

VALID

Evaluation of Community Management of Acute Malnutrition (CMAM) in Sudan, 2015 - 2019

Inception Report

August 30, 2020

Dr. Camille Eric Kouam Kouotso

Emmanuel Mandalazi

Simon Mollison

Dr. Khalid Abd Rahman Abdelsalam

Dr. Steve Collins

CONTENTS

List of Acronyms	3
1. Introduction	5
1.1 Overview of the Inception Report	5
1.2 Background	5
1.3 Evaluation Purpose, Objectives and Scope	6
1.4 CMAM Stakeholders	7
2. Evaluation Design and Methodology	7
2.1 Approach	7
2.2 Overview of expected programme results at different levels	7
2.3 Evaluation Criteria and Questions	10
2.4 Evaluation Methodology	12
2.1.1 Sampling of Sites to be Visited	12
2.1.2 Review of Documents and Secondary Data	14
2.1.3 Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)	15
2.1.4 Financial Assessment	18
2.1.5 Semi-Structured Key Informant Interviews (KII)	18
2.1.6 Focus Group Discussions	19
2.1.7 Direct Observations	19
2.1.8 Data Collection Tools	19
2.5 Data Analysis	20
2.6 Ethical Considerations	20
2.7 Expected Challenges/Limitations and Mitigation Factors	21
3. Tentative Workplan and Calendar	23
4. Team Composition	25
5. References	26
6. Annexes	28
6.1 Annex 1: Draft Stakeholder Mapping CMAM Evaluation Sudan	28
6.2 Annex 2: Evaluation Matrix	31
6.3 Annex 3: Routine Data Collection Forms for SQUEAC Assessment	38
6.4 Annex 4: Interview and FGD guides for primary qualitative data collection	49
6.5 Annex 5: Checklist for Direct Observation in Health Structures	57
6.6 Annex 6: Free and Informed Consent Template	59
6.7 Annex 7: Terms of Reference	60
6.8 Annex 8: Elaboration of the Evaluation Questions in the Terms of Reference	67

LIST OF ACRONYMS

BBQ	Barriers, Boosters and Questions
CBV	Community Based Volunteer
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
CO	Country Office
DAC	Development Assistance Committee
DHS	Demographic and Health Surveys
ECHO	European Civil Protection and Humanitarian Aid Operations
EM	Evaluation Matrix
EPI	Expanded Programme on Immunization
ERG	Evaluation Reference Group
FAO	Food and Agriculture Organization
FFP	Food for Peace
FGD	Focus Group Discussion
FMoH	Sudan Federal Ministry of Health
GAM	Global Acute Malnutrition
GoS	Government of Sudan
ICCM	Integrated Community Case Management
IDP	Internally Displaced Population
IMCI	Integrated Management of Childhood Illnesses
INGO	International Non-Governmental Organisation
IR	Inception Report
IYCF	Infant and Young Child Feeding
KI	Key Informant
KII	Key Informants Interview
MAM	Moderate Acute Malnutrition
MoH	Ministry of Health
MoUs	Memorandum of Understandings
MUAC	Mid-Upper Arm Circumference
NACS	Nutrition Assessment, Counselling and Support
NGO	Non-Governmental Organisation

OECD	The Organisation for Economic Co-operation and Development
OFDA	Office of Foreign Disaster Assistance
OTP	Outpatient Therapeutic Care
PHC	Primary Health Care
PII	Personal Identification Information
PLW	Pregnant and Lactating Women
RUTF	Ready-to-Use Therapeutic Food
S3M	Simple Spatial Surveying Method
SAM	Severe Acute Malnutrition
SFP	Supplementary Feeding Programme
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
SUN	Scaling Up Nutrition
TBA	Traditional Birth Attendant
TFC	Therapeutic Feeding Centre
ToC	Theory of Change
ToR	Terms of Reference
TSFP	Targeted Supplementary Feeding Programmes
UNEG	UN Evaluation Group
UNICEF	The United Nations Children's Fund
UN OCHA	United Nations Office for the Coordination of Humanitarian Affairs
Valid	Valid International
W/H	Weight/Height
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization

1. INTRODUCTION

1.1 Overview of the Inception Report

1. This Inception Report (IR) is for the evaluation of the Community-based Management of Acute Malnutrition (CMAM) in Sudan over the period from 2015-2019. It is commissioned by the UNICEF country office (CO) in Sudan. Initially planned for the period January to June 2020, it will finally take place from January 2020 to January 2021. It was delayed because of the COVID-19 situation. The addition of a new State has also extended the evaluation calendar.

2. The IR is a working document developed based on the terms of reference (ToR) of the evaluation, a preliminary review of the documents and exchanges with the UNICEF CO, the Federal Ministry of Health (FMoH) and the Evaluation Reference Group (ERG) during the inception phase. The document provides information on the context, approach, methodology and work plan of the evaluation. Once approved, it will serve as guidance for the evaluation team and guide the evaluation phases.

1.2 Background

3. Sudan is a country in Northeast Africa. It is bordered by Egypt to the north, the Red Sea to the northeast, Eritrea to the east, Ethiopia to the southeast, South Sudan to the south, the Central African Republic to the southwest, Chad to the west, and Libya to the northwest. Sudan is the third-largest country in Africa, having a total estimated 41 million inhabitants in 2019 (CBS 2018). The majority of the population is composed of people below the age of 18 (about 20 million), and children under five represent 16 percent of the population (about 6.5 million).

4. Sudan has the third highest prevalence of acute malnutrition in the world and the highest in the Middle East and North Africa region at 14.1 percent global acute malnutrition (GAM) amongst children under five years. The under-five mortality rate in the country was estimated at 63.5 per 1,000 live births in 2018 compared with 108 per 1,000 live births in 2000 (S3M II 2018). Access to primary health care (PHC), especially the integrated management of childhood illnesses (IMCI) at health facilities, has increased from 43 percent to 46.1 percent in 2013.

5. The problem of undernutrition in Sudan is known to be a manifestation of multiple factors related to: low health status and health services coverage, water availability, food insecurity, periodic humanitarian crises, limited safety nets, and poor economic and education status at all levels (IIIE 2018). However, most of the donor funding for nutrition in Sudan is for short-term support of humanitarian action with limited longer-term outcomes. Insufficient investment in nutrition over the past 30 years has been identified as a missed opportunity for development and economic progress (UNICEF, WFP, FMoH 2016).

6. Since 2009, UNICEF Sudan has focused on scaling up CMAM as one of the approaches to decrease the prevalence and incidence of acute malnutrition. To achieve this, the Sudan Federal Ministry of Health (FMoH) adopted, endorsed and implemented a CMAM scale-up plan for the years 2015-2018 (FMoH 2015). The scale-up plan for CMAM was developed based on the Simple Spatial Surveying Method (S3M) national survey results of 2013 (S3M 2013) and the 2013 recommendations of CMAM review (FMoH, UNICEF, Valid 2013).

7. To achieve universal health coverage, the Government of Sudan is moving in many strategic directions such as expanding the primary health care program and strengthening health systems at locality level. The transitioning strategy will contribute to moving the CMAM programme from being siloed towards being part of an integrated system within Ministry of Health plans and programmes. The UNICEF country program for 2018-2021 is also focusing more on programmatic integration, moving from solely humanitarian based interventions towards

a more developmental focus, while still continuing to address humanitarian needs (UNICEF, 2018). These changes are expected to influence the development of the upcoming CMAM scale-up plan.

8. In this context, the findings and recommendations of the evaluation of the CMAM programme will be instrumental in designing the CMAM scale-up plan 2020-2023 to effectively contribute to achieving both the FMoH and UNICEF's strategic visions for children as well as providing insights on how to improve the existing strategies to achieve a high-quality CMAM programme. To this end, Valid International (Valid) is pleased to present this proposal to implement the CMAM evaluation that will provide guidance to improve the quality of service provision, inform the development and redesign of the CMAM strategy in line with FMoH strategies and facilitate the implementation of the CMAM scale-up plan for 2020-2023.

1.3 Evaluation Purpose, Objectives and Scope

9. As per the ToR, the evaluation aims to serve the two purposes of:
- A. **Learning** from experience; identifying strengths/good practices and determinant factors where results fall short of expectations, to facilitate adjustment and doing business differently; and,
 - B. **Accountability** to affected populations, communities, and donors about the return on investments made in Darfur in responses to the huge humanitarian needs of displaced populations and host communities.
10. The specific objectives of the evaluation are the following:
- a) To assess CMAM-related interventions relevance and appropriateness, efficiency and quality of services (2015-2019) and explain how programme effectiveness could be improved.
 - b) To assess the impact of the current CMAM programme (2015 – 2019) in terms of reduction of acute malnutrition prevalence and determine how the programme can be sustainable and ensure nationwide coverage.
 - c) To measure the current level of integration between CMAM components, and between the CMAM programme and other programmes such as water, sanitation and hygiene (WASH), integrated management of childhood illnesses/integrated community case management (IMCI/ICCM), expanded programme on immunization (EPI), micronutrient programme, infant and young child feeding (IYCF) and reproductive health programme and to advise on how this integration could be fostered in a way that contributes to health system strengthening rather than overburdening it.
 - d) To assess to what extent the implementation of CMAM has contributed to system strengthening, i.e. coordination, governance and management, capacity development, advocacy and policy development.
 - e) To assess the adequacy of the monitoring and information management systems for the CMAM programme and provide recommendations on how this could be extended to lowest level possible (locality and community levels) taking into consideration the different contexts in Sudan (accessible and hard-to-reach areas).
 - f) To document good practices and evidence-based lessons in supporting the recommendations of the evaluation in order to strengthen ongoing efforts towards expansion and quality improvement of CMAM coverage in Sudan.
11. CMAM has four components: a) community outreach/mobilisation; b) outpatient therapeutic programme (OTP) for children with severe acute malnutrition (SAM) without medical complications at decentralised health

facilities; c) inpatient therapeutic feeding centre (TFC) care for children with SAM with medical complications or no appetite; and, d) supplementary feeding programme (SFP) for children with moderate acute malnutrition (MAM) (FMoH, 2014). Although the main focus of the evaluation is the outpatient therapeutic care for SAM, the four CMAM components will be assessed during the evaluation to capture the coherence and continuum of care within the CMAM approach.

12. The evaluation will use the OECD DAC criteria of relevance, effectiveness, efficiency, impact, and sustainability, and will cover the period from 2015 to 2019. The cross cutting issues and aspects such as equity, gender, protection will be considered within each evaluation criteria throughout the evaluation process.

1.4 CMAM Stakeholders

13. Key stakeholders involved in the design and implementation of CMAM in Sudan for the targeted evaluation period (2015 – 2019) included donors such as ECHO, FFP, OFDA, and UN OCHA. Technical partners included UNICEF, WHO and WFP. The main implementation partners are the FMoH and State MoH through their decentralised structures (Locality Health Offices, health workers and nutritionists in the locality health facilities, community health workers (CHWs), and volunteers), as well as non-governmental organisations (NGOs). Other important stakeholders include FAO and Scaling Up Nutrition (SUN) network, which ensure the linkages with nutrition sensitive interventions, and the Ministry of Finance (through its support to the FMoH). Another stakeholder is the private company that produces ready-to-use therapeutic food (RUTF) and supplementary foods locally. At community level, stakeholders include community leaders and members, as well as beneficiaries of the programme. A detailed description of the role of each stakeholder in CMAM, their involvement in the evaluation and the potential use of the evaluation findings and recommendations is presented in Annex 1.

2. EVALUATION DESIGN AND METHODOLOGY

2.1 Approach

13. The evaluation team will adopt a **participatory approach**, which will help ensure that existing stakeholder knowledge is shared and conclusions are verified. Those who have the most to profit from this evaluation, i.e. UNICEF, the Government of Sudan and other key stakeholders, will play an active role throughout the different phases of the evaluation, particularly in shaping the strong learning focus of this evaluation.

14. The evaluation team will also adopt a theory-driven approach (Chen 2012) to unveil the results and outcomes of CMAM in light of the assumptions that support the programme's theory of action and the dynamics of the socio-political, cultural, economic and health system context in which programme activities are implemented.

15. A mixed approach to the collection and analysis of quantitative and qualitative data will also be applied, as well as triangulation of information collected from different sources. The evaluation will be both retrospective in response to accountability, and prospective to respond to organisational learning. It will follow the codes of conduct, the ethics guide, guidelines, norms and standards of the UN Evaluation Group (UNEG), and will specifically integrate human rights, gender and equity under each criterion and evaluation question, as well as data collection tools.

2.2 Overview of expected programme results at different levels

16. According to Vogel (2012), “theories of change for evaluation purposes tend to drill down into the detail of theories about cause-effect, the different pathways, actors and mechanisms the programme has influenced, as well as significant contextual conditions that had an influence”. A theory of change (ToC) can be roughly defined

in three components: i) explore assumptions; ii) analyse the context; and iii) assess the evidence. Defining clear, concrete and evidence-based assumptions based on a ToC perspective, to be tested during the evaluation, is one of the key activities for the evaluation team aiming to design the most suitable data collection methodology. The CMAM logic model links intervention investment (inputs) to process and outputs, and to anticipated changes (outcomes) in the target population (Figure 1). No ToC specific to the CMAM programme was developed either during the design of the 2014 scaling up plan (FMoH 2015), or in national nutrition policy/strategy documents. The interim manual and operational guidelines for SAM and MAM were mainly activity-based. Moreover, the evaluation conducted in 2013 did not develop a ToC that could guide the current evaluation. Therefore, the evaluation team drafted an overview of expected programme results at different levels based on the review of national CMAM protocol and operational guidelines, the log frame developed for CMAM scale-up in the country (FMoH 2014; FMoH 2015a; FMoH 2015b), and the model developed for the CMAM global evaluation conducted by UNICEF Head Quarter in 2013 in five countries (UNICEF 2013), which the team adapted to the context of Sudan. The underlying assumptions were explored through exchanges with key informants (KIs) during the inception mission in Khartoum on 23-25 February 2020, along with the identification of indicators that can reflect the evaluation criteria. The description of this model represents how the Evaluation Team understands the functioning of CMAM programme in Sudan at this point of time.

