Terms of Reference

EVALUATION of

A Pilot Project towards Improving Infant and Young Child Nutrition through the Integrated Child Development Services scheme in Jaipur District of Rajasthan during 2020-2023

WFP India Office

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1. Introduction

1. This Terms of Reference (TOR) is for the evaluation of a pilot project towards **improving the Infant and Young Child Nutrition (IYCN) through the Integrated Child Development Services (ICDS) scheme in Jaipur District of Rajasthan during 2020-2023**. This evaluation is commissioned by WFP India Country Office (CO) and is a **pilot evaluation**. This evaluation will cover the tentative period from November/2020 to November/2023.
2. This TOR was prepared by the WFP India Country Office based upon an initial document review and consultation with stakeholders such as GoR and following a standard template. The purpose of the TOR is twofold. Firstly, it provides key information to the evaluation team and helps guide them throughout the evaluation process; and secondly, it provides key information to stakeholders about the proposed evaluation and their roles and responsibilities.
3. The ICDS Scheme is one of the flagship programmes of the Government of India and represents one of the world's largest and unique programmes for early childhood care and development. This scheme offers health, nutrition and hygiene education to mothers, non-formal preschool education to children aged three to six, supplementary feeding for all children (6 month - 6 years of age) and pregnant and nursing mothers, growth monitoring and promotion, and links to primary healthcare services such as immunization and vitamin A supplements. These services are delivered in an integrated manner at the Anganwadi Centers (AWCs), or childcare centre. Each centre is run by an Anganwadi Worker (AWW) and one helper.
4. Under ICDS scheme, as part of supplementary nutrition, Take Home Rations (THR) are provided to children (6 to 36 months old) and pregnant and lactating women. THR has the potential to address nutrition gap during the critical period of first 1,000 days, which is often referred to as the "window of opportunity" to prevent the serious and irreparable damage caused by hunger and malnutrition in children. However, for the THR to be effective, it is required that a quality, nutritious and age-appropriate product is seamlessly delivered to the beneficiary.
5. Thus, towards improving the IYCN through the ICDS scheme in Rajasthan, WFP establishes a local production unit by working with women's Self-Help Groups (WSHGs) to produce a quality, nutritious, fortified and age-appropriate THR distributed to the children and pregnant and lactating women (PLW) under the ICDS scheme. Currently in state of Rajasthan, THR is locally produced by WSHGs and one WSHG is attached to 1-5 AWCs. In addition, WFP will undertake research to develop Social Behaviour Change Communication (SBCC) packages to improve knowledge, attitudes and practices around maternal and child nutrition. Under this pilot project, required SBCC would be directed to all sections of the community to improve nutritional practices.

2. Reasons for the Evaluation

6. The reasons for the evaluation being commissioned are presented below.

2.1. Rationale

7. The evaluation would assess how effectively the pilot project has established a replicable and demonstrable model, that ensures a nutritious THR as well as improved infant and young child feeding practices, and creating nutritional awareness at all levels in the community; and promoting healthy lifestyles and increasing nutrition counselling skills of frontline functionaries through capacity building, all leading to improved infant and young child feeding practices and nutritional outcomes.

8. A rigorous and scientific evaluation design will be adopted by using a pre and post intervention design based on the evaluation criteria mentioned below and using a set of indicators for measuring the results. As part of evaluation, hired evaluation team will be responsible for the following:

    - baseline study which will provide an in-depth analysis of the situation (in terms of current nutrition status of children, IYCF practices, awareness and behaviour, THR consumption, acceptability of THR, on-going practices of WSHGs) in the operational area to support benchmarking of key performance indicators, facilitating operational planning and establishing basis for evaluation on completion of the project.
    - undertake an endline evaluation in order to evaluate the performance of the pilot project against established benchmarks at baseline, including gender and age dis-aggregations. Based on the findings of the end line evaluation, lessons would be drawn towards the learning of WFP, GoR and others and accordingly decision on the scale-up of the pilot project would be undertaken.

9. The evaluation will have the following uses for the WFP India CO: WFP India CO has a direct stake in the evaluation and an interest in learning from the experience to inform decision-making towards the replication and scale-up of the intervention. It is also called upon to account internally as well as to its indirect beneficiaries, donor and partners for performance and results of this intervention, which would be provided at the time of end line evaluation.

10. The evaluation will be used by the GoR: GoR is the most important user of this evaluation. Based on the comparative findings of the baseline and end line evaluation, GoR would take the decision on scale-up and sustainability of the pilot project.

2.2. Objectives

11. Evaluations in WFP serve the dual and mutually reinforcing objectives of accountability and learning.

    Accountability – Based on the comparison of the baseline and end line evaluation findings, performance and results of the IYCF interventions through the ICDS scheme in Jaipur district of Rajasthan would be assessed and reported.

    Learning – The evaluation will determine the reasons why certain results occurred or not to draw lessons, derive good practices and pointers for learning. It will provide evidence-based findings to inform operational and strategic decision-making for future scale-up.

