FORMATIVE EVALUATION OF THE INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION

(2013-2018)

AFGHANISTAN

Commissioned by UNICEF Afghanistan

INCEPTION REPORT

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ACRONYMS

ANDS	Afghanistan National Development Strategy
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
CHC	Comprehensive Health Centre
CHW	Community Health Worker
CMAM	Community Based Management of Acute Malnutrition
CRC	Convention on the Rights of the Child
DAC	Development Assistance Committee
DH	District Hospitals
EPHS	Essential Package of Hospital Services
ESC	Evaluation Screening Committee
GAM	General Acute Malnutrition
GCMU	Grants and Service Contract Management Unit
GoIRA	Government of Islamic Republic of Afghanistan
HP	Health Post
HRP	Humanitarian Response plan
HSC	Health Sub-Centre
ICESCR	International Covenant on Economic, Social and Cultural Rights
IED	Improvised Explosive Device
IMAM	Integrated Management of Acute Malnutrition
IPD	Inpatient Department
IDP	Internally Displaced People
MAM	Moderate Acute Malnutrition
MHT	Mobile Health Teams
MoPH	Ministry of Public Health
NGO	Non-Governmental Organisation
NNC	National Nutrition Cluster
OCHA	Office for the Coordination of Humanitarian Affairs
ODK	Open Data Kit
OECD	Organization for Economic Cooperation and Development
OPD	Outpatient Department
PH	Provincial Hospitals
PND	Public Nutrition Directorate
RH	Regional Hospitals
RUTF	Ready to Use Therapeutic Food
SEHAT	System Enhancement for Health Action in Transition
SAM	Severe Acute Malnutrition
SM	Strengthening Mechanism
SPEAR	Social Policy, Evaluation, and Research
ToR	Terms of Reference
TSFP	Therapeutic Supplementary Feeding Programme
U5	Under 5
UHDR	Universal Declaration of Human Rights

WASH	Water, Sanitation and Hygiene
WB	World Bank
WFP	World Food Program
WHO	World Health Organization

1. INTRODUCTION

PURPOSE OF THE INCEPTION REPORT

This inception report is a culmination of initial discussions with the United Nations Children's Fund (UNICEF) (via two remote calls), preliminary review of documentation and data relevant to the integrated management of acute malnutrition (IMAM) and a one week in-country inception mission by the evaluation Team Leader and Project Director from Action Against Hunger (ACF). The purpose of this report is to present the evaluation team's understanding of the evaluation requirements, including its purpose, objectives, evaluation questions, methodology, governance structure and revised workplan. This report is the first deliverable within the evaluation process and sets out the process to be followed including timelines.

PREPARATION FOR AND THE INCEPTION MISSION

Prior to the inception mission a detailed review of the ToR revealed that there were duplications in evaluation questions, and at times misalignment between the evaluation criteria and questions. Due to this and the time lag between the award of the contract and the inception mission (over five months), the evaluation team took the decision to use the in-country visit as an opportunity to consult with key stakeholders about their information needs, perceived purpose of the evaluation, its use, scope, key IMAM stakeholders, evaluation management/governance structure and details about the IMAM approach (refer to Annex 9 for list of questions used during stakeholder consultations).

The evaluation team conducted individual and group consultations with actors involved within IMAM (refer to Annex 4 for a full list of people met) and the Evaluation Steering Committee (ESC), constituted during the inception mission by Ministry of Public Health (in collaboration with Public Nutrition Directorate (PND) and General Directorate of Monitoring, Evaluation, and Health Information System) (refer to Annex 6).

Information obtained from the consultations was used to present to the ESC and gain consensus on:

- Revised evaluation criteria and questions
- Scope, purpose and objectives of the evaluation
- Results framework/strategy to be used for framing the evaluation
- Sampling criteria
- Evaluation management and governance structure

The Evaluation Team also sought clarity from UNICEF on whether the evaluation focus should be UNICEF and its role in IMAM or IMAM and the related actors involved. UNICEF clarified that the evaluation is about the IMAM approach in Afghanistan and not UNICEF. The Evaluation Team also understands that the scope will include children under 5 (U5) and pregnant and lactating women as its target groups. The methodology developed is based on this understanding.

2. CONTEXT AND DESCRIPTION OF THE OBJECT OF EVALUATION

Afghanistan is one of the world's most complex humanitarian emergencies, characterized by escalating conflict causing over one million people to be living in new and prolonged displacement. In 2017, ongoing conflict displaced an estimated 360,000 people from their homes and resulted in 8,019 civilian casualties; two thirds of these women and children. The high level of population movements has had a profound impact in parts of the country; overloading health facilities, schools, depressing labour wages and increasing rents. Violations of international and human rights law are commonplace, with frequent deliberate attacks on civilians and civilian objects, including aid workers and schools and medical facilities, as well as the persistent use of indiscriminate and often disproportionate tactics, such as suicide and improvised explosive devices (IEDs). The combined effect of conflict, natural disaster and cross-border movement has resulted in persistently high humanitarian needs. In 2018, the Office for the Coordination of Humanitarian Affairs (OCHA) estimated that 3.3 million people were in need of lifesaving assistance[1].

In 1994, Afghanistan ratified the United Nations Committee Conventions on the Rights of the Child (CRC) and reaffirmed these commitments in 2011. In the first Public Nutrition Policy and Strategy (2003), the Government of Afghanistan, and the Ministry of Public Health (MoPH) in particular, affirmed its commitment to promote, protect and fulfil the rights of all people to adequate food and nutrition as stated in the International Declarations and Conventions on Human Rights (UDHR) Article 25; International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 11; the International Convention on the Rights of the Child (CRC) Article 27.

In order to address the problem of acute malnutrition, the country introduced Community based Management of Acute Malnutrition (CMAM) in 2008, establishing the programme initially in 4 provinces. The CMAM programme comprised 3 main elements;

1. Community Mobilisation: Community health workers (CHW) conducted frequent screening in the community to promote the early identification of children with severe acute malnutrition (SAM)
2. Outpatient Therapeutic Programme: Children with SAM with no major medical complications and with adequate appetite were treated with systematic antibiotics and Ready to Use Therapeutic Food (RUTF) at the Comprehensive Health Centre (CHC) and Basic Health Care Centre (BHC)
3. Inpatient Treatment: Children with SAM with major complications or without appetite for RUTF were admitted for inpatient care in existing hospitals at District or Provincial level

[1] Humanitarian Response Plan January 2018-2021, United Nations Office for the Coordination of Humanitarian Affairs, December 2017 https://reliefweb.int/report/afghanistan/afghanistan-humanitarian-response-plan-january-2018-december-2021-endarips

From 2008 to 2014, treatment for children aged 6-59 months with Moderate Acute Malnutrition (MAM) was provided by the World Food Programme (WFP) and partners in Therapeutic Supplementary Feeding Programmes (TSFP) which were located in separate facilities.

In 2014 the CMAM programme evolved significantly to become the Integrated Management of Acute Malnutrition (IMAM) public health approach, harmonizing with the Basic and Essential Packages of Health & Hospital Services (BPHS/EPHS) and integrating the treatment of children U5 with moderate acute malnutrition (MAM) and pregnant and breastfeeding mothers with an infant aged less than 6 months. IMAM was geographically scaled up in all 34 provinces in Afghanistan and nearly 78 percent (313/399) of the districts with at least one component of IMAM by mid-2017.

From 2014 to 2017, In-Patient Department of Severe Acute Malnutrition (IPD-SAM) services scaled up from 87 to 172 health facilities (15% increase since 2014) in all 34 provinces. Similarly, Out-Patient Department of Severe Acute Malnutrition (OPD-SAM) services scaled up from 611 to 1028 health facilities in all 34 provinces. While the Out-Patient Department of Moderate Acute Malnutrition (OPD-MAM) services scaled up from 22 (65%) to 26 (76%) provinces, and from 490 (25%) to 529 (27%) health facilities.

In-terms of reach, the country provided IMAM services (SAM and MAM) for 236,121 of total acutely malnourished girls and boys in 2014, 315,890 in 2015, 400,488 in 2016 and around 178,012 by mid-2017. During 2017, 235,000 children U5 with SAM were treated, representing 99.6% of the 2017 target[2]. During the same period, TSFPs treated 162,816 children aged 6-59 months (74% of target) and 157,797 PLWs with MAM (130% of target)[3].

Since the introduction of the CMAM programme, new priorities and challenges have arisen which required new strategies. Thus, in 2008 the National Nutrition Policy & Strategy was revised for the period of 2009 to 2013. Strategic priorities were proposed and integrated in the MoPH Strategic Plan for 2011- 2015. In 2015 the **Public Nutrition Policy & Strategy** was revised for the period of 2015 to 2020. It was revised to be in line with the Ministry of Public Health's mission and vision and with the Afghanistan National Development Strategy (ANDS). The intermediate results are as follows:

1. **Increased access to nutrition services and products**
    a. Increased availability of essential nutrition services at public and private facilities
    b. Improved availability of nutrition products
    c. Strengthened community-based nutrition services.
2. **Improved nutrition behaviours and practices of public**
    a. Improved knowledge of caretakers and community leaders/influencers on optimal nutrition behaviours
    b. Increased awareness and engagement of media in promotion of optimal nutrition behaviours and products

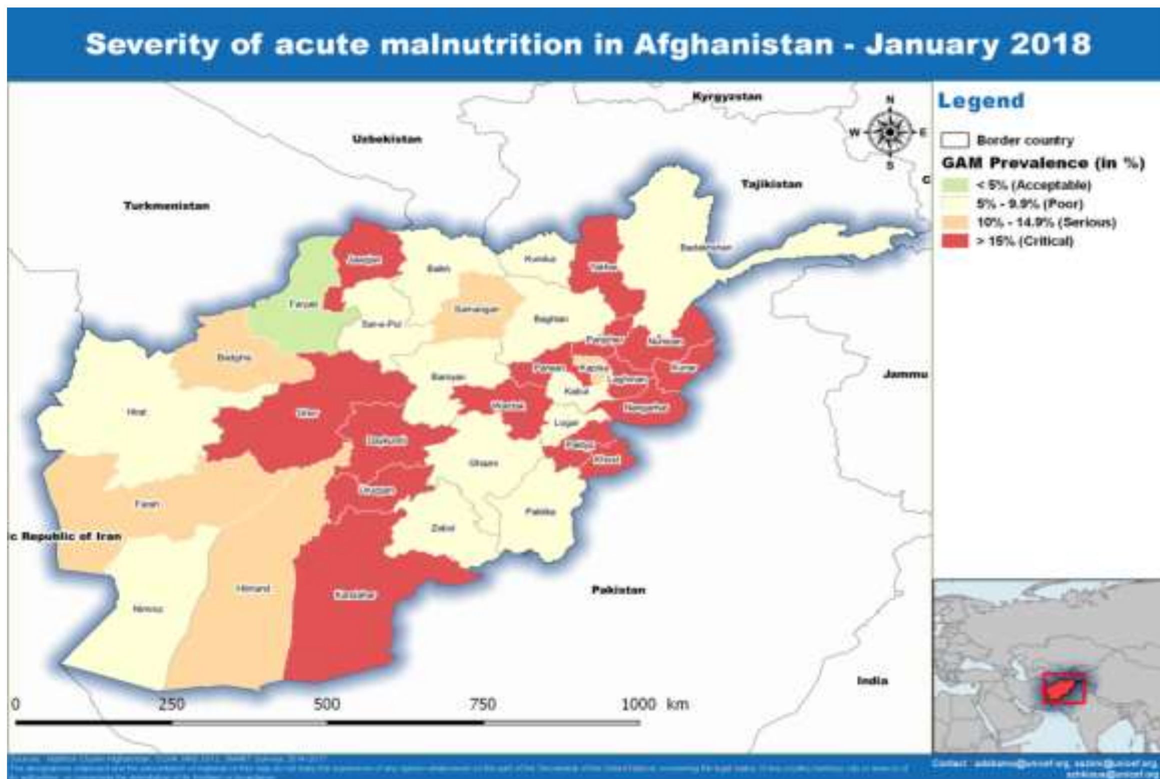
[2] Source: UNICEF presentation to evaluation team during inception visit
[3] Source: Nutrition Cluster Bulletin issue 1 (2018)

   c. Increased basic nutrition education for front line workers in health, education, agriculture, rural development and other institutions.
3. **Improved quality of nutrition services and products**
   a. Strengthened capacity of service providers and facilities to deliver nutrition interventions
   b. Improved performance monitoring of nutrition services;
   c. Improved quality assurance system for nutrition products; and
   d. Strengthened nutritional status monitoring and surveillance system.
4. **Strengthened social, regulatory and political environment for nutrition**
   a. Strengthened the stewardship and governance role of MoPH in leading and coordinating multi-sectoral nutrition programs
   b. Improved capacity to generate and use knowledge and evidence for nutrition programming and policy
   c. Increased resources for nutrition
   d. Strengthened nutrition policies, standards and regulations.

Significant attention is given to improving coverage of acute malnutrition in the 2015-2020 strategy. Intermediate result 1 “Increased access to and availability of nutrition services and products” proposes a target of 80% for treatment coverage by 2020 compared to 38% baseline in 2015. To complement this strategy, the National Nutrition Communication Strategy 2015-2020 identified Key optimal Behaviours in the management of children U5 with acute malnutrition.

Figure 1 illustrates the prevalence of global acute malnutrition (GAM) in Afghanistan as of January 2018, highlighting areas considered to be “critical” (as defined by GAM > 15%).

Figure 1: Prevalence of global acute malnutrition by province in Afghanistan in January 2018



Source: Afghanistan Nutrition Cluster Bulletin. Issue 1 (2018)

The current strategy for addressing acute malnutrition in priority provinces focuses on the close collaboration of stakeholders in addressing priority provinces with the highest reported prevalence of Global Acute Malnutrition (GAM) and SAM. These priorities are listed below:

Priority 1:

17 Provinces with SAM > 3%, it was agreed that UNICEF and WFP should work together in all accessible districts using the same facilities and partners.

Priority 2:

8 Provinces with SAM < 3%, it was agreed that in provinces where MAM management services are functioning, to maintain the services and ensure complementarities of SAM and MAM management in the same facilities and using the same partners**.**

Priority 3:

9 Provinces where WFP will not be implementing due to funding constraints and other reasons, UNICEF will be implementing SAM management services but will not be matched with MAM management services.

The direct stakeholders and partners in the 34 provinces are numerous and are comprised of the MoPH, BPHS and EPHS contract holders, UNICEF, WFP and international Non-Governmental Organisations (NGO)

The projected activity costs for the admission and treatment alone for acutely malnourished girls and boys aged 0-59 months and pregnant and lactating women in the Nutrition Cluster

Humanitarian Response Plan (HRP) to 2020 is $48,347,175, excluding costs for other related nutrition interventions and assessment, monitoring and treatment activities.

While no theory of change has currently been developed for the IMAM and Nutrition Communication strategies, the complementary activities of raising the awareness of behaviours for the prevention and treatment of acute malnutrition and the targeted increase in the availability and utilisation of treatment are logical requisites to achieve the targeted reductions in child mortality as defined by the mission statement of the MoPH and National Health Nutrition Communication Strategy 2015-2020 (Optimal Behaviours for Acute Malnutrition).

3. PURPOSE, OBJECTIVE AND SCOPE OF EVALUATION

Purpose of the evaluation

This is the first IMAM evaluation being undertaken almost five years since IMAM entered its scale up phase (from 2014). It is a formative evaluation with the purpose, as stated in the Terms of Reference (ToR), to gather evidence on the processes and results of IMAM, and contribute to:

- Promoting accountability among stakeholders and partners;
- Evidence-based policymaking in preventing and treating acute malnutrition among affected children;
- Organizational and global learning, and improving programming on effective treatment of children diagnosed with acute malnutrition.

Expected users/intended users

Public Nutrition Directorate (PND) within the General Directorate of Preventive Medicine of the Ministry of Public Health (MoPH) was established in 2003 and has since been responsible for programmes for treating severe acute malnutrition. PND is supported by UNICEF, WFP and the World Health Organisation (WHO) (via supplies, training and capacity building) for the implementation of IMAM. The PND implements the programme mainly through the EPHS (for inpatient care) and the BPHS for community based services contracted out to national and international NGOs. The BPHS partners are contracted by the Grants and Service Contract Management Unit (GCMU) using funds from the SEHAT/SEHAT MANDI programme provided by the World Bank (WB)[4].

The primary audience of the evaluation are therefore those stakeholders involved in the assessment and management of malnutrition in Afghanistan. This includes:

The Government of the Islamic Republic of Afghanistan (GoIRA) (including the PND and MoPH), the United Nations (UN) (including UNICEF (Nutrition and Social Policy, Evaluation, and Research

[4] The Evaluation Team will further clarify how PND implements BPHS through 'non-partners' and distinguish between BPHS partners and non-partners based on information obtained during data collection phase

(SPEAR) and nutrition Sections), WFP and WHO), implementing partners for BPHS and EPHS, non-BPHS[5] partners, the National Nutrition Cluster (NNC) and recipients of IMAM services.

Secondary audience, for whom the results of this evaluation may be beneficial include: World Bank (funding the SEHAT MANDI programme), Grants and Service Contract Management (GCMU, GoIRA), Directorate of M&EHIS (MoPH), other national clusters, other MoPH departments and government and non-government actors implementing programmes such as WASH, food security/ livelihoods and education which may be complementary to IMAM's effort to reduce malnutrition.

It is expected that these users will stand to benefit from the results of this evaluation because the evaluation will deliver findings and recommendations that will help in improving IMAM processes and hence performance.

Evaluation objectives

The evaluation's **main objective is to yield results that will contribute to enhancing IMAM's performance and strategies to deliver effective results** through:

- Assessing the progress made and identifying gaps, good practices and lessons learned;
- Evaluating IMAM's relevance, efficiency, effectiveness, coverage and sustainability;
- Generating knowledge and providing recommendations that will be useful for strengthening IMAM performance, advocacy and policy dialogue on acute malnutrition among children U5.

The recommendations that the evaluation will deliver are expected to cover:

- Strategies for developing policy on effective implementation of the IMAM interventions in addressing acute malnutrition issues, improving the quality of services, and achieving equitable outcomes for children U5 at the national level.
- The effectiveness of related crosscutting issues such as coordination and management; gender and other forms of equity; capacity development; advocacy and policy development; and information/data management.

Evaluation Scope

The evaluation scope will be as follows:

Time scope: The ToR outlined that the evaluation will cover overall IMAM activities and implementation strategies at the national level from 2013 to 2018. In addition to this it was also stated that the evaluation will highlight the trends of acute malnutrition cases and actions implemented by UNICEF and partners from 2010 to 2017.

During consultations with the IMAM Evaluation Steering Committee (ESC), it was decided that the time scope of the evaluation would be limited to the period 2013-2018. This coincides with the IMAM scale-up and the National Public Nutrition Strategy 2015-2020 (which will act as the

[5] The Evaluation Team will further clarify what constitutes 'non-BPHS' during data collection phase based on information collected, for example does this contain private clinics or/and EPHS facilities.

framework for this evaluation), whilst the 2009-2013 Public Nutrition Strategy will also be consulted since this would have acted as the baseline for the 2015-2020 strategy.

Geographic locations: By mid-2017 IMAM had been scaled up to all 34 provinces in Afghanistan and nearly 78 percent (313/399) of the districts with at least one component of IMAM. OPD-MAM services operated in 26 out of 34 provinces and OPD-SAM in 34 provinces OPD-SAM[6]. By the end of 2017 there were 1,028 sites for outpatient SAM treatment and 667 sites for outpatient MAM treatment[7].

All districts and provinces with IMAM services will be within the scope of the evaluation. A selection of provinces and districts will be selected based on the sampling criteria detailed in Section 5. Accessible districts will be visited by the evaluation team to collect any required data. Districts considered inaccessible will also be selected and assessed through remote data collection techniques.

Implementation modalities: In government controlled areas the package of IMAM services is being provided in community and facility-based primary and secondary healthcare as part of the BPHS and EPHS. BPHS is outsourced to over 30 national NGOs that manage and support implementation under a performance-based funding scheme–the System Enhancement for Health Action in Transition (SEHAT) Project. SEHAT covers approximately 80% of the country's population. Three provinces (Pansjir, Parwan and Kapisa) were covered not by SEHAT but by the MOPH Strengthening Mechanism (SM). The remaining 20% of the country is in emergency status. The government does not have the capacity to provide services in these areas. Therefore IMAM is supported by emergency health and nutrition partners consisting of INGOs, grouped under the NNC. This modality only partially covers some areas leaving many areas uncovered.

All these implementing modalities will be within the scope of the evaluation.

Health facilities: Regulated by the BPHS and EPHS, IMAM services were to be provided in all the national teaching hospitals in Kabul, regional hospitals (RHs), provincial hospitals (PHs), district hospitals (DHs) comprehensive health centres (CHCs), basic health centres (BHCs), mobile health teams (MHTs) and health sub-centres (HSCs). Community-based health posts (HPs) provide community screening and referral to facilities where IMAM services are provided. Non-BPHS/EPHS partners support health and malnutrition services in areas not reached by the government through emergency funding. All these levels will be within the scope of this evaluation.

