by National and State Centers of Excellence for supporting roll-out of CMAM programs in the respective states (five states for assessing role of Centers of Excellence – Madhya Pradesh, Gujarat, Rajasthan, Bihar, Jharkhand). Further, the evaluation would also focus on how effectively this support has translated in terms of implementation of the CMAM program on ground in two districts each of two States (Madhya Pradesh, Gujarat). The CIFF-led evaluation is expected include a baseline assessment (currently planned to be undertaken in December 2020-January 2021) and would also include mid-line assessment focusing on role of centers of excellence (tentatively in March/April 2021) and followed by an end-line assessment (tentatively in October/November 2021).

This evaluation will run in parallel with the CIFF-led Evaluation and would rely largely on the same data collection methods, participants for the evaluation, etc. Consideration of the complementarity of the two evaluations by the consultant in the design, implementation and interpretation of data is essential. For this, a thorough review of the existing CIFF-led evaluation scope, methods, tools, etc. would be required to assess and confirm that the findings from the CIFF-led evaluation would help answer many of the questions that

this Evaluation aims to answer. The outstanding issues would need development of separate tools and methods – which would require additional qualitative assessments.

UNICEF's CMAM program support in India is unique given the leadership role played by Government, varied models across various States, use of different kinds of therapeutic foods, context of low mortality relative to the wasting prevalence (compared to other regions of the world) and well-designed community based primary health care delivery platforms. The purpose of the CMAM program evaluation being commissioned by UNICEF (this TOR) is to better prepare for the strategy to support SAM management as part of the UNICEF country program 2023-2027. Further, the CMAM Evaluation would help UNICEF strengthen on-going and future CMAM programs by generating and disseminating evidence on CMAM experiences.

Annexure 4: Table – draft Evaluation Matrix

DAC Criteria	Questions	What to look for	Data sources
Relevance/ appropriateness	How appropriate is the CMAM strategy adopted in each state and to what extent do the strategies and interventions respond to the state specific context (health system and nutrition context)?	- Coherence of CMAM guidelines - Alignment of CMAM guidelines with VHSND guidelines - Nutrition context (burden, prevalence, needs of beneficiaries, needs, policies and priorities of country, state government and local administration) - Opinions of health workers at all levels	- State CMAM guidelines - VHSND guidelines - CNNS & NFHS data on burden and prevalence of wasting - Interviews with frontline workers, beneficiaries, block, district and state level officials
	How has the CMAM programme influenced (strengthened/weakened) existing health and nutrition services at the health center and community levels, from the perspective of both the provider and demand sides? How can any gaps or weaknesses be addressed? How synergistic are the services?	- Admissions over time and annual trends - Discharge outcomes - Discharge trends over time - Frequency of growth monitoring prior to CMAM - Referral between CMAM services and ICDS THR - AWW and ASHA workload of non-CMAM activities - VHSND attendance	- Interviews with frontline workers, beneficiaries, block, district and state level officials - Field observations - Routine programme data - VHSND ANM records - CIFF Evaluation findings
Effectiveness and quality of services	Are programme outcomes acceptable as per international standards? How do outcomes vary across the state and why? Consider programme maturity.	- Discharge outcomes overall and annual trends, disaggregated by block/NRC - Are children admitted discharged correctly - Length of stay and mean weight gain of cured cases	- Routine programme data supplemented by data from health unit as required - Seasonal calendar - Review of anthropometric status reported on cards/register at admission/discharge.
	What are the bottlenecks that limit programme performance and the boosters that facilitate good performance? Consider human resources, supplies and community mobilization.	- Frontline worker, supervisor, block and district staff skills, motivation, vacancies and workload - Additional roles expected due to COVID and its impact on workload - Availability and quality of medical and nutrition supplies	- Observation checklists - Key informant interviews with block and district staff - Focus group discussions (FGDs) with beneficiaries and frontline workers &