Findings will be actively disseminated, and lessons will be incorporated into relevant lesson sharing systems.

12. The primary objective of the evaluation will be to evaluate (1) how effectively the project has established a replicable, efficient, and demonstrable model, that ensures a nutritious and affordable THR to PLW, infants and young children in a sustainable way and (2) improvement in the knowledge, awareness and behaviours of caregivers, adolescents, PLWs and other stakeholders. Additionally, based on the request of the Government, this evaluation will also evaluate to what extent the project has led to improvement in the nutritional status of children in the target age group.
13. Comparison of the findings of the baseline evaluation with the endline evaluation would provide the critical insights on the performance of the project.

2.3. Stakeholders and Users

14. A number of stakeholders both inside and outside of WFP have interests in the results of the evaluation and some of these will be asked to play a role in the evaluation process. Table 1 below provides a preliminary stakeholder analysis, which should be further developed by the evaluation team as part of the Inception phase.
15. Accountability to affected populations, is tied to WFP's commitments to include beneficiaries as key stakeholders in WFP's work. As such, WFP is committed to ensuring gender equality and empowerment of women (GEEW) in the evaluation process, with participation and consultation in the evaluation by women, men, boys and girls from different groups.

Table 1: Preliminary Stakeholders' analysis

Stakeholders	Interest in evaluation & likely uses of evaluation report to this stakeholder
INTERNAL STAKEHOLDERS	
Country Office (CO) India	Responsible for the country level planning and operations implementation, it has a direct stake in the evaluation and an interest in learning from experience to inform decision-making.
Regional Bureau (RB) Bangkok	Responsible for both oversight of COs and technical guidance and support, the RB management has an interest in an independent/impartial account of the operational performance as well as in learning from the evaluation findings to apply this learning to other country offices.
Office of Evaluation (OEV)	OEV has a stake in ensuring that decentralized evaluations deliver quality, credible and useful evaluations respecting provisions for impartiality as well as roles and accountabilities of various decentralised evaluation stakeholders as identified in the evaluation policy. This evaluation's findings may feed into thematic and/or regional syntheses and corporate learning processes.
EXTERNAL STAKEHOLDERS	

Beneficiaries	As the ultimate recipients of assistance, ICDS scheme beneficiaries (pregnant and lactating women, adolescent girls, men, boys and girls), AWWs and members of WSHGs of this pilot project have a stake in WFP determining whether its assistance is appropriate and effective.
Government of Rajasthan	Primarily this evaluation is been conducted to inform the Government, to take the decision on scale-up and sustainability of the project. The key government department that WFP shall liaison is the Department of Women and Child Development (DWCD) of the Government of Rajasthan.
UN Country team	As part of the Results Group (RG) IV, WFP along with other UN agencies are supporting the food and nutrition security efforts of the state and national government. It has therefore an interest in ensuring that WFP programmes are effective in contributing to the UN concerted efforts.
Donor - Cargill India	This pilot project of WFP and GoR is funded by Cargill India. They have an interest in knowing whether their funds have been spent efficiently and if WFP's work has been effective and contributed to their own strategies and programmes.

16. The primary users of this evaluation will be:

- The most critical users of this evaluation would be the DWCD of GoR and Ministry of Women and Child Development, Government of India. Findings of this evaluation would support the Government of Rajasthan in decision making related to the scale-up of the intervention and towards improving the nutritional status of children and PLWs in Rajasthan. Findings of evaluation would provide evidence to the Ministry of Women and Child Development, Government of India in taking a policy-level decision at the national-level towards reforming the ICDS scheme.
- The WFP India in decision-making, notably related to programme implementation and/or design, Country Strategy and partnerships towards improving the nutritional status of children and PLW and further, applying the learning to other states.
- WFP Regional Bureau (RB) and HQ may use evaluations for wider organizational learning and accountability.
- OEV may use the evaluation findings, as appropriate, to feed into evaluation syntheses as well as for annual reporting to the Executive Board.

3. Context and subject of the Evaluation

3.1. Context

17. Adequate nutrition during pregnancy of mother, infancy and early childhood is essential to ensure the growth, health, and development of children to their full potential. Based on evidence of the effectiveness of interventions, achievement of universal coverage of optimal breastfeeding could prevent 13 percent of deaths in children less than 5 years of age, while appropriate complementary feeding practices would result in an additional 6 percent reduction in under-five mortality.

18. High levels of maternal and child undernutrition in India have persisted, despite strong Constitutional, legislative policy, plan and programme commitments. Legislations such as the National Food Security Act 2013 mandating food and nutrition entitlements for children, pregnant and breastfeeding mothers. The National Nutrition Policy 1993, complemented by other policies such as the National Health Policy 2002, the National Policy for Children, 2013 provides a strong foundation for addressing the immediate and the underlying determinants of undernutrition through both direct interventions and indirect interventions. A wide spectrum of national programmes contribute to improved nutrition outcomes, addressing both the immediate and the underlying determinants of undernutrition through nutrition specific and nutrition sensitive interventions. These include the ICDS, National Health Mission, Mid Day Meals Scheme, Targeted Public Distribution System, and National Food Security Mission. GoI rolled-out Poshan Abhiyan scheme in 2017-18 to reduce stunting, undernutrition, anaemia (among young children, women and adolescent girls) and low birth weight by leveraging technology, a targeted approach and convergence. However, the problem in Rajasthan is the low coverage of these interventions and the consequences of manifest in terms of poor nutrition status of children and women.