Implementing partners, supporting actors and other relevant stakeholders: This includes the MoPH (identified as implementers in some provinces), EPHS, BPHS and non BPHS implementing partners, WHO, WFP and UNICEF as providers of technical, operational and financial support to both the government and implementing partners. It also includes other stakeholders (such as the WB) directly or indirectly involved or whose funding for programmes may have a link to or the potential to complement IMAM efforts (food and livelihoods, WASH etc.) and the communities/recipients of IMAM services. These will all be within the scope of this evaluation

Target group[8]: The target groups for IMAM and therefore who are within the scope of this evaluation include:

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[6] Data taken from Terms of Reference of evaluation
[7] Data from presentation shared with evaluation team during inception visit in May 2019
[8] PND Presentation to Evaluation Steering Committee on 8th May, 2019

- Children aged 6-59 months with moderate acute malnutrition (MAM) or Severe Acute Malnutrition (SAM) without complications who are treated in OPD SAM and MAM
- Pregnant and lactating women with MAM who are treated in OPD MAM
- Children aged 0-59 years with SAM with medical complications who are treated in the IPD-SAM.

4. EVALUATION CRITERIA, QUESTIONS AND FRAMEWORK

EVALUATION CRITERIA

The evaluation criteria for this study were pre-assigned to the original list of evaluation questions (as given in the ToR). These are the Organisation for Economic Cooperation and Development (OECD) / Development Assistance Committee (DAC) criteria, relevance, effectiveness, efficiency, and sustainability. Coverage was assigned as an additional criterion as a result of consultations during the inception phase and after consensus with the ESC. The reason for adding this was the ESC's decision on the importance of identifying the coverage of IMAM against the estimated needs, reach in hard to reach areas and differences in uptake of IMAM services. Questions which would require assessment of contribution and impact were not deemed appropriate for this evaluation due to its formative nature and focus on processes.

- **Relevance**: This will include reviewing the extent to which IMAM is situated within existing health structures; evolution of inputs in response to changing context, needs and priorities; and constitution of equity issues in IMAM delivery and access
- **Effectiveness**: This will include assessment of user perceptions and satisfaction; IMAM supplies, quality of service, capacity of implementing partners, motivation and satisfaction of front line staff and achievement of results
- **Coverage**: Assessment of geographical and treatment coverage against estimated needs, hard to reach population, differences in uptake of services, challenges and success factors and implications of IMAM expansion on quality of services
- **Efficiency**: Assessment of complementarity of IMAM M&E related systems and forums; use of evidence to inform IMAM performance and detect bottlenecks; efficiency of various IMAM delivery modalities
- **Sustainability**: Assessment of IMAM integration into health system; converging service delivery with other similar public health approaches into systems and capacities to cope without support; and coordination across IMAM stakeholders and partners

EVALUATION QUESTIONS

Given the consultations with key stakeholders and the ESC during the in-country Inception Mission, the evaluation team re-developed the evaluation questions which are now based on the current information needs of the stakeholders. The PND and other partners agreed that the information needs of key stakeholders may have changed since the evaluation was commissioned. The questions in the original ToR (Annex 1) were therefore set aside. Initial evaluation focus areas were first identified based on the information collected from consultations with stakeholders. These are given in Table 1:

Table 1: Evaluation Criteria and Corresponding Evaluation Focus Areas

Relevance	Situation/compliance of IMAM within existing structures Consideration of equity issues in IMAM service delivery and access Evolution of IMAM inputs in response to context, needs and priorities
Effectiveness	User perceptions and satisfaction with IMAM services IMAM supplies (use, timeliness, distribution and adequate quantity) Quality of service delivery Motivation and satisfaction of front line staff Capacity of implementing partners IMAM activities and influence on achievement of results and targets
Efficiency	Complementarity of IMAM M&E related systems and forums Use of evidence generated to inform IMAM performance and detect bottlenecks Efficiency of various IMAM delivery modalities
Coverage	Geographical coverage against estimated needs and changes, hard to reach populations, challenges/success factors Differences in take up of IMAM Services Expansion of geographical and programmatic coverage and quality of service provision
Sustainability	IMAM Integration into health system Internal/external support for IMAM Systems, capacities, policies and strategies for continued implementation of IMAM without support Coordination across IMAM stakeholders and implementing partners

The evaluation team, in consultation with the ESC used these focus areas to develop a new set of evaluation questions against the five evaluation criteria already discussed. These questions were reviewed by the ESC. During a collective meeting of the ESC held on 9th May 2019 which was facilitated by the General Director of EHIS (Research Coordination and Evaluation Directorate) and the Public Nutrition Directorate, the draft questions were jointly prioritised and finalised.

Table 2 provides details of evaluation questions from the ToR. Table 3 lists the re-developed evaluation questions defined during the inception mission.

Table 2: Evaluation questions as per the original Terms of Reference

Evaluation criteria		Evaluation questions as per the original TOR
Relevance	R1	To what extent have IMAM interventions met the needs of children and their mothers? Did the IMAM interventions adequately target the needs of the poorest quantile, remote populations and the most vulnerable children?
	R2	To what extent were UNICEF's interventions gender-proportionate? How the cases of girls and boys were adequately addressed in both UNICEF's downstream and upstream interventions?
	R3	Are there any issues related to gender, geographic or other form of equity in CMAM service delivery and access that are evident? What measures could be proposed to improve targeting?
	R4	To what extent have IMAM capacity development activities covered the development needs of communities and Government partners in preventing and treating acute malnutrition?
	R5	How are the efforts of UNICEF and partners in treating acute malnutrition aligned with the national priorities in nutrition?
Efficiency	E1	Are UNICEF's investments to implement IMAM sufficient to achieve intended results in the context of the country? Are there less costly options that UNICEF could have used for achieving planned results in treating SAM?
	E2	To what extent has UNICEF partnership with WFP, WHO and Government stakeholders at different levels support the delivery of the programme results?
	E3	How have UNICEF's monitoring and reporting systems been used to gather credible evidence on the response to SAM, measure results, detect and prevent bottlenecks on time?
	E4	To what extent does the service delivery meet expected quality standards? What factors have contributed to meeting quality standards?
	E5	Where quality standards are not met, what are the key bottlenecks/constraints that need to be addressed in order to meet quality standards?
	E6	What are per unit costs of IMAM implementation in the context of Afghanistan? Can any conclusions be drawn regarding cost effectiveness / efficiency?
Effectiveness	EF1	To what extent have the expected outputs and outcomes been realised through the IMAM programme? If there are shortfalls, what are the contributing factors?
	EF2	How developed and successful are the specific IMAM components and strategies (community outreach and mobilisation, screening/enrolment, feeding, treatment, information management, follow up) and the interventions (as per the programme logic model) in realising overall programme objectives?
	EF3	Have all targeted number of children diagnosed with SAM and MAM, and their families been reached in the planned timeline?
	EF4	Have UNICEF and partners achieved the optimum level coverage for acute malnutrition treatment?

	EF5	Have the counselling services led by UNICEF to mothers and caretakers yielded substantive results? What is the difference between understanding of mothers and caretakers of nutrition needs of children before and after UNICEF provided them with the counselling services?
	EF6	Has treatment of acute malnutrition by UNICEF and partners through the IMAM approaches contributed to reducing nutrition mortality and morbidity among the population? Has it contributed to economic development and changing social norms and behaviour of the population?
	EF7	How effective is the vertical and horizontal coordination (involvement of various sectors) in planning and implementing IMAM?
	EF8	How strong is the national /sub-national engagement and ownership of CMAM programme (including national budget allocations)?
Sustainability	S1	Have UNICEF and partners set up a system at the national level that will continue responding to acute malnutrition cases effectively without external support?
	S2	Are there relapsed cases of children who were treated? If so, what are those issues that caused SAM and MAM among those children again?
	S3	To what extent do mothers and caretakers who received counselling sessions continue practicing the knowledge that they gained through the IMAM?
	S4	How systematically has institutional capacity development been pursued at all levels for long term sustainability of the programme? What more needs to be done?

Table 3: Revised evaluation questions following the inception visit in May 2019

		Redeveloped evaluation questions
Relevance	R1	To what extent is IMAM situated/in compliance with existing structures at various levels (national, sub-national and field level)?
	R2	Have issues related to equity been considered in IMAM service delivery and access, (gender, geography, prioritization of areas where need is greatest)? What measures could be proposed to improve targeting?
	R3	To what extent have IMAM inputs evolved to respond to the local context, needs and priorities?
Efficiency	E1	To what extent has delivery of IMAM services been efficient using the following modalities: • HCSs (sub health centres) and mobile health teams? • Presence of an international NGO as provider of technical support to a national NGO?
	E2	How complementary are the IMAM related M&E systems (IMAM database, M&E database, SCM and EUM)? Are there any duplications/overlaps?

	E3	To what extent has the gathered evidence been used to inform programme performance, detect and resolve bottlenecks on time?
	E4	How complementary are the IMAM related forums, included nutrition related forums with IMAM component? Are there any duplications/overlaps?
Coverage	C1	What is the geographic coverage of IMAM services against estimated national, provincial needs? How has this changed since start of IMAM?
	C2	To what extent is IMAM reaching those in hard to reach areas?
	C3	What are the success factors, challenges faced in reaching the target populations?
	C4	Are there any differences in take up of IMAM services and what are the reasons for these differences (if any)?
	C5	To what extent has the expansion of geographical and programmatic coverage been accompanied by quality service provision?
Effectiveness	EF1	To what extent are service users satisfied with IMAM services? And what are their perceptions about programme purpose?
	EF2	To what extent are IMAM supplies timely, being used/functional, appropriate and distributed via pharmacy/health system? What is the effect of lack of supplies?
	EF3	To what extent does service delivery meet expected quality? What are the key bottlenecks/constraints that need to be addressed in order to meet required quality of services?
	EF4	To what extent do implementing partners have the required capacity to deliver IMAM services?
	EF5	To what have specific IMAM interventions/activities helped to achieve the planned results and targets (including treatment of children and mothers for malnutrition?
	EF6	What have been enabling and hindering factors/challenges?
	EF7	How motivated and satisfied are front line staff to deliver IMAM services? What are the constraining factors including staff workload?
Sustainability	S1	To what extent has IMAM been integrated into the health system services and how does this affect provision of IMAM services?
	S2	To what extent can PND continue to implement and scale up IMAM without financial, technical, logistical and other (including supplies) support from internal and external agencies?
	S3	What systems, policies, strategies, capacities, (at national, provincial, regional, district, community levels) have been/need to be developed so that IMAM can continue to be implemented and scaled up without internal and external support?
	S4	To what extent is there coordination across IMAM stakeholders and implementing partners at various levels?
	S5	What are the gaps and barriers to coordination and the effect of these on IMAM services? Are there any duplications?

Alignment between the OECD-DAC criteria, evaluation questions, data sources and data collection instruments is presented in the evaluation matrix provided in Annex 2.

5. METHODOLOGY

5.1. OVERVIEW OF EVALUATION METHODOLOGY

The evaluation methodology is designed using internationally recognised data collection methods and tools for IMAM evaluations, adapted for the Afghanistan context, and based on the evaluation criteria (defined in the Terms of Reference and revised during the Inception Mission) of the Organisation for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC); Relevance, Efficiency, Coverage, Effectiveness and Sustainability.

The evaluation will be conducted using a mixed methods and participatory approach, generating quantitative and qualitative data by using a variety of sources and methods to enable triangulation of information and ensure data validity. The data collected will enable the evaluation team to respond to the evaluation questions set out, by OECD/ DAC criteria, in the Evaluation Matrix provided in Annex 2. Where it is not possible to obtain data to assess the outcomes of the IMAM strategy, proxy indicators will be used.

5.2. DATA STREAMS

Four streams of data will help the evaluation team to respond to the questions listed in the evaluation matrix. This section summarises the data streams. Section 9 outlines the approaches to analyse the data in order to inform the questions on the evaluation matrix.

Data steam 1: IMAM documentation and secondary data

During a desk review, key documentation and secondary programme and population data will be reviewed and analysed. Documents to be reviewed will include governmental and UNICEF strategy documents, policies and plans, national guidelines, IMAM monitoring reports, nutrition sector meeting minutes and nutrition assessment reports. Information gleaned from the review of these documents will help identify the objectives and indicators of various related programmes, how the strategies were developed and any commonalities between programmes and possibilities to synergise them.

A list of documents and secondary data to be reviewed and additional documents and data needed to complete the analysis can be found in Annex 5. Additional documentation may be requested during the course of the evaluation as required.

Data stream 2: Qualitative data from interviews with key stakeholders at national level implicated in IMAM

Semi-structured interviews will be conducted with selected officials and stakeholders at national level to collect qualitative data about IMAM. The interviews will be conducted using interview guides made up of relevant questions for the individual based on their role and involvement in IMAM. The questions will be arranged thematically to ease with categorisation and triangulation during the analysis phase (described in Section 9). All interviews will be recorded and then translated into English and transcribed into word documents prior to analysis.

These interviews will help to obtain further explorations of the reasons why certain aspects of IMAM have been successful while others have not been successful. The interviews will also indicate any deviance of outcomes which may not be possible to identify from quantitative data reviews.

A list of proposed stakeholders to interview is included in Annex 7. This will be further developed in consultation with stakeholders prior to and during the evaluation.

Data stream 3: Quantitative and qualitative data from hospitals, health centres and communities in selected provinces, districts, health facilities and villages / urban blocks

Based on the sampling strategy outlined in Section 5.3 of the methodology, health facilities and villages or urban blocks will be selected for the data collection teams to visit to collect quantitative and qualitative data. Information obtained from this data stream will help substantiate the quality and efficiency of IMAM in addition to identifying structural systems which might need improvement.

Data will be collected using observation checklists, individual treatment forms for children U5 in IPD-SAM and OPD-SAM and for children U5 and PLWs in OPD-MAM, semi-structured interviews with key staff members and key community members and focus group discussions with community members. All data collection instruments will collect data on the numbers and gender of participants. These are described in more detail in Section 5.8.

Provincial hospitals will be visited by the provincial supervisor of the data collection team. The provincial supervisor will conduct key informant interviews with relevant personnel involved in IMAM at provincial level (e.g. BPHS and EPHS managers, Health Shura, Provincial Nutrition Officers and Doctors, IPD-SAM nurses and the Community-based Health Care (CBHC) coordinator) and will complete IPD-SAM programme quality checklists.

Within districts, the proposed key informants to be interviewed (using semi-structured interviews and focus group discussions as relevant) will include:

- **In District Hospitals:** Doctors, IPD Nurses
- **In CHCs/ BHCs / SHCs**: Doctors, nurses, carers of malnourished children U5, Community health supervisors, Health Shura and nutrition counsellors
- **In villages or urban blocks:** Female and male carers of malnourished children U5, Health Shura, Community health workers, Imams, traditional healers and community members.

More information about the proposed data collection methods is outlined in the section 5.8.

Data stream 4: Lot Quality Assurance Sampling (LQAS) coverage survey findings

Coverage surveys will be conducted in a selection of villages in each district visited (Sampling strategy outlined in Section 5.3) in order to assess the treatment coverage of IMAM. Treatment coverage will be classified on a three-tier scale as being low, moderate or high (Analysis method described in more detail in Section 5.9).

The data collectors will also interview malnourished PLWs and carers of malnourished children U5 to determine the primary reasons for participation in IMAM services (for PLWs and children U5 enrolled in treatment) or for non-attendance to the programme (for PLWs and children U5 who never enrolled or who defaulted from treatment). More details about the questionnaires are included in Section 5.8.

5.3 SAMPLING STRATEGY

This section outlines the proposed geographical sampling strategy to select zones, provinces, districts, health facilities and communities to be visited during the primary data collection phase to collect data for Data streams 3 and 4.

With the resources available for the evaluation, this strategy should enable the collection of data from a sufficiently large sample of provinces, districts, health facilities and communities to allow for a generalisation of findings representative of the IMAM approach in all of the contexts in which it operates.

The section also describes the sampling methodology for individual child treatment data and the in-community sampling technique to identify children U5 according to the case definition for SAM / MAM during the coverage survey.

Prior to province and district sampling, all provinces and districts deemed to be inaccessible and therefore not possible to visit will be excluded. “Accessible” and “Non-accessible” provinces and districts will be determined by multiple partners including Assess, Transform, Reach (ATR) consulting (the data collection agency), UNICEF, the Public Health Department and UNDSS. Remote data collection from insecure provinces or districts will be attempted. The proposed methodology for this is outlined in Section 7.

Geographical sampling strategy:

a. Zonal level sampling

Data collection will take place in **each** of the six zones identified in the Terms of Reference.

During the review of the first draft of the inception report, the UNICEF nutrition team requested that the provinces in Southeast zone should be further disaggregated into two zones: Southeast and **South** and that Daykundi should be moved from Southeast zone to Central zone. Therefore sampling will take place in the seven zones. This will ensure spatial stratification at national level.

The zones and provinces are summarised below:

- **Northeast zone** : Badakshan, Baghlan, Kunduz and Takhar
- **Northwest zone**: Balkh, Faryab, Jowzjan, Samangan and Sar-e-pol
- **Central zone:** Daykundi, Kabul, Kapisa, Logar, Panjshir, Parwan and Wardak
- **Eastern zone**: Kunar, Laghman, Nangahar and Nuristan
- **Western zone**: Baghdis, Bamyan, Farah, Ghor and Herat
- **Southeast zone**: Ghazni, Paktika, Paktia and Khost
- **South zone:** Helmand, Kandahar, Nimruz, Oruzgan and Zabul,

b. Province level sampling

From the list of accessible provinces, one province will be purposively selected in each zone (7 in total).

Provinces will be sampled to ensure that there is a representative sample of the three priority levels used by partners which are detailed in Section 2. The priority levels are defined based on the estimated prevalence of SAM and on the different levels of support provided by UNICEF and WFP.

At least two provinces from each priority level will be selected. Other considerations for the selection of provinces will include:

- Indirect coverage of the treatment (based on admissions versus province targets for admissions)
- Outsourced and insourced implementation (IMAM in some provinces are covered by BPHS / EPHS and while others are covered by the MoPH SM)
- The presence or absence of humanitarian partners (INGOs)

This sampling strategy will enable the comparison of different approaches taken in terms of stakeholder support in provinces with different priority levels.

c. District level sampling

Districts will be selected based on the performance indicators of IMAM in each province. The proposed performance indicators to be used are summarised in Table 4.

Table 4: Proposed performance indicators

Indicator	Details
Indirect coverage	Percentage of 2018 SAM / MAM admissions compared to target SAM / MAM admissions
Cure rate	Percentage of SAM / MAM cases discharged as cured during 2018
Defaulter rate	Percentage of SAM / MAM cases discharged as defaulter during 2018
Death rate	Percentage of SAM / MAM cases who died during treatment in 2018
Inpatient admissions	Percentage of admissions to IPD SAM compared to total OPD-SAM admissions during 2018

The purposive selection of districts within provinces will be based on comparative data to decide good performance versus poor performance rather than absolute values for each indicator. Where possible the highest performing and lowest performing districts will be selected. Disaggregated district level programme performance data (for 2018) will be requested for all districts in the selected provinces and the selection will be made based on the data provided.

Other considerations for the selection of districts will include whether or not Mobile Health Teams (MHT) operate in the district and the presence of minority communities (e.g. Jogi and Chori Frosh semi-nomadic communities) and Internal Displaced People (IDP).

d. Sampling of health facilities

In each district, the evaluation team will endeavour to visit at least one of each of the following **four** health facilities:

- The District Hospital
- One Comprehensive Health Centre (CHC)
- Two Basic Health centres (BHC) and / or Sub-Health Centres (SHC)
- Mobile health teams (if relevant)

The district hospital will be visited by the team supervisor.

The CHC will be selected randomly from a list of all CHCs in the district. The two additional BHCs / SHCs will be selected randomly from within the catchment area of the CHC. Random sampling

of the CHC and the additional health facilities within each district will mitigate any bias due to convenience sampling.

e. Sampling of villages / communities for community based qualitative data collection

Within the catchment area of the selected CHC, four communities will be purposively selected for qualitative data collection. The four communities selected will comprise two communities 'near' to a health facility and two communities 'far' from a health facility.

The classification of 'near' and 'far' villages will depend on the CHC catchment area and the distribution of villages or urban blocks within it. Far villages will be villages located at least 70% of the distance between the village located **furthest** from health facilities and its nearest health facility. For example, in a selected CHC catchment area the village located furthest from health facilities is 10km from its nearest health facility. Therefore all villages located 7km or more from their closest health facilities would be classified as being 'far' villages. Near villages would be all those within 7km.

When near and far villages are identified and listed in the CHC catchment area, 2 near and 2 far villages would be selected at randomly from the lists.