17. The **investments/inputs** are provided by the Government of Sudan (GoS), technical partners such as UNICEF, WHO, WFP and donors. Under the support of technical partners, the GoS developed CMAM guidelines and operational plans within the National Health Strategic Plan, trained health workers and CHWs, provided human resources in the health facilities and the communities, and supported health infrastructure. Technical partners ensured the provision of adequate equipment and supplies (purchase and delivery of therapeutic milk, RUTF and supplementary foods), with significant investment in logistics, support for materials and capacity building (e.g. training, advocacy, conducting nutrition surveys). UNICEF helped provide leadership and coordination of different stakeholders implementing CMAM in the country. The SUN secretariat ensured such coordination for nutrition-specific and -sensitive interventions in the country. The overall CMAM strategy was funded by different donors (ECHO, FFP, OFDA, UN OCHA).

18. The **activities/processes** carried out by the FMoH include continuous technical support provided by the CMAM support team. This includes capacity-strengthening throughout the country, in-service training and mentoring support of health workers and community outreach workers, and establishment of learning sites for inpatient care, outpatient care and community outreach at the national and state levels (in one locality per state). Additional activities include development of training materials and provision of job aids to health care providers and managers at health facilities, admission and treatment of SAM and MAM children, facilitation of technical review meetings and workshops, and sensitisation of beneficiaries and the community on optimal hygiene and child health and nutrition practices. The government also monitors and supervises programme activities and ensures linkages between CMAM and other nutrition-specific and nutrition-sensitive interventions through the National Nutrition Programme. The diagram under activities and processes (Figure 1) depicts the relationship between the four components and the implementation context. Stakeholders such as training institutions for health professions and national research institutions delivered pre-service training for CMAM and undertake research on acute malnutrition in the country. UNICEF, WHO and WFP and operational NGOs supported the integration of CMAM into the national health system, particularly the supply system for storage and distribution of therapeutic milk, RUTF and supplementary foods, equipment and medicines for the management of acute malnutrition. UNICEF also ensured the development and distribution of quality assurance tools for planning, implementing, monitoring, supervision and reporting on CMAM, and ensured adequate budget management.

19. The main **outputs** of the intervention include the availability of health workers, community health workers and volunteers trained on screening, referral and treatment of acutely malnourished children, sensitized communities, children with MAM and SAM identified, referred, admitted, treated and followed up, and well-equipped and supplied health facilities. The programme also achieved adequate geographic and treatment coverage. Good coordination is ensured within CMAM components and between CMAM and other nutrition-specific and nutrition-sensitive interventions. Health workers, CHWs and volunteers are regularly supervised. Nutrition supplies are regularly ordered and delivered to health facilities.

20. The expected **outcomes** of CMAM include appropriate management of MAM and SAM children, translated into acceptable Sphere performance indicators (cure rate, death rate, and default rate). The gender and equity gaps are also reduced in the localities.

21. The overall objective of scaling up CMAM services in Sudan was to contribute to reduced under-five morbidity and mortality rates through increased access to quality services for the management of acute malnutrition (6). Therefore, the **potential impact** of the programme includes improved feeding practices among children under five years of age along with improvement in their nutritional status. Ownership of the programme by the national authorities is also an important element of the potential programme impact.

22. The CMAM programme is also implemented in a socio-demographic, political, economic and cultural context that can influence the expected outputs and outcomes in the country. Socio-political and demographic external factors include, among others, social instability (movement of internally displaced persons and refugees), admission of beneficiaries living outside a health facility's coverage area, high turnover of health staff, lack of qualified human resources, poor coordination among stakeholders, and cultural taboos regarding feeding practices.

23. In summary, the investments (inputs) produce changes at the level of children (improved nutritional and health status), the community (awareness and involvement), the health workers (improved management capacity), and the local authorities (ownership of the programme).

24. Several **assumptions** underlie the proper implementation of the CMAM programme, including but not limited to the following:

- **If** CMAM planning and service delivery are implemented according to the national CMAM protocol and the CMAM scaling-up plan, **then** the resources will be adequately used, **because** the financial and technical resources were based on a good estimation of expected beneficiaries;
- **If** stakeholders at all levels understand the benefit of their participation, **then** the demand, awareness and utility of the CMAM programme will increase, **because** the interest of individuals and institutions increased;
- **If** there is a good health information system, **then** information will be used to inform strategies and plans, **because** the skills to target vulnerabilities and health priorities will be improved;
- The supply of dietary supplements is assured without stock-outs;
- Behaviour change communication (BCC) activities are provided on a regular basis; and,
- The socio-political and security environment is conducive to the deployment of programme activities in the country.

25. **Figure 1** below illustrates the draft overview of programme expected results developed by the evaluation team. It also guided the development of the evaluation matrix and the identification of different indicators for measuring the outcomes that occurred in the course of the implementation of the CMAM programme. Although

the ToC is missing, the Evaluation Team believes it will be able to answer the evaluation questions with the existing secondary data and the additional data that will be collected during field visits.

2.3 Evaluation Criteria and Questions

26. The ToR highlighted the criteria of relevance, effectiveness, coverage, efficiency, impact, and sustainability for evaluating CMAM in Sudan, with specific questions designed under each criterion. The evaluation team reviewed these criteria and questions and made some adjustments while developing the evaluation matrix (see Annex 2):

- The criteria of effectiveness and coverage were merged as coverage is an element of programme effectiveness.
- The ToR mainly emphasised SAM (supported by UNICEF) while talking about CMAM. The national CMAM model has four main components, and it is known that a good continuum of care is relevant for SAM and MAM effectiveness as well as prevention of acute malnutrition. Therefore the team has added the assessment of community outreach, inpatient SAM treatment and MAM management in the scope of the evaluation to get a broader picture of the programme. Given that inpatient SAM and MAM databases are available with WHO and WFP, the team will assess the effectiveness of these components with regards to outpatient SAM management, and formulate conclusions and recommendations which are as comprehensive as possible in terms of CMAM implementation. Under the relevance criteria ‘SAM and MAM’ have been mentioned in the first question, while under the first question on effectiveness the expected standard quality of care will be assessed for OTP, SFP, and TSFP.
- Under each criterion, some questions which looked alike were merged for coherence and consistency. For example, under the criterion of relevance, the team merged question 1 and question 2 of the ToR as they looked similar. Under the criterion of efficiency, the second and the sixth question were merged as they were complementary. This was also the case for the first and the second question of the sustainability criterion.
- A few questions were deleted, especially those for which getting the corresponding indicators would not be possible. This was the case for the fourth question under the criterion of efficiency in the ToR (To what extent UNICEF and other partners have adequately supported CMAM for achieving results. What are the missed opportunities that if used CMAM support would have been maximised?), and the second question under the impact criterion (How many lives were saved with the current CMAM programme?).
- Under the relevance criterion, the team added one question (current question 1.2 under relevance) to illustrate the alignment of the CMAM programme with national policies on gender equality, as the involvement of men and women in the implementation and follow up of activities is key for optimal effect on child health and feeding practices at household level. Similarly, the team also added one question under the impact criterion (Does the intervention have the potential to positively influence gender equality in the long term?)
- The team supplemented all evaluation questions with sub-questions, rationale indicators for verification, data sources, and data collection techniques.

27. Details on the adjustments made on the evaluation criteria and questions against the UNICEF proposed ToR criteria and questions can be found in the Annex 2 (Evaluation Matrix) and Annex 7 (Evaluation ToR).

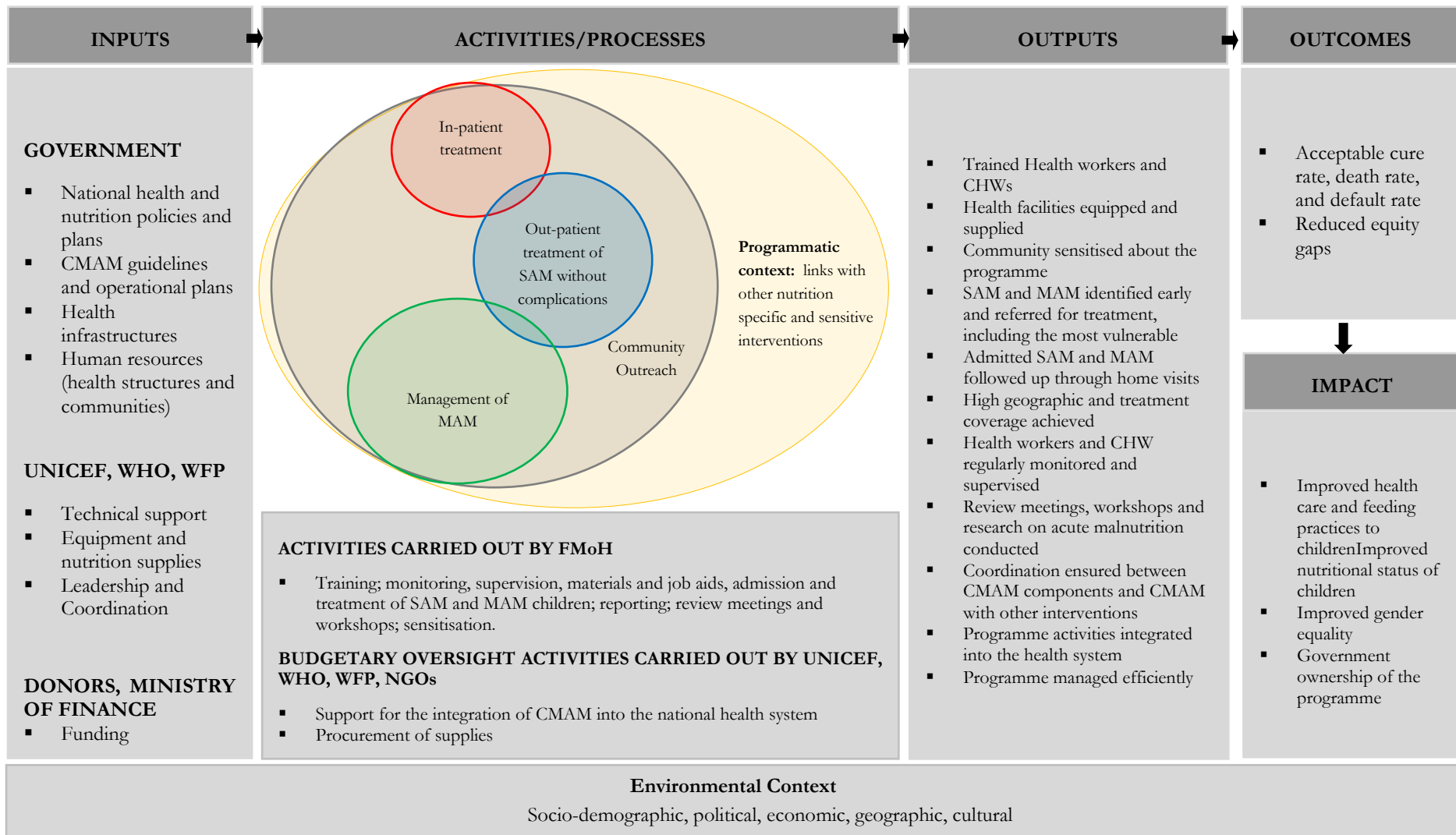


Figure 1. Draft Overview of CMAM programme expected result and each level used for CMAM evaluation in Sudan

2.4 Evaluation Methodology

28. This will be a process, output and outcome evaluation using a combination of qualitative and quantitative data methods to triangulate the information obtained from (A) desk review and (B) primary data collection using the following main techniques: a) Semi-Quantitative Evaluation of Access and Coverage (SQUEAC); b) semi-structured individual interviews with key informants; c) Focus group discussion (FGD); and d) direct observation of CMAM operations.

29. These different techniques are complementary in the sense that the review of documents will facilitate the understanding of the programme context and identification of indicators useful for assessing programme achievements, whilst individual interviews will allow for understanding participants' experiences and perspectives with regard to the different activities of the programme. FGDs are appropriate for getting the perception of programme providers and beneficiaries at community level. Direct observations will be useful for understanding the process of CMAM activities delivered through health facilities, mobile clinics and within the community. The SQUEAC exercise will elicit factors (boosters and barriers) affecting programme coverage and access (Myatt et al 2012).

30. An in-depth stakeholder mapping will be performed in collaboration with UNICEF prior to data collection to define the key stakeholders to be contacted for interviews and FGDs, taking into account gender and equity aspects. Data collection will take place at the national, state, locality and community levels.

2.1.1 Sampling of Sites to be Visited

31. Given that the CMAM programme is implemented nationwide, the evaluation will cover the whole country (for document and data reviews, as well as financial analysis), but field visits for primary qualitative data collection and the SQUEAC will be conducted in the three States of North Darfur, Al Jazirah and Kassala. This will address the scope that ranges from stable developmental settings (Al Jazirah and Kassala States) where the nutrition programme is implemented as part of resilience activities, to a humanitarian setting (North Darfur State) where the population ranges between post-conflict and current IDPs, refugees and returnees. The three States also cover a wide range of the diet diversity and availability in Sudan, which reflects the strengths and weaknesses of the programme implementation.

32. Al Jazirah State lies between the Blue Nile and the White Nile. It is the site of one of the largest irrigation projects in the world, making Al-Jazirah the most productive agricultural area of Sudan, with more than 10,000 square kilometres under cultivation. Most of the population engages in agriculture, and crops include cotton, cereals, oilseeds, peanuts (groundnuts), wheat, sesame, durra (sorghum), dukhn (millet), and vegetables. Industries also produce ginned cotton, sesame and peanut oils, cigarettes, leather goods, soap, and processed foods. Kassala State in many ways reflects the range from water abundance to water shortages, from rain-fed seasonal farming to irrigation schemes, and from urban settlements to nomadic communities that include a variety of gender specific traditions perceived to affect the nutritional status in the community. In contrast, North Darfur is one of the states that is affected by conflict and has IDPs, returnees and refugees. The climate in the state ranges from desert in the north to water rich-valleys, and covers the agro-pastoral communities from a different gender perspective. Kassala and North Darfur States cover the different programme working modalities where activities are implemented by MoH and the locality staff, as well as national and international NGOs, while in Al Jazirah, CMAM is mainly implemented with the exclusive support of the MoH. Main reasons for selecting the three States are summarised in the table below:

Al Jazirah	<ul style="list-style-type: none">• More stable and development-oriented
-------------------	--

	<ul style="list-style-type: none"> • Strong MoH engagement. • CMAM implemented without support of NGOs
Kassala	<ul style="list-style-type: none"> • More stable and development-oriented. • Highest proportion of stunted children in Sudan (55 percent). • CMAM is implemented as part of resilience programming. • CMAM is integrated with WASH in some localities.
North Darfur	<ul style="list-style-type: none"> • State with strong MoH engagement. • High burden State. • Highest target and highest coverage.

