Terms of Reference for Conducting Annual Outcome Survey of Nurture Every Future: Poshan Nepal

Background

The Nurture every future: Poshan Program, implemented by CARE, and iDE aims to improve maternal and child health by addressing gender relations and social norms influencing nutrition. The project will achieve comprehensive development outcomes through integrated solutions by working with Health Systems, Food Systems, Market Systems and Empowering Women for Household Decision to address nutrition challenges at individual, household, and community level. The program has been implemented in Sudurpaschim, Karnali, Lumbini, and Madhesh Provinces, targeting seven districts with high rates of poverty, poor health and nutrition outcomes, and high rates of food and nutrition insecurity. The theory of change defined for the project is IF we ensure equitable availability, access and consumption of diverse, nutritious, safe and healthy food by women and children, and IF we improve women's access to and control over resources and increase knowledge and care seeking practices among women and children in marginalized households, and IF we improve delivery of quality health and nutrition care and outreach services along with adoption and operation of Nepal's Nutrition Friendly Governance Framework by local government THEN women and children in marginalized households within target municipalities will be healthy, well-nourished, and food secure. To accomplish this, a set of multi-sectoral interventions aimed at affecting change in the individual, household, community, and institutional levels has been designed.

The Poshan Program aims to achieve three results:

- Increased equitable consumption of diverse, nutritious, safe, and healthy diets
- Increased equitable access to and use of quality health and nutrition services
- Improved delivery of multi-sectoral nutrition services and supplies by local government

The baseline study of Poshan has established benchmarks for the program's impact and identify critical areas of intervention. For instance, A substantial proportion of HHs (28%) experienced food insecurity, with variations across districts and wealth ($p<0.001$), MDD-W met by 53.9% of women, 55.8% of children aged 6-23 months met MDD (consuming food from at least five food groups), 7.4% of households adopted five or more CSA practices, 38.1% of women attended eight or more ANC visits, only 3.4% of the children aged 0-23 months underwent the GMP services, the majority of children (70.6%) aged 6-23 months were fed unhealthy foods and 64% of mothers were currently exclusively breastfeeding their child aged 0–5 months. Only 8.3% of HHs practiced handwashing at all six critical times, with 91.7% failing to consistently follow recommended handwashing, (7.6%) experienced diarrhea in the two weeks prior to the survey. Thus, the project has been designed different activities to strengthen demand for and supply of quality nutrition-related services from the health system; improve maternal and children's care and feeding practices including increased access to and affordability of diverse, safe, and nutritious foods in markets and through household production; promote food safety and hygiene at household, community and market levels; and, increase the voices of women and marginalized communities to advocate for nutrition-friendly local governance, ensuring equitable investments through Nepal's Multi-Sectoral Nutrition Plan (MSNP III) by local and national government.

In addition to this climate change has resulted in a wider impact on the food system and nutrition Food and Agriculture sector has directly impacted by weather extremes, depletion of water

sources, declining soil fertility and soil nutrients, impacting food nutrients and increasing social stress. climate shocks, loss of biodiversity, and damage to water, air and soil have dramatically lowered the quantity, diversity and quality of food available to children and families, increasing food insecurity and nutrition poverty among vulnerable children, household and populations. Climate change also negatively impacts child feeding and care practices, such as by diverting women's labor allocation away from childcare. And rising global temperatures are disrupting access to clean and safe water, exposing children to life-threating childhood diseases that impact nutrition, including diarrhea and respiratory infections. (UNICEF,2023) Thus it is very important to understand the impact of climate change in Household nutrition from the POSHAN working area expect to achieve nutrition security.

Impact and target group of the program

The program worked with 158,137 project participants specifically targeting pregnant and lactating women, and the critical 1,000 days between pregnancy and a child's 2nd birthday. The program also targeted other vulnerable and marginalized groups, including persons with disabilities, those at risk of health or nutrition shocks, women or child-headed households, and marginalized groups based on geography, religion, ethnicity, language, etc. To meet their individual and household needs, the program worked with Community Health Workers (CHWs), primary health care facility staff, agricultural extension agents, small-scale farmers (predominantly women), and government and private sector providers of health, nutrition, agricultural, and WASH services.