Where relevant, minority communities and Internal Displaced People (IDP) will be visited for qualitative data collection in addition to communities in the host population.

f. Sampling of villages / communities for LQAS coverage survey

An additional four villages / communities (two near and two far) will be selected for LQAS coverage surveys within the catchment area of the same CHC using the same method described for the sampling of villages for community based qualitative data collection.

In villages or towns with large populations (e.g. greater than 1000 people) where the data collection team cannot complete data collection in the whole village in one day, a suitable method will be used by the team leader to segregate the village or town into sectors. The team leader will then randomly select the sector(s) to sample. For example, the village or town could be segregated by geographical features (e.g. roads or rivers) and the team leader could select sector (randomly) and data collection would take place only in this sector.

Where possible, the sampling of CHCs, BHCs / SHCs, villages / towns and sectors within towns or villages will be done in advance using facility and village lists. If no village lists are available, or if selection of communities in urban areas is needed, satellite imagery may be used to select sectors or urban blocks to visit.

Table 5 and Figure 3 summarise the sampling levels of the primary data collection in zones.

Table 5: Summary of sampling levels, number of sampling points and sampling methods and criteria

Level of sampling	Number	Total	Sampling method	Sampling criteria (if relevant)
Zone	1	7	n/a	All zones
Province	1	7	Purposive	-Provinces from 3 priority levels -High / low coverage provinces -Different configurations of partner support

Health districts	2	14	Purposive	High and low performance district (based on predefined categories of performance)
District hospital	1	14	n/a	All district hospitals in selected districts
CHC	1	14	Random	n/a
SHC / BHC	2	28	Random	n/a
Villages for qualitative investigation	4	56	Purposive	2 near and 2 far villages in CHC catchment area (based on predefined categories of distance relevant to the district)
Villages for coverage survey	4	56	Purposive	2 high coverage and 2 low coverage villages in CHC catchment area (based on predefined categories of distance relevant to the district)

5.4. KEY INFORMANT SELECTION

During primary data collection in health facilities, data collection teams will endeavour to conduct interviews with a representative selection of key informants. To ensure that this takes place, when the full range of possible health facility staff has been identified (following consultation with UNICEF and PND), the evaluation team will design a qualitative sampling matrix. This will help them to ensure that there a representative sample of different roles are interviewed by data collection teams throughout the country and that there is a balanced of sexes targeted. Each supervisor will be provided with a target list of key informants to interview in the health facilities which they visit.

A similar matrix will be used to ensure that a representative sample of community members and community groups are interviewed using semi-structured interviews and focus group discussions during the qualitative investigation. The matrix will help ensure the data is representative in terms of sex and types of key informant.

5.5. INDIVIDUAL TREATMENT DATA

In CHCs, BHCs and SHCs selected for the evaluation, the data collection teams will collect key data from treatment registers and OTP/SFP cards for children U5 and PLWs admitted and discharged from IMAM services. They will collect this using forms uploaded onto tablets and smartphones using Open Data Kit (ODK) software.

In each **outpatient** health facility, the teams will need to gather data from at least 30 recent OPD SAM and OPD MAM cases (including children U5 and PLWs) discharged from the health facility from treatment cards or registers.

In each **inpatient** facility, the team supervisor will need to gather data from at least 10 recent cases discharged from inpatient care from treatment cards or registers.

In both types of facility, the teams will take photographs of the treatment registers and of one out of every ten treatment cards reviewed.

5.6. IN-COMMUNITY SAMPLING DURING COVERAGE SURVEY

During the coverage survey, the data collection teams will attempt to identify all children and PLWs who fall with the "case definitions" of the coverage survey in selected villages. The case definitions will be as follows:

Children aged 6-59 months who are SAM or MAM and/or who are currently enrolled in the OPD-SAM or OPD-MAM

and

Pregnant and Lactacting Mothers (mothers who have children up to 6 months old) who are MAM and/or who are currently enrolled in the OPD-MAM

Teams will use door-to-door sampling to locate children and PLWs who fall within the case definitions, in addition to asking other community members if they know of children or PLWs who meet the case definition (expressed in culturally appropriate terms). Where possible, after the team's independent case finding efforts, the teams will complete case finding with the support of local CHWs to find any remaining unidentified cases.

5.7. INACCESSIBLE DISTRICTS

In provinces and districts judged to be inaccessible by stakeholders, a sample of districts will be evaluated remotely in addition to the sampling framework described in Section 5.3 and in order to mitigate any potential selection bias. Remote evaluation will be completed by contacting a selection of health facilities in the selected districts (health facilities will be selected using the same sampling method as in accessible districts) and asking them to provide the following:

- Photos of a sample of OPD-SAM cards and OPD-MAM cards (front and back) from recently discharged cases (minimum 10)
- Photos of previous three months of monthly reports
- Telephone interviews with officials / staff (where possible recorded)

The photos will be reviewed to identify any errors in treatment card and register compilation and by analysing the responses of the interviewees.

The sample size of inaccessible districts selected for the evaluation will depend on the total number of districts deemed to be inaccessible at the time of the evaluation.

5.8. DATA COLLECTION INSTRUMENTS

The following data collection instruments will be used to collect primary data during the evaluation:

Semi-structured interviews (Data streams 2 and 3)

Semi-structured interviews will be conducted with up to two key informants at a time using standardised interview guides. The advantage of interview guides is that the interviewers will have the flexibility to ask follow up questions not included on the interview guide based on responses of the key informant rather than having to stick rigidly to the questions on the interview guide.

The interview guides will be arranged thematically to allow for triangulation between sources. The questions included in the interview guides will be adapted according to the key informant/s being interviewed.

All interview guides are included in Annex 3. The interviewers will record responses directly onto the interview guides, or in a notebook and then summarise the responses after the completion of the interview. The interview guides will include fields relating to the number, sex and (if relevant) ethnic origin of participants.

Focus group discussions (Data streams 2 and 3)

Focus group discussions will be conducted with 3-10 key informants, typically community members, in order to gather demand side qualitative information. Interview guides will used by data collection agents to help guide discussions and gather responses. The data collection agents will also be trained on the key skills needed to lead focus group discussions and on recording data succinctly and accurately.

Health facility questionnaires (Data stream 3)

Programme quality checklists will be used to collect data from health facility personnel in the form of structured questionnaires. There will be separate questionnaires for personnel in inpatient and outpatient facilities. Examples of the checklists are included in Annex 3.

Simple questionnaires will also be used to collect individual child anthropometric and treatment data from treatment registers in health facilities. Examples of the data to be collected are included in Annex 3.

Both of these questionnaires will be uploaded to ODK and administered using tablets or mobile phones on a suitable platform (e.g. ODK collect or KoboCollect).

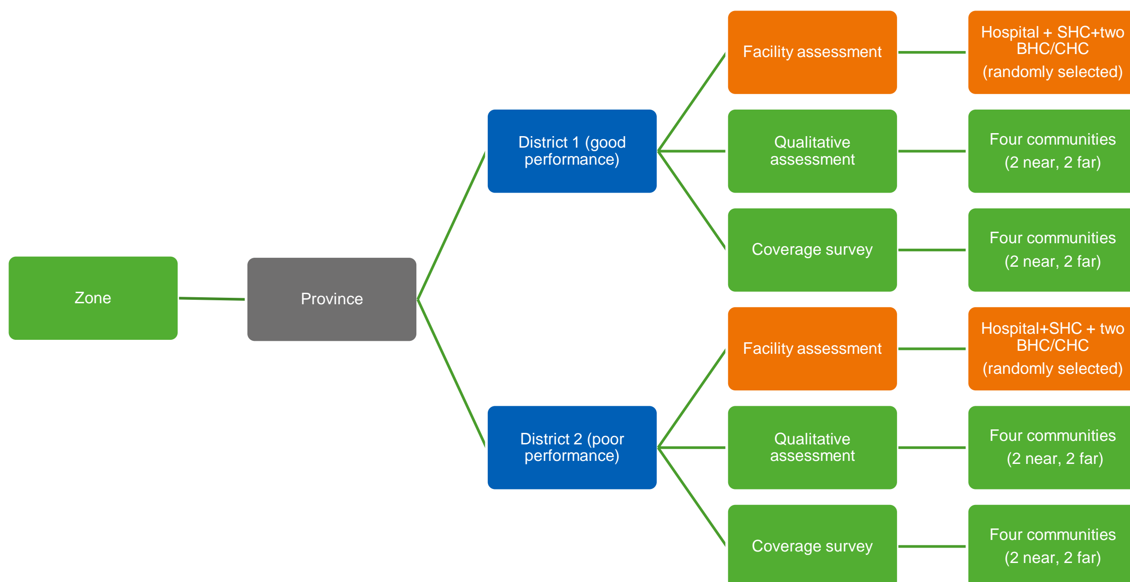
Coverage survey questionnaires (Data stream 4)

Structured questionnaires will be used to interview PLWs and the carers of malnourished children (who meet the case definitions) identified during the coverage survey. Separate questionnaires will be administered depending on the identified case:

- For those enrolled in IMAM services, the data collectors will ask questions to understand why the PLW / carer decided to go to the health facility for treatment (i.e. who or what influenced their decision to go).
- For those NOT enrolled in IMAM services, the data collectors will ask questions to understand why the PLW / carer had not gone to the nearest health facility to seek treatment.

Examples of these questionnaires are included in Annex 3. These questionnaires will also be uploaded to ODK and will be made available on tablets or mobile phones on a suitable mobile data collection platform.

Figure 3: Proposed zonal level primary data collection for IMAM evaluation



5.9. ANALYTICAL APPROACH

Overview of analytical approach

The performance of IMAM services can be measured by combining its coverage (the number / proportion of the target groups accessing treatment) and its effectiveness (i.e. the cure rate). The specific data streams will contribute data to both sides of this equation.

The **coverage surveys** will identify the classification of coverage and the positive and negative factors which affect coverage. This will be triangulated with other factors that contribute to good or poor service delivery such as **IMAM data**, **quantitative data** from health facilities and **qualitative data** from semi-structured interviews and focus group discussions with key informants. The findings from the analysis these data streams will be triangulated by source and method with analysis from other data streams using the evaluation matrix.

Data will also be triangulated within service delivery units to understand why the service performs well or not in selected districts. Data will also be compared across zones, provinces and other sampling criteria to understand common factors contributing to performance.

All of these will be compared to the targets set in the relevant **IMAM documents** to indicate if the indicators are on track to meet 2020 targets. If they are not track, the analysis will endeavour to identify the primary reasons why not and how to boost performance. Targets which are not appropriate (or areas where there are no targets when there should be) will be identified.

All of the above will contribute to a theory of change that will be illustrated in the final report.

The analytical approaches for the individual data types is as follows:

IMAM documents: IMAM documents will be reviewed to identify relevant strategies, logic models and indicator frameworks. These will then be analysed to assess the extent to which they are coherent with other policies, strategies and guidelines. Findings will be organised and categorised based on the evaluation criteria.

IMAM data: IMAM data supplied in advance of the evaluation will be analysed to identify evolving trends over time and by province (if possible) of the following data:

- SAM and MAM prevalence
- Geographic coverage of IMAM services
- IMAM admissions
- IMAM outcome data

Qualitative data: During data collection in a village or health facility, responses from semi-structured interviews and focus group discussions will be written directly onto interview guides by the interviewers. The team supervisors will then collect the forms, compile the responses, translate them into English, enter the responses into 'response sheet' templates on Microsoft Word and send them to the evaluation team. The team supervisors will debrief with the data collection teams as frequently as possible to understand challenges encountered during data collection and to feedback to the evaluation coordination team.

The evaluation team will analyse the responses thematically. Based on the agreed evaluation questions and sub-questions, the team will develop a coding framework so that data collected from interviews and focus groups can be coded and analysed by key informant type, type of partners (if relevant), location and gender. In order to do this, completed response sheets will be uploaded into a qualitative analysis software such as Nvivo[9] and coded according to the framework.

Quantitative data: Quantitative data collected from health facilities will be compiled, cleaned and analysed to assess the quality and effectiveness of service provision. The Afghanistan National IMAM guidelines (2018) will set the standard of care for the evaluation of IMAM components and will be compared with accepted international standards of practice.

The data collected from individual child records in in-patient and outpatient facilities will be analysed to assess adherence to treatment protocols set out in the IMAM guidelines. Data collected will include anthropometric data, treatment data and discharge outcomes. The in-patient and outpatient collection forms are included in Annex 3.

Coverage survey results: Coverage survey results will be analysed by district using the Lot Quality Assurance Sampling (LQAS) classification system. This system enables teams to classify treatment coverage[10] on a three-tier scale (e.g. low, moderate or high) based on a relatively small sample size[11]. The proposed ranges, which are based on the Afghanistan IMAM guidelines (2018, p210) are:

- Low coverage: 0-30%
- Moderate coverage: 30-60%
- High coverage: >60%

Where possible results will also be presented according to Sphere standards for rural, urban and camp contexts.

[9] Nvivo is a qualitative data analysis software used for deep levels of analysis of large volumes of data. More information is available here: https://www.qsrinternational.com/nvivo/nvivo-products/nvivo-12-plus. The evaluation team has a subscription to the "Nvivo Plus 12" package

[10] Treatment coverage is defined as the proportion of children that are eligible for treatment and are enrolled in the CMAM programme compared to all SAM or MAM cases identified during the survey.

[11] The LQAS three tier classification system is explained in more detail in the SQUEAC / SLEAC Technical Reference: http://www.coverage-monitoring.org/wp-content/uploads/2014/10/SQUEAC-SLEAC-Technical-Reference-Oct2012.pdf

5.10. TEAM LOGISTICS

The proposed team logistics for the primary data collection in each zone is as follows.

Team composition:

- One zonal supervisor for each of six zones (seven zonal supervisors)
- Two data collection teams for each zone (14 teams total)

Each team comprises:

- One Team Supervisor
- Three enumerators (one female, two males)

Each data collection team will operate in one province and sample one district.

The **Team Supervisor** will conduct the facility level evaluation and visit health facilities at each level (e.g. district level hospital, CHC and BHC/SHC). Approximately ½ to one day will be required at each health facility.

The **Enumerators** will conduct the community-based qualitative data collection and the coverage survey.

Evaluation quality extenders:

Prior to this evaluation, the Research and Evaluation Directorate of MoPH will hire two extenders to monitor the implementation of both IMAM and CBNP evaluations, including this evaluation. The extenders will oversee the quality assurance of the evaluation during field visits and report back to the ESC.

Duration of data collection:

It is estimated that primary data collection in all zones will take approximately 2 months to complete (refer to Table 6 below)

Table 6: Data collection activities and duration

Activity	Location	Estimated duration
Training of supervisors and enumerators and testing of data collection tools	Kabul	2 weeks
Data collection in districts	National	3 weeks per district
Debrief of supervisors and enumerators	Kabul	1 week
Debrief of provincial / zonal supervisors	Kabul	1 week
TOTAL		6 weeks (enumerators) 7 weeks (supervisors)

At district level, it is estimated that it will take each team approximately 12 working days to complete data collection in a district (not including travel) (refer to Table 7 below).

Table 7: Data collection activities and duration at district level

Activity	Estimated duration
Planning on arrival in district	1 day
Qualitative data collection	4 days (+1 contingency)
Debrief after qualitative data collection	1 day
Coverage survey	4 days (+1 contingency)

Zonal Supervisors should be available for one week more to review and debrief on the data collection exercise to identify quality issues and limitations in data collection.

5.11. LIMITATIONS AND CONTINGENCY

Limitations and mitigating measures related to this methodology are summarised in Table 8:

Table 8: Limitations and mitigation measures

Limitation	Description	Mitigating measures
Not possible to sample to redundancy due to time limitations	Given the number of provinces and districts to visit in the time and with the resources available, it will not be possible to sample to redundancy using key informant interviews.	- The representative of findings will be ensured by using sampling matrices - Nvivo will be used to compile and organise qualitative findings which will help triangulate findings and provide useful evidence
Inaccessible areas for ATR	Some districts and even provinces may be inaccessible to the data collection company due to insecurity and due to mountainous terrain. While these areas will be within the catchment areas of IMAM services, the data collection teams will not be able to visit communities to gather data and perceptions about IMAM services.	- Remote programme quality verification will be conducted by reviewing photos or scans of records
Selected villages found to be inaccessible	During data collection, it is possible that villages selected for sampling are found to be inaccessible due to recent security concerns or physical access issues	- In these situations, the data collection teams will visit “reserve” villages which are selected in advance.
Limited access for international staff	International staff in the evaluation team are unlikely to be able to travel outside of Kabul to supervise data collection. Therefore nearly all	- Verification / quality assurance visits to areas accessible to international staff

	supervision will need to be done remotely.	- Review of photographs of treatment cards, reports and GPS data of data collection teams - Independent verification of results by UNICEF / stakeholder staff - Photographs of treatment cards, reports - Quality assurance will be provided by Evaluation Extenders (more information in section above).
Limited coverage information	It will not be possible to conduct a large-scale coverage survey within the scale of this evaluation. Conducting SLEAC at national or even provincial level would require a large amount of resources and time. Therefore it will not be possible to classify or estimate coverage at any level during this investigation.	- The coverage surveys that will be completed will indicate in what range of classification coverage is likely to be in different districts and why it is particularly high or low in different areas. - Geolocation of data collection will provide information about the spatial coverage of the services
Stock out of RUTF or RUSF at time of visit	If, during visits to health facilities, there is a stock out of RUTF or RUSF, it will be impossible for the data collection team to observe treatment and it is likely that there will be non-covered IMAM cases in the community who do not have access to treatment. Therefore measuring the quality and coverage of IMAM services in the Health facility and surrounding communities will be impossible	-On arrival in the district, where possible the team supervisor will verify that selected health facilities have good stock availability. -Available IMAM data will be collected from the health facility (from periods when stock was available) -A reserve health facility will be selected to visit in the district which has stock availability.

6. EVALUATION WORKPLAN

Table 9: Evaluation Phases, Associated Activities and Deliverables

Evaluation phases	Activities	Timeline	Deliverables
Phase 1: Inception	• In-country inception mission • Preliminary desk review of key IMAM documents • Review and refine sampling strategy • Refine and finalise evaluation methodology, workplan, context and evaluation framework • Receive feedback from UNICEF/ESC/Ethics Board • Incorporate feedback on inception report and finalise	May-July	**Deliverable 1** • Draft Inception Report/Draft Data Collection Instruments **Deliverable 2** • Final Inception Report and final data collection instruments **Deliverable 3** • Presentation of summary of finalised inception report to Evaluation Steering Committee
Phase 2: Data collection	• Training of data collection team • Quality assurance of trainings • Pilot testing and revision of data collection instruments • Collect data • Conduct data quality assurance	Aug-Sept	**Deliverable 4** • Weekly progress reports **Deliverable 5** • Quality assurance report **Deliverable 6** • Data collection field work report

Phase 3: Data Analysis and Report Writing	• Clean, scrutinize and analyse data • Develop draft evaluation report • Incorporate comments received from UNICEF/ESC members • Revise and finalise report	Oct-Dec	**Deliverable 7** • Draft evaluation report **Deliverable 8** In-country presentation to UNICEF/ESC and other stakeholders **Deliverable 9** • Final evaluation report • Summary report and infographics • Clean data sets plus FGD and interview transcripts

For detailed time lines refer to the Gantt Chart in Annex 8.

7. TEAM COMPOSITION AND ROLE AND RESPONSIBILITIES

The evaluation team consists of nutrition, public health and evaluation consultants. Each has technical experience in the nutrition and evaluation sector. The team composition will articulate an understanding of the dynamics and global technical issues behind the evaluation through their experience and previous work conducted in many regions around the globe. The team will be led by Dr. Delwar Hussain who will serve as the overall focal point of this evaluation through all stages. The overall oversight and evaluation direction will be overseen by Dr. Robina Shaheen who will serve as the evaluation's Project Director.

Primary data collection will be undertaken by the national data collection firm, Assess, Transform, Reach Consulting (ATR). Other members of the team, including, Hugh Lort-Phillips, the Nutrition Evaluator, will coordinate the entire data collection process overseeing and working closely with ATR. The exchanges with the local community will be handled by ATR. High level interviews[12] at national level will be undertaken by Hugh Lort-Phillips and supported by Cleo Chevalier-Riffard where required. Data compilation, and cleaning will be undertaken by ATR with oversight from Hugh Lort-Phillips.