33. Consequently, conducting field visits in the three states will ensure a comprehensive understanding of programme implementation modalities and contexts, as well as realistic data collection that will be triangulated through a variety of means.

34. At the meeting of the National Evaluation Reference Group on Monday, 24 February 2020, an initial discussion was held on the key determinants of the evaluation of CMAM in Sudan, and the participants had an opportunity to seek clarification from the Ministry of Health, UNICEF and the Evaluation Team Leader. The two States of Kassala and North Darfur were initially selected for field visits to collect primary data. During the meeting, the National Evaluation Steering Committee asked to assess the possibility to conduct the data collection in a third State. After different exchanges, Valid International, together with the FMoH and UNICEF Sudan have come to the agreement of adding Al Jazirah as the third State.

•

35. The evaluation timeline and budget have been adjusted accordingly.

Selection of localities and health facilities for SQUEAC Assessment

36. A purposive random sampling frame will be used in selecting the sites to collect additional quantitative data for the second phase of the SQUEAC assessment. The point of departure will be the initial analysis of routine data, which will focus on sites that have high or low coverage in the three States. The following criteria and indicators will be used to select the health facilities (CMAM sites) to focus on for the SQUEAC investigations:

- Implementer: Ministry of Health versus non-governmental organisations.
- Type of CMAM services offered: both OTP & SFP, OTP only, or SFP only, and static versus satellite and mobile.
- Geographical location: distance from the state capital i.e. far from versus near to state.
- Internally displaced populations (IDPs) versus non-IDPs and refugee population

37. The specific localities and sites for collection of additional routine data in the three States will be determined by the initial data analysis, as the process is iterative. Once this analysis is completed, a combination of sites and localities showing both high and low coverage will be included in the sample for the second stage.

Selection of localities and health facilities for Qualitative Exploration

38. Given the significant number of CMAM sites in the country, a number of criteria and indicators were used to sample the ones to be visited in the three states of Al Jazirah, North Darfur and Kassala. For example, in addition to interviews with key informants in central positions (Khartoum, Wad Madani, Kassala and El Fasher), a number of “sites” will be explored. Each “site” comprises a treatment centre and the communities it serves (including those at considerable distance). Sites are chosen to be different to each other in significant ways. Potential sites will be selected based on the following:

Types of Variation	Sample
Implementers (MoH, NGOs)	Should sample all (but if there are many NGOs will do fewer)
Type of site – village/ small town/ camp/ big town	At least one of each
Isolation and/or distance between service site and communities served	At least 2 isolated sites
Geographical spread	Ensure a good spread
Delivery of SAM and MAM services or SAM without MAM services (continuum of care)	
Performance of the centre against national standards	
Nomadic and farmer/ productive and less productive	Cover both in both productive and poorly productive environments

39. A tentative initial list of sites to be visited for primary data collection (including SQUEAC assessment) in the three States is presented in the table below; however the evaluation team remains flexible to select different sites based on the results from the initial analysis conducted during the SQUEAC assessment process.

Sites in Al Jazirah
Wad Medani; Al Hilaliya; Al Manaqi; Alshbarga
Sites in Kassala
Kassala; Es New Halfa; Masjid Wad; Khashm al Qirba; Malawiya; Aroma; Eriba; Ungatiri
Sites in North Darfur
Al Fasher; Tawila; Dar el Salam (EL Fasher Locality); Kuma; Kebkabiya; Kutum; Malit; Malha; Um Keddada; Burush; Al Tawisha; Zamzam Camp

2.1.2 Review of Documents and Secondary Data

40. An attempt will be made to ensure, as much as possible, an adequate representation of OTP, TFC, SFP and mobile clinics while considering the selection criteria. Community outreach activities will also be assessed. In all, the team aims to visit at least 12 health facilities involved in CMAM activities (4 in Kassala and 8 in North Darfur) and to follow through to the communities they serve. If possible, more sites will be covered, however any sort of representative coverage in North Darfur will involve considerable travel and the time may be insufficient to cover

more sites thoroughly. Although some sites for inclusion can be anticipated, it is not desirable to name all the sites that will be examined prior to the field work. This is partly because variations in food security reflect the quality of local harvests and the incidence of conflict in recent years as well as shifting opportunities for wage labour. It is also important to involve important stakeholders in arriving at choices that reflect important differences in the above criteria and to get some suggestions about where the programme has worked well and where there have been challenges. Furthermore, consultation on the current security situation is desirable before arriving at final choices in North Darfur.

41. The evaluation team conducted a preliminary literature review, which considered the various action plans, reports and documents developed under the programme. The documents analysed included the national protocol for the management of acute malnutrition; monthly, quarterly and annual activity reports; reports of nutrition surveys; national nutrition and health policies and strategies; and data from nutrition and health information systems. The review generally focused on actions that have been undertaken in order to capture the appropriateness of the strategy with regards to national and international requirements, its significance, and the constraints in its implementation. This review will also guide the development of the Theory of Change (currently ongoing) by adapting it to the programmatic context. A more in-depth review of these documents will be conducted during the analysis phase to identify elements that will assist in addressing evaluation criteria and questions.

42. In addition to the document review, the evaluation team will examine the programme's quantitative databases obtained from UNICEF, in order to analyse the trends in outputs and outcomes of the programme over the 2015-2019 implementation period in the country.

2.1.3 Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)

43. The team will undertake a SQUEAC assessment using secondary quantitative data, in order to evaluate programme coverage during the implementation period (2015-2019). The SQUEAC will mainly assess access and coverage-related factors that may have hindered ("barriers") or facilitated/ promoted ("boosters") access to the CMAM programmes across all 18 states in Sudan. A desk review of existing programme databases, documents and reports, and results from previous coverage studies/assessments will be an initial step of the bespoke SQUEAC assessment. A mind- and concept-mapping exercise will therefore start during the desk review and an initial mind/concept map will be developed based on the themes emerging from the desk review and analysis of the secondary quantitative data. The identified access and coverage issues will serve as the first lines of enquiry for fieldwork, and additional data will be collected from registers and beneficiary cards in the sampled CMAM sites in North Darfur and Kassala states. The additional data collection and analysis will help to refine the concept map in the selected sites. The findings and observations from the SQUEAC analysis will contribute to lines of enquiry in the subsequent qualitative assessment.

Proposed Steps

Step 1: Review of existing or routine programme monitoring data

44. An initial step of reviewing the existing programme monitoring data such as admission trends, performance outcomes (cure, default, death rates) will be conducted remotely prior to the field visit for all the CMAM sites across all 18 states in Sudan which have been implementing CMAM between 2015 and 2019. This secondary data review will not involve collection of names or PII. The SQUEAC assessment will use records that have names but data collection will not capture any names. We are only interested in the anthropometric measurements and other coverage indicators to see how the programme is doing coverage wise.

Step 2: Collection of additional data

45. Additional data will be collected in-country, focusing on the Kassala and North Darfur CMAM programmes based on the observations made during the desk review and routine data analysis. This will specifically involve reviewing health facility records which include patients' data and aggregate statistics. We do not anticipate this to pose any risks on the programme beneficiaries. This is an important part of the SQUEAC assessment because it allows further development of the hypotheses (high or low coverage in some of the sites) which were initially formed during the analysis of existing secondary data. A spatial distribution of the beneficiaries in each of the different aspects of the SAM and MAM treatment will inform where to collect additional data. This stage is important because it will also be used to identify areas for further investigation which can feed into the qualitative study that is intended to overlap with the SQUEAC assessment. Depending on the emerging themes from the routine data, issues requiring further investigation will be identified. For example, qualitative investigations can be conducted in a sample of sites with a high number of admissions versus those with low admissions. Other sites with high default rates can be investigated and compared to those with low default rates etc. In other words, this additional data will provide vital information concerning the underlying causes of low or high coverage, including the principal barriers to programme access.

Step 3: Synthesise boosters and barriers to coverage into a BBQ and/or concept map

46. The SQUEAC investigation will use the barriers, boosters and questions (BBQ) method to summarise findings on boosters and barriers throughout the coverage assessment process. As such, barriers and boosters will be organised through a concept map to illustrate the interactions between the various factors for the OTP and SFP. As shown in Figure 2 below, the Evaluation Team has attempted to graphically represent how good programme coverage can be achieved, and will use this as a basis for the analysis.

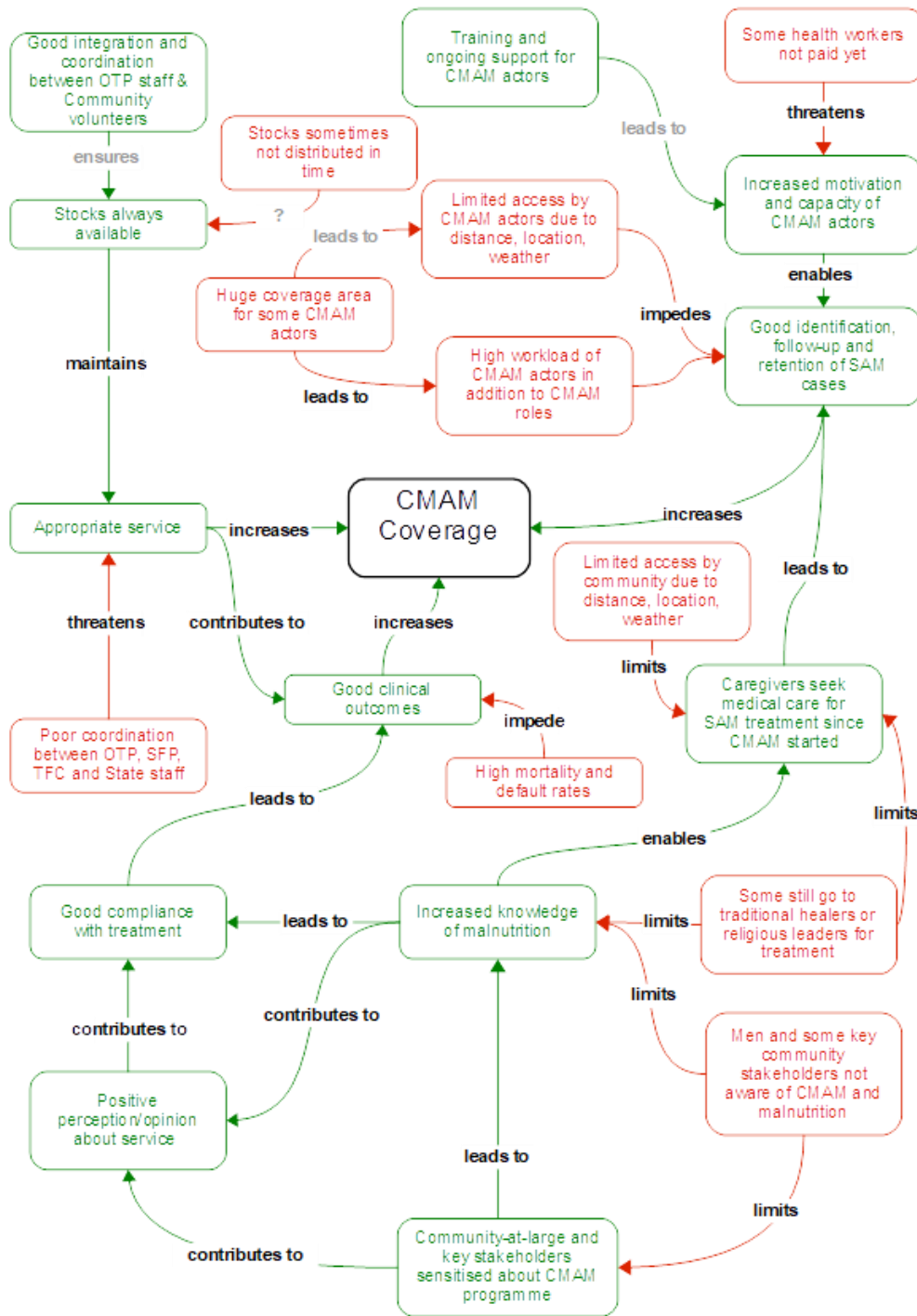


Figure 2: Example of Concept Map of Boosters and Barriers to Coverage for OTP Group

Step 4: Determining high and low coverage sites

47. This stage will involve updating the initial concept map developed during the initial analysis of the routine data for each of the two states: Kassala and North Darfur. A sample of OTP and SFP sites will be drawn purposively in order to determine which ones have high or low coverage. The following additional data will then be collected from these selected sites from OTP and SFP cards and registers:

- Admission mid-upper arm circumference (MUAC) to check if there is early case finding and presentation in the CMAM programmes
- Admission and default trends versus seasonal/disease calendars to assess if programmes are responding to needs
- Length of stay
- Referral system
- Distance to CMAM sites

2.1.4 Financial Assessment

48. A review of the programme's budget databases made available to the evaluation team by UNICEF helped to guide the type of financial analysis, which is planned to assess the adequacy of resources for the intervention. A breakdown of expenditures is envisaged in the following elements (distributed with respect to the codes used by the team managing the CMAM budget):

- Contractual services
- Equipment, vehicles and furniture
- General operating and other direct costs
- Incremental indirect cost
- Staff and other personnel costs
- Supplies and commodities
- Transfers and grants to counterparts
- Transportation/travel
- Cost per cured child

49. Comparing these different elements across states will enable the team to assess assumptions and factors that determine the efficiency of the CMAM programme.

2.1.5 Semi-Structured Key Informant Interviews (KII)

50. The evaluation team will map all potential interview participants at national, state and locality levels with the support of UNICEF, and will purposively select key informants (Palinkas et al 2013; Tongco 2007). Following this initial round of sampling, the evaluation team will use snowball sampling, a non-probability technique in which identified key informants recruit future subjects from among their acquaintances. KIIs will be conducted at national, state, and locality levels with facility staff as well as implementing agency staff at management levels. Respondents from within the CMAM/treatment centre management in Khartoum, Kassala and El Fasher will be recruited by appointment. In rural sites, recruitment of both community volunteers and other community members, will be based on availability and willingness/ interest to participate on the day. Where mothers below the age of 18 are recruited we will ensure the presence of a guardian. Interviews will be recorded as written notes.