19. WFP and the Government of Rajasthan signed a Memorandum of Understanding (MoU) to work together to achieve food security and improved nutrition in the state to make significant progress towards Sustainable Development Goal 2.

20. WFP in partnership with Government of Kerala has conducted a similar pilot project of fortification of THR distributed under ICDS and improving the IYCF practices in few panchayats of Wayanad district of state of Kerala. The duration of the pilot project was from January 2017 to December 2018. Government of Kerala has scaled-up the pilot project in the entire state.

21. **Background of Rajasthan**: Rajasthan is a state in north-western India, which covers an area of 342,239 square kilometres and has a population of 68.5 million. Rajasthan has 13.48 percent of Scheduled Tribes[1] (STs) and 17.83 percent of Scheduled Castes (SCs). As per Census 2011, Rajasthan's literacy rate is 66 percent. In the state, 79 percent male and 52 percent female are literate, which reflects a huge gender gap in literacy. A low child sex ratio with only 928 girls for every 1000 boys shows how gender inequality impacts girls' survival. As per National Family Health Survey 2015-16 (NFHS-4), there is a huge preference for sons in the state.

22. Regarding the **gender and women issues**, in Rajasthan overall status of women is poor, which gets reflected through various gender-related indicators (NFHS-4). In context to employment, only 29 percent of women were employed, while in the same period, 75 percent of men aged 15-49 years were employed. In relation to the occurrence of domestic violence, almost one-quarter (23 percent) of women in Rajasthan have experienced physical or sexual violence and the most common perpetrator for ever-married women was the husband (90 percent). Media exposure is higher among men than women in

[1] The STs and SCs are officially designated groups of people in India. The terms are recognised in the Constitution of India. As per available data and literature, they are socially and economically most deprived group. The Constitution lays down the general principles of positive discrimination for SCs and STs.

Rajasthan. Men (57 percent) are much more likely than women (22 percent) to read a newspaper or magazine at least once a week.

23. **Status of IYCF and Nutrition in Rajasthan**: According to the NFHS-4, only 6 out of 10 children under six months of age are exclusively breastfed; solid and semi-solid foods were added to the diets of only about 30 percent children between 6-8 months of age and about 3.4 percent children between 6-23 months of age receive an adequate diet in Rajasthan. Among the children under the age of five, an estimated 23 percent are wasted, 39.1 percent are stunted, and 36.7 percent are underweight in Rajasthan. There is no significant difference among girls and boys in terms of prevalence of wasting, stunting and underweight. Furthermore, as compared to men (17 percent), a much higher proportion of women (47 percent) aged 15 to 49 years suffer from anaemia; the prevalence being the same even during pregnancy. Twenty-seven percent of women and 23 percent of men in Rajasthan have low BMI (too thin for their height).

24. In Rajasthan, a higher percentage of ST children are anaemic (74 percent), as compared to SC (59 percent), other backward class[2] (58 percent) and others (56 percent). A slightly higher percentage of children residing in rural area are anaemic (62 percent), as compared to children living in urban areas (56 percent). NFHS-4 results shows that with the increase in the mother's years of schooling, prevalence of anaemia among their children decreases. Mother's anaemia status affects their child's anaemia status3: a lower percentage of children of non-anaemic mothers have anaemia (52 percent), as compared to mothers with severe/moderate anaemia (77 percent) and mild anaemia (65 percent). Through the ICDS in Rajasthan, take home rations are distributed to children between 6-36 months of age and pregnant/lactating women in the form of a mix of wheat, soya, gram flour, oil and sugar - both commodities are produced in a de-centralized modality. 750 grams and 930 grams of this mix are distributed to children and women on a weekly basis.

3.2. Subject of the evaluation

25. This evaluation of IYCN through the ICDS scheme in Jaipur during 2020-2023 is a pilot evaluation. Baseline evaluation would take place from January 2021 to August 2021 and end line evaluation would be conducted in 2023.

26. Given that improving nutritional practices in first 1,000 days can prevent the serious and irreparable damage caused by hunger and malnutrition in children even in resource poor settings, WFP will work towards ensuring seamless delivery of a quality, nutritious and age-appropriate THR to the child and pregnant/lactating women through a newly set-up THR production unit along with required social behaviour change communication - SBCC being directed to all sections of the community to improve nutritional practices andincreased capacity of the WSHGs in terms of entrepreneurship, financial literacy, leadership etc. required for the efficient production of THR and functioning of the production unit. The

[2] Other Backward Classes (OBCs) is a collective term used by the Government of India to classify castes which are educationally or socially disadvantaged.