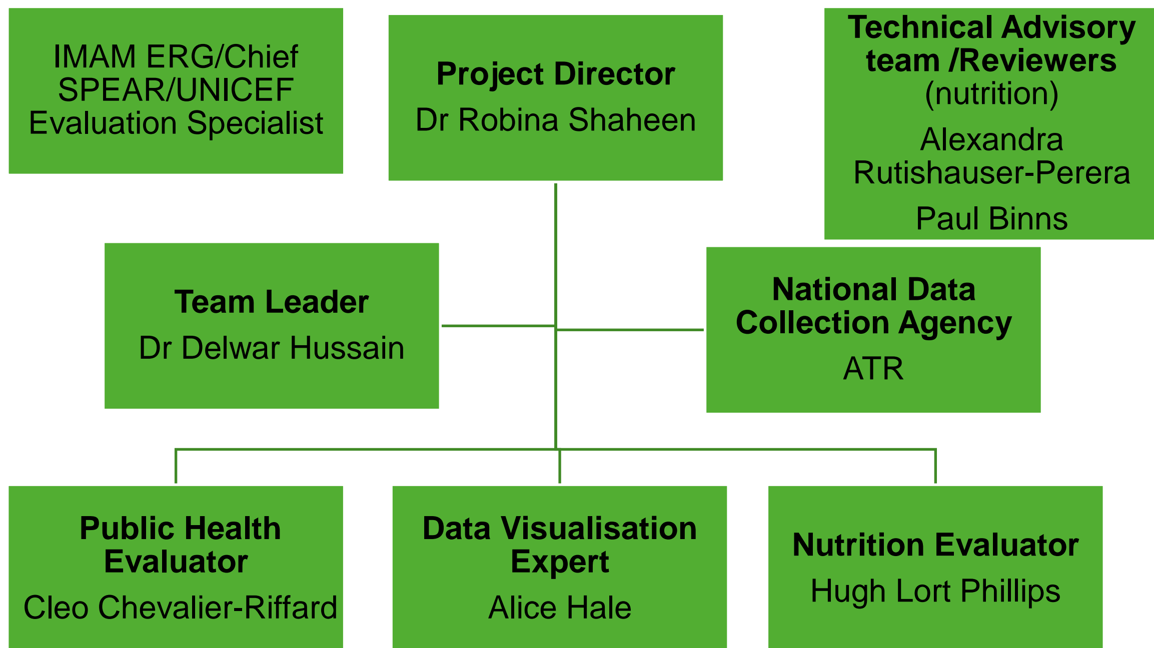
Data analysis will be guided by Dr. Hussain, with technical advice from Paul Binns and Alexandra Rutishauser-Perera. Data will be analysed by Hugh Lort-Phillips, Cleo Chevalier-Riffard and supported by ACF UK MEAL services team where required.

Report writing will be overseen by the Project Director and written with the support of the other team members. Data visualization expert, Alice Hale, will ensure that the report and its content is presented professionally. Technical review of the report will be undertaken by Paul Bınns and Alexandra Rutishauser-Perera. The presentation of the evaluation findings, lessons learnt and recommendations to IMAM Evaluation Steering Committee will be coordinated by Dr. Shaheen.

The team structure for this evaluation has been presented below, which showcases the names and proposed position for team members (Figure 1). The Project Director will be overall responsible for the deployment of resources to deliver the services outlined in the terms of reference, whilst the Team Leader will ensure the team implements the required activities. Majority of the country specific field work will be primarily undertaken by ATR, managed by ACF and complemented by the key experts.

[12] List of key informant interviews with officials from GoIRA / UN / partners will be defined as part of methodology

Figure 4: Proposed Team Structure



An overview of each team member and their availability for conducting this evaluation is given below in Table 10.

Table 10: Team members, assigned roles and responsibilities within the evaluation

Team Member	Assigned role	Responsibility within the evaluation team	No of days
Dr. Robina Shaheen	Project Director (UK)	• Contractually responsible for overseeing implementation, management and quality assurance of the evaluation. Responsible for supporting the Team Leader and the evaluation team to ensure rigorous design and management of the evaluation, robustness of methods and data as well as production of high quality deliverables. Liaise with UNICEF during the evaluation process and submission of deliverables on time and within budget.	12
Dr. Delwar Hussain	Team Leader (Bangladesh and Afghanistan)	• Responsible for managing overall evaluation activities liaising closely with the team members, project director. Primarily responsible for working with the team for designing the methodology, preparing the inception report as well as the draft and final evaluation reports in line with the approved inception report. Direct and support the team to complete key deliverables.	30
Alexandra Rutishauser-Perera	Senior Nutrition Technical Advisor (UK)	• Technical review of key deliverables from nutrition perspective.	2
Paul Binns	Nutrition Technical Advisor (UK)	• Provide technical advice to the team during the evaluation drawing upon nutrition and evaluation expertise as well as experience of working on IMAM in Afghanistan	9
Cleo Chevalier-Riffard	Public Health Evaluator (UK)	• Undertake qualitative data analysis	30
Hugh Lort Philips	Nutrition Evaluator (UK and Afghanistan)	• Lead of sampling strategy, sample selection and design of data collection instruments with support from Team Leader and Nutrition Advisor. Coordinate data collection with the in-country data collection team, conduct high level interviews and support quantitate data analysis working with other team members.	60
Alice Hale	Data Visualisation Expert (UK)	• Design key evaluation deliverables (reports, infographic)	5
ATR	In-country data collection (Afghanistan)	• Review data collection instruments (to ensure suitability from contextual view point) • Translate instruments into local language • Test instruments and support finalisation • Provide support if required for sampling • Arrange ToT • Arrange training of field enumerators • Develop database/ ODK version • Supervise data collection and assure data quality (including call backs and spot checks) • Data entry and cleaning	TBC (over two month period)

8. MANAGEMENT, LOGISTIC SUPPORT AND ETHICAL APPROVAL

IMAM Evaluation Steering Committee has been established in collaboration with General Directorate of Monitoring, Evaluation, and Health Information System and Public Nutrition Directorate. The members are expected to engage stakeholders for timely implementation of activities, review protocols, provide technical support, and approval of the study design, sampling, sample size, and tools, facilitate the implementation, review and approve key deliverables, support wider dissemination of findings. For more details refer to the IMAM ESC ToR in Annex 6.

UNICEF is expected to facilitate the consultant's in-country visits, coordinate with the IMAM ESC and other stakeholders at national and sub-national levels. UNICEF's Evaluation Specialist under the overall oversight and guidance of the Chief of the SPPME Section, will be the evaluation team's point of contact for all matters pertaining to this evaluation. This includes regular meetings with the evaluation Project Director, coordination with and access to stakeholders, providing key documents /data, collating feedback on evaluation deliverables and signing off the key deliverables. UNICEF is also expected to provide letters authorizing movement for consultants (if required), and data collection teams, and to coordinate with MoPH review board for ethical approval.

Action Against Hunger will be contractually responsible for delivering this contract. The Project Director has the overall responsibility to direct the team and deliver the assignment in time, and on budget. The data collection agency is contractually responsible to ACF who will ensure their performance and facilitate the data collection working in close coordination with UNICEF and the ESC.

9. EVALUATION QUALITY ASSURANCE PROCESS

The Project Director, Dr Robina Shaheen, will have overall responsibility and be accountable for delivering this contract including review of all deliverables before submitting to UNICEF, technical direction and support. We will ensure that deliverables are produced on time, on budget and to the desired quality; staff are kept safe and secure; and client data is protected. Our key quality assurance processes are as follows:

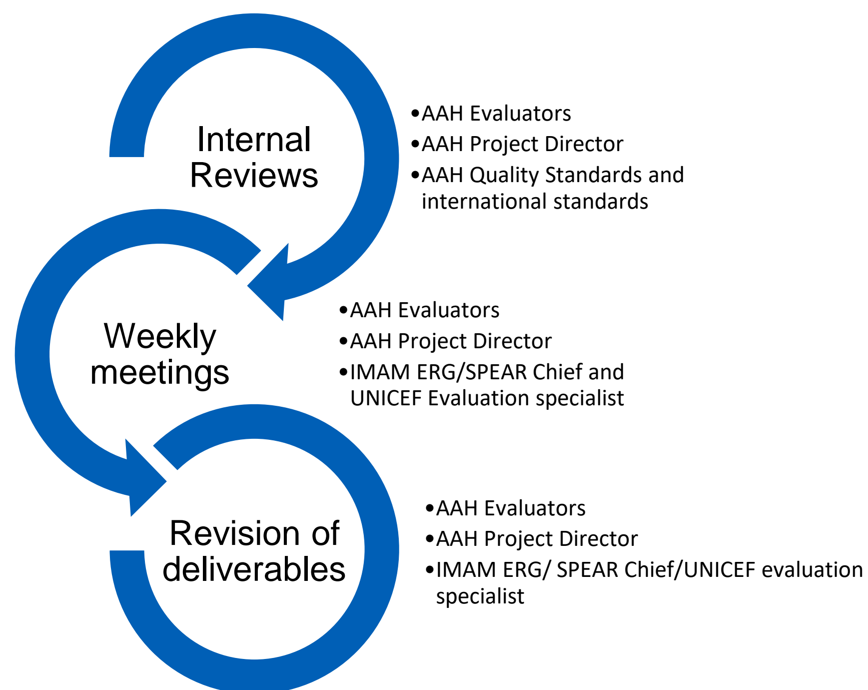
To ensure the quality of the evaluation products the evaluation team will:

- Hold regular internal project management meetings to track delivery and quality, deal with problems as they arise;
- Compile and document in the project files relevant information (including meeting minutes, work plans and deadlines, programme documentation and relevant reports);
- Maintain clear and open communication with the client at all times;

- Seek feedback from the client and incorporate all feedback into evaluation design, process and outputs; and
- Conduct an internal evaluation team review of all deliverables, including internal quality assurance

Action Against Hunger has proposed consultants that are highly respected in their field and will ensure high quality products. The evaluators will work with SMRC to ensure that all enumerators are adequately trained on data collection and will undertake spot checks in order to ensure collection of reliable and quality data. In addition, the evaluators will refine and pilot the data collection tools together with the national consultants, as well as in discussion with UNICEF, to ensure suitability. [13]

Figure 5: Quality Assurance Flow



Quality assurance during data collection is described in the methodology section.

10. ETHICS

The ACF Project Director will be primarily responsible for ethical oversight, conduct and design of the evaluation in close coordination with the Team Leader, the evaluation team and data collection agency (ATR). We will follow the UNEG ethical guidelines[14] to fulfil our obligations to respondents participating in this evaluation. These are as follows:

Respect for dignity and diversity: We will respect the differences in culture, local customs, religious beliefs, gender, disability, age and ethnicity and the potential implications of these when carrying out our research. We will minimise any risk of disruption to the respondents, provide ample notice and respect their privacy.

[13] Action Against Hunger M&E Guidelines, MSTK 10: Preparing Quantitative And Qualitative Data

14 http://www.unevaluation.org/document/detail/102

Rights: We will ensure that participants are treated as 'autonomous agents' and will be given the time and information to decide whether or not they wish to participate, and not pressurized into participating. The participants will be selected as per the defined sampling methodology. We will comply with any codes of conduct governing vulnerable groups, such as young people[15].

Redress. Participants will be provided sufficient information to seek redress and how to register a complaint. The mechanisms for redress will defined in coordination with UNICEF.

Confidentiality: We will respect respondent's right to provide information in confidence and make them aware of the scope and limits of confidentiality. Names and any other sensitive information will be anonymised.

Data security: Data will be stored systematically and securely and in line with ACF's data protection policy, which has been updated to be fully compliant with the 2018 GDPR standards. Data will be stored in a way that makes it available and clearly accessible to the evaluation team only. If requested and following appropriate anonymization, the data will also be shared with UNICEF. Data will be retained for a period, as determined in consultation with UNICEF, and then upon approval from UNICEF deleted.

15 http://www.childethics.com/

11. ANNEXES

Annex 1: Evaluation ToR

Annex 2: Evaluation Matrix

Annex 3: Data collection instruments

Annex 4: List of people consulted

Annex 5: List of documents

Annex 6: ToR for the Evaluation Steering Committee

Annex 7: List of proposed stakeholders to be interviewed

Annex 8: List of question for inception mission

Annex 9: Gantt Chart (Workplan)

ANNEX 1: EVALUATION TERMS OF REFERENCE

Double click PDF Icon to open: Adobe Acrc

ANNEX 2: EVALUATION MATRIX

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
Relevance	R1: To what extent is IMAM situated/in compliance with existing structures at various levels (national, sub-national and field level)?	• Description of existing health structures • Guidelines on positioning IMAM within existing structures • Actual positioning against guidelines or otherwise (if guidelines don't exist)	• Guidance documents • Previous assessment reports/situation analysis • Health/IMAM official interviews (at all relevant levels) Other relevant actor interviews	• Document review • Key Informant Interviews (KIIs)
	R2: Have issues related to equity been considered in IMAM service delivery and access, (gender, disability and geography, prioritization of areas where need is greatest)? What measures could be proposed to improve programme targeting?	Targeting criteria/actual targeting • Province v province • Dari v Pashto (and other languages) • Tribal areas v non-tribal areas • Nomads (mobile teams) • Urban v Rural[16] • Alignment/discrepancies between need and actual targeting • Admission profiles by Mid Upper Arm Circumference (MUAC) & Weight for Height (WFH) (More females w/ MUAC admissions about = or more boys with WFH). • Age / gender profile of admissions • Provisions made for children with disabilities (identification,	• Population data (disaggregated) • Who? what ? Where? (3W) programme info • Interviews with officials and clinicians • Nutrition strategy documents • Data from OPD-SAM and OPD-MAM cards • Sex disaggregated programme reports / databases	• Secondary data review • Document review • KIIs • Analysis of data from OPD-SAM and OPD-MAM cards • Remote sampling of treatment cards • Remote sampling of programme reports / data bases

[1616] Once the Evaluation Team has selected locations they will review to determine whether these categories have been adequately represented

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
		accessibility, treatment and reporting)		
	R3: To what extent have IMAM inputs evolved to respond to the local context, needs and priorities?	• Admissions over time • Admission trends responsive to nutritional stressors • Discharge outcomes • Discharge trends over time • Appropriate treatment protocols • Quantity of supplies, budgets, levels of technical support, changes in guidelines/protocols • Changes in needs, context, priorities • Beneficiary perceptions of IMAM services	• National database • National / Provincial / District level nutrition surveys • Semi Quantitative Evaluation of Access and Coverage (SQUEAC) survey reports • Routine programme data • HMIS reports • Interviews with officials and clinicians, beneficiaries • Seasonal calendars of nutritional stressors • Situational analyses • Nutrition strategy Documents • Guidelines • Field observations	• Secondary data review • Key informant interviews • Document review • Observation • checklists • Beneficiary Questionnaires/ interviews
Efficiency	E1: To what extent has delivery of IMAM services been efficient using the following modalities: - SHCs (sub health centres) and mobile health teams? - Presence of an international NGO as provider of technical	• Number treated / service delivery unit • Timely treatment admission and discharge • Comparison of treatment outcomes • Comparison of lengths of stay in treatment • Differences in access to treatment • Absenteeism and default	• Health Management information System (HMIS) reports • Routine programme data • OTP card analysis • Qualitative data from community based KIIs • Lot Quality Assurance Sampling (LQAS) data	• KII – Government of Islamic Republic of Afghanistan (GoIRA) • KII community leaders • KII / Focus group discussions (FGD) beneficiaries • OPD-SAM / OPD-MAM card sampling • LQAS survey

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
	support to a national NGO?			
	E2: How complementary are the IMAM related M&E systems (IMAM database, M&E database, SCM and EUM)? Are there any duplications/overlaps?	Description of IMAM Monitoring and Evaluation (M&E) systems Examples of consistencies /inconsistencies /overlaps /duplications across IMAM M&E systems	M&E Manuals/ Standard Operational Procedures (SOPs) Interviews with M&E staff and users of M&E products/systems	Document Review Interviews Review of field records in relation to M&E (verifications?)
	E3: To what extent has the gathered evidence been used to inform programme performance, detect and resolve bottlenecks on time?	Description of IMAM M&E systems Examples of consistencies/ inconsistencies/overlaps /duplications across IMAM M&E systems Dissemination of evidence-based changes of interventions Dissemination of evidence-based training, Information, Education and Communication (IEC) materials	M&E Manuals/SOPs Interviews with M&E staff and users of M&E products/systems	Document Review Interviews Review of field records in relation to M&E (verifications?)
	E4. How complementary are the IMAM related forums, included nutrition related forums with IMAM component? Are there any duplications/overlaps?	Examples of interventions based on credible evidence / analysis Examples of bottlenecks detected and solutions Overlaps/ duplications in mandates for different forums Complementarity of UNICEF / GoIRA nutrition strategies Complementarity of GoIRA coordination structures and UN nutrition cluster	Bottleneck Analysis (BNA) / dashboards Programme reports Relevant Officials Policy documents Strategy documents Minutes of meetings Who? What? Where? (3 W) documents UN / GoIRA coordination structure documentation	Document review Interviews

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
Coverage	C1: What is the geographic coverage of IMAM services against estimated national, provincial needs? How has this changed since start of IMAM?	• Comparison of nutrition survey data vs. programme admissions / discharge data. Met need = cure rate x coverage • Admission numbers match with policy / strategy targets (indirect estimate) • Disaggregate targets and achievements by province (if possible) • Admission trends of MAM / SAM • Admission trends in areas of expansion relevant to context • Review of year on year targets and timeline of expansion (number of sites / geographical coverage) • Geographical coverage of IMAM services over time • Reasons for non-attendance to IMAM programme for carers of non-covered cases • Reasons provided for cases that have defaulted	• Programme performance data over time • Historical programme documents and reports • IMAM services mapping over time • Community-based coverage survey • Carers of non-covered and defaulted cases • Health facility staff • Coverage surveys and meta analyses	• Key informant interviews • Document review • Beneficiary interviews • Beneficiary questionnaires
	C2: To what extent is the programme reaching those in hard to reach areas?	• Programme coverage in these areas/to these populations against listed hard to reach areas • Mapping of programme sites vs. population • Mapping of prevalence of malnutrition vs. programme sites • Treatment coverage in surveyed communities	• List/definition of hard to reach areas /populations • IMAM coverage data (disaggregated by district and province) • Needs assessments • Interviews with officials, implementing partners • FGD with populations in these areas	• LQAS coverage evaluation • Secondary data analysis • Interviews • FGDs/ beneficiary questionnaire • Review of documents/records

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
			• Population data (disaggregated) • 3W programme info • Facility records /records of implementing partners • Coverage surveys and meta analyses • Carers of non-covered and defaulted cases • Health facility staff	
	C3: What are the success factors, challenges faced in reaching the target populations?	List/examples of success factors/challenges perceived	• Existing research/evaluations • Situation analysis • Interviews with officials/implementing partners • FGD with populations in hard to reach areas (pending accessibility) • Carers of non-covered and defaulted cases • Health facility staff	• LQAS coverage evaluation • Document review • Interviews • FGDs
	C4: Are there any differences in take up of IMAM services and what are the reasons for these differences (if any)?	• Level of take up of imam services Incidence of differences/lack of differences (according to need	• Disaggregated assessment/treatment data • Facility records Interviews with officials/clinicians facility staff	• Document review • Secondary Data review • Interviews

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
	C5: To what extent has the expansion of geographical and programmatic coverage been accompanied by quality service provision?	• Admission trends of MAM / SAM • Increasing ratio of MAM: SAM • Discharge outcomes (cure > 75%, Deaths < 10%, default < 15%) • Timeline for expansion of programme in relation to need • Admission trends in areas of expansion relevant to context • Geographical coverage • Case coverage according to context	• Routine programme data disaggregated by province • Disaggregated data for MAM / SAM • Programme Documentation Former coverage surveys	• Health Management information System (HMIS) reports • LQAS coverage evaluation • Beneficiary questionnaires • Document review • Treatment records • information retrieval • Key informant Interviews • Beneficiary • Interviews/questionnaire
Effectiveness	EF1: To what extent are service users satisfied with IMAM services? And what are their perceptions about programme purpose?	• List of programme purpose as perceived by IMAM service users • Level of satisfaction of IMAM service users • Impressions of IMAM from community members in selected communities for qualitative data collection • Impressions of IMAM from officials and hospital directors • Impressions of IMAM from health facility staff	• Programme beneficiaries • IMAM officials/implementing partners • Previous user satisfaction surveys	• Beneficiary questionnaire • Beneficiary FGDs • Key informant interviews (with officials, hospital staff and health centre staff) • Document review/ data on user satisfaction/perceptions
	EF2: To what extent are IMAM supplies timely, being used/functional, appropriate	• Time taken from requests for supplies v delivery of supplies	• IMAM Implementing staff	• Beneficiary questionnaire • Key informant interviews • Document review