51. For management and health workers, unless otherwise requested by the interviewee, the interviews will be conducted at the workplace or in the typical locality of the interviewee. The evaluation team will plan to gather all information needed in one visit so as not to unduly disturb the interviewee's work or personal time. Reflecting

international standards, written notes will be kept for all the interviews. Individual interviews will be conducted in English, Arabic or local language when necessary. Copies of relevant materials such as written reports, guiding policy documents, project documents, will be requested at the end of each interview, enabling an iterative and mutually informed data collection period. KIs in communities will be selected on arrival through looking for those who have used the service or are volunteers associated with the service. All will be advised that their participation is voluntary. All interviews will be conducted privately.

52. KIIs will be conducted until theoretical saturation of content, which occurs when further interviews do not add new information to the findings and become merely redundant (Mason 2010).

2.1.6 Focus Group Discussions

53. The team will administer FGDs at locality and village levels to ensure responses and opinions received are as accurate as possible. The FGDs will be conducted with groups of the same sex and same role in the programme (client, volunteer etc.) but mostly among mothers, including some who have had a child admitted to the CMAM programme, and key community members and community health volunteers who contribute to the programme. Where mothers are below the age of 18 we will ensure the presence of a guardian.

54. Seven to ten participants will be gathered for each session, and the evaluation team will attempt to ensure a gender balance, even geographic distribution, and representation of all population groups, especially the most vulnerable target groups, each of whom will be grouped separately to ensure homogenous groups, particularly in respect of gender and role in the programme. The facilitators and their note-takers will work to create a trust-inspiring and culturally sensitive environment for all participants during discussions about personal experiences.

55. During the FGDs, the facilitator will also encourage participants to elaborate on the points they make, so that there is rich contextual data on the communities' perception of CMAM. Throughout, the facilitator will assess how far opinions are representative of the whole group, and will encourage the participation of all members, rather than relying on answers of the most vocal participants. FGD sessions will be held in Arabic or local dialects. Focus group participants will be recruited upon arrival in the same way as KIs.

2.1.7 Direct Observations

56. Direct observations will be made of live CMAM activities at community and health facility levels. Sampled TFC, OTP and SFP sites will be observed with a focus on infrastructure, available human resources, equipment and supplies, as well as services delivered. At community level, the observation will focus on mobilisation activities such as sensitisation, IYCF counselling, active case finding and referral through mother support groups and community volunteers.

2.1.8 Data Collection Tools

57. Several tools were developed by the evaluation team to collect the data:

- a) **Interview guides** and **FGD guides** were developed in light of evaluation criteria, questions and sub questions developed in the evaluation matrix, and the **stakeholder mapping**. The questions were customised according to stakeholder groups; that is, questions will be directed according to respondents' level of involvement in CMAM, their ability to understand the questions asked and to provide the appropriate answers.
- b) The evaluation team also developed an **observation checklist** to assess CMAM operations in the health facilities (Annex 5). The tools will be translated and back-translated into English for accuracy and coherence, and so they can be administered in the appropriate local language for the locality.

58. The evaluation team will pre-test the tools and refine them accordingly prior data collection. The locality selected for the pre-test will not be included in the final evaluation sample.

2.5 Data Analysis

59. The evaluation team will use quantitative and qualitative data analysis techniques. The standard CMAM programme implemented in the country has four main components each supported by different technical partners and NGOs; therefore the analysis will be disaggregated according to programme component, state/locality, age and sex in order to appraise which component is more efficient and/or effective, in which locality and on which sub-categories of beneficiaries (age and sex). The “reference period” for the analysis will be 2015 – 2019.

60. **Quantitative analysis:** Descriptive analysis such as measures of incidence, caseloads, seasonal variations, and trends over time will be presented. Programme performance indicators such as coverage, recovery rate, death rate and default rate will be computed and assessed against Sphere Standards for CMAM implementation, as well as descriptive frequencies of data obtained from observation checklists. The review of budget data will facilitate the descriptive financial analysis of programme expenditures, and cost per cured child.

61. **Qualitative analysis:** Interview notes will be entered into separate files in MS Word or Excel, including relevant portions of the documents reviewed. A thematic content analysis will be conducted manually. The analysis will use a deductive and inductive approach. Following the deductive approach, coding will be done on the basis of the evaluation themes/criteria and sub-themes/evaluation questions (Boyatziz 1998; Ritchie et al 1994). Data obtained from different sources will be coded under each evaluation theme or sub-theme. The evaluation team will also apply inductive analysis in order to identify any emerging theme (Thomas 2006). After encoding, vertical and horizontal analyses will be carried out. Vertical analysis will assess the different themes emerging, while horizontal analysis will assess the variations in themes to be analysed according to the characteristics of respondents or the subgroups of interest in the study. During the assessment of each criterion, facilitating factors and barriers affecting the programme achievements will be identified, along with a summary of lessons learned.

62. **Data triangulation:** Triangulation will be employed, with findings obtained from secondary and primary sources compared to ensure coherence, reliability and validity.

63. The **draft report** will be shared by the evaluation team with UNICEF and the Evaluation Reference Group for comments and validation of findings. Public dissemination of the final report will be done by the FMoH.

2.6 Ethical Considerations

64. The evaluation methodology and tools were developed in line with the procedure of UNICEF’s ethical standards in research, evaluation, data collection and analysis. Within this procedure, the principles and requirements for evidence generation are applied to four core ethical issues, namely: harms and benefits, informed consent, privacy and confidentiality, and compensation and payment (UNICEF 2015).

65. In terms of *harms and benefits*, the primary data collection methods (interviews, FGDs, observation) and the tools developed will not have any negative repercussions on the health and well-being of participants. The data collection team will be trained on cultural and ethical considerations for interviewing women and men in the localities and villages. No children will be consulted and no risk is foreseen for respondents.

66. *Informed written consent* will be obtained from all participants prior to conducting interviews and FGDs. They will be aware of the voluntary nature of their participation, and their decision on whether to participate or not will be respected. Written informed consent will be collected from officials and health workers as well as communities. Officials and health workers will receive and sign the document (one document per session). Obtaining written

informed consent may be difficult in rural Sudan. Many of the respondents will be illiterate and will not be able to sign or, even if they can, to fully understand the document they are signing. The Informed Consent form will inform community groups about the purpose of the sessions and how their information will be used. This will be read to informants and available for their inspection. They will be asked to place a mark or signature on the form but our emphasis will be on a verbal understanding. As FGD sessions will often of necessity be held outside, it is likely that there will be an audience of “non-participants” (who may still attempt to participate from the side-lines) and meeting facilitation will seek to control this. The evaluation team will not explore complaints or poor experiences within hearing of non-participants (more forward-looking questions about possible improvements will be used instead).

67. In the village setting, additional people may join the group and sometimes it will create suspicion when the moderator asks people not to join. Therefore additional audiences from the same target group may be tolerated. Additionally, resentment from those not participating in FGDs (or selected for interview) is unlikely as the criteria for FGDs will be made clear and participation in the groups will bring no benefits. Space can be made for individuals who wish to communicate something by recruiting them as KIs. Resentment because of inclusion will not occur as participation is voluntary.

68. The evaluation team will also pledge *confidentiality* to interviewees and FGD participants. The names of respondents will not be given in reports. Direct identifiers (e.g. personal information such as names and addresses), if present in the data provided by UNICEF, will be removed and anonymised in the data sets so that the responses cannot be attributed to the respondents. The anonymised evaluation data will be securely saved and protected and only used by Valid for the purpose of this evaluation, and shared with UNICEF (Boddy et al 2014).

69. Regarding *payment and compensation*, no payment will be provided, however the evaluation team will offer some light refreshments to participants as recognition for participating in FGDs.

70. *Ethical approval* will be obtained from the HML Ethics Review Board of UNICEF prior to data collection in the field¹.

2.7 Expected Challenges/Limitations and Mitigation Factors

71. The following are noted as challenges to data collection, analysis and reporting that should be anticipated to smooth the evaluation process.

Expected challenges	Means of mitigation
<p>Developing a theory of change ex-post</p> <p>Given the ex-post nature of the development of the ToC, the assumptions and indicators highlighted to assess the changes that have occurred in individuals and institutions might not fully reflect the expectations of evaluation criteria and questions.</p>	<p>The drafted ToC will be amended through exchanges with key informants during the inception mission, and comments provided by members of the evaluation steering committee. The final version of the ToC validated during the exchanges could be used by the UNICEF Country Office while designing the next CMAM scale-up plan and road map in the country.</p>
<p>Representativeness of the findings</p>	<p>The desk review (documents and secondary quantitative data analysis) will cover all 18 states in order to get an overall picture of CMAM implementation in the country.</p>

¹ Please note that MoH has confirmed that the MoH ethical approval for this evaluation is not required.

<p>Due to limited budget and time constraints, the primary data collection will take place only in two states (North Darfur and Kassala).</p>	<p>The sites selected in the two states for SQUEAC assessment and primary qualitative data collection will fully reflect the requirements for getting an in-depth understanding of programme implementation, issues and hypothesis that emerged from secondary data review.</p>
<p>Comparing programmes set in different states and localities, with various levels of development, resources and capacity.</p>	<p>The team will take into account contextual factors while comparing findings among different states/localities.</p>
<p>The security situation in the country may impact the smooth implementation of the evaluation, restricting the mobility of the evaluation team.</p>	<p>Alternative localities/sites will be selected in case the evaluation team cannot travel to certain areas.</p>
<p>Limited reliable secondary data and insufficient documentation at locality levels may pose challenges in the evaluation process.</p> <p>There might be a lack of uniformity in record keeping/documentation between health facilities and/or supporting organisations.</p>	<p>In such circumstances the evaluation team will rely on evidence obtained from interviews and FGDs.</p>
<p>Availability of financial data: Organisations implementing CMAM programmes in Sudan include UNICEF, WFP, WHO and NGOs (that also have some operational costs).</p> <p>These different organisations have financial databases which are often sensitive for sharing, and if shared, the categories of expenditure might not be structured the same way.</p> <p>The government, on the other hand, may lack financial information on programme expenditure.</p>	<p>The evaluation team will design and conduct financial analysis according to the type of programme expenditure data available.</p>

3. TENTATIVE WORKPLAN AND CALENDAR

72. The evaluation started in January 2020 and will last until June 2020.

Activities	Key Dates
Inception Report and evaluation tools	
Conduct in depth desk review of key documents related to CMAM implementation	27 Jan – 02 Feb 2020
Draft the protocol	03 – 12 Feb 2020
Submission of the protocol to UNICEF for preliminary feedback	12-Feb-20
UNICEF to provide feedback	12 – 17 Feb 2020
Submission of the protocol	19-Feb-20
Development of the Inception Report	13 – 20 Feb 2020
Team Leader visit to Sudan to present the Inception Report	22 – 25 Feb 2020
Finalise the Inception Report after incorporating feedback from UNICEF and stakeholders	25 Feb – 02 Mar 2020
Submission of the Final Inception Report for UNICEF feedback	02-Mar-20
UNICEF to provide feedback	04-Mar-20
Submission of the Final Inception Report for ethical approval	06-Mar-20
Submission of the Final Inception Report Evaluation Steering Committee	06-Mar-20
Evaluation Steering Committee to provide Feedback	15-Mar-20
Ethical approval obtained	22-Mar-20
Evaluation for the core process/outcome indicators (including observation checklist for Clinical CMAM evaluation)	
Evaluate the programme coverage and quality performance indicators	24 Mar – 02 Apr 2020
Translation of tools	24 Mar – 30 Apr 2020
Conduct key informant interviews	04 – 13 Apr 2020
Conduct observation of CMAM sites (TFC, OTP, SFP, Outreach), using an observation checklist in Kassala and North Darfur	04 – 19 Apr 2020
Collect data using SQUEAC 1.0 method & completion of SQUEAC data analysis	
Recruitment of the Field Staff	17 - 18 Mar 2020
Organise logistics (transport, accommodation...)	20 - 21 Mar 2020
Conduct secondary analysis for routine programme data and training	23 - 27 Mar 2020
Collect data from admission cards from the clinics, average length of stay and average medium weight gain, and factors to coverage including boosters and barriers to service uptake (Kassala)	28 March – 05 Apr 2020

Collect data from admission cards from the clinics, average length of stay and average medium weight gain, and factors to coverage including boosters and barriers to service uptake (North Darfur)	06 - 13 Apr 2020
Supervise the data entry by CMAM Evaluation Assistant	28 Mar – 19 Apr 2020
Review the evaluation design based on preliminary findings from SQUEAC	28 Mar – 19 Apr 2020
Analyse the findings (SQUEAC)	22 - 29 Apr 2020
Write findings (SQUEAC)	30 April - 7 May
Submission of the analysis and findings (SQUEAC)	08-May-20
Complete financial data analysis	
Develop the financial analysis and provide inputs to the Final Evaluation Report	13 April – 8 May 2020
Completion of qualitative data collection and analysis	
Develop question guides	22 February - 2 March 2020
Train the translators on interviewing beneficiaries (North Darfur and Kassala)	28 Mar – 29 Mar 2020
Monitor Translators and assist in logistics and interviews planning (North Darfur and Kassala)	23 Mar – 3 Apr 2020
Conduct interviews and FGDs with beneficiaries and implementing partners (Kassala)	28 Mar – 12 Apr 2020
Conduct interviews and FGDs with beneficiaries and implementing partners (North Darfur)	13 – 30 Apr 2020
Analyse the qualitative data	1 - 5 May 2020
Write the qualitative findings	6 - 8 May 2020
Submission of the final qualitative analysis report	08-May-20
Complete data processing and finalise Draft Evaluation Report	
Triangulate findings from different data collection methods	11-15 May 2020
Draft the evaluation final report	15-22 May 2020
Submission of the draft final evaluation report	25-May-20
UNICEF to provide feedback	25 May - 2 June 2020
Evaluation Steering Committee to provide Feedback	25 May - 2 June 2020
A final revised and quality edited report approved by UNICEF and FMOH	
Finalise the final report incorporating feedback from team members, FMOH & UNICEF	3 - 10 June 2020
Submission of the Final Evaluation Report	11-Jun-20
Disseminate the findings (remotely)	15 - 19 June 2020

4. TEAM COMPOSITION

73. The evaluation team includes international evaluators from Valid International. The Team Leader proposed by Valid International is Dr. Camille Eric Kouam Kouotso, who has extensive experience in leading large teams conducting complex health and nutrition assessments, using both quantitative and qualitative approaches. Other team members include Emmanuel Mandalazi (SQUEAC Survey Expert); Simon Mollison (Qualitative Research Expert); and Dr. Khalid Abd Rahman Abdelsalam (CMAM Evaluation Manager). Dr. Steve Collins, a specialist in public health nutrition and an experienced nutrition intervention evaluator, will provide quality assurance for the whole project. Finally, Manar Marzouk (Valid Programme Manager) will provide management support to the entire evaluation team during project implementation.