Program location: The program is implemented across five districts (over four provinces):

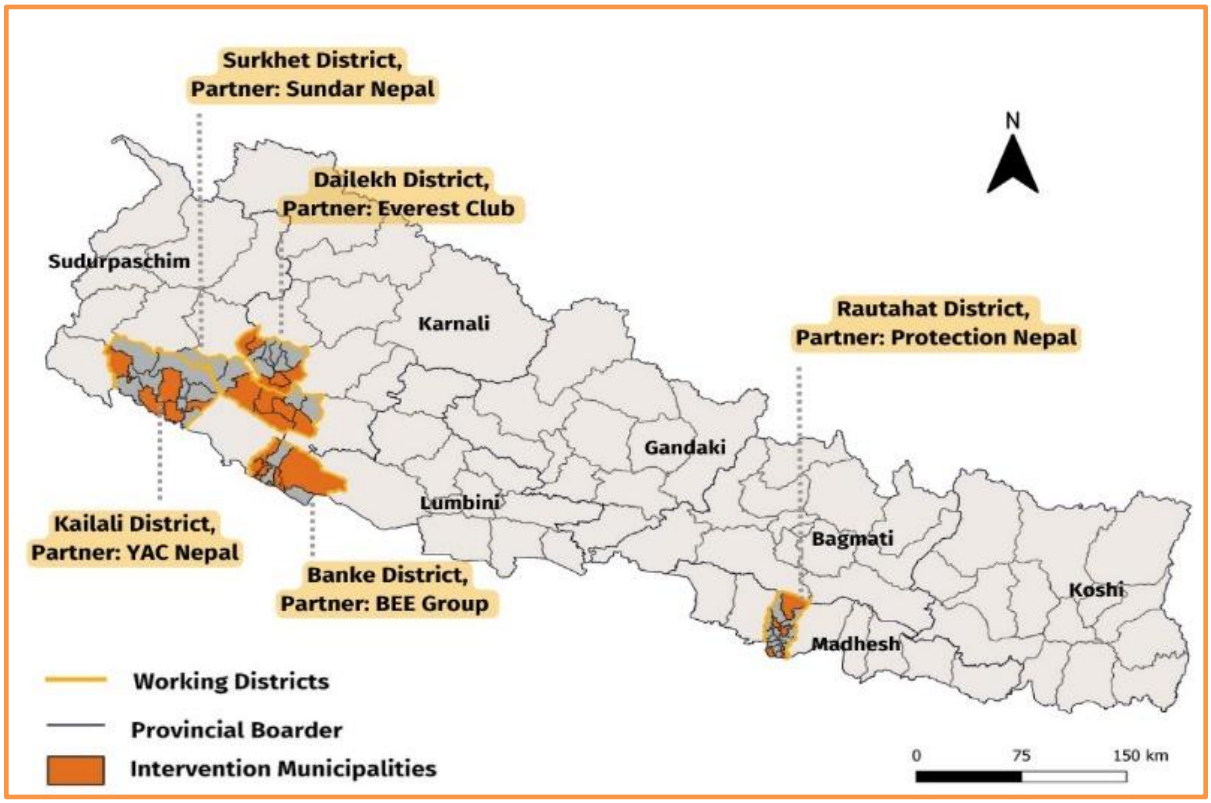
Purpose and Scope of the assignment
After a year of program implementation, CARE is planning to explore and review the progress achieved in different result areas of the Poshan program. Thus, we are seeking a firm/institution to carry out the annual household survey to compare the progress made by the project intervention against the baseline benchmarks. Additionally, this iteration of the survey will include climate change module to explore impact of climate change on mother and child nutrition.

Objectives for conducting the annual survey
The objectives include:

- Determine nutritional status of mothers and children (6 to 59 months) at the household level across program areas
- Understand situation of household decision making and power status around agricultural production, access to market, nutrition, and seeking maternal and child health services
- Explore household level WASH, food hygiene, and food consumptions practices across program areas
- Depict socio-demographic and socio-economic, gender equality and inclusion related factors influencing access to and consumption of nutritious food
- Explore quality of health and nutrition services being delivered through peripheral level health facilities in program areas
- Assess status of program quality of project around meeting the expectations of program participants, partners, donors and other stakeholders, and adherence to our principles, standards and commitments.
- Explore the effect of climate change on mother and child nutrition

- Identify gaps and areas for improvement in program implementation.

Methodology
The survey will follow concurrent mixed method design. It is expected that the team will use, *but not be limited* to, the following briefly stated methodology:



- **Survey design:** The survey will follow concurrent mixed method design. The quantitative component will involve a structured household survey targeting both intervention and non-intervention households, following a propensity score matching during analysis to strengthen causal inference and control for selection bias. The qualitative component will explore the contextual and behavioral dimensions of nutrition at the household level especially focusing on child and mother's nutritional status.
- Desk review: The evaluation team will review relevant documents related to the program. This could include, but is not restricted to, project proposals, log frames, implementation plans, relevant literature, and secondary data, baseline reports among others.
- Development of participatory data collection tools / methods, including household level questionnaires: This will include development of KII and FGD guidelines (or any other participatory qualitative tools), closed-ended household questionnaires, and health facility quality assessment checklist. The incumbent is also expected to prepare the list of stakeholders to be consulted/interviewed during this process in consultation with the project team. The following indicators need to be considered while developing the survey tools:

Statement	Indicator
Women and children in poor, marginalized	Prevalence of wasting (low weight-for-height) in children under 5
	Prevalence of low birth weight (among children under 2)

households within target municipalities are healthy, well-nourished, and food secure	Prevalence of low body mass index (BMI) among women of reproductive age
	% of people supported through/by CARE who report gender equitable attitudes towards social norms (GEM Scale).
	% of people with moderate or severe food insecurity, based on the Food Insecurity Experience Scale
	# and % of women who have actively participated in household decision-making in (a) agricultural production (b) use of household income. /Women involved in household decisions on nutrition, healthcare, and finances (sub indicator of 3 where outcomes are expected to inform behaviors
IR 1: Increased equitable access to diverse, safe, and nutritious food	Percentage of new mothers following recommended feeding and dietary practices
	Increase in number of households producing or consuming nutrient-rich crops
	New mother initiating exclusive breast-feeding within two hours of delivery
	Dietary diversity score among pregnant and lactating women. /Minimum dietary diversity for women: Mean number of food groups consumed by women of reproductive age (using MDDW and DQQ)
	Percentage of children aged 6-23 months meeting minimum dietary diversity.
	% of children (U5) who meet age-specific minimum meal frequency (MMF)
	% of children who received one dose of Vitamin A Supplementation (VAS) in the past 6 month
	% of children who received one dose of deworming in the past 6 months
	Availability of nutritious foods in local markets
	% of households practicing safe food handling and storage to prevent foodborne illnesses. /Households with improved food handling and preparation skills
	Farmers using at least 25% of climate-smart agriculture practices
	% of women and their families practice nutrition related harmful social norms
	% of women who received antenatal care 4+ times from a skilled provider during pregnancy (whether in a health facility, or at home)
	% of births attended by a skilled health personnel (doctor, nurse, midwife; not traditional birth attendant, CHW, unskilled relative, etc.)
IR 2: Improved inclusive nutrition, health, and	% of children under five receive regular growth monitoring and promotion services. /Increase in community members who demonstrate improved health seeking behaviors

WASH services at facility and community levels	Households with improved hand washing practices with defined checklist (appropriate handwashing behaviors)-
	Mothers who can correctly identify six key hygiene messages
	% of households at each level of the JMP ladders for water, sanitation, and hygiene
	Usual water treatment (self-reported), child feces disposal (self-reported), and handwashing station (spot check) (using DHS modules)
	% of caregivers access maternal and child health information through mobile applications, SMS reminders, and interactive voice response systems.
	Pregnant or lactating mothers who access maternal related health services in project facilities
	Children receiving services in government-supported health centers
	# of Health Facilities Meeting Minimum Standard of Quality of Care Either in Nutrition, Maternal and Child Health
IR 3: Improved adoption and operation of Nutrition Friendly Local Governance Framework	Increase in community awareness about services offered at government supported facilities
	No. of local government mainstreamed nutrition in local development priorities/plans and programs
	Ability of government to support supply chain sustainability of vitamins and supplements (by type of vitamin and supplement)
	No. of Nutrition and Food Security Steering Committees strengthened and activated
	% of budget allocated by local government for NFLG

- Study area: The survey will be conducted across 25 intervention municipalities.
- HH survey: The team is expected to undertake household interviews with impact groups regarding the knowledge, behavior, and practices around improving nutrition and measuring nutritional status of mothers and children. The household survey will also encompass measurements of existing social norms and household level decision making including collection of socio-demographic and socio-economic variables and impact of climate change on nutrition
- Qualitative component: The team is expected to interview the stakeholders concerned with program implementation, government representatives, private sector actors, partner staff, and community members.
- Sample population, size and sampling technique: For household survey, the target groups are households with mothers and at least one child under five years of age. The team is expected to compute adequate sample size based on evaluation design and current prevalence of impact/outcome level indicators which are representative across five program districts. A probability sampling strategy will be used to ensure representation across geographic areas, socioeconomic strata, and program exposure levels.
- Ethical considerations, safeguarding, and code of conduct: We have a zero-tolerance approach towards fraud, corruption, and any kind of abuse, exploitation, or harassment. The team is expected to obtain ethical clearance from the Nepal Health Research Council. Before the interview, the team will develop informed consent forms in Nepali and provide

appropriate training to the enumerators on ethics and safeguarding. This should also include the need to maintain the privacy and confidentiality of the data and identity of interview participants, as well as proper orientation on responsible data management practices and processes. The firm/consultant must receive prior permission before taking and using still still/moving images for specific purposes. After the interview, in line with responsible data management principles, the data will be protected, stored, and transferred in a safe manner.