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
	and distributed pharmacy/health system? What is the effect of lack of supplies?	• Extent of use of supplies and for what purpose • Perceived appropriateness to serve the need • Supply distribution mechanisms • Examples of incidences of delay in/lack of supplies and effects	• Documents detailing information related to supplies • IMAM officials and agencies providing supplies • Beneficiaries	
	EF3: To what extent does service delivery meet expected quality? What are the key bottlenecks/ constraints that need to be addressed in order to meet required quality of services?	• Service delivery v service delivery indicators • Examples of bottlenecks • Appropriate ward environment • Appropriate admission • Discharge outcomes compared to Sphere minimum standards and national guidelines • Treatment protocols conform to United Nations standards (WHO / • UNICEF / national guidelines) • Contextually appropriate length of stay in treatment • Appropriate use of antibiotics / medicines • Appropriate rations of therapeutic milk / Ready to Use Therapeutic Food (RUTF) / Ready to Use Supplementary Food (RUSF) • Assessment of pharmacy stock-outs	• Observation of quality service delivery through observation checklists • Review of IPD/ OPD-SAM / OPD-MAM cards / monthly reports for adherence to quality indicators • Ward observations • Guidelines • Treatment records • Key informants • Beneficiaries • National Guidelines	• Field observations • Observation checklists • Key informant interviews • Beneficiary questionnaires • Document review

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
	EF4: To what extent do implementing partners have the required capacity to deliver IMAM services?	• Capacity needs assessments • Trainings (pre post assessments) • Staffing • Current availability of trained human resources by implementing partner	• Interviews with officials and clinicians, implementing partners • Beneficiary interviews • Documents	• Key informant interviews • Beneficiary questionnaires • Document review
	EF5: To what extent have specific IMAM interventions/activities helped to achieve the planned results and targets (including treatment of children and mothers for malnutrition)? What have been enabling and hindering factors/challenges?	• Planned targets v actual achieved for given results areas • Examples of enabling/hindering factors	• OPD-SAM / OPD-MAM treatment cards • IPD treatment cards • National guidelines • Various stakeholders interviews • Documents Beneficiary questionnaire	• Document review • Beneficiary Questionnaire • Field observations • KII with officials / clinicians
	EF6: How motivated and satisfied are front line staff to deliver IMAM services? What are the constraining factors including staff workload?	• Perceptions of frontline staff and others on their level of motivation and workload • Number of staff /population targeted • Views of target beneficiaries • Actual Staffing v needed staffing	• Documents • Frontline staff, their supervisors and other stakeholders including implementing agencies	• KIIs • FGDs • Document review
Sustainability	S1: To what extent has IMAM been integrated into the health system services and	• Impressions of IMAM from officials and hospital directors • Human resource commitments • Financial commitments	• Observation of protocol implementation • Key informants • Pharmacy records	• Observation checklist • Bottleneck analysis • Treatment records information retrieval

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
	how does this affect provision of IMAM services?	• Coordination meetings • Training • Supportive supervision • Effective commodity management • Assessment of capacity to implement based on theoretical / practical knowledge		• Key informant interviews • Document review
	S2: To what extent can PND continue to implement and scale up IMAM without financial, technical, logistical and other (including supplies) support from internal and external agencies?	• Impressions of IMAM/other officials • and hospital directors • Human resource commitments • Financial commitments Commodity management	• Documents Interviews with stakeholders	• Document review • Interviews
	S3: What systems, policies, strategies, capacities, (at national, provincial, regional, district, community levels) have been/need to be developed so that IMAM can continue to be implemented and scaled up without internal and external support?	• Impressions of IMAM from officials and hospital directors	• Documents Interviews with stakeholders	• Document review • Interviews
	S4: To what extent is there coordination across IMAM stakeholders and implementing partners at various levels?	• Evidence of coordination in nutrition and nutrition sensitive policies / guidelines Participation in sectoral / inter-sectoral coordination meetings	• Documents • Interviews with stakeholders	• Document review • Interviews

OECD / DAC criteria	Questions	What to look for	Data sources	Data collection methods
		• Examples of improved planning & implementation		
	S5: What are the gaps and barriers to coordination and the effect of these on IMAM services? Are there any duplications?	• Examples of gaps/barriers Examples of duplications	• Documents (tors of coordination mechanisms, minutes) • Interviews with stakeholders	• Document review • Interviews

ANNEX 3: DATA COLLECTION INSTRUMENTS

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A. INTERVIEW GUIDE: UNICEF, WFP AND WHO[17] STAFF INVOLVED IN IMAM

General

1. What is your role?
2. What is your involvement with IMAM in Afghanistan?
3. What is your general impression of IMAM in Afghanistan?
    a. What works well?
    b. What does not work so well?

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[17] This interview guide includes a comprehensive list of questions designed primarily for UNICEF key informants. Not all of the questions will be relevant for WFP and WHO key informants. The guide will therefore be edited prior to interviewing them.

UN agency roles

4. What role does your agency play in the implementation of IMAM in Afghanistan?
5. How does your agency work alongside other UN agencies to support the delivery of IMAM in Afghanistan?
6. How does IMAM overlap with other departments and activities within your organisation?
7. To what extent does your organisation support the capacity needs of the government in delivering IMAM? If there are gaps in capacity, what are they?
8. Which activities of your agency have proven most successful? Which activities have been least successful?

   Specifically in the areas of:

   a. Human rights
   b. Protection / security
   c. MDG / SDG targets (2013-18)
   d. How are issues of equity being addressed? (gender, disability, ethnicity)
   e. What still needs to be done in these areas?
9. Which areas of IMAM require the most support financially? And at which levels are support needed most (i.e. national, provincial or district level)?

Achievements

10. What have been the major achievements in the scale up of IMAM in the last 5 years?
11. What have been the barriers and boosters to progress?

Adaptability

12. To what extent have IMAM inputs (including human resources and treatment products and medicines) evolved to respond to local contexts, needs and priorities? Can you provide examples?
13. If IMAM has not evolved to respond to local contexts, why do you think this is the case?

Quality of IMAM

14. What are the key bottlenecks/ constraints that need to be addressed in order to meet required **quality of services** for IMAM?
15. To what extent has the programme addressed the bottlenecks identified in 2017?

***Summary of BNA 2017 findings**: Lack of stock management training; non-inclusion of RUTF in essential drug list; lack of proper mapping and monitoring at provincial level; low prioritization of CHW training; lack of SOP for CHWs on community component of IMAM; limited time allocation for beneficiaries due to high patient load; limited nutrition staff in HFs, many recording tools.*

16. Where high quality services are being delivered, what factors encourage quality service delivery?
17. To what extent do implementing partners have the required capacity to deliver quality IMAM services?
18. Where gaps in capacity exist, what are the causes of these gaps? Can you provide some specific examples?

Coverage

19. What are the key bottlenecks / constraints that need to be addressed in order to reach IMAM target populations?
    a. Children under 5
    b. Pregnant and lactating women
    c. Hard to reach communities / nomads / insecure areas
20. What examples can you provide of successful strategies/activities to reach IMAM target populations in hard to reach areas?
21. Are you aware of innovations in IMAM that could be adopted in Afghanistan? If so, why would they be successful? What is preventing them from being adopted?

M&E systems

22. Which IMAM M&E systems exist? What purpose/s do they serve? Who is responsible for building and maintaining M&E systems (PND / Nutrition Cluster/ others)?
23. How do the M&E systems facilitate coordination of nutrition programming within PND and between stakeholders? And with external sectors (eg WaSH, Health)?
24. Are IMAM M&E systems clear and easy to use? If not, why not? How could they be improved for users?
25. How complementary are M&E systems? Are there any duplications /overlaps?
26. To what extent is gathered evidence been used to make changes to the programme? Can you provide some examples?
27. If M&E evidence has **not** been used to inform and address programme performance and bottlenecks, why not? What needs to be changed to address this?

Coordination

28. Which formal IMAM coordination mechanisms exist within the MoPH? And in the wider nutrition sector?
29. How effective are these mechanisms? How could they be improved? Are there any overlaps in coordination? Are there any gaps?
    a. Nutrition Cluster
    b. Humanitarian County Team (HCT)
    c. IMAM working group
30. If there are gaps, how do these affect the delivery of IMAM services?
31. What would be required to allow the nutrition cluster to hand over responsibility of the coordination of IMAM to the PND? What is being done to build the capacity of the government to lead on coordination?
32. Are you aware of informal coordination mechanisms? If so, which ones? What is your perception of these?

Integration within government structures

33. To what extent is IMAM integrated into government structures?
34. What have the main successes and challenges been in integrating IMAM into existing government structures?
35. How could the guidelines on positioning IMAM within existing structures be improved? Which elements are missing from the guidelines?
36. To what extent does integration vary across provinces? If yes, why is there a variance across provinces?
37. What are the barriers to full integration within health services? What positive factors encourage integration?

38. What systems, policies, strategies and capacities (at national, provincial, regional, district, community levels) need to be developed so that IMAM can continue to be implemented and scaled up without external support?
39. Other than the health system, in which other sectors has IMAM been integrated? Or where else should it be integrated? If elements of IMAM have been integrated into other sectors, what successes and challenges are you aware of?

B. INTERVIEW GUIDE: KEY STAKEHOLDERS IN MINISTRY OF PUBLIC HEALTH

General questions

1. What role do you play in the implementation of the IMAM approach at national level?
2. Please explain the roles of other Government actors in the IMAM approach
3. *[For PND stakeholders]* How does the PND coordinate with other directorates under the directorate for Preventative Medicine and Health Promotion and the Directorate for Curative Medicine?
4. What is your general opinion of the IMAM approach?
    a. What works well?
    b. What does not work so well?

Role of partners

5. To what extent do IMAM interventions provided by UN agencies meet the capacity needs of the government in delivering IMAM? If there are gaps in capacity, where are they?
6. Which interventions have proven most successful? Which activities have been least successful?
7. Which areas of IMAM require the most support financially? And at which levels is most support needed (i.e. national, provincial or district level)?

Achievements

8. What have been the major achievements in the scale up of IMAM in the last 5 years?
9. What have been the barriers and boosters to progress?

Adaptability

10. To what extent have IMAM inputs (including human resources and treatment products and medicines) evolved to respond to local contexts, needs and priorities? Can you provide examples?
11. If the IMAM programme has not evolved, why do you think this is the case?

Quality of IMAM

12. What are the key bottlenecks/ constraints to delivering **quality IMAM services**?
13. To what extent has the programme addressed the bottlenecks identified in 2017?

    ***Summary of BNA 2017 findings**: Lack of stock management training; non-inclusion of RUTF in essential drug list; lack of proper mapping and monitoring at provincial level; low prioritization of CHW training; lack of SOP for CHWs on community component of IMAM; limited time allocation for beneficiaries due to high patient load; limited nutrition staff in HFs, many recording tools.*

14. Where high quality services are being delivered, what factors encourage quality service delivery?

15. To what extent do implementing partners have the required capacity to deliver quality IMAM services? Where gaps exist, what are the causes of these gaps? Can you provide some specific examples?
16. What are the constraining factors which limit facility-level staff from delivering IMAM services?

Coverage

17. What are the key bottlenecks / constraints that need to be addressed in order to reach IMAM target populations?
    a. Children under 5
    b. Pregnant and lactating women
    c. Hard to reach communities / nomads / insecure areas
18. What examples can you provide of successful strategies/activities to reach IMAM target populations in hard to reach areas?

M&E systems

19. Which IMAM M&E systems exist? What purpose/s do they serve?
20. Who is responsible for building and maintaining M&E systems (PND / Nutrition Cluster/ others)?
21. Are IMAM M&E systems clear and easy to use? If not, why not? How could they be improved for users?
22. Have nutrition indicators been integrated into the health information systems which are used at national level?
23. How do the M&E systems facilitate coordination of nutrition programming within PND and between stakeholders? And with external sectors (eg WaSH, Health)?
24. To what extent is gathered evidence been used to make changes to the programme? Can you provide some examples?
25. If M&E evidence has **not** been used to inform and address programme performance and bottlenecks, why not? What needs to be changed to address this?
26. Are the findings / outputs of M&E systems shared with you in any way? If yes, how are the findings shared? Do you find them useful or interesting?

Coordination

27. Which formal IMAM coordination mechanisms are you aware of?
28. How effective are these mechanisms? How could they be improved?
29. Are there any duplications / overlaps or gaps in coordination? If so, how do these affect the delivery of IMAM services?
30. Does the PND coordinate within / across other government directorates?
31. What is being done to build the capacity of government to lead on coordination? What would be required to allow the nutrition cluster to hand over responsibility of the coordination of IMAM to the PND?
32. Are you aware of informal coordination mechanisms? If so, which ones? What is your perception of these?

Integration within government structures

33. To what extent is IMAM integrated into government structures?
34. How does the BPHS / EPHS contracting system work? How does this affect implementation, quality and coordination of IMAM programming?

35. What have the main successes and challenges been in integrating IMAM into existing government structures?
36. How could the guidelines on positioning IMAM within existing structures be improved? Which elements are missing from the guidelines?
37. To what extent does integration vary across provinces? If yes, why is there a variance across provinces?
38. What are the barriers to full integration within health services? What positive factors encourage integration?
39. What systems, policies, strategies, coordination and capacities (at national, provincial, regional, district, community levels) need to be developed so that IMAM can continue to be implemented and scaled up without external support?
40. Other than the health system, in which other sectors has IMAM been integrated? Or where else should it be integrated? If elements of IMAM have been integrated into other sectors, what successes and challenges are you aware of?

C. INTERVIEW GUIDE: OTHER IMAM TECHNICAL GROUP AND NUTRITION CLUSTER MEMBERS (BPHS AND EPHS PARTNERS (NATIONAL LEVEL), NON-BPHS PARTNERS, INTERNATIONAL NGOS, AND NATIONAL NGOS)

General questions

1. What is your role?
2. What role does your organisation play in the implementation of the IMAM programme in Afghanistan?
3. What is your general opinion of the IMAM programme?
    a. What works well?
    b. What does not work so well?

Achievements

4. What have been the major achievements in the scale up of IMAM in the last 5 years?
5. What have been the barriers and boosters to progress?

Adaptability

6. To what extent have IMAM inputs (including human resources and treatment products and medicines) evolved to respond to local contexts, needs and priorities? Can you provide examples?
7. If the IMAM programme has not evolved, why do you think this is the case?

Quality of IMAM

8. What are the key bottlenecks/ constraints to delivering **quality IMAM services**?
9. Where high quality services are being delivered, what factors encourage quality service delivery?
10. What are the constraining factors which limit facility-level staff from delivering IMAM services?

11. Are the findings / outputs of M&E systems shared with you in any way? If yes, how are the findings shared? Do you find them useful or interesting?

Coverage

12. What are the key bottlenecks / constraints that need to be addressed in order to reach IMAM target populations?
    a. Children under 5
    b. Pregnant and lactating women
    c. Hard to reach communities / nomads / insecure areas
13. What examples can you provide of successful strategies/activities to reach IMAM target populations in hard to reach areas?

Coordination

14. Which formal IMAM coordination mechanisms are you aware of?
15. How effective are these mechanisms? How could they be improved? Are there any duplications / overlaps?
16. Are you aware of informal coordination mechanisms? If so, which ones? What is your perception of these?
17. What are the gaps and barriers to effective coordination between IMAM stakeholders? How do these affect the delivery of IMAM services?

Coordination [BPHS / EPHS only]

18. How effective is internal (intra-agency) coordination of IMAM with other nutrition / health services? What lessons can be learned?
19. How effective is coordination between BPHS and EPHS contract holders within provinces / districts in which you operate?
20. To what extent do your teams coordinate with district nutrition advisors / Provincial Nutrition Officers?
21. How effective is coordination at national level?

Integration within government structures

22. What have the main successes and challenges been in integrating IMAM into existing government structures?
23. How does the BPHS / EPHS contracting system work and how does this affect implementation, quality and coordination of IMAM programming?
24. How could the guidelines on positioning IMAM within existing structures be improved? Which elements are missing from the guidelines?
25. To what extent does integration vary across provinces? If yes, why is there a variance across provinces?
26. What are the barriers to full integration within health services? What positive factors encourage integration?
27. What systems, policies, strategies and capacities (at national, provincial, regional, district, community levels) need to be developed so that IMAM can continue to be implemented and scaled up without external support?
28. Other than the health system, in which other sectors has IMAM been integrated? Or where else should it be integrated? If elements of IMAM have been integrated into other sectors, what successes and challenges are you aware of?

D. INTERVIEW GUIDE: EPHS AND BPHS MANAGERS (PROVINCE AND DISTRICT LEVEL), CHBC COORDINATORS, MEDICAL DIRECTORS PROVINCIAL AND DISTRICT HOSPITALS, PROVINCIAL NUTRITION OFFICERS (PROVINCIAL LEVEL)

General questions:

1. What role do you play in the implementation of the IMAM programme in your province / district?
2. What is your general opinion of the IMAM programme?
    a. What works well?
    b. What does not work so well?

Achievements

3. What have been the major achievements in the scale up of IMAM in the last 5 years?
4. What have been the barriers and boosters to progress?

Adaptability

5. To what extent have IMAM inputs (including human resources and treatment products and medicines) evolved to respond to local contexts, needs and priorities in your province? Can you provide examples?
6. If the IMAM programme has not evolved, why do you think this is the case?

Quality of IMAM

7. In your province / district, what are the key bottlenecks/ constraints to delivering quality IMAM services?
8. Where high quality services are being delivered, what factors encourage quality service delivery?
9. Has the IMAM programme in your province / district experienced stock breaks in the last 12 months?
10. If so, how many times has there been a break in supplies in the last 12 months? How long do the stock-outs last? How long does resupply take at each level?
11. What are the main causes of stock breaks? Where is the choke-point (national / province / district level)?
12. What effect does a lack of supplies have on the running of the programme and on the way it is perceived? What are the main causes of stock breaks?
13. Has supply changed since 2013? Has it improved or deteriorated? Has it stayed the same? Why do you think this is?
14. Is there adequate storage for stock at each level (province / district / CHC)?
15. Do you ever see over-ordering of stock or expired stock? Why is this the case?
16. How effective is distribution via pharmacies and the wider health systems?
17. How functional and appropriate are IMAM supplies for their intended use?
18. What are the constraining factors which limit facility-level staff from delivering IMAM services?
19. Do you think that front line staff receive the training, support and supervision that they need / expect?

Coverage

20. What are the key bottlenecks / constraints that need to be addressed in order to reach IMAM target populations?
    a. Children under 5 (boys and girls)
    b. Pregnant and lactating women
    c. Hard to reach communities / nomads / insecure areas
21. What examples can you provide of successful strategies/activities to reach IMAM target populations in hard to reach areas?
22. What measures could be proposed to improve programme targeting in your province / district?
    a. Is targeting equitable? (gender / disability / ethnicity etc.)
23. Are the findings / outputs of M&E systems shared with you in any way by national level colleagues / partners? If yes, how are the findings shared? Do you find them useful or interesting?
24. What do you do with the data you collect at provincial / district level? How do you use it?
25. *[Provincial level stakeholders]*Do you need to wait for direction from national level to address programmatic issues at provincial level?
26. *[Provincial level stakeholders]* What capacity needs to be built to enable Provincial Nutrition Officers to act on data?

Coordination *[Provincial level stakeholders]*

27. Which formal IMAM coordination mechanisms are you aware of in your province?
28. How effective are these mechanisms? How could they be improved? Are there any duplications / overlaps?
29. What are the gaps and barriers to effective coordination between IMAM stakeholders? How do these affect the delivery of IMAM services?

Integration within government services *[Provincial level stakeholders]*

30. What have the main successes and challenges been in integrating IMAM into existing government health structures in your province?
31. What are the barriers to full integration of services? What positive factors encourage integration?

E. INTERVIEW GUIDE: HEALTH FACILITY STAFF IN HOSPITALS, CHC, BHC, HSC, MHT (DISTRICT LEVEL)

General questions

1. What role do you play in the implementation of IMAM?
2. What is your general impression of IMAM?
    a. What works well?
    b. What does not work so well?

General IMAM involvement

3. How long have you been working on IMAM?
4. Are all staff in the clinic involved / trained on IMAM?
5. How many male versus female staff are trained?
6. Who trained you on IMAM?

7. Have you had a refresher training? If yes, when?
8. Is there any additional training you feel you need?
9. What contact / support have you had with focal people / ministry to help you in your job?
10. What difficulties, if any, do you have? E.g.
    a. High number of patients
    b. Time
    c. Completing paperwork accurately and keeping up to date
    d. Supply breakages
11. If any supply breakages have happened, what were the causes of these?

Calendar

12. What are the main childhood diseases you see in the clinic / hospital?
13. Which is the most common? Rank from most common to least common.
14. What time of year do they occur?
15. What do you think are the causes of malnutrition in this area?
    a. In children U5?
    b. In Pregnant and lactating women?

Referral

16. How do children U5 usually come to the clinic / hospital for IMAM? Rank in order of importance.
    a. Referred by CHWs
    b. Heard about it from other beneficiary
    c. Heard about it from other person in the village
    d. Heard about it at the clinic / hospital
    e. Heard via the radio or other media, etc.
    f. Other source
17. How are malnourished PLWs usually referred to the clinic?
18. Do children and PLWs who are referred from the community / clinic / hospital come with a referral slip/ paper? If yes, what do you do with the referral slips?
19. Do the CHWs check that children and PLWs they have referred actually present at the clinic / hospital?
20. Do you report back to CHWs on the number of children and PLWs you have seen that are referred by them?
21. Have you had any incorrect referrals from community screening?
    a. How many? What was the problem?
    b. What did you do?
    c. Did you report back to the community mobilization staff?
22. How do you refer patients to the stabilization centre or back to clinic?
    a. Do you give them a slip?
    b. How do you know if they have arrived at the stabilization centre / clinic?
    c. How do you know what happens to them?
    d. When patients are referred back do they come with any paperwork?
    e. Is there any trend in the numbers of children referred / admitted for treatment?