5. REFERENCES

Boddy, J., Neumann, T., Jennings, S., Morrow, V., Alderson, P., Rees, R., and W. Gibson (2014). The Research Ethics Guidebook: A resource for social scientists, University of London, <http://www.ethicsguidebook.ac.uk/>.

Boyatzis, R.E., Transforming qualitative information: Thematic analysis and code development. 1998, Thousand Oaks, CA, US: Sage Publications, Inc. xvi, 184.

Central Bureau of Statistics, Sudan, 2018.

Chen HT. 2012. Theory-driven evaluation: Conceptual framework, application and advancement. In: R. Strobl et al. (Ed.), editor. Evaluation von Programmen und Projekten für eine demokratische Kultur. p. 17–8.

Rogers PJ. 2008. Using programme theory to evaluate complicated and complex aspects of interventions. Evaluation; 14(1):29–48.

FMoH, UNICEF, Valid I. CMAM review, Sudan. Summary report, December 2013. By Caroline Tanner and Anne Walsh.

FMoH. Interim Manual Community-Based Management of Severe Acute Malnutrition Version 1.0. 2014.

FMoH. National Nutrition Programme. Management and prevention of moderate malnutrition. Operation Guide for health and nutrition providers. February 2015.

FMoH. National Nutrition Programme. Outpatient management of Severe Acute Malnutrition at Primary Health Care level (PHC). Operation Guide for health workers. February 2015.

FMoH. National plan for scaling up of CMAM in Sudan, 2015 – 2018. January 2015.

International Initiative for Impact Evaluation (3ie). Impact evaluation of the World Food Programme's moderate acute malnutrition treatment and prevention programmes in Sudan, July 2018. Impact Evaluation Report 79. By Ernest Guevarra Emmanuel Mandalazi Safari Balegamire Kristine Albrektsen Kate Sadler Khalid Abdelsalam Gloria Urrea Salma Alawad.

Mason M: Sample Size and Saturation in PhD Studies Using Qualitative Interviews. Oxford: Forum: Qualitative Social Research; 2010.

Myatt et al, 2012. Boosters, Barriers and Questions: An approach to organising and analysing SQUEAC data

Palinkas, L.A., et al., Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. Adm Policy Ment Health, 2013.

Ritchie J, Spenser L: Qualitative Data Analysis for Applied Policy Research. In *Analysing Qualitative Data*. Edited by Bryman A, Burgess R. London and New York Rotledge; 1994:173–194.

Sudan S3M (2013): Executive Summary. Federal Ministry of Health, Sudan. 2013.

Sudan S3M II (2018): Report of a Simple Spatial Surveying Method S3M II in Sudan. Federal Ministry of Health, Sudan. 2018.

Thomas, D.R., A General Inductive Approach for Analyzing Qualitative Evaluation Data. *American Journal of Evaluation*, 2006. 27(2): p. 237- 246.

Tongco, M., Purposive Sampling as a Tool for Informant Selection. *Ethnobotany Research & Applications*, 2007. 5: p. 147 - 158.

UNICEF, WFP, FMoH. *The Case for Investment in Nutrition in Sudan, 2016*. By Flora Sibanda-Mulder Davide De Beni.

UNICEF. *Evaluation of Community Management of Acute Malnutrition (CMAM), Global Synthesis Report*. UNICEF Evaluation Office, May 2013.

UNICEF. *The 2018-2021 Country Programme Action Plan (CPAP) between the Government of the Republic of Sudan and the United Nations Children’s Fund (UNICEF) CPAP 2018-2021*.

UNICEF. *UNICEF procedure for ethical standards in research, evaluation, data collection and analysis*. Division of Data, Research and Policy (DRP), April 2015. Document Number: CF/PD/DRP/2015-001. P8-12.

Vogel, Isabelle (2012). *Review of the use of ‘Theory of Change’ in international Development*, UK Department of International Development.

6. ANNEXES

6.1 Annex 1: Draft Stakeholder Mapping CMAM Evaluation Sudan

Stakeholders	Role in CMAM	Involvement in the evaluation and possible use of the findings	Person to contact for the evaluation
FEDERAL/ NATIONAL LEVEL/ KHARTOUM			
Implementing partners			
Federal Ministry of Health	<ul style="list-style-type: none"> UNICEF's main implementation partner for CMAM in the country Provides strategic guidance, capacity building, supervise service delivery, etc. 	<ul style="list-style-type: none"> Use evaluation findings and recommendations to guide future CMAM scale-up plan and road map Member of the Evaluation Steering Committee and the ERG 	<ol style="list-style-type: none"> 1. Head Maternal and Child 2. Head National Nutrition Programme 3. Head Nutrition Emergency section 4. Focal person in charge of CMAM 5. Focal person in charge of EPI 6. Focal person in charge of IYCF 7. Focal person in charge of IMCI 8. Logistics Manager in charge of CMAM supplies (RUTF, Therapeutic Milk, Supplementary Foods) 9. Manager in charge of the national supply chain
Ministry of Finance	<ul style="list-style-type: none"> Contributes to the funding of CMAM (providing support to MoH) 	<ul style="list-style-type: none"> Use evaluation findings and recommendations to guide future direct program funding arrangements to ensure sustainability 	<ol style="list-style-type: none"> 1. Focal person
Other key Ministries (Water and Sanitation, Agriculture)	<ul style="list-style-type: none"> Planning and implementation of some nutrition sensitive interventions 	<ul style="list-style-type: none"> Use the findings and recommendations of the evaluation to strengthen prevention strategies 	<ol style="list-style-type: none"> 1. Focal person
NGOs (list of national and international NGOs involved in CMAM will be provided by UNICEF, WFP, WHO and the government)	<ul style="list-style-type: none"> Support the implementation of CMAM activities in the States and localities 	<ul style="list-style-type: none"> Use the evaluation findings and recommendations to strengthen the implementation of activities in the States and localities 	<ol style="list-style-type: none"> 1. Nutrition/Food Security Manager
Donors			
ECHO FFP UN OCHA OFDA (Therapeutic Milk) for inpatient SAM children	<ul style="list-style-type: none"> Funding CMAM Programme Ensuring that allocated funds have been used efficiently and effectively 	<ul style="list-style-type: none"> Part of the Evaluation Steering Committee and Evaluation Reference Group (ERG) Will learn from experience to inform next scaling up plan and road map 	<ol style="list-style-type: none"> 1. Focal person ECHO 2. Focal person FFP 3. Focal person OCHA 4. Focal person OFDA

Stakeholders	Role in CMAM	Involvement in the evaluation and possible use of the findings	Person to contact for the evaluation
United Nations agencies/technical partners			
UNICEF Country Office Khartoum	<ul style="list-style-type: none"> • Planning and supervision of the implementation of treatment of SAM without complication in the country. • Ensures that implementation of CMAM is well coordinated (especially during emergency response) • Collaborates with WFP and WHO 	<ul style="list-style-type: none"> • Facilitates the implementation of the assessment in-country • Participates as a stakeholder (one-on-one conversations) • Member of the Evaluation Steering Committee and the ERG • Will learn from experience to develop the next scaling up plan and road map 	<ol style="list-style-type: none"> 1. Representative/Deputy representative 2. Head of Health & Nutrition 3. Nutrition Specialist in charge of CMAM 4. Nutrition Cluster Coordinator 5. Head of M&E 6. M&E Specialist 7. Logistics Manager 8. Finance/ Budget Team 9. WASH focal person
WHO	<ul style="list-style-type: none"> • Planning and implementation of SAM treatment with complications (Inpatient Treatment) in the country • Collaborates with UNICEF and WFP 	<ul style="list-style-type: none"> • Use the findings and recommendations of the evaluation to strengthen the continuum of care 	<ol style="list-style-type: none"> 1. Nutrition Specialist
WFP	<ul style="list-style-type: none"> • Planning and implementation of MAM treatment in the country • Collaborates with UNICEF and WHO 	<ul style="list-style-type: none"> • Use the evaluation findings and recommendations to strengthen the continuum of care (SAM and MAM) • Member of the Evaluation Steering Committee and the ERG 	<ol style="list-style-type: none"> 1. Nutrition Specialist
FAO	<ul style="list-style-type: none"> • Planning and implementation of some nutrition sensitive interventions 	<ul style="list-style-type: none"> • Use the findings and recommendations of the evaluation to strengthen the prevention strategies 	<ol style="list-style-type: none"> 1. Focal person
SUN Secretariat	<ul style="list-style-type: none"> • Ensures that nutrition and other sectors are well embedded in the achievement of the Sudan's development objectives 	<ul style="list-style-type: none"> • Use the findings and recommendations of the evaluation to strengthen strategies for prevention of malnutrition in Sudan • Part of the ERG 	<ol style="list-style-type: none"> 1. Secretariat/focal point (no secretariat at the moment in Sudan; under restructure). Saja (Head of UNICEF Health and Nutrition) and Rasha (UNICEF Nutrition Specialist) can respond on behalf of SUN.
Private Sector: SAMIL Company	<ul style="list-style-type: none"> • Locally produce RUTF for SAM children and supplementary foods for MAM children 	<ul style="list-style-type: none"> • Use evaluation findings and recommendations to guide future CMAM scale-up 	<ol style="list-style-type: none"> 1. Focal person
Institutions for health professions and national research institutions	<ul style="list-style-type: none"> • Deliver pre-service training for CMAM to health professionals • Undertake research on acute malnutrition 		
STATE LEVEL			
State MoH	<ul style="list-style-type: none"> • Facilitates the deployment of programme activities in the State 	<ul style="list-style-type: none"> • Use evaluation findings and recommendations to improve the implementation of CMAM 	<ol style="list-style-type: none"> 1. Nutrition focal point at the MoH

Stakeholders	Role in CMAM	Involvement in the evaluation and possible use of the findings	Person to contact for the evaluation
UNICEF State Office and other UN Offices (if existing)	<ul style="list-style-type: none"> Oversees the implementation of the programme in the State 	<ul style="list-style-type: none"> Use the findings and recommendations to improve the implementation of CMAM in the State 	<ol style="list-style-type: none"> Nutrition Manager Logistics Officer Monitoring Officer
NGOs	<ul style="list-style-type: none"> Support the implementation of CMAM activities in the States and localities 	<ul style="list-style-type: none"> Use the evaluation findings and recommendations to strengthen the implementation of CMAM 	<ol style="list-style-type: none"> Nutrition/ Food Security Manager
LOCALITY AND COMMUNITY LEVELS			
Locality Health Office	<ul style="list-style-type: none"> Facilitates the implementation of CMAM activities at locality level 	<ul style="list-style-type: none"> Use evaluation findings and recommendations to improve the implementation of CMAM 	<ol style="list-style-type: none"> Nutrition focal point Locality focal point
Health Workers	<ul style="list-style-type: none"> Ensure service delivery in the health facilities 	<ul style="list-style-type: none"> Use evaluation findings and recommendations to improve the implementation of CMAM 	<ol style="list-style-type: none"> Health Centre Manager Nutritionist
Community Leaders and Members	<ul style="list-style-type: none"> Facilitate social and community mobilisation for program adherence and retention Screen children at households and refer malnourished children for appropriate care Household follow up and sensitisation 	<ul style="list-style-type: none"> Use the findings and recommendations of the evaluation to improve their facilitation activities 	<ol style="list-style-type: none"> Religious leaders Mothers' support groups Nutrition community volunteers (females) Community Health Workers (not in all localities, mainly females) Health promoters (male and female) Traditional birth attendants
Beneficiaries	<ul style="list-style-type: none"> Use the services provided by the programme Contribute to the effectiveness of the support provided by UNICEF and other technical partners 	<ul style="list-style-type: none"> Use evaluation findings and recommendations to improve programme uptake and retention 	<ol style="list-style-type: none"> Parents (women and men) of children under five years of age admitted to the CMAM programme

6.2 Annex 2: Evaluation Matrix

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
1. Relevance					
1.1	To what extent CMAM programme objectives, programming and implementation are well aligned to national priorities and strategies; and have been adequate and implemented to address the specific needs of SAM and MAM children?	<ul style="list-style-type: none"> ▪ Was the design of the CMAM programme consistent with government priorities? ▪ How does this programme address the needs of children under five years of age? ▪ Is the CMAM intervention coherent with other child health and nutritional protocols? 	<ul style="list-style-type: none"> ▪ Extent to which CMAM objectives, activities are in line with national priorities ▪ Links between programme activities and the needs of children under five years of age ▪ Interactions between the CMAM programme and other child health and nutritional interventions 	<ul style="list-style-type: none"> ▪ National health and nutrition policies targeting children under five years of age ▪ UNICEF Country Programme ▪ Key informants 	<ul style="list-style-type: none"> ▪ Document review ▪ Individual interviews
1.2	To what extent is the CMAM intervention aligned with national policies on gender equality? <i>(Question inserted by the evaluation team)</i>	<ul style="list-style-type: none"> ▪ What elements of the programme determine the active participation of women in CMAM? ▪ Have certain measures been taken to address inequalities due to age and/or gender? ▪ Have principles of equality been incorporated into the nutrition messages? 	<ul style="list-style-type: none"> ▪ Participation of women and men in the different activities (screening, management, follow-up, prevention) ▪ Key messages used in community and advocacy activities to promote gender equality 	<ul style="list-style-type: none"> ▪ National health and nutrition policies targeting children ▪ Project proposal from UNICEF ▪ Key informants 	<ul style="list-style-type: none"> ▪ Document review ▪ Individual interviews ▪ Focus group discussions
1.3	To what extent has CMAM programme coordination been implemented in partnership with the relevant various actors/sectors in order to avoid gaps	<ul style="list-style-type: none"> ▪ How has the CMAM programme been implemented in coordination with partners so as to avoid gaps or overlaps? ▪ What referral mechanism has been put in place to coordinate 	<ul style="list-style-type: none"> ▪ Functioning of the referral mechanism and counter-referral with other nutrition programmes and other sectors (criteria for targeting beneficiaries, referrals and counter-referrals) 	<ul style="list-style-type: none"> ▪ Programme Progress Reports ▪ Key informants 	<ul style="list-style-type: none"> ▪ Document review ▪ Individual interviews ▪ Focus group discussions