		- Community knowledge and engagement in service provision - Reasons for defaulting and death - Referral between inpatient, outpatient and ICDS THR	community members - Referral data - CIFF Evaluation findings
	To what extent are services responding to seasonality in terms of wasting incidence and migration and how could the response be strengthened?	- Reasons for children defaulting from services - Defaulter trends over the year - Actions taken to overcome impact of migration	- Routine data - Interviews with frontline workers
	How effective are outpatient services in ensuring the SAM child receives the correct nutrition component of treatment at the required time?	- Amount of food that the child is estimated to consume in each state on average. - Factors that affect consumption (pre-packaged, home prepared, time of caregiver) - Consider supply chain timeliness, stock outs and safety of the food when given to the child.	- To be decided - Likely combination of 24 hr dietary recall and observation in the home. - Elements of the supply chain, stock lists - Key informant interviews - Beneficiary FGDs - Observations of preparation, if relevant - Details of contents of products used
	How effective have community mobilization strategies been in mobilizing the communities to continuously engage with services and why?	- Community mobilisation activity implementation	- Community mobilisation strategy - Interviews and FGDs
	Do CMAM services provide a complete continuum of care from screening to the transition to home foods on recovery?	- Referral between inpatient, outpatient and ICDS THR - Practices of children that have exited the programme	- Referral data - Interviews/FDGs with caretakers
	Is the programme able to achieve sustained recovery post-discharge?	- Relapse rate post discharge and suspected reasons for relapse	- Relapse data
	Are data management systems effective in enabling collection, management and use of data for timely corrective action?	- Data management systems and monitoring cycle - How data are used in meetings at the facility and at higher levels	- Routine data - Data collected from registers in AWCs - Interviews with data managers and analysts
	What quality assurance is in place used at the point of data entry (at the AWCs)	- How accurate are the data reported from the AWC?	- Sample check of registers and cards against

		- Understanding of AWWs and their supervisors of the importance of accurate reporting - What checks are in place to ensure accuracy of data -	monthly/weekly reports - Interviews with AWWs and their supervisors
Coverage	What is the estimated geographic and treatment coverage of CMAM services? How appropriate is the level of coverage?	- Geographical coverage (90%). treatment coverage (>70%)	- CIFF Evaluation Data
	Has the geographical expansion of services been accompanied by quality service provision?	- Timeline for expansion of programme in relation to need - Admission trends and outcomes in areas of expansion relevant to context	- CNNS and NFHS 4 data - Key informant interviews - FGDs with current and past beneficiaries
	How does ICDS growth monitoring coverage affect CMAM inpatient and outpatient service coverage?	- How are children identified for screening? Door to door active case finding or AWW lists? - Proportion of children U5 screened - Frequency of screening	- Screening data
	What are the boosters that facilitate good coverage and the barriers that limit coverage?	- Who are being missed – gender, caste group, any geography, etc.? - Explainers for the level of coverage found	- Interviews and FGDs - Screening and Programme data
Efficiency	To what extent is the intervention efficient in making the best possible use of available resources to achieve its outcomes?	- Review human resources, supplies, community mobilization and geographical access, monitoring	- Programme data (severity of admissions) - Interviews and FGDs
	What are the key inefficiencies at each level of implementation (community, AWC, block, district)?	- Review human resources, supplies, community mobilization and geographical access, monitoring	-
	To what extent is the coordination between government ministries strengthening or limiting efficiency?	- Frequency and content of coordination meetings between departments at district and block level - Extent of collaboration of frontline workers for child's treatment on VHSND. - Reporting systems	- Interviews and FGDs - Monitoring systems review (forms)

Sustainability and opportunities for scale up	Is the existing programme sustainable in terms of the national and state-level policy environments? Why? How can sustainability be improved?	- Perception of CMAM by state and district officials - Financial commitments for all programme components - Policy development plans	- Key informant interviews with district and state officials
Cross-cutting issues	Does the programme effectively consider equity, especially gender and caste to ensure access to those that need services?	- Admissions and outcomes by sex and age - Review of admissions and outcomes from vulnerable groups e.g. tribal	- Routine data - Health registers - Interviews and FGDs – ensuring participation of vulnerable groups, such as women and respondents from tribal areas
	How does the coordination and management of the programme by DWCD and DHFW affect service quality? How could it be strengthened?	- Coordination mechanisms for CMAM at state, district and block levels - Training - Supportive supervision (frequency and quality)	- Key informant interviews - FGDs with community members and beneficiaries - Observations