Admission / Non-admission

23. Do children and PLWs who are referred incorrectly arrive at the clinic / hospital?

    a. Approximately how many of each arrive each month?
    b. What do you say when the child / PLW cannot be enrolled?
24. How do you decide to admit a child as inpatient versus outpatient?

Defaulting (children U5)

25. How many children are absent for more than two weeks during the course of treatment?
26. Why do you think children default from treatment?
27. Is there a trend in the pattern of defaulting?
28. What do you do when children default?
29. How could we encourage children who default to return for treatment?
30. What barriers prevent mothers from bringing their children to the OPD SAM or MAM?

Defaulting (PLWs)

31. How many PLWs are absent for more than two months during the course of treatment?
32. Why do you think PLWs default from treatment?
33. Is there a trend in the pattern of defaulting?
34. What do you do when PLWs default?
35. How could we encourage PLWs who default to return for treatment?
36. What barriers prevent PLWs mothers from coming to the OPD MAM?

Communications

37. What communications do you have with provincial staff?
38. Who does community mobilization in this area?
39. What activities are included?
40. How often do you see the community mobilization staff?
41. How do you communicate with them?
42. How do they report activities to you?

Language

43. What is the main language you speak at home?
44. What languages / dialects are spoken by members of the community in this catchment area?
45. In which languages / dialects can you easily communicate health and nutrition information?

Any other comments?

46. Do you have any other comments about IMAM?

F. INTERVIEW GUIDE: COMMUNITY HEALTH SUPERVISORS / WORKERS, VILLAGE SHURA, FAMILY HEALTH ACTION GROUP

General questions

1. What role do you play in the implementation of IMAM?

General IMAM involvement

2. How long have you been working on IMAM?

3. Who trained you on IMAM?
4. Have you had a refresher training? If yes, when?
5. Is there any additional training you feel you need?
6. Are you supervised? If yes, how frequently does supervision take place?
7. Do you work with other CHWs? If yes, how do you work with others?

Sensitisation

8. Do you organise sensitisation sessions about IMAM and acute malnutrition in your community?
    a. If **yes**, how do you organise the sensitisations & how often do they take place them?
9. What sensitisation tools do you have at your disposal?
10. Who do you target in your sensitisation sessions? Why?
11. What other people should be targeted by your sensitisation sessions? Why? Why don't you target them?
12. Which other people should play a role in sensitising the community? Why?
13. How could sensitisation be improved?

Language

14. What is the main language you speak at home?
15. What languages / dialects are spoken by members of the community in this catchment area?
16. In which languages / dialects can you easily communicate health and nutrition information?

Screening

17. Do you conduct screening for children and pregnant and lactating women with infants less than 6 months old (PLW) to detect acute malnutrition?
    a. If **yes**, how & how often do you organise this activity?
18. What tools do you have at your disposal?
19. How do you refer children and PLWs to the nutrition facility?
20. Do nutrition facilities accept your referrals?
    a. If **no**, why not?
21. Who follows up on referred children and PLWs? How often?

Active cases

22. Approximately how many children in your community attend the OPD SAM and OPD MAM?
23. How many PLWs in your community attend the OPD MAM?
24. Do you know other children or PLWs in your community who need treatment for acute malnutrition ?
    a. If **yes**, why aren't they in the programme?
25. Do you know children who abandoned treatment?
    a. If **yes**, why? How could we motivate their carers to return?
26. Do you know PLWs who abandoned treatment?
    a. If **yes**, why? How could we motivate their carers to return?
27. Who follows up on defaulting children and PLWs? How often?
    a. If **no** follow up is done, why?

Decision-making & refusal of treatment

28. Which family member tends to make the decision if a child needs to be referred to a nutrition facility?
29. What do you do if a family member refuses your instruction to the carer of the malnourished child or PLW to go to the health centre? Does this happen often?

Knowledge and perception of malnutrition

30. Which local terms depicting malnutrition are used in your community?
31. How is malnutrition perceived? Why?
32. Do community members understand its causes?
    a. If **yes**, how do they describe them?
33. Do community members understand its effects?
    a. If **yes**, how do they describe them?
34. Do you think that this condition is stigmatised? Why?
    a. If **yes**, how does this stigmatisation affect people's behaviour towards parents with malnourished children or to malnourished PLWs?

Perception of IMAM programme

35. How do you perceive the IMAM programme?
36. What are strengths/weaknesses of the programme?
37. What would you change to improve its quality?
38. How is the programme perceived by the community? Why?
39. Are there any obstacles/barriers preventing the community from using this service?
    a. If **yes**, explain.

Any other comments

40. Do you have any questions or other comments about the IMAM programme?

G. INTERVIEW/FOCUS GROUP DISCUSSION GUIDE: CARERS OF MALNOURISHED CHILDREN WHO ARE IN THE IMAM PROGRAMME

Understanding of malnutrition

1. When did you first notice that your child was unwell?
2. What was wrong with them?
3. What symptoms did they have?
4. What did you do?
5. Did you try other treatments first? If so, what and how long?

Outreach

6. How did you first hear about the IMAM service?
7. Who told you?
8. Have you heard about it from any other source since?
9. Who is telling people about it in your village / town?
10. What did you hear about it?
11. What made you come to the clinic?
12. How long has your child been attending the clinic?

Explanation from staff

13. What did the clinic staff tell you about your child's condition?
14. What were you told about the treatment?

15. What do doctors call the treatment? What do you call the treatment?

Other cases / case referral

16. Do you know of other children who have the same problem but who are not attending the clinic
    a. If yes, why not?
17. Have you told anyone else to bring their child to the clinic?
18. Why / why not?

Distance

19. How far is it from your home to the clinic?
20. How do you get here? Walk / transport?
21. How long does it take?
22. Determine the farthest distance travelled.
23. Do you have any other reason to come to this clinic / this place?

Standard of service

24. What do you think of the IMAM service?
25. What are the strengths / good things?
26. What are the difficulties?
27. What are your opinions about RUTF / RUSF?
28. Have you seen RUTF of RUSF for sale in local markets? Why do you think that it is sold?
29. Do you share RUTF or RUSF with your other children or family members?
30. What could be done to make the service better?
31. How long do you usually wait to see the doctor?
32. How much time do you spend with the staff?
33. What happens during the consultation?
34. What treatment does your child receive?
35. Have there been any shortages on any week?
36. Have you ever not received the full amount or received something else instead?

Absence / defaulting

37. How easy is it for you to come every week?
38. What makes it difficult for you to come / what stops you from coming sometimes?
39. Do you know of any children who have stopped coming?
    a. If yes, why?
40. How can we encourage these children to return and continue the treatment?

Perception of IMAM / feedback

41. What are people saying about the service in your village / town?
42. What works well for you in this programme?
43. What difficulties do you have in this programme?
44. How could we make the service better for you?

Communication

45. What is the main language you speak at home?
46. Which language do you prefer to receive written information in?
47. Which language do you prefer to receive verbal information in?
48. How do you prefer to receive information? (e.g. poster, leaflet, radio, TV, in person, SMS)
49. Are you able to easily understand the health / nutrition information given at the health centre?

Any other comments

50. Do you have any questions or comments about the service?

H. INTERVIEW GUIDE: COMMUNITY LEADERS / IMAMS AND FOCUS GROUP DISCUSSION GUIDE: MALE AND FEMALE COMMUNITY MEMBERS

General [*only for community leaders and imams*]

1. What is your role in the community?
2. What does your role involve?

Knowledge of childhood diseases and malnutrition

3. Which childhood diseases are the most frequent in your community?
4. What are causes of these diseases?
5. Who do you go to for help or advice if your child gets sick or if you see a sick child?
6. Are there children in your community who look like this? (show images of marasmus / kwashiorkor)
7. Do you consider it to be a disease like others? Why? Why not?
8. Which local terms are used to describe it?
9. How is it perceived in the community? Why?
10. Do you think that this condition is stigmatised (perceived negatively by community members)? Why?
11. If yes, how does this stigmatisation affect people's behaviour and/or community relationships?
12. Do you know what treatment is used to treat this disease? Why?

Awareness and perception of IMAM programme

13. Have you heard about the IMAM programme?
    a. If yes, from whom? What did you hear?

14. Do you hear about these programmes often? How often?
15. Do you know who in the community is targeted by the programme?
    a. If yes, who?

16. Do you know which treatment they receive?
    a. If yes, which treatment?
    b. [Show them the packets of RUTF and RUSF] Do know the difference between these two products? If yes, ask them to explain.

17. *[Show them a packet of supercereal]* Do you recognise this product? If so, who or what is the product used for?
18. What is your opinion about these treatments and the programmes?
19. How are they perceived in the community? Why?
20. What is your opinion about this programme?
21. What factors prevent carers of sick children and PLWs from using this programme?
22. Have you seen IMAM treatment products for sale in the local community or market?
    a. If yes, why do you think that it is sold by community members?

Coverage / rejection / defaulting

23. Are you aware of any children or PLWs with symptoms of malnutrition who are not in the programme?

a. If yes, do you know why are they not in the programme?

24. Are you aware of any children or PLWs that have been rejected from the programme? Why were they rejected?
25. Do you know any children or PLWs who abandoned the treatment? Why?
    a. If yes, how could we motivate them to return?

Sensitisation / screening

26. Who tells the community about childhood diseases and about the IMAM programme? How often? What topics do they cover?
27. Do you participate in sensitisation sessions? Why? Why not?
28. What do you think of these sessions? Are they interesting and useful? Why?
29. Do you think the sensitisation sessions are sufficient? Why? Why not?
    b. If **no**, how could it be reinforced?

Communication

30. What is the main language you speak at home?
31. Which language do you prefer to receive written information in?
32. Which language do you prefer to receive verbal information in?
33. How do you prefer to receive information? (e.g. poster, leaflet, radio, TV, in person, SMS)
34. Are you able to easily understand the health / nutrition information given at the health centre?

Any other comments

35. Do you have any questions or comments about the service?

I. PROGRAMME QUALITY CHECKLIST: INPATIENT CARE

Facility

- Name of Facility:
- Health facility code:
- Type of health facility: (HP / SHC / BHC / CHC / DH / PH / NH)
- Province:
- District:
- Location: (city / town / village)
- Date of evaluation:
- Patient census (SAM):
- Facility has disabled access to SAM / paediatric ward: Yes / No
- Facility is an accredited Baby Friendly Hospital: Yes / No
- Evaluator comment:

Staffing for SAM care:

- # of Dr's
- # of Nurses
- # of Nutritionists (ward based)
- # of Care assistants

Evaluator comment:

Documentation

Is the following documentation available on the ward? (this must be seen by evaluator and be on the ward, not locked in the Doctor's office)

- IMAM national guidelines 2018

Evaluator comment:

Equipment

The following equipment is available and of good quality

- MUAC tapes are present: Yes / No
    - MUAC tapes have correct cut offs marked: RED (<11.5cm), YELLOW (< 12.5 – 11.5cm), GREEN (≥ 12.5cm)
    - Quality: Good, worn, broken
    - Correct use demonstrated: Yes / No / Not tested
- Weighing scales are present and functional:
    - Infants scales accurate to 10-20g: Yes / No
    - Child scales accurate to 100g: Yes / No / Not tested
    - Type of child scale: Digital (e.g. SECA) / hanging scale (E.g. Salter) / bathroom scale

    - Correct use demonstrated: Yes / No
- Height boards
    - Condition: Excellent / good / poor
    - Measuring scale is clearly readable: Yes / No
    - Correct use demonstrated: Yes / No / Not tested
- Weight for height tables (WHO 2006 growth standards)
    - Type: Unisex / Sex disaggregated

Evaluator comment:

Eligibility criteria

Without prompting ask which children are eligible for treatment in inpatient in IMAM. Indicate (yes / no) if the following criteria are mentioned.

- Oedema + 3: Yes / No
- Marasmic kwashiorkor (combined wasting and oedema): Yes / No
- MUAC < 11.5 cm: Yes / No
- WHZ < -3: Yes / No
- Oedema + 1 or + 2: Yes / No
  WITH
- No appetite for RUTF: Yes / No
- Medical complications (IMCI danger signs): Yes / No
- Referrals from OPD-SAM: Yes / No
- Infants aged < 6 months: Yes / No

Evaluator comment:

Milk preparation

Ask about the correct prescription of therapeutic milk using these examples:

Amount of F75 for a child of 5.6kg

- Per day: Amount____ ml
- Per meal (8 meals per day): Amount___ ml

Amount of F100 for a child of 5.6 kg

- Per day: Amount ____ ml
- Per meal (5-6 meals per day): Amount___ ml

How was milk requirement calculated?

- Using milk tables: Yes / No
- Calculation by hand: Yes / No

Evaluator comment:

Treatment card review

The evaluator should 30 treatment records of the most recent discharges from inpatient care. For each treatment card collect the following information:

Child ID: 01 to 30

- Registration number __________ / Not recorded on treatment card
- Age of child: ___ months
- Sex: Male / Female
- Approximate distance from home to nearest health facility: ___ km (if available)
- Approximate distance from home to IPD-SAM: ___ km
- Source of referral: ________ (if available)
- Date of admission:
- Date of discharge:
- MUAC on admission: ___ cm / Not recorded
- Weight on admission: ___ kg / Not recorded
- Height on admission: ___ cm / Not recorded
- WHZ on admission: ___ z scores / Not recorded
- MUAC on discharge ___ cm / not recorded
- Weight on discharge ___ kg / not recorded
- # days on F75 (or diluted F100): ___ days Amount: ___ ml / Not recorded
- # days on F100 ___ days Amount: ___ ml / Not recorded
- # days on RUTF ___ days Amount___ ml / Not recorded
- NGT used: Yes / No
- Vomiting / uneaten meals charted correctly: Yes / No / Not recorded
- Number of days feeds are charted fully and correctly: ___ days / not recorded
- Type of infant feeding used: Cup / Supplementary suckling technique / bottle feeding *(tick all that apply)*
- Bottles / bottle feeding observed by evaluator: Yes / No
- Antibiotic given on admission: Yes / No / not recorded

Evaluator comment:

Reporting

The evaluator should review monthly reports for the previous 3 months

- # Reports reviewed: ____
- # completed correctly (no mathematical errors): ____

Discharge rate to full recovery:

- Month 1: ___ %
- Month 2: ___ %
- Month 3: ___ %

Discharge rate to OPD-SAM

- Month 1: ___ %
- Month 2: ___ %
- Month 3: ___ %

Default rate:

- Month 1: ___ %
- Month 2: ___ %
- Month 3: ___ %

Death rate:

- Month 1: ___ %
- Month 2: ___ %
- Month 3: ___ %

Evaluator comment:

Stock records

- # Boxes of F75: ____ Boxes (Expiry date ____)
- # Boxes of F100: ___ Boxes (Expiry date ____)
- # Boxes of RUTF: ___ Boxes (Expiry date ____)
- Stock record reflects correct count of supplies: Yes / No
- # Number of stock outs in the previous 12 months

- # F75 stockouts: ___ (Average length of stockout: ____ weeks)
- # F100 stockouts ___ (Average length of stockout: ____ weeks)
- # RUTF stockouts ___ (Average length of stock out: ____ weeks)

- Stock room floors and walls are clean: Yes / No
- Stock room is free of any damage to windows / doors: Yes / No
- Therapeutic supplies stacked correctly: Yes / No (correct = 5 boxes high or less)
- Signs of leakage or damage to boxes: Yes / No
- Signs of insects / pests (e.g. insects, cockroaches, droppings or chewed boxes): Yes / No

Evaluator comment:

Supervision

Number of supportive supervision visits during the previous 12 months

- # visits by Provincial nutritionist ____ (Documented: Yes / No)
- # visits by District nutritionist ___ (Documented: Yes / No)
- # visits by UNICEF ___ (Documented: Yes / No)

Evaluator comment:

General evaluator comments on any aspect of the evaluation visit:

J. PROGRAMME QUALITY CHECKLIST: OUTPATIENT CARE IN OPD SAM AND MAM FOR CHILDREN U5 AND PLWS

Facility

- Name of Facility:
- Type of health facility: (MHT/ HP / HSC / BHC / CHC / DH / PH / NH)
- Province:
- District:
- Location: (city / town / village)
- Date of evaluation:
- Patient census
  - OPD SAM
  - OPD MAM (Children U5)
  - OPD MAM (PLWs)
- Facility has disabled access: Yes / No

Evaluator comment:

Staffing for SAM / MAM care:

- # of Dr's
- # of Nurses
- # of Nutritionists (ward based)
- # of Care assistants
- # of Midwives

Evaluator comment:

Who is responsible for the following activities?

- Measuring MUAC / oedema *(for children and PLWs)*
- Measuring height
- Measuring weight
- Calculating WFH
- Appetite test
- Decision to treat
- Decision to discharge

On which days during the week is the IMAM service available in the facility?

On average, how many children per day are screened for acute malnutrition? And how many PLWs?

Is exhaustive screening conducted of all children aged 6-59 months and PLWs?

If not, how do you select those are screened?

How is your workload during the day (for the OPD nurse)? Indicate which is the closest description

- **Extremely busy** (too busy to diagnose and treat all cases arriving at facility)
- **Quite busy** (able to see all cases but stretched and under resourced)
- **Not too busy** (able to see all cases with time to spare)
- **Very quiet** (seeing very few cases during the day)

Details:

Documentation

Is the following documentation available in the facility (must be seen by evaluator in clinic (not locked in Dr's office)

- IMAM national guidelines 2018

Evaluator comment:

Equipment

The following equipment is available and of good quality

- MUAC tapes for measuring children are present: Yes / No
  - MUAC tapes have correct cut offs marked: RED (<11.5cm), YELLOW (< 12.5 – 11.5cm), GREEN (≥ 12.5cm)
  - Quality: Good, worn, broken
  - Correct use demonstrated: Yes / No / Not tested
- MUAC tapes for measuring PLWs are present : Yes / No
  - MUAC tapes have correct cut offs marked
  - Quality: Good, worn, broken
  - Correct use demonstrated: Yes / No / Not tested
- Weighing scales are present and functional:
  - Infants scales accurate to 10-20g: Yes / No
  - Child scales accurate to 100g: Yes / No / Not tested
  - Type of child scale: Digital (e.g. SECA) / hanging scale (E.g. Salter) / bathroom scale
  - Correct use demonstrated: Yes / No
- Height boards
  - Condition: Excellent / good / poor
  - Measuring scale is clearly readable: Yes / No
  - Correct use demonstrated: Yes / No / Not tested
- Weight for height tables (WHO 2006 growth standards)
  - Type: Unisex / Sex disaggregated

Evaluator comment:

Eligibility criteria

Without prompting, ask the OPD nurse **which children** are eligible for the following treatment modalities:

1. **OPD SAM** (tick **Yes** or **No** if the following criteria are mentioned).
Children aged 6-59 months who have ONE of:

	Yes	No
Oedema +1 or +2		
MUAC <115mm		
WHZ <-3		
WITH		
Demonstrated appetite for RUTF		

Evaluator comment:

2. **IPD SAM** (tick **Yes** or **No** if the following criteria are mentioned)
Children aged 6-59 months who have ONE of:

	Yes	No
Oedema +3		
Any sign of oedema **and** MUAC <115mm or WHZ <-3		
MUAC <115mm **and** oedema <-3		
OR		
MUAC <115mm or oedema <-3 WITH ONE OF		
Failed appetite test		
A general danger sign or serious associated disease		
Weight <4kg		

Evaluator comment

3. **OPD MAM** (tick **Yes** or **No** if the following criteria are mentioned)
Children aged 6-59 months who have ONE of:

	Yes	No
MUAC ≥115 to <125mm		
WHZ ≥-3 to <-2		

Evaluator comment

Without prompting, ask the OPD nurse **which women** are eligible for the following treatment modalities:

4. OPD MAM (tick **Yes** or **No** if the following criteria are mentioned)
Pregnant or lactating women with children under 6 months who have:

	Yes	No

MUAC <230mm		

Evaluator comment:

5. IPD SAM (tick **Yes** or **No** if the following criteria are mentioned)

Pregnant or lactating women with children under 6 months who have one of:

	Yes	**No**
MUAC <185mm		
Any sign of bilateral pitting oedema		

Evaluator comment:

Therapeutic food preparation

Ask about the correct prescription of therapeutic foods:

Amount of RUTF for a SAM child who is 5.2kg

- Per day: Amount____ packets per week , ____ packets per day

Amount of RUTF for a child with who is 8.6kg

- Per day: Amount____ packets per week , ____ packets per day

Amount of RUSF for MAM child:

- Per day: Amount____ packets per week, ____ packets per day

Quantity of Super cereal flour:

- ____ kgs to last ____ weeks

Evaluator comment:

Counselling

Please provide details of the counselling that you give to carers of malnourished children at the point of treatment:

Treatment card review

The evaluator should review up to 30 treatment (minimum 15) records of the most recent discharges from OPD SAM **and** OPD MAM **children aged 6-59 months**. For each treatment card collect the following information:

- Child ID: 01 to 30
- Registration number __________ / Not recorded on treatment card
- Age of child: ___ months
- Sex: Male / Female

- Approximate distance from home to health facility: ___ km
- Source of referral: ________ (if available)
- Date of admission:
- Date of discharge:
- MUAC on admission: ___ cm / Not recorded
- Weight on admission: ___ kg / Not recorded
- Height on admission: ___ cm / Not recorded
- WHZ on admission: ___ z scores / Not recorded
- MUAC on discharge ___ cm / not recorded
- Weight on discharge ___ kg / not recorded
- # days on RUTF / RUSF ___ days / Not recorded
- Antibiotic given on admission: Yes / No / not recorded

Evaluator comment:

The evaluator should review up to 20 treatment (minimum 10) records of the most recent discharges from OPD MAM **PLWs**. For each treatment card collect the following information:

- PLW ID: 01 to 20
- Registration number __________ / Not recorded on treatment card
- Age of child: ___ years
- Date of admission:
- Date of discharge:
- MUAC on admission: ___ cm / Not recorded

Reporting

The evaluator should review monthly reports for the previous 3 months

- # OPD SAM Reports reviewed: ____
- # OPD MAM (Children U5) reports reviewed: ____
- # OPD MAM (PLWs) reports reviewed: ____

OPD SAM	OPD MAM (Children U5)	OPD MAM (PLWs)
Cure rate: • Month 1: ___ % • Month 2: ___ % • Month 3: ___ %	**Cure rate**: • Month 1: ___ % • Month 2: ___ % • Month 3: ___ %	**Cure rate**: • Month 1: ___ % • Month 2: ___ % • Month 3: ___ %
Default rate: • Month 1: ___ % • Month 2: ___ % • Month 3: ___ %	**Default rate:** • Month 1: ___ % • Month 2: ___ % • Month 3: ___ %	**Default rate:** • Month 1: ___ % • Month 2: ___ % • Month 3: ___ %
Death rate:	**Death rate:**	**Death rate:**

• Month 1: ___ % • Month 2: ___ % • Month 3: ___ %	• Month 1: ___ % • Month 2: ___ % • Month 3: ___ %	• Month 1: ___ % • Month 2: ___ % • Month 3: ___ %
Evaluator comments		

Stock records

- # Boxes of RUTF: ___ Boxes (Expiry date ____)
- # Boxes of RUSF: ___ Boxes (Expiry date ____)
- # Boxes of Super cereal: ___ Boxes (Expiry date ____)
- Stock record reflects correct count of supplies: Yes / No
- # Number of stock outs in the previous 12 months:
    - # RUTF stockouts ___ (Average length of stock out: ____ weeks)
    - # RUSF stockouts ___ (Average length of stock out: ____ weeks)
    - # Boxes of Super cereal: ___ Boxes (Expiry date ____)
- If any stockouts have happened, what were the causes of these stockouts?
- What actions did you take when the stockouts happened?
- Stock room floors and walls are clean: Yes / No
- Stock room is free of any damage to windows / doors: Yes / No
- Therapeutic supplies stacked correctly: Yes / No (correct = 5 boxes high or less)
- Signs of leakage or damage to boxes: Yes / No
- Signs of insects / pests (e.g. insects, cockroaches, droppings or chewed boxes): Yes / No

Evaluator comment:

Supervision

Number of supportive supervision visits during the previous 12 months

- # visits by Provincial nutritionist ____ (Documented: Yes / No)
- # visits by District nutritionist ___ (Documented: Yes / No)
- # visits by UNICEF ___ (Documented: Yes / No)

Evaluator comment:

____

General evaluator comments on any aspect of the evaluation visit:

K: QUESTIONNAIRES WITH CARERS OF COVERED OPD SAM AND OPD MAM CASES (CHILDREN U5)

☐ OPD SAM Covered ☐ OPD MAM Covered

Team: ______________________	**Name of interviewer:** ______________________
Province: ____________ **District:** ____________	**Date:** ____________
Village: ________ ______________________	**Walking Distance:** ☐ Near (<30 mins)
Nearest Health facility: _____	☐ Far (30-60 mins) ☐ Very far (> 60 mins)

Gender: ☐ Male ☐ Female **Age** (in months): ______	
MUAC (mm): ____________	**Oedema** (circle correct value): + ++ +++ n/a
Child status: ☐ **Child is SAM** ☐ **Child is MAM** ☐ **Child is Well-nourished**	

IF OPD SAM**,** proof that child is in programme:	☐ OPD SAM treatment card	☐ Packet of RUTF	☐ Verification by CHW
IF OPD MAM**,** proof that child is in programme**:**	☐ OPD MAM treatment card	☐ Packet of RUSF	☐ Verification by CHW

1. **Has your child / children been measured with this tape in your village previously? [Prompt: Show the carer the MUAC tape]**						
☐ Yes	a. Who assessed your child's / children's health using this tool	☐ CHW	☐Village health Shura	☐Community clinic staff	☐ Yourself	☐ Someone else (please specify)
	b. How long ago were they measured?	☐ Last 7 days	☐ During last month	☐ 1 to 6 months ago	☐ More than 6 months ago	
☐ No						

2. Is this the first time that your child has been enrolled in OPD SAM / OPD MAM treatment?

☐ Yes → **Q5** ☐ No → **Q2**

3. How many packets of RUTF / RUSF did you receive during your last visit to the health centre?

4. How many times has your child been enrolled in OPD SAM / OPD MAM treatment?

☐ 1	☐ 2	☐ 3	☐>3

5. Why has your child returned to the programme?

☐ a. Child has discontinued the programme and returned. a[1]. Why? ______________________

☐ b. Child was cured and relapsed. b[1]. Why? ______________________

6. Do you have other children enrolled in OPD SAM / OPD MAM treatment?

☐ Yes a[1]. How many? ☐ 1 ☐ 2 ☐ 3

☐ No

7. Why did you decide to enrol your child in OPD SAM / OPD MAM treatment?

- ☐ Recognised that child is malnourished
- ☐ Malnutrition diagnosed by health personnel/ health centre during routine visit
- ☐ Referral during community screening by CHW
- ☐ Referral by traditional healer/village doctor
- ☐ Short distance: Min___________
- ☐ Minimal or non-existing security risks
- ☐ Accessibility (no seasonal barriers)
- ☐ Availability of company during the journey to the health centre
- ☐ Efficiency of treatment (quick and visible results)
- ☐ Known child cured receiving treatment
- ☐ Support and encouragement of the husband
- ☐ Support and encouragement of another family member
- ☐ Support and encouragement of parents with malnourished children
- ☐ Support, follow up and encouragement of a community nutrition volunteer
- ☐ Support and encouragement of neighbours
- ☐ Support and encouragement of community leaders
- ☐ Programme appreciated by the community
- ☐ Programme staff is friendly and patient
- ☐ Free service
- ☐ Other: Please specify:_____________________

8. a. Which is the main language you speak at home?

b. Which language do you prefer to receive written information in?

c. Which language do you prefer to receive verbal information in?

d. How do you prefer to receive information? (e.g. poster, leaflet, radio, TV, in person, SMS)

e. Are you able to easily understand the health / nutrition information given at the health centre?

Thank you!

Comments:

L: QUESTIONNAIRES WITH CARERS OF NON-COVERED OPD SAM AND OPD MAM CASES (CHILDREN UNDER 5)

☐ **NON-COVERED OPD SAM** ☐ **NON-COVERED OPD MAM CASES**

Team: ____________	**Name of interviewer:** ____________
Province: ____________ **District:** ____________	**Date:** ____________
Village: ____________	**Walking Distance:** ☐ Near (<30 mins) ☐ Far (30-60 mins) ☐ Very far (> 60 mins)
Nearest Health facility: ______	

Gender: ☐ Male ☐ Female	**Age** (in months): ______
MUAC (mm): ________	**Oedema** (circle correct value): + ++ +++ n/a
Child status: ☐ **Child is SAM** ☐ **Child is MAM** ☐ **Child is Well-nourished**	

1. **Has your child / children been measured with this tape in your village previously? [Prompt: Show the carer the MUAC tape]**						
☐ Yes	a. Who assessed your child's / children's health using this tool	☐ CHW	☐Village health Shura	☐Community clinic staff	☐ Yourself	☐ Someone else (please specify)
	b. How long ago were they measured?	☐ Last 7 days	☐ During last month	☐ 1 to 6 months ago	☐ More than 6 months ago	
☐ No						

2. **Do you think your child is ill?**	
☐ Yes	☐ No → **End**

3a. What symptoms is your child suffering from?		
☐ a. Vomiting	☐ b. Fever	☐ c. Diarrhoea
☐ d. Weight loss	☐ e. Loss of appetite	☐ f. Apathy
☐ g. Swelling	☐ h. Loss of hair	☐ i. Skin lesion
☐ j. Difficulty breathing	☐ k. Cough / runny nose	☐ l. Other, please specify: ________

3b. What illness has caused these symptoms?		
☐ a. I don't know	☐ b. Malnutrition	☐ c. Spiritual disease/witchcraft
☐ d. Weight loss	☐ e. Malaria	☐ f. Diarrhoea
☐ g. Skin disease	☐ h. Worm infestation	☐ i. Measles
☐ K. Other, please specify: ________		

3c. How have you tried to treat this illness or how are you going to treat it?		
☐ a. Consultation at government Clinic / hospital	☐ b. Consultation in private clinic	☐ c. No treatment
☐ d. Medicinal products (bought at the pharmacy)	☐ e. Medicinal products (bought at the market)	☐ f. Other, please specify:________

3d. Who made a decision about the choice of treatment?		
☐ a. Mother	☐ b. Father	☐ c. Other family member
☐ d. CHWs	☐ e. Health personnel	☐ f. Other. Please specify:

4. Do you know that there is a service at the health centre dedicated to the treatment of malnutrition? What do you know about this service?	
☐ Yes, ______________________________	☐ No → STOP

5. Why didn't you bring your child to the health centre for the treatment?

- ☐ Health centre too far; walking distance (min):
- ☐ Insecurity
- ☐ Inaccessibility (e.g. monsoon, seasonal flooding, etc.)
- ☐ Non-availability of the company for the journey
- ☐ Husband/family refusal
- ☐ Carer ill
- ☐ Family member ill
- ☐ Too busy: Reason:-----------------
- ☐ No-one to look after other children
- ☐ Ashamed to go to the centre or feel ashamed to get service from the programme
- ☐ Lack of conviction that the programme can help the child
- ☐ Fear of hospital stay (away from HH, fees)
- ☐ Preference of traditional treatment
- ☐ Previous rejection of child from centre: Specify why _____ and When_______?
- ☐ Rejection of a known child: Reason_______
- ☐ Long waiting time at health centre
- ☐ Quantity of Super cereal is too little to justify the journey
- ☐ Transportation cost is too high
- ☐ Other: Please specify:__________________

6. Has your child been already enrolled in OPD SAM / OPD MAM treatment?		
☐ Yes	☐ No → STOP	
6a. Why isn't your child still in the programme?		
☐ a. Defaulted	a[1]. When? ☐< 2 weeks ☐2-4 weeks ☐> 1 month	☐ a[2]. Why? __________
☐ b. Discharged as cured	b[1]. When? ☐< 2 weeks ☐2-4 weeks ☐> 1 month	
☐ c. Discharged but not cured	c[1]. When? ☐< 2 weeks ☐2-4 weeks ☐> 1 month	☐c[2]. Why? __________
☐ d. Other reason, please specify: ______________________________		

7. a. Which is the main language you speak at home?
b. Which language do you prefer to receive written information in?
c. Which language do you prefer to receive verbal information in?
d. How do you prefer to receive information? (e.g. poster, leaflet, radio, TV, in person, SMS)
e. Are you able to easily understand the health / nutrition information given at the health centre?

Comments:

M: QUESTIONNAIRES WITH COVERED OPD MAM CASES (PLWS)

Team: ______________________	**Name of interviewer:** ______________________
Province: ______________ **District:** ______________	**Date:** ______________
Village: ______________________	**Walking Distance:** ☐ Near (<30 mins)
Nearest Health facility: ______	☐ Far (30-60 mins) ☐ Very far (> 60 mins)

Age (in years): _______	
MUAC (mm): ______________	**Oedema** (circle correct value): + ++ +++ n/a
Status: ☐ **PLW is MAM**	☐ **PLW is Well-nourished**

IF OPD MAM**,** proof that PLW is in programme**:**	☐ OPD MAM treatment card	☐ Packet of Super cereal	☐ Verification by CHW

1. **Have you been measured with this tape in your village previously?**
[Prompt: Show the PLW the MUAC tape]

☐ Yes	c. Who assessed you using this tool	☐ CHW	☐Village health Shura	☐Community clinic staff	☐ Someone else (please specify)	
	d. How long ago were you measured?	☐ Last 7 days	☐ During last month	☐ 1 to 6 months ago	☐ More than 6 months ago	
☐ No						

2. **Is this the first time that you have been enrolled in OPD MAM treatment?**

☐ Yes → **Q5**	☐ No → **Q2**

3. **How many times have you been enrolled in OPD MAM treatment?**

☐ 1	☐ 2	☐ 3	☐>3

4. **Why did you decide to enrol in the OPD MAM programme?**

- ☐ Recognised that I was malnourished
- ☐ Malnutrition diagnosed by health personnel/ health centre during routine visit
- ☐ Referral during community screening by CHW
- ☐ Referral by traditional healer/village doctor
- ☐ Short distance: Min___________
- ☐ Minimal or non-existing security risks
- ☐ Accessibility (no seasonal barriers)
- ☐ Availability of company during the journey to the health centre
- ☐ Efficiency of treatment (quick and visible results)
- ☐ Known PLW cured after receiving treatment
- ☐ Support and encouragement of the husband
- ☐ Support and encouragement of another family member
- ☐ Support and encouragement of a neighbour
- ☐ Support, follow up and encouragement of a community nutrition worker
- ☐ Support and encouragement of community leaders
- ☐ Programme appreciated by the community
- ☐ Programme staff is friendly and patient
- ☐ Free service
- ☐ Other: Please specify:_______ ______________

5. a. Which is the main language you speak at home?
b. Which language do you prefer to receive written information in?
c. Which language do you prefer to receive verbal information in?
d. How do you prefer to receive information? (e.g. poster, leaflet, radio, TV, in person, SMS)
e. Are you able to easily understand the health / nutrition information given at the health centre?

Comments:

N: QUESTIONNAIRES WITH NON-COVERED OPD MAM CASES (PLWS)

Team: ______	**Name of interviewer:** ______
Province: ______ **District:** ______	**Date:** ______
Village: ______	**Walking Distance:** ☐ Near (<30 mins)
Nearest Health facility: ______	☐ Far (30-60 mins) ☐ Very far (> 60 mins)

Age (in years): ______	
MUAC (mm): ______	**Oedema** (circle correct value): + ++ +++ n/a

1. **Have you been measured with this tape in your village previously?** **[Prompt: Show the carer the MUAC tape]**						
☐ Yes	c. Who assessed your health using this tool?	☐ CHW	☐Village health Shura	☐Community clinic staff	☐ Someone else (please specify)	
	d. How long ago were you measured?	☐ Last 7 days	☐ During last month	☐ 1 to 6 months ago	☐ More than 6 months ago	
☐ No						

2. **Do you think that you are suffering from an illness?**	
☐ Yes	☐ No → **End**

3a. What symptoms are you suffering from?		
☐ a. Vomiting	☐ b. Fever	☐ c. Diarrhoea
☐ d. Weight loss	☐ e. Loss of appetite	☐ f. Apathy
☐ g. Swelling	☐ h. Loss of hair	☐ i. Skin lesion
☐ j. Difficulty breathing	☐ k. Cough / runny nose	☐ l. Other, please specify: ______

3b. Which illness do you think has caused these symptoms?		
☐ a. I don't know	☐ b. Malnutrition	☐ c. Spiritual disease/witchcraft
☐ d. Weight loss	☐ e. Malaria	☐ f. Diarrhoea
☐ g. Skin disease	☐ h. Worm infestation	☐ i. Measles
☐ K. Other, please specify: ______		

3c. How have you tried to treat this illness or how are you going to treat it?		
☐ a. Consultation at government Clinic / hospital	☐ b. Consultation in private clinic	☐ c. No treatment
☐ d. Medicinal products (bought at the pharmacy)	☐ e. Medicinal products (bought at the market)	☐ f. Other, please specify: ______

3d. Who made a decision about the choice of treatment?		
☐ a. I did	☐ b. My husband	☐ c. Other family member

☐ d. CHWs	☐ e. Health personnel	☐ f. Other. Please specify:

4. Do you know that there is a service at the health centre dedicated to the treatment of malnutrition? What do you know about this service?

☐ Yes, ____________________ ☐ No → **STOP**

5. Why didn't you go to the health centre to seek treatment?

- ☐ Health centre too far; walking distance (min):
- ☐ Insecurity
- ☐ Inaccessibility (e.g. monsoon, seasonal flooding, etc.)
- ☐ Non-availability of the company for the journey
- ☐ Husband/family refusal
- ☐ Family member ill
- ☐ Too busy: Reason:-----------------
- ☐ No-one to look after children
- ☐ Ashamed to go to the centre or feel ashamed to get service from the programme
- ☐ Lack of conviction that the programme can help
- ☐ Fear of hospital stay (away from HH, fees)
- ☐ Preference of traditional treatment
- ☐ Previous rejection from centre: Specify why _____ and When_______?
- ☐ Rejection of another PLW: Reason_______
- ☐ Long waiting time at health centre
- ☐ Quantity of Supercereal is too little to justify the journey
- ☐ Transportation cost is too high
- ☐ Other: Please specify:__________________

6. Have you been previously enrolled in OPD MAM treatment?

☐ Yes ☐ No → **STOP**

6a. Why aren't you still in the programme?

☐ a. Defaulted	a[1]. When?	☐< 2 weeks ☐2-4 weeks ☐> 1 month	☐ a[2]. Why? ________
☐ b. Discharged as cured	b[1]. When?	☐< 2 weeks ☐2-4 weeks ☐> 1 month	
☐ c. Discharged but not cured	c[1]. When?	☐< 2 weeks ☐2-4 weeks ☐> 1 month	☐c[2]. Why? ________
☐ d. Other reason, please specify: ____________________			

7. a. Which is the main language you speak at home?
b. Which language do you prefer to receive written information in?
c. Which language do you prefer to receive verbal information in?
d. How do you prefer to receive information? (e.g. poster, leaflet, radio, TV, in person, SMS)
e. Are you able to easily understand the health / nutrition information given at the health centre?