Inception Report: CMAM Evaluation Sudan

	Evaluation criteria/questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
	or overlapping interventions including coordination within UNICEF and with WHO, and WFP?	programme activities with other partners? <ul style="list-style-type: none"> What was the coordination between CMAM and other nutrition-specific and nutrition-sensitive interventions? 	<ul style="list-style-type: none"> Existence of coordination with other nutrition programmes (influence on the implementation of CMAM) 		
2. Effectiveness					
2.1	To what extent has the CMAM programme contributed in achieving expected results of the results framework (outcomes and outputs) of the National Nutrition Strategy, the Nutrition Investment Case, the Country Programme of Cooperation 2013-2017?	<ul style="list-style-type: none"> To what extent have the performance indicators been met? What was the coverage (geographic and treatment) of the programme? Was the procurement adequate with regards to the expected beneficiaries for SAM and MAM? What factors have contributed or limited the achievement of acceptable coverage? 	<ul style="list-style-type: none"> Achievements of the programme against Sphere Standards (recovery rate, death rate, default rate) Proportion of health centres offering TSFP, outpatient SAM and MAM services Proportion of the eligible population (children) participating in the programme Proportion of the target population participating in an adequate number of distributions Barriers and boosters of acceptable coverage Proportion of total children under five years screened for malnutrition Proportion of referred children that are admitted to services Proportion of caretakers attending counselling and 	<ul style="list-style-type: none"> Programme Progress Reports Coverage reports Quantitative programme databases Key informants 	<ul style="list-style-type: none"> Document review Individual interviews Focus group discussions Quantitative data analysis

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
			sensitisation sessions ■ Proportion of RUTF and supplementary foods delivered against planned		
2.2	Has CMAM achieved expected standard quality of care of children admitted to OTP, SFP & TSFP centres? If expected result and quality are not achieved what have been the main factors that hindered the achievement and how could this be improved?	■ What were the enablers and constraints for achieving the programme standards?	■ Acceptable standards on the following targets <ul style="list-style-type: none"> • Nutritional assessment and classification • Application of treatment protocols • Record keeping • Equipment and material 	■ Programme Progress Reports ■ Key informants	■ Document review ■ Individual interviews ■ Observation ■ Focus group discussions
2.3	To what extent has the CMAM programme contributed to reducing the bottlenecks and barriers that determine equity gaps affecting vulnerable children?	■ What are the categories of beneficiaries that have not been reached? ■ What are the socio-demographic characteristics of admitted families?	■ Proportion of children not reached among the most vulnerable ones (distance, disability, culturally marginalised)	■ Programme progress reports ■ Key informants	■ Document review ■ Individual interviews ■ Focus group discussions
2.4	What is the current CMAM programme monitoring mechanism? Is it sufficient to monitor the expected results? If not how can it be improved and	■ What mechanism has been put in place to monitor the CMAM programme? ■ What are the main elements/ indicators monitored at the different levels of the health system?	■ Comprehensiveness of the existing monitoring mechanism/ system ■ Indicators monitored at all levels ■ CMAM reporting & data collection/ data flow	■ Programme progress reports ■ Key informants	■ Document review ■ Individual interviews

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
	decentralised to the health facility in real time and in an adaptable way?				
2.5	How have gender and equity concerns been addressed in the design, implementation and monitoring of the programme?	<ul style="list-style-type: none"> ▪ What elements of the programme determine the active participation and commitment of women and men in CMAM? ▪ What measures have been taken to address inequalities due to age, gender and/ or location? ▪ Have principles of equality been incorporated into the nutrition messages? 	<ul style="list-style-type: none"> ▪ Participation of women and men in the different activities (screening, management, follow-up, prevention) ▪ Effects of key messages used in community and advocacy activities to promote gender equality and prevent cultural and/ or social barriers that may negatively impact on nutritional status 	<ul style="list-style-type: none"> ▪ National health and nutrition policies targeting children ▪ Project proposal from UNICEF ▪ Key informants 	<ul style="list-style-type: none"> ▪ Document review ▪ Individual interviews ▪ Focus group discussions
3. Efficiency					
3.1	How well has the CMAM programme implementation been managed in the programme states?	<ul style="list-style-type: none"> ▪ How did stakeholders collaborate in planning and implementing? ▪ What was their involvement in the management so as to avoid duplication of efforts? 	<ul style="list-style-type: none"> ▪ Duplication of activities and reports ▪ Participation of other stakeholders 	<ul style="list-style-type: none"> ▪ Programme Progress Reports ▪ Quantitative databases of the programme ▪ Key informants 	<ul style="list-style-type: none"> ▪ Document review ▪ Individual interviews
3.2	To what extent is current CMAM implementation cost efficient? Could the same be achieved using different strategies and with less resources? What are the good practices/	<ul style="list-style-type: none"> ▪ What are the best practices that determine programme efficiency? ▪ How could these elements be used to improve the efficiency of CMAM programme? Could the same results be 	<ul style="list-style-type: none"> ▪ Programme costs compared to similar interventions in other contexts ▪ Alternatives to the treatment of SAM children ▪ Implementation modality across different states ▪ Good practices 	<ul style="list-style-type: none"> ▪ Programme progress reports ▪ Programme financial reports ▪ Programme financial databases ▪ Key informants 	<ul style="list-style-type: none"> ▪ Document review ▪ Individual interviews ▪ Financial analysis

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
	comparative advantages between programming in different states?	<p>achieved with fewer resources?</p> <ul style="list-style-type: none"> How did CMAM implementation evolve across states? What are the good practices that are replicable within and between states? 			
3.3	To what extent was the CMAM programme efficient in terms of utilising existing systems and considering value for money?	<ul style="list-style-type: none"> What is the added value of integrating CMAM into the different pillars of the health system versus implementation in parallel to the health system? 	<ul style="list-style-type: none"> Financial and operational benefits of implementing CMAM through the health system 	<ul style="list-style-type: none"> Programme Progress Reports Key informants 	<ul style="list-style-type: none"> Document review Individual interviews
3.4	To what extent has the CMAM programme engaged communities in the design, implementation and monitoring of the programme?	<ul style="list-style-type: none"> To what extent were individuals, in all their diversity, consulted to judge the relevance prior to the implementation of the programme? What consultations have been initiated? How do these consultations influence programme design and implementation? 	<ul style="list-style-type: none"> Number of interaction sessions between UNICEF, WFP, NGOs and the community Content of exchanges between the interactions and their consideration for improving the programme If interactions are not happening, the reasons why 	<ul style="list-style-type: none"> National health and nutrition policies targeting children UNICEF country programme document Programme progress reports Key informants 	<ul style="list-style-type: none"> Document review Individual interviews Focus group discussions
4. Impact					
4.1	What significant changes happened to children and communities with the implementation of CMAM in terms of improving malnutrition status (prevalence) and reduction in	<ul style="list-style-type: none"> What is the influence of the intervention on the nutritional status of children aged 6 to 59 months? 	<ul style="list-style-type: none"> Anecdotal evidences of changes in health and feeding practices to children 	<ul style="list-style-type: none"> Programme progress reports Key informants 	<ul style="list-style-type: none"> Document review Individual interviews Focus group discussions

	Evaluation criteria/questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
	mortalities due to severe acute malnutrition?				
4.2	What were the positive and negative, intended and unintended consequences of the CMAM programme?	<ul style="list-style-type: none"> ▪ What were the unexpected positive outcomes? ▪ What were the unexpected negative outcomes? ▪ To what extent has the availability of therapeutic and supplementary foods in health facilities had a positive or negative influence on participation in and use of other health and nutrition services? 	<ul style="list-style-type: none"> ▪ Unexpected results ▪ Anecdotal evidences on the trends in admissions to other health and nutrition services 	<ul style="list-style-type: none"> ▪ Programme progress reports ▪ Key informants 	<ul style="list-style-type: none"> ▪ Document review ▪ Individual interviews ▪ Focus group discussions ▪ Quantitative data analysis
4.3	Does the intervention have the potential to positively influence gender equality in the long term? <i>(Question inserted by the evaluation team)</i>	<ul style="list-style-type: none"> ▪ How are men involved in decision making about food consumption at household level after receiving nutritional advice and messages? ▪ How do men support women who participate in CMAM? 	<ul style="list-style-type: none"> ▪ Knowledge and retention of nutrition messages by men and women ▪ Measures taken by women to change their feeding practices in the household and the results of their actions ▪ Men's participation in decisions concerning food in the household 	<ul style="list-style-type: none"> ▪ Programme progress reports ▪ Key informants 	<ul style="list-style-type: none"> ▪ Document review ▪ Individual interviews ▪ Focus group discussions
5. Sustainability					
5.1	To what extent has CMAM been integrated and contributed to health system strengthening?	<ul style="list-style-type: none"> ▪ To what extent has CMAM been integrated into the health system? ▪ To what extent has this integration contributed to health system strengthening? 	<ul style="list-style-type: none"> ▪ Level of CMAM integration measured against WHO Health System Strengthening framework 	<ul style="list-style-type: none"> ▪ Programme progress reports ▪ UNICEF Country Programme ▪ Key informants 	<ul style="list-style-type: none"> ▪ Document review ▪ Individual interviews

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
5.2	What is the current government investment in CMAM and how could this investment be maximised?	<ul style="list-style-type: none"> ▪ To what extent has the government been influenced to increase investments in CMAM? ▪ To what extent has the programme influenced government involvement in nutrition? 	<ul style="list-style-type: none"> ▪ Government commitment to invest in CMAM and in nutrition in the country ▪ Government advocacy for attracting the funds 	<ul style="list-style-type: none"> ▪ Programme progress reports ▪ Financial reports ▪ Key informants 	<ul style="list-style-type: none"> ▪ Document review ▪ Individual interviews
5.3	What are the opportunities and the risks for the sustainability of the programme's benefits in the short, medium and long term?	<ul style="list-style-type: none"> ▪ To what extent will the benefits of the intervention continue for children after the end of donor support? ▪ What is the Government's policy on the sustainability of nutrition interventions? ▪ What exit strategies do UNICEF and other partners have in place for the government to take over the programme? 	<ul style="list-style-type: none"> ▪ Government strategy to take over the intervention ▪ UNICEF and other partner exit strategies 	<ul style="list-style-type: none"> ▪ National Policies and Strategies ▪ UNICEF Country Programme ▪ Key informants 	<ul style="list-style-type: none"> ▪ Document review ▪ Individual interviews

6.3 Annex 3: Routine Data Collection Forms for SQUEAC Assessment

Different forms in word format (see Tables 1-12) will be used to collect and compile additional data in the field. This data will then be analysed using Excel and manually wherever necessary.

TABLE 1. ADMISSIONS AND DEFAULTERS MONTH-WISE

Site: _____

Month	Total admissions				Total defaulters			
	2015	2016	2017	2018	2015	2016	2017	2018
January								
February								
March								
April								
May								
June								
July								
August								
September								
October								
November								
December								
Total								

TABLE 5. TALLY SHEET FOR NUMBER OF VISITS BEFORE DEFAULTING OTP

Site: _____ Year: _____

Number of visits	≥8 th	
	7 th	
	6 th	
	5 th	
	4 th	
	3 rd	
	2 nd	
	1 st	
		Number

TABLE 6. TALLY SHEET FOR NUMBER OF VISITS BEFORE DEFAULTING FOR TSFP FOR CHILDREN

Site: _____ Year: _____

Number of visits	≥8 th	
	7 th	
	6 th	
	5 th	
	4 th	
	3 rd	
	2 nd	
	1 st	
		Number

TABLE 7. TALLY SHEET FOR NUMBER OF VISITS BEFORE DEFAULTING FOR SFP FOR PLW

Site: _____ Year: _____

Number of visits	≥8 th	
	7 th	
	6 th	
	5 th	
	4 th	
	3 rd	
	2 nd	
	1 st	
		Number

TABLE 8. TALLY SHEET FOR ADMISSION MUAC FOR OTP⁸

Site: _____ Year: _____

MUAC	Tally
13.5	
13.4	
13.3	
13.2	
13.1	
13.0	
12.9	
12.8	
12.7	
12.6	
12.5	
12.4	
12.3	
12.2	
12.1	
12.0	
11.9	
11.8	
11.7	
11.6	
11.5	
11.4	
11.3	
11.2	
11.1	
11.0	
10.9	
10.8	
10.7	
10.6	
10.5	

⁸ This should be for all admissions in the first 6 months of each of the three years (2015-2018)

10.4	
10.3	
10.2	
10.1	
10.0	
9	
8	
7	
6	

TABLE 9. TALLY SHEET FOR ADMISSION MUAC⁹ FOR TSFP FOR CHILDREN

Site: _____ Year: _____

MUAC	Tally
13.5	
13.4	
13.3	
13.2	
13.1	
13.0	
12.9	
12.8	
12.7	
12.6	
12.5	
12.4	
12.3	
12.2	
12.1	
12.0	
11.9	
11.8	
11.7	
11.6	
11.5	
11.4	
11.3	
11.2	
11.1	
11.0	
10.9	
10.8	
10.7	
10.6	
10.5	
10.4	

⁹ This should be for all admissions in the first 6 months of each of the three years (2015-2018)

10.3	
10.2	
10.1	
10.0	
9	
8	
7	
6	

TABLE 10. TALLY SHEET FOR ADMISSION MUAC¹⁰ FOR SFP FOR PLW

Site: _____ Year: _____

MUAC	Tally
23.0	
22.9	
22.8	
22.7	
22.6	
22.5	
22.4	
22.3	
22.1	
22.0	
21.9	
21.8	
21.7	
21.6	
21.5	
21.4	
21.3	
21.2	
21.1	
≤21.0	

¹⁰This should be for all admissions in the first 6 months of each of the three years (2015-2018)

TABLE 11. OUTREACH VISITS/EDUCATION SESSIONSSite: _____ Year¹¹ _____

Category of Outreach activities	Number of education sessions held												
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Education sessions (in waiting areas)													
Peer support groups (at community level)													
Mothers' clubs at centre level													
Individual Counselling Sessions													
Community Sessions (Mobilisation)													

TABLE 12. SOURCE OF REFERRALSSite: _____ Year¹²: _____

Referral source	Number of cases referred to		
	OTP	SFP for children	SFP for PLW
Popular committee			
Self/mothers			
THs/TBAs			
CBVs/VMWS			
Other			

¹¹ This should be for all sessions in the first 6 months of each of the three years (2015-2018)¹² This should be in the first 6 months of each of the three years (2015-2018)

6.4 Annex 4: Interview and FGD guides for primary qualitative data collection

Interview guide at Federal and State level

With government officials (Ministry of Health, Ministry of Finance, other key Ministries), UN Agencies, SUN secretariat, Donors, NGOs, Private Sector, institutions for health professions and national research institutions

Introduction, confidentiality and access to information

This interview is being conducted as part of the evaluation of the CMAM programme in Sudan. The purpose of this evaluation is to examine the process, outputs, outcomes and possibly the impact of the intervention in the country, in order to make appropriate recommendations for its improvement and scaling up. An essential part of the evaluation process is to conduct interviews with key informants such as you, in order to get your opinion on the implementation of the programme. We would like to thank you for giving your consent to participate in this evaluation. Be assured that your answers will be strictly confidential. Although you may be quoted in the evaluation report, the source of the citation will not be identified by your name, title or institutional affiliation.