Deliverables

The following are the expected deliverables from the consultancy:

- An inception report outlining the approach/methodology and plan including planned timeline, methodology, planned stakeholders to be consulted, sampling technique, sample size calculations, data collection and analysis tools (including questionnaires, protocols, and interview guidelines), data quality procedures, and qualitative and quantitative data analysis procedures. The report shall be submitted for review and approval by CARE. 4 days after the signature of the contract and should not exceed more than 10 pages (excluding annexes).
- Approval letter from Nepal Health Research Council (NHRC)
- Survey/Data Collection Debriefings. Template for field progress reports to be determined jointly by consultant CARE & iDE
- A draft report (in English) and recommendations (not more than 40 pages, excluding Annexes) including indicator matrix in separate data table with survey results for the selected indicators with disaggregation by variables such as location (district), gender, wealth quintile and so on.
- Presentation of the key findings to accommodate the views of CARE, iDE, and stakeholders' suggestions or recommendations.
- A final report (in English) after incorporating stakeholders' inputs.
- Brief 2-3 pager informative summary document extracted from the final report.
- Softcopy of raw and cleaned dataset of the household survey in .csv or other readable formats (such as for Stata) including codebook and syntaxes used for data wrangling and data analysis.
- Transcribed and coded Interviews

Terms of Payment

The firm is advised to submit an itemized budget for the assignment based on the understanding of Terms of Reference and the current market rates. Where need be, CARE Nepal and iDE will engage the firm/consultant to an agreeable budget. The budget should include all the costs to be borne by the firm in carrying out the tasks and for ensuring timely submission of deliverables.

Payment will be based on the submission of deliverables that are satisfactory to CARE Nepal and iDE as agreed upon after discussion with CARE Nepal and iDE in the inception meeting. The payments will only be made when the deliverables have been assessed by the CARE Nepal and iDE teams to be of good quality. Taxation laws will apply to the total contract value (TCV).

The following payments will be paid to the firm/consultant using an agreed mode of payment.

- 40% of the contract value after approval of the inception report.
- 60% of the contract value after approval of the final report and submission of all data sets.

Timeline and Level of Effort (LOE)
We estimate that the assignment will take approximately 50 days (10 days preparation, 25 days survey, and 15 days analysis, report preparation, and sharing), and a consultant is required to provide a detailed timeline for different activities based on the understanding of ToR.

Required Evaluator Qualification

The evaluation consulting firm will meet the following qualification requirements:

- The lead consultant shall have at least a Master's Degree/Ph.D. preferred in nutrition/public health
- A minimum of 5 years of work experience in using research methodologies, including designing and carrying out complex surveys encompassing both quantitative and qualitative data collection and analysis, especially in nutrition programs with multi-sectoral framework
- The consultant/team has demonstrated excellent data analysis, interpretation and writing skills in similar evaluation tasks
- The consulting firm should have experience of carrying out similar assignments in nutrition, health, and agriculture sectors including experience in designing and managing large scale and complex socio-economic and health and nutrition surveys and qualitative study for similar scope and scale in Nepal.
- Demonstrated experience in undertaking GESI sensitive surveys
- Examples of at least three similar completed assignments and outputs shall be shared during the discussion meeting

Evaluation Criteria

- Experience working on program Baseline/evaluations of similar size and scope, and a sample report for reference
- Alignment with qualification requirements stated for each position/key staff,
- Proposed work plan and methodologies, including timeliness of implementation and adherence to key dates, and
- Price competitiveness
- Technical content of the proposal will hold 80% of the total marks.

Point of Contract (PoC)

The evaluation team will report to MEAL Manager from CARE Nepal.

CARE and iDE responsibility:

- Support the consultant with project information, documents and feedback on study methodology with inputs on deliverables.
- Organize the meeting with project team when required
- Oversee and monitor timeliness of activities in line with agreed workplan
- Ensure adherence to detail implementation plan and particulars proposed by and agreed with the contractor
- Timely review and feedback provided on draft report and other products shared by the contractor

- Release of payment as agreed in terms and conditions.

Submission of Proposals

- Please send a brief proposal (not more than 8-10 pages, excluding Annex) detailing
    - You or your firm's relevant experience.
    - Team composition
    - Detailed technical approaches or methodology include sample size, sampling strategy, and analysis approach.
    - Workplan, timeline, and Financial Proposal.
    - Resume or CV for the team members included in the proposal.
    - Legal documents (Copy of VAT Registration, Copy of Company Registration and Latest Tax Clerance Certificate).

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