Comments:

ANNEX 4: LIST OF PEOPLE CONSULTED

Meeting with IMAM working group

May 5, 2019 Sunday

Dr. Shafiqullah Safi-IMAM Supply and Emergency Senior Officer, PND

Dr. Mursal Manati-Director, PND

Dr. Iftekhar Sadat-Director Evaluation

Dr. Asif -Directorate of Evaluation Department

Dr. Shams Mohammad Qasem-WHO

Dr. Niamat Ullah Hayat-WFP

Dr. Ruhullah-BPHS Implementer (BDN)

Dr. Ghulam Ali -PUAMI

Dr. Navid Ahmad-AKHS

Dr. Ahmad Nawid Qarizada-UNICEF

Mr. Ivan Ssenkubuge-UNICEF

Ms. Robina Shaheen

Dr. Delwar Hussain

Meeting with Evaluation Directorate

May 5, 2019

Dr. Iftekhar Sadat-Director Evaluation

Dr. Asif -Directorate of Evaluation Department

Dr. Shams Mohammad Qasem-WHO

Dr. Ahmad Nawid Qarizada-UNICEF

Mr. Ivan Ssenkubuge-UNICEF

Ms. Robina Shaheen-ACF

Dr. Delwar Hussain-Consultant to ACF

Meeting with World Bank, Kabul

May 6, 2019

Dr. Habib -World Bank

Ms. Robina Shaheen-ACF

Dr. Delwar Hussain-Consultant ACF

Meeting with GCMU and BPHS implementer

May 7, 2019

Dr. Motwali Younusi-Head of IMNCI programme

Dr. Mohammad Nawrozuddin Noorzad-Senior Grant Consultant GCMU

Dr. Abdul Qadir-BPHS Implementer (ADA)

Dr. Isatullah Akbari-BPHS Implementer (MOVE)

Dr. Zahedulla Sagawil-Save the Children

Meeting with Evaluation taskforce meeting

May 8, 2019 Wednesday

Dr. Shafiqullah Safi-IMAM Supply and Emergency Senior Officer, PND

Dr. Iftekhar Sadat-Director Evaluation

Dr. Asif Alokozay-Directorate of Evaluation Department

Dr. Niamat Ullah Hayat-WFP

Dr. Gulam Ali Wahadat- PUAMI-BPHS Impementer

Dr. Ahmad Nawid Qarizada-UNICEF

Mr. Ivan Ssenkubuge-UNICEF

Ms. Robina Shaheen-ACF

Dr. Delwar Hussain-ACF Consultant

Meeting with UNICEF Colleagues

May 9, 2019

Maureen Gallagher-UNICEF

UNICEF -WASH Programme

UNICEF -Child Health Programme

ANNEX 5: LIST OF DOCUMENTS

Type of documents	Documents details
Policies, Strategies and Plans	Afghanistan Food Security and Nutrition Agenda (AFSANA) A Policy and Strategic Framework, 2012
	Community Based Health Care Strategy, 2015-2020, 2014
	A Basic Package of Health Services for Afghanistan, 2010
	The Essential Package of Hospital Services for Afghanistan, 2005
	Humanitarian Response Plan, Nutrition Cluster Plan, 2016
	Humanitarian Response Plan, Nutrition Cluster Plan, 2017
	Humanitarian Response Plan, 2017
	Humanitarian Response Plan, Nutrition Cluster Plan, 2018
	Humanitarian Response Plan, 2018-2021, 2017
	Humanitarian Response Plan, 2018-2021, Revised financial requirements due to drought, 2018
	Humanitarian Response Plan, 2018-2021, 2019 Update, December 2018
Guidelines	Integrated Management of Acute Malnutrition National Guidelines, 2018
	Nutrition Supply Chain Management, Standard Operating Procedures, 2017
	Integrated Management of New Natal and Childhood Illness, Chart booklet, 2015
	Community Case Management for Charts for Community Health Workers, 2018
Articles	Safi, S et al 2018 Exploring the health system for sustainable and integrated acute malnutrition services applying a systems lens: the case of Afghanistan. International Journal of Integrated Care, 18(S2): A225, pp. 1-8, DOI: dx.doi.org/10.5334/ijic.s2225
	Screening for maternal and child malnutrition using sentinel-based national nutrition surveillance in Afghanistan, Field Exchange 58, September 2018
	Ahmad Nawid Qarizada, Piyali Mustaphi, Jecinter Akinyi Oketch and Shafiqullah Safi (2018). Scale-up of IMAM services in Afghanistan. Field Exchange 57, March 2018. p48. www.ennonline.net/fex/57/imamafghanistan
	Akseer, N et al Achieving maternal and child health gains in Afghanistan: a Countdown to 2015 country case study. Lancet Global Health , June 2016
Data	IMAM Programme, Admissions Data, 2010-2016
	CMAM Tables analysis Jan-Dec 2013
	IMAM Performance reports analysis, Jan-Dec 2014
	IMAM Performance reports analysis, Jan-Dec 2015
	IMAM Performance reports analysis, Jan-Dec 2016
	IMAM Performance reports, Trends 2010-2016
	IMAM Programme, SAM Performance Data , 2017-2018
	Humanitarian Response Plan, Nutrition Cluster Beneficiaries, Caseload 2016
	Afghanistan Nutrition Cluster - Caseload and targets calculation 2017
	CHAP 2017 -Vulnerability Analysis Framework, 2017
	Humanitarian Needs Overview, People in need 2017
	Caseload 2018

	IMAM caseload and coverage 2018
	Acute malnutrition burden 2018
	Database of Nutrition Assessments results, 2014-2017, 2017
Periodic publications	Humanitarian Needs Overview, 2017-2018 (Annual)
	Afghanistan National Nutrition Surveillance Bulletin, Issues 1 to 14, 2015-2018 (Quaterly)
Surveys and Assessments	Afghanistan Mortality Survey, 2010
	Afghanistan Multiple Indicator Cluster Survey, 2010-2011
	Afghanistan Demographic and Health Survey, 2015
	Afghanistan National Nutrition Survey, 2004
	Afghanistan National Nutrition Survey, 2013
	Rapid Nutrition Assessment Reports and Local SMART survey reports, 2011-2018
	Afghanistan Nutrition Assessment Synthesis: Key findings from 31 SMART nutrition surveys conducted in Afghanistan 2015-2018
	National Risk and Vulnerability Assessment, 2007-2008
	National Risk and Vulnerability Assessment, 2011-2012
	National Risk and Vulnerability Assessment, 2013-2014
	Afghanistan Seasonal Food Security Assessments, 2013 to 2017 (Annual)
	Drought Emergency Food Security Assessment Report, August 2011
	Drought Impact Emergency Food Security Assessment in 14 provinces in Afghanistan, Second Phase Report, November 2011
Miscellaneous	Afghanistan Health Indicators, 2014
	A review of SAM management in Afghanistan: Lessons from 2013-2015, 2016
	The Balanced Scorecard Report, Basic Package of Health Services, 2016
	The Balanced Scorecard Report, Afghanistan Hospitals 2016
	Afghanistan Zero Hunger Strategic Review, 2017
	Afghanistan: Sehatmandi Project (P160615)and Programmatic Advisory Service and Analytics Implementation Support Review, 2018
	Workshop report on Nutrition Information Management (NIM) in Afghanistan, 2018
	Key Messages Afghanistan HNO and HRP 2018
	Prevalence of Acute Malnutrition Map, December 2017
	Consultancy for Revising the Integrated Management of Acute Malnutrition Service Delivery Package for Afghanistan, End of mission report, 2018
	Review of IMAM in Afghanistan, Inception Report, 2017
	IMAM Service Implementation in Afghanistan: A Situation Analysis, 2017
	Integrated Food Security Phase Classification, Current and projected food insecurity, 2018
	Integrated Food Security Phase Classification, Acute food security analysis, 2018
	Strengthening Data and Programme Quality by Identifying Barriers and Bottlenecks to Enhance Effective Coverage of Integrated Management of Acute Malnutrition (IMAM) / Severe Acute Malnutrition (SAM) Services in Afghanistan, 2017
	ToR for Nutrition Counselor, 2016
	ToR Nutrition Officer, 2008

	Nutrition Cluster Situation and Response Dashboard, January-May, 2018
	Nutrition Cluster Coordination Mechanism, Focal point, April 2018
	Afghanistan Nutrition Cluster, 2017 Annual Report, 2018
	Afghanistan Nutrition Cluster IMAM services 3W map, October 2018
	Severity of Acute Malnutrition in Afghanistan, December 2018
	World Bank, Nutrition Implementation Support Mission Outputs, November 2018
	World Bank, Nutrition Implementation Support Mission Outputs, March 2019
Monitoring and Evaluation Tools	Assessment checklists: - Out-patient Assessment Checklist - In-patient Assessment Checklist
	Monitoring checklists – Dari: - Flour fortification Monitoring checklist - Micronutritient Supplementation Monitoring checklist - OPD SAM and MAM Monitoring Check list - IPD SAM and IYCF Monitoring Check list - USI External Monitoring Checklist - USI In the market Monitoring Checklist Monitoring checklists – English: - Flour fortification Monitoring checklist - Nutrition Monitoring Checklists
	Quality Assurance Standard Checklist for IMAM: - Outpatient checklist - Inpatient checklist
	Referral slips: - IPD-SAM to OPD-SAM, - OPD-MAM to OPD-SAM, - OPD-MAM, - OPD-SAM to IPD-SAM
	Registration Tools: - IPD-SAM Register book, - IYCF Register, - OPD PLW Register book, - OPD MAM Register book, - OPD SAM Register book, - Surveillance register
	Reporting Tools – Dari: - Iodized Salt Factory - IYCF Monthly report Reporting Tools – English: - BMS code violation monitoring report - IPD and OPD SAM, Monthly Statistics Report Format - IYCF Monthly Counselling, Monthly Statistics Report Format - Micronutrients supplementation Monthly report - OPD MAM AM-PLW Project completion report - OPD MAM, Monthly Statistics Report Format - OPD MAM & OPD-AM, PLW, Monthly Statistics Report Format
	Tally sheets: - Case Mapping Tally Sheet - IYCF Tally Sheet - Micronutrients Tally Sheet

	Treatment and Follow-up tools: - Defaulter tracing questionnaire - Home visit questionnaire - Home visit recording form - Home-base treatment card - Medical surveillance sheet - OPD-MAM/OPD-AM PLW card - OPD-SAM treatment and follow-up card - Therapeutic surveillance sheet

ANNEX 6: TOR FOR THE EVALUATION STEERING COMMITTEE

BACKGROUND

The Ministry of Public Health is strongly committed to strengthen coordination in the health sector within the framework of good governance of the Ministry as a state institution. It is also committed to improve the evidence-based and participatory decision making at all levels of the health system under the 6th strategic direction of the MoPH strategy 2016-2020. In addition to this, Public Nutrition Strategy 2019-2023 is recommending strengthening nutrition status monitoring and surveillance system under Sub Intermediate Result 3.6. The General Directorate of Evaluation and Health Information System of the Ministry of Public Health is responsible to steward and ensure the availability, coordination, dissemination and use of accurate, valid and user-friendly health information in order to facilitate evidence-based decision- and policy-making for health system improvement. The Research Coordination and Evaluation Directorate under GD M&EHIS is responsible for coordinating the research studies and evaluations for ensuring their quality from the design to the implementation and dissemination of results with specifically ensuring the data quality in the field. Public Nutrition Directorate is willing to use all available opportunities with relevant MoPH departments and nutrition partners for understanding the nutrition situation through conducting the IMAM Evaluation for planning of the further nutrition interventions related to integrated management of acute malnutrition for optimal nutrition status of vulnerable groups.

Purpose of IMAM Evaluation Steering Committee

The purpose of the IMAM Evaluation Steering Committee is to improve coordination from the design to implementation, ensure quality of the data collected, and facilitate its proper dissemination and sharing the result with MoPH high decision makers through different existing M&E HIS technical platforms.

Specific objectives

- To engage various stakeholders for better coordination and implementation of IMAM evaluation
- To review the protocol, provide technical support, and give approval of the study design, sampling, sample size, and tools

- To oversee and facilitate the study implementation through subnational coordination, field monitoring
- To review the data set for technical inputs and validation
- To review the draft report and provide inputs on the design and program related issues
- To approve the final report of the IMAM evaluation
- To support the wider dissemination of the IMAM evaluation
- To reflect the IMAM evaluation results in M&E HIS information sharing events

Chair and composition

The chair of the steering committee is the General Director of EHIS (Research Coordination and Evaluation directorate) and the co-chair will be the Public Nutrition Directorate. The steering committee members are representing their relevant departments or organizations. The secretariat will be performed by the Research Coordination and Evaluation Directorate. The following departments or organization will be members:

1. GD of M&EHIS (Research Coordination and Evaluation Directorate)
2. PND
3. UNICEF
4. World Health Organization
5. World Food Program
6. MEDAIR
7. AADA
8. PU-AMI
9. SCI

Ad hoc members will be added by the chair of the board.

Responsibility of chair and co-chair:

- To ensure that every board member have the equal chance
- To prioritize the issues to be presented to the board
- In the absence of the chair, the co-chair has the right to represent him/her,
- The chair/co-chair should sign all official documents related to the business of the steering committee
- To assign technical working groups for specialized tasks

Responsibility of Members:

- The members are required to attend the meetings unless notified in advance by identifying his/her substitute

- The members should follow the actions taken during the steering committee meeting
- The members should actively participate by voting to the decisions taken by the steering committee
- The members are required to show accountability for his/her stand regarding the dissemination of the results of IMAM evaluation.
- The members should sign the undertaking document.

Responsibilities of M&EHIS (RC&E)

- To facilitate the information need identification
- To identify the need for information generation to avoid duplication
- To facilitate the capacity development
- To ensure the IMAM evaluation data quality through regular coverage and content monitoring approaches in coordination with PND
- To oversee the technical aspects of the IMAM evaluation such as study designs, sampling and sample size calculations, study results, and dissemination
- To support the survey implementation at the national and subnational levels

Responsibilities of PND

- To ensure that IMAM evaluation is well-coordinated with steering committee
- To facilitate the communication between evaluation conducting partners and M&E HIS (RC&E) directorate
- Participating in the steering committee to facilitate technical discussions specifically related to the IMAM program
- Follow up of action points agreed in the steering committee

Meetings:

Meetings will be conducted on ad hoc basis. However, the chair or co-chair can invite meetings based on need as well.

Quorum:

The decisions will be taken by the consensus of present majority of member.

ANNEX 7: LIST OF PROPOSED STAKEHOLDERS TO BE INTERVIEWED

Organization	Type of Organization
UNICEF	UN (SPEAR, Nutrition, WASH, Health, Polio, Nutrition Cluster Coordinator, National and Regional Section Heads and Managers, Emergency Section)
WHO	UN (National and regional Section Heads and Managers of relevant sections for IMAM)
WFP	UN (National and regional Section Heads and Managers of relevant sections for IMAM)
MoPH (PND and Evaluation Directorate)	Government
IMAM TWG	
GCMU	Government
RMNCH	Government
IMNCI	Government
CBHC	Government
SM	Government
AADA	National NGO
MOVE	National NGO
BDN CAF	National NGO
AHDS	National NGO
ORCD	National NGO
CHA	National NGO
HN-TPO	National NGO
ACF	International NGO
MEDAIR	International NGO
SCI	International NGO
AKHS	International NGO
WVI	International NGO
USAID	Donor
World Bank	Donor
DFID	
EU	
CHF	

ANNEX 8: INTERVIEW QUESTIONS FOR INCEPTION MISSION

Purpose

- Why is evaluation being done
- How it will be used
- Why is it being conducted now (what triggered it)
- Who will use it
- What decisions will be taken after the evaluation is complete (Evaluations are most used when they are planned to coincide or are driven by a decision that needs to be taken)
- What do you want recommendations to cover, for who and why
- **Is the evaluation of UNICEF contribution/components or overall IMAM (for unicef)**

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Partners, implementers other stakeholders (define stakeholders)

- Who the partners are and how they will be involved in the evaluation
- What has their role been in the programme (Gov (national, provincial, district), UN (unicef, WFP, WHO, NGOs(BPHS, non-BPHS, their donors, FH360)
- What do they contribute to programme, what , where, how, why (budget, manpower, equipment/supplies etc)
- What would they like to see from the evaluation (what are your information needs, questions they want answered, issues to look at and what will they do with the information provided by the evaluation)
- Partnership with unicef (what, why, issues, how long)
- Who are primary secondary stakeholders

IMAM programme

- Issues in implementation (including locations, how are challenging locations defined, monitoring, data collection
- Coverage
- Evolution of the programme (changes made through the years, and why)
- Availability of action plans
- The needs of the target population (what problem is being addressed, has this evolved over the programme, define needs)
- Target population/beneficiaries
- Programme components/activities, strategies
- Implementation period

Programme Beneficiaries

- Children, women with acute malnutrition (is women within WFP's remit, if unicef then what, is both women and child component being evaluated)
- Most vulnerable and marginalized children(how is this defined)
- The ToR refers to P&LW and to MAM children. Are programme components for these groups funded by UNICEF? The inclusion of these components for evaluation makes methodologies far more extensive. complex and costly-

Evaluation Scope:

Time:

- IMAM started in 2014 so what is the reason for wanting to know trends from 2010 (the evaluation is about IMAM)- should the scope be from 2014-2018
- Why is it 2013-17
- Is data available from 2010-2013/ 2013-2018
- Why is 2018 not part of scope (is data available for 2018)
- how would highlighting the trends of acute malnutrition cases and actions implemented by UNICEF and partners from 2010 help

Geographical:

Implementers: collaboration of UNICEF, WFP, WHO, Implementing NGOs and the Government of Afghanistan.

- **Were these still implementing partners in 2018 (who/which departments specifically involved)** ,
- IMAM started in 2014 so were these involved in 2013- as it was design phase- how involved IMAM technical group has members from the MoPH, NGOs, UNICEF, WHO,WFP and FHI 360, who, how are they involved, their role in the evaluation

Programme components:

Detection of acute malnutrition among patients at different levels of health facilities;

Treatment through out-patient and inpatient departments;
Counselling of mothers and caretakers;
Assessing /managing the main causes of malnutrition, such as: micronutrients, infant and young child feeding practices and home-based caring.

- Assume both SAM and MAM are include- are interventions different for each
- Who are the patients for IMAM?
- What are the different levels of health facilities?
- What did counselling of mothers/caretakers involve, how are 'caretakers defined')(where was this done)

Results: Considering the **national nutrition strategies** of the Government of Afghanistan, the evaluation will examine **the IMAM's performance** in:
Increasing access to nutrition services and products for children and their families
Improving nutrition behaviours and practices among target groups
Improving the quality of nutrition services and products
Strengthening social, regulatory and political environment for nutrition

- Are the above aligned/from nutrition strategy 2015-2020 and/or 2009-2013, what results were being used to report against in 2014
- To assess 2013-2017 what results framework do we use (results, indicators, targets, geographical coverage)
- What results did the programme intend to achieve at outcome, output levels and where could we find a description of these
- Are targets aligned to international, national, regional benchmarks (what are these benchmarks
- Have targets, results been redefined- based on progress/analysis- any changes in strategies/activities/targets as a results of any analysis
- were indicators being met- targets being met- did they expand appropriately- were barriers tackled
- 2013- IMAM guidelines published, integrated into health system, any evolution in guidelines, was evolution appropriate to context, could anything have been done better
- Identify the extent of the integration of other nutrition interventions into IMAM. This will determine the extent to which this evaluation can answer some questions in the ToR
- **What evaluation will not cover about IMAM programme**

Evaluation management structure

- Identify evaluation management structure (their roles/responsibilities)
    - Evaluation oversight (Country rep / ROSA MEAL team)
    - Stakeholder representative group (all stakeholders in IMAM)
    - Evaluation management group (primary stakeholders)
    - Evaluation teams
        - ACF team
        - Enumerator team

Evaluation ethics

Who do we need ethical clearance from for the evaluation – (IMAM members and national ethical bodies)

Sample

Sampling criteria

ANNEX 8: GANTT CHART (WORKPLAN)

	Phase-wise activities and deliverables		2019																												2020							
			June				July				Aug - Sep				Oct			Nov					Dec				Jan				Feb				Mar			
		May	10-Jun	17-Jun	24-Jun	01-Jul	08-Jul	15-Jul	22-Jul	29-Jul	05-Aug	12-Aug	19-Aug	26/08 - 13/10	14-Oct	21-Oct	28-Oct	04-Nov	11-Nov	18-Nov	25-Nov	02-Dec	09-Dec	16-Dec	23-Dec	30-Dec	06-Jan	13-Jan	20-Jan	27-Jan	03-Feb	10-Feb	17-Feb	24-Feb	02-Mar	09-Mar	16-Mar	23-Mar
	Phase I:Inception Phase																																					
1	Kick-off meeting with UNICEF commissioning team to review the proposal submited and seek clarifications																																					
2	Develop data collection instruments																																					
3	Refine and finalise evaluation methodology including analytical framework																																					
4	**Deliverable 1: Draft Inception Report submitted**																																					
5	Feedback received from UNICEF/ESG/Ethics Board																																					
6	Incorporate feedback on inception report																																					
7	**Deliverable 2: Final Inception Report and data collection intruments**																																					
8	**Deliverable 3: Presentation of summary of finalised inception report to Evaluation Steering Group**																																					
9	Desk review of IMAM's key programme documents																																					
10	Review and refine sampling strategy given in the proposal and select representative sample																																					
	IRB sign off of methodology and sampled districts																																					
11	Prepare for training and data collection																																					
	Phase II: Data collection																																					
12	Training of data collection team on evaluation back ground, survey instruments, data collection protocols, ethical and quality assurance procedures																																					
13	Pilot testing and revision of data collection instruments where required																																					
14	Data collection in Provinces																																					
15	Interviews with key informants in Kabul																																					
16	**Deliverable 4: Submit weekly progress reports**																																					
17	Conduct data quality assurance to verify accuracy and validity of collected data																																					
18	**Deliverable 5: Submit quality assurance report**																																					
19	**Deliverable 6: Submit end of data collection field work report** summrizing process for data collection, conditions in sample areas, issues and coping mechanisms																																					
	Phase III: Data Analysis and Report Writing																																					
20	Clean, scrutinize and analyse data																																					
21	Develop draft evaluation report																																					
22	**Deliverable 7: Submit draft report to UNICEF**																																					
23	Review of report by partners																																					
24	Receive comments from UNICEF/ESG members																																					
25	Incorporate comments and revise report																																					
26	**Deliverable 8: Prepare and deliver presentation of evaluation findings, lessons learned and recommendations to UNICEF/ESC and other stakeholders**																																					
27	**Deliverable 9: Submit summary report 2-4 pages with key findings and infographics, final report, clean data sets plus fgd and interview trans cripts**																																					