This interview will last maximum 60 minutes.

The Evaluation Team¹³

Participant information

Date:	Name:		
	Name of organisation:	Title/Function:	Contact details:

RELEVANCE

1. Please can you tell us to what extent the design of CMAM programme was consistent with government priorities in addressing the needs of children under five years of age?
2. What are the linkages between CMAM and the other child health and nutrition interventions such as:
 - EPI
 - IMCI
 - IYCF
 - WASH
 - Food Security

¹³ **Note to the interviewer:** Questions are structured according to evaluation criteria. Not of them will be asked to each participant. Each question will be addressed to the person most likely to provide the appropriate answer. The pre-test phase will help to better adjust and orient the questions according to each stakeholder.

3. In this regard, how have local partners implementing CMAM programme activities been chosen and mandated, and what supervision, support and guidance is provided to them?
4. What measures have been taken to ensure the programme is available for all who need it?

EFFECTIVENESS

1. What do you think about the effectiveness of CMAM programme (each component) in terms of:
 - Coverage of health facilities?
 - Coverage of beneficiaries?
 - Do you think there were beneficiaries that have not been reached? If yes, which one? And for which reasons?
 - Procurement of supplies (RUTF, Supplementary Foods, Therapeutic Milk)?
 - Meeting the Sphere Standards(performance)?
 - Monitoring of the programme?
 - Addressing inequalities due to age, sex, location?
2. What factors contributed to these achievements?
3. What were the main challenges for achieving the expected results? How did you address these challenges?
4. What improvement still needs to be done?

EFFICIENCY

1. During the planning process of CMAM, how did partners collaborated in designing the different component?
2. How is the collaboration of partners managed?
3. How do these arrangements ensure that duplication of efforts is avoided?
4. Compared to the implementation of CMAM by NGOs in parallel to the health system (as practiced before), what positive changes have you observed with the implementation of the programme within the health system?
5. Tell us about your interactions with the communities during the planning and implementation phases of CMAM

IMPACT

1. What changes have you observed on the nutritional status of children as a result of being admitted to the programme?
2. What would happen to the children if there was no CMAM intervention in the country/state/locality?
3. Were there positive changes that were not expected?
4. Were there any unexpected negative outcome?

SUSTAINABILITY

1. To what extent has CMAM strengthened the national health system in terms of:
 - Financing the intervention? / government investment or commitment to invest in CMAM
 - Government human resource involvement, development and retention?
 - Delivery of services in primary health care services in the health facilities and the communities?
 - National procurement and delivery of supplies?
 - National monitoring, supervision and reporting system?
 - Development of national nutrition guidelines and operational plans?
2. What were the main challenges for full integration of each of the above components?
3. What is the government strategy to take over the intervention?
4. What exit strategies does UNICEF/WHO/WFP and the Government have in place for CMAM?

Interview guide at Locality, Health facilities and mobile clinics

With Locality Nutrition Focal Point, Health Workers and Nutritionists

Introduction, confidentiality and access to information

This interview is being conducted as part of the evaluation of the CMAM programme in Sudan. The purpose of this evaluation is to examine the process, outputs, outcomes and possibly the impact of the intervention in the country, in order to make appropriate recommendations for its improvement and scaling up. An essential part of the evaluation process is to conduct interviews with key informants such as you, in order to get your opinion on the implementation of the programme. We would like to thank you for giving your consent to participate in this evaluation. Be assured that your answers will be strictly confidential. Although you may be quoted in the evaluation report, the source of the citation will not be identified by your name, title or institutional affiliation.

This interview will last maximum 60 minutes.

The Evaluation Team

Participant information

Date:	Name:		
	Name of organisation:	Title/Function:	Contact details:

RELEVANCE

1. Please can you tell us to what extend the CMAM programme is adequate for addressing the needs of SAM and MAM children in your locality?
2. What are the linkages between CMAM and the other child health programme you are delivering?
 - EPI
 - IMCI
 - IYCF
3. Please tell us about the involvement in the community of women and men in the different activities of the programme (screening, management, follow-up, prevention).

EFFECTIVENESS

1. What do you think about the effectiveness of CMAM programme (each component) in terms of:
 - Coverage of beneficiaries?
 - Do you think there were beneficiaries that have not been reached? If yes, which one? And for which reasons?

- Procurement of supplies (RUTF, Supplementary Foods, Therapeutic Milk)? Did you experience shortages? If yes, what were the reasons?
 - Meeting the Sphere Standards(performance)?
 - How often do you get refresher training and supervised for CMAM?
2. According to you, what factors contributed to these achievements?

EFFICIENCY

1. Tell us about the referral mechanism between SAM, MAM and community outreach component you oversee?
2. What are the other interventions in the locality/community that targets the same beneficiaries as CMAM?
3. What are the linkages between CMAM and these interventions for prevention of malnutrition?
4. What difficulties have you often experienced in delivering CMAM services in your health facility? How did you address these difficulties?
5. According to you, what improvement still needs to be done for CMAM service delivery in your health facility and the locality?

IMPACT

1. What changes have you observed on the nutritional status of children as a result of being admitted to the programme?
2. What did you observed as positive changes that were not expected from the delivery of CMAM services?
3. What were the unexpected negative outcomes that occurred?

SUSTAINABILITY

1. Once you discharge a child as cured from the programme, how do you make sure the child will not slide back to malnutrition?
2. What would happen to the children if there was no CMAM service delivery in your health facility/locality?

FGD Guide at Community Level

With the following categories of participants:

- 1) Community leaders (religious leaders, teachers, traditional birth attendants, member of local health management committees)
- 2) Community members (mothers' support groups, nutrition community volunteers, Community Health Workers, Health Promoters)
- 3) Parents (women and men) of children under five years of age admitted to the CMAM programme

Introduction, confidentiality and access to information

This discussion is being conducted as part of the evaluation of the CMAM programme in Sudan. The purpose of this evaluation is to examine the process, outputs, outcomes and possibly the impact of the intervention in order to make appropriate recommendations for its improvement. An essential part of the evaluation process is to conduct focus group discussions with community members and beneficiaries. We would like to thank you for giving your consent to participate in this discussion. Be assured that your answers will be kept strictly confidential. Although you may be cited in the evaluation report, the source of the citation will not be identified by your name, title or position.

This discussion will last maximum 90 minutes.

The evaluation team¹⁴

Information on the activity and participants

Date: _____		
Name of the locality/community: _____		
Category of participants:		
1) Community leaders (religious leaders, teachers, traditional birth attendants, member of local health management committees)		
2) Community members (mothers' support groups, nutrition community volunteers, Community Health Workers, Health Promoters)		
3) Parents (women and men) of children under five years of age admitted to the CMAM programme		
Number of male participants	Number of female participants	Total number of participants

¹⁴ All questions will not be asked to all categories of participants. This FGD guide will be further adapted to these different categories after pre-test and prior to data collection.

RELEVANCE

1. Please can you tell us to what extent the CMAM programme is adequate for addressing the needs of SAM and MAM children in your locality?
2. What are the linkages between CMAM and the other child health programmes?
 - EPI
 - IMCI
 - IYCF
3. Please tell us about your involvement (women and men) in the different activities of the programme (screening, management, follow-up, prevention)
4. What motivated you to get involved in the programme?

EFFECTIVENESS

1. Do you think there were beneficiaries that have not been reached? If yes, which one? And for which reasons?
2. Please tell us how your children were referred to the health facility for treatment
3. Why some referred children do not go for treatment?
4. What difficulties have you often experienced in accessing the health facility/services for CMAM? How did you overcome these difficulties?
5. Did you experience any issue using RUTF/Supplementary Foods at home? Please explain.
6. According to you, what improvement needs to be done for CMAM service delivery in your locality?

EFFICIENCY

1. What are the other interventions in your locality/community for prevention of malnutrition that targets the same beneficiaries as CMAM?
2. Were your children admitted to these programmes concomitantly to their admission to CMAM? If yes, what were the reasons of being admitted?
3. Tell us about the consultation you had with programme implementers (MoH/NGO) to get your opinion on the relevance of the programme prior its implementation
4. How do these consultations influence programme design and implementation?

IMPACT

1. What changes have you observed on the nutritional status of your child as a result of being admitted to the programme?
2. According to you, what produced these changes?
3. What other changes have you observed in the household as a result of being admitted to the programme?

SUSTAINABILITY

1. Once your child was discharged as cured, how did you manage to prevent him from falling back into malnutrition again?
2. What would happen to the children of this locality if there was no CMAM service delivery?

6.5 Annex 5: Checklist for Direct Observation in Health Structures

The evaluation team will use this checklist to observe the environment within the health facilities, the adequacy of its tools for social behaviour change, the quality of the assessment and classification of the nutritional status of children under five years of age, the availability and use of the protocol for the management of acute malnutrition, the availability of adequately trained staff, therapeutic and supplementary foods and adequate infrastructure, stock management and record keeping.

Checklist adapted from Nutrition Assessment, Counselling and Support (NACS)

Equipment and Materials		Yes	No
	The site has at least one functional scale for measuring the weight of children in kg to the nearest 100g.		
	The site has at least one adult weighing scale/ scale for adults.		
	The site has at least one height gauge that measures the height of children to the nearest cm.		
	The site has tape measures for measuring the brachial perimeter of children.		
	The site has copies of algorithms/guidelines for the management of acute malnutrition in children.		
	The site has at least one set of nutritional advice cards to be used in advising carers (mothers and fathers) of children on the prevention and treatment of acute malnutrition.		
	The site has data entry forms and a system for compiling data that includes data on the treatment of acute malnutrition in children under five years of age.		
	The site has a graph with the weight/height (W/H) thresholds in z-score of the WHO child growth standards, year 2006.		
	The site has utensils (e.g. bowls, tablespoons, saucepans, kitchen) for cooking demonstrations.		
Nutritional Assessment and Classification		Yes	No
	At least two healthcare providers are trained in the management of acute malnutrition in children under five years of age.		
	For all children arriving at the site for the first time, weight is measured to the nearest 100g, height is measured in cm, P/T index is calculated and brachial perimeter is measured to the nearest mm.		
	The weight/height index and/or brachial perimeter are recorded on the registration cards of children under five years of age.		
Nutritional Treatment Plans		Yes	No
	Each MAM child receives therapeutic or supplementary foods on the basis of a treatment plan developed for his or her nutritional and health status.		

	Each accompanying person receives an explanation on the criteria for entry and exit of the child, the purpose of therapeutic or supplementary food and how to consume it.		
	Entry and exit criteria for therapeutic foods or dietary supplements are posted in a place easily visible to health workers and caregivers of children under five.		
	Every SAM child receives enough packets of therapeutic foods to last until the next visit to the health centre, according to national guidelines.		
Infrastructure and Amenities		Yes	No
	The site has enough therapeutic foods to handle SAM cases for at least 3 months.		
	The site has enough supplementary foods to handle MAM cases for at least 3 months.		
	The site has sufficient space to store therapeutic and supplementary foods/products.		
	The space available for storage of therapeutic and supplementary foods and related products is clean and sufficiently ventilated.		
Inventory Management and Record Keeping		Yes	No
	The head of the health centre submits a regular monthly report on the number of children under five years of age receiving therapeutic foods according to the agreed schedule.		
	The manager of the health centre regularly submits an estimate of therapeutic food supply needs according to the agreed schedule.		
	The site store in charge of the nutritional inputs correctly keeps stock records for therapeutic foods.		
	The health worker completes the counselling record for each client consulted.		
	The data officer compiles the nutritional data according to the agreed (monthly) schedule.		
	“First to expire, first out” procedures and inventory management are used for therapeutic foods and other commodities.		
	Therapeutic foods are ordered at least 3 months in advance to avoid stock-outs.		

6.6 Annex 6: Free and Informed Consent Template

Section for the Interviewer/Facilitator of the focus group discussion

- You are cordially invited to participate in this evaluation of the programme for *Community Management of Acute Malnutrition (CMAM)* in Sudan, implemented from 2015 to 2018. This evaluation is sponsored by the UNICEF Country Office, and it is implemented in collaboration with the Government of Sudan. If you agree to participate, we will ask you a few questions on different topics, and we may have access to your records, documents and databases.
- Participation in this project does not present any risk to you. The information collected will be kept strictly confidential and will be reviewed only by those responsible for the evaluation. It will not be shared with anyone outside of this independent team.
- Your participation is voluntary, and you are free to request the removal of your information and responses at any time.
- Participation will not provide any immediate benefit to you, however the information you provide will help to improve the design and implementation of the CMAM programme in the country.

FGDs Only

- Please do not share anything you hear in this group with people who are not present now.

The interview/discussion today is being run by the following team:	They can be contacted later by calling:

Section reserved for the participant(s)

I, the undersigned

Mr/Mrs/Ms.....

Having received a detailed explanation of the evaluation being conducted by UNICEF and having received a satisfactory response to all the questions I asked to the evaluation team, I give my voluntary and free consent to participate in this evaluation.

I retain the right to suspend my participation at any time and without any prejudice.

Conducted at....., on.....

Mr/Mrs/Ms

For all purposes, you may contact the evaluation team or the UNICEF Deputy Country Director in Sudan at any time if you have any questions about the evaluation.

6.7 Annex 7: Terms of Reference



UNITED NATIONS CHILDREN'S FUND SUDAN COUNTRY OFFICE TERMS OF REFERENCE (TOR) FOR INSTITUTIONAL CONTRACTORS

Project/Program Title: e.g. Planning, Evaluation and Innovation	
Position Title/Services description:	CMAM Evaluation
Duration of Contract:	6 months
Duty Station:	Khartoum with travel to the states
RWP Reference Details:	
Output Details:	4020/A0/07/885/001
Activity Details:	4020/A0/07/885/001/052
Supervisor:	Chief Planning, Monitoring and Evaluation
1. Background:	
<p>The Global agenda of SDG 2030 aims to achieve the elimination of all forms of malnutrition including the reduction of stunting by 45%. At the country level, the national goal related to child nutrition within the Health-Nutrition sector five-year national strategy of Maternal, Neonatal and Child Health 2016-2020 is to reduce wasting prevalence from 16% to 6%. The purpose of the costed Nutrition Investment Case 2015-2019 was to achieve the reduction of stunting from 35% to 25% the wasting from 16% to 6%.</p> <p>As one of the approaches to decrease prevalence and incidence of acute malnutrition, UNICEF Sudan has significantly focused on scaling up community management of acute malnutrition in Sudan since 2009 to date. To achieve this end, that the Federal Ministry of Health of Sudan adopted, endorsed and implemented CMAM scale up plan for years 2015-2017. In Sudan, currently there are 1,450 SAM treatment sites which cover all 18 states of Sudan, (1310 outpatient treatment centers and 140 inpatient treatment centers). The scaling up plan for CMAM was developed based on the S3M national survey results (2013) and recommendations of CMAM review (2013).</p> <p>More than USD 20 million are spent annually for CMAM interventions funded mostly through humanitarian funds from Donors but since the last three years also includes Government's contribution. These are implemented through an extensive partnership established for the implementation of CMAM including with the MoH playing a key leadership role at all levels, sector line ministries, Communities engagement, UN agencies joint efforts (UNICEF, WFP, FAO and WHO), Donors and CSOs. Sudan has also endorsed the global SUN movement which ensures adequate overall multi sectoral coordination at policy level.</p> <p>Government of Sudan is moving into many strategic directions to achieve universal health coverage such as expanding primary health care program and also strengthening health systems at district level. The transitioning strategy will contribute to moving the focus of the CMAM programme from that of a siloed program to being part of an integrated system within Ministry of Health plans and programmes. The UNICEF country program for 2018-2021 is also focusing more on programmatic integration and moving from solely humanitarian based interventions in to more development</p>	

focus while continuing to address humanitarian needs. These changes are expected to influence the development CMAM scale up plan 2019-2022.

In this context the findings and recommendations of the evaluation of the CMAM programme will be instrumental in defining the CMAM scale up plan 2019-2022 to effectively contribute to achieving both FMOH and UNICEF strategic visions for children and provide insights on how to improve the existing strategies achieving how high quality CMAM program.

2. Purpose of Assignment:

The CMAM evaluation is commissioned in response to the need to evaluate the overall progress in implementing the CMAM scale up plan for years 2015-2018, the effectiveness and efficiency of its strategies and issue related to sustainability, equity, gender and national/sub-national ownership. The evaluation aims to serve **two purposes** of:

1. **Learning** of strengths/good practices and determinants factors of shortfalls of expected results for adjustment and doing business differently;
2. **Accountability** to affected population and communities and donors about the return of investments made in Darfur in responses to the huge humanitarian needs of displaced populations and host communities.

3. Basic objectives of consultancy/contractor (assignment) services (2-5 Objectives).

- Assess CMAM related interventions relevance and appropriateness, efficiency and quality of services (2015-2018) and explain how program effectiveness could be increased/improved
- Assess the impact of the current CMAM program (2015 – 2018) in terms of lives saved, reduction of acute malnutrition prevalence and how can the programme be sustainable and ensure nationwide coverage.
- Measure the current level of integration between CMAM program, WASH, IMCI/ICCM and EPI as well as IYCF program and advise how this integration could be fostered in a way that contribute to health system rather than over burden it.

Objective 1: Assess CMAM related interventions relevance and appropriateness, efficiency and quality of services (2015-2018) and explain how program effectiveness could be increased/improved		
Key Activities/ Tasks	Output(s)/ Deliverable(s)	Expected Time Frame
A. Design the CMAM evaluation plan and develop inception report	<ul style="list-style-type: none"> Inception report including: a summary of the evaluation plan, the methodology to be used, the evaluation matrix, a work plan/schedule and a proposed table of content of the evaluation report is developed and shared 	November 2019
B. Conduct field Data collection, and Client satisfaction survey including collection of series of routine data from State Line Ministries on Health, Nutrition and WASH.	<ul style="list-style-type: none"> Field Data collection/ Client satisfaction survey including collection of series of routine data from State Line Ministries on Health, Nutrition and WASH is completed Draft Evaluation Report is submitted 	December 2019
C. Complete data analysis, processing and finalize draft evaluation report	<ul style="list-style-type: none"> Final evaluation report is submitted 	February 2020
D. Finalize the evaluation report		March 2020
Objective 2: Assess the impact of the current CMAM program (2015 – 2018) in terms of lives saved, reduction of acute malnutrition prevalence and how can the programme be sustainable and ensure nationwide coverage.		
Key Activities/Tasks	Output(s)/Deliverable(s)	Expected Time Frame
A. Design the CMAM evaluation plan and develop inception report	<ul style="list-style-type: none"> Inception report including: a summary of the evaluation plan, the methodology to be used, the evaluation matrix, a work plan/schedule and a proposed table of content of the evaluation report is developed and shared 	November 2019
B. Conduct field Data collection, and Client satisfaction survey including collection of series of routine data from State Line Ministries on Health, Nutrition and WASH.	<ul style="list-style-type: none"> Field Data collection/Client satisfaction survey including collection of series of routine data from State Line Ministries on Health, Nutrition and WASH is completed Draft Evaluation Report is submitted 	December 2019
C. Complete data analysis, processing and finalize draft evaluation report	<ul style="list-style-type: none"> Final evaluation report is submitted 	February 2020

D. Finalize the evaluation report		March 2020
Objective 3: Measure the current level of integration between CMAM program, WASH, IMCI/ICCM and EPI as well as IYCF program and advise how this integration could be fostered in a way that contribute to health system rather than over burden it.		
Key Activities/Tasks	Output(s)/Deliverable(s)	Expected Time Frame
A. Design the CMAM evaluation plan and develop inception report	<ul style="list-style-type: none"> Inception report including: a summary of the evaluation plan, the methodology to be used, the evaluation matrix, a work plan/schedule and a proposed table of content of the evaluation report is developed and shared 	November 2019
B. Conduct field Data collection, and Client satisfaction survey including collection of series of routine data from State Line Ministries on Health, Nutrition and WASH.	<ul style="list-style-type: none"> Field Data collection/Client satisfaction survey including collection of series of routine data from State Line Ministries on Health, Nutrition and WASH is completed Draft Evaluation Report is submitted 	December 2019
C. Complete data analysis, processing and finalize draft evaluation report	<ul style="list-style-type: none"> Final evaluation report is submitted 	February 2020
D. Finalize the evaluation report		March 2020

3. Estimated cost of Consultancy/Contractor Service and WBS and Grant: (For Internal Planning purposes)
4. Amount budgeted (Overall Approved Budget in AWP Activity) <ul style="list-style-type: none"> TBD
5. Qualification or specialized knowledge/experience/expertise required for the assignment: <ul style="list-style-type: none"> An experienced consultant or team, or legally registered consulting firm with an extensive experience of evaluation of complex projects, research methods, analytical skills and approaches in the nutrition and health sector. Good understanding of development issue and knowledge of the country context, including policy and programming, including: National Nutrition Programme, and other associated policies. Extensive knowledge of CMAM, especially capacity building approaches. Understanding of health systems Ability to communicate clearly with a wide range of stakeholders. Previous experience working with the UN Excellent writing skills in English.

NB. Please see below on page#6&7 **Annex 1 Proposal Evaluation Criteria (Technical and Financial, and Minimum Contents of Proposal)**

6. General Terms and Conditions of the Contract:

- Under the consultancy agreements, payment is deliverable based as defined in the ToR
- All remuneration must be within the contract agreement.
- No contract may commence unless the contract is signed by both UNICEF and the consultant or Contractor.
- For international consultants outside the duty station, signed contracts must be sent by fax or email.
- Unless authorized, UNICEF will buy the tickets for the consultant. In exceptional cases, the consultant may be authorized to buy their travel tickets and shall be reimbursed at the “most economical and direct route” but this must be agreed to beforehand.
- Consultants will not have supervisory responsibilities or authority on UNICEF budget.
- Consultant will be required to sign the Health statement for consultants/Individual contractor prior to taking up the assignment, and to document that they have appropriate health insurance, including Medical Evacuation.
- Mention it as per the General Terms and Conditions of the Contract.
- Mention “Grace Period” for submission of deliverables, after which payment will not be processed

Annex 1 Proposal Evaluation Criteria (Technical and Financial, and Minimum Contents of Proposal)

The proposals will be evaluated against the Technical Evaluation Criteria (70%) and Price Proposal Evaluation Criteria (30%). The details of the Evaluation Criteria and the minimum content of the technical and financial proposal is as below.

Technical evaluation criteria:

All technical proposals will be evaluated using the evaluation criteria as indicated below. Bidders are advised to devote chapters of their submissions to demonstrate each of the criteria and be consistent with the tasks detailed in the ToR under Section #. Bidders are advised to avoid submitting brochures and pamphlet that have no direct bearing on the requirements under this RFP.

Category	Points allocated to each factor
<p>1. Organizational Capacity and Quality Control</p> <p>1.1. Credential of the organisation in terms of reliability, experience, and capacity:</p> <p>a) Organization's/institution's background and experience in conducting a quantitative and qualitative evaluation of high complexity, including the presence of effective mechanisms for recruitment and management of relevant staff, managing logistics and funds (two recent audit reports attached).</p> <p>b) Understanding of the purpose of the assignments to be completed as well as results expected to be achieved under the Terms of Reference through brief introduction/overview of the assignment. Clear presentation of thoughts in a logical sequence.</p>	<p>(25)</p> <p>10</p> <p>15</p>
<p>2: Adequacy of the proposed work plan & approach</p> <p>2.1. Approach</p> <p>a) Proposed work plan and approach of implementation of the tasks as per the ToR, including</p> <p>(i) detailed methodology, guidelines, and proposed tools for collecting information; (ii) methodology in selecting participants for FGDs and/or KIIs; (iii) data analysis, validation of findings and report writing.</p> <p>b) Proposed quality control mechanism for data collection/analysis, oversight, and supervision.</p> <p>c) Risk management and flexibility of proposal in the context of needs to make changes regarding time, duration, location, and kind of activities.</p>	<p>(20)</p> <p>10</p> <p>5</p> <p>5</p>
<p>2.2. Planning and Schedule:</p> <p>a) Background and experience of implementation team; adequate and right staff combination in relation to the respective expected outputs of the assignment.</p> <p>b) Proposed supervision and implementation plan with timetable and key indicators as per ToR.</p>	<p>(10)</p> <p>5</p> <p>5</p>

Category	Points allocated to each factor
3: Expertise of the organization:	(15)
a) Proven track record of previous experience in conducting similar evaluations, reviews and assessments (reports of 2 recent evaluations conducted attached).	5
b) Expertise in Country Programme Sectors, particularly in Nutrition programming, in developing countries, especially in Africa (any work in Sudan will be an asset).	5
c) Demonstrated experience in working with large stakeholder group (UN, international development organizations, government departments, NGOs, etc.) in conducting an evaluation in relation to similar scope and complexity of this assignment.	5
Total Marks	70
Minimum score for technical compliance	55
Total Maximum for Commercial evaluation (Overall Price)	30
TOTAL POINTS (Total of combined evaluation)	100

6.8 Annex 8: Elaboration of the Evaluation Questions in the Terms of Reference

The purpose of the evaluation is to assess the performance of CMAM programme in terms of its

- i) Relevance/appropriateness,
- ii) Effectiveness,
- iii) Efficiency/cost-effectiveness/value for money,
- iv) Coverage,
- v) Impact; and
- vi) Sustainability of CMAM program

The OECD/DAC will be applied to programme objectives and strategic result areas. The evaluation will seek to answer, but not limited to the following evaluation questions:

Relevance/Appropriateness

1. To what extent CMAM program programming and implementation are well aligned to the national priorities and strategies; and have been adequate and implemented to address the specific needs of SAM children?
2. Were the CMAM objectives appropriate in the overall problem context, needs and priorities?
3. To what extent adequate the CMAM programme coordination has been implemented in partnership with the relevant various actors/sectors in order to avoid gaps or overlapping interventions including coordination within UNICEF and with WHO and WFP.

Effectiveness

4. To what extent has the CMAM program contributed in achieving expected results of the results framework (outcomes and outputs) of the National Nutrition Strategy, the Nutrition Investment Case, the Country Programme of Cooperation 2013-2017?
5. Have CMAM achieved expected standard quality of care of children admitted to OTP centers, if expected result and quality are not achieved what have been the main factors that hindered the achievement and how this could be improved?
6. To what extent the CMAM programme contributed to reducing the bottlenecks and barriers that determine equity gaps affecting vulnerable children.
7. What is current CMAM program monitoring mechanism? is it sufficient to monitor the expected results? if not how can it be improved and decentralized to the health facility in real time and adaptable way?
8. How have gender and equity concerns been addressed in the design, implementation and monitoring of the programme;

Efficiency:

9. How well the CMAM programme implementation been managed in the programme states.
10. To what extent current CMAM implementation is cost efficient? Could the same be achieved using different strategies and with less resources.
11. To what extent the CMAM program was efficient in terms of utilizing existing systems and considering value for money.

12. To what extent UNICEF and other partners have adequately supported CMAM for achieving results. What are the missed opportunities that if used CMAM support would have been maximized?
13. To what extent CMAM program engaged communities in the design, implementation and monitoring of the programme
14. What are the good practices/comparative advantages between programming in different states?

Coverage

15. Is CMAM program coverage within acceptable range?
16. What factors that have acted as barriers and boosters for achieving acceptable coverage?
17. How could coverage increase and measured not only at state or locality levels but at health facility levels. How could coverage increase and measured not only at state or locality levels but at health facility levels.

Impact

18. What significant changes happened to children and communities with the implementation of CMAM in terms of improving malnutrition status (prevalence's) and reduction in mortalities due to severe acute malnutrition?
19. How many lives were saved with the current CMAM program?
20. What were the positive and negative, intended and unintended consequences of CMAM program?

Sustainability

21. To what extent, CMAM has been integrated and contributed into health system strengthening?
22. To what extent has the intervention contributed to promoting ownership, including capacity building of national/State stakeholders.
23. What is the current government investment in CMAM and how this investment could be maximized?
24. What are the opportunities for and the risks for the sustainability of the programmes benefits in the short, medium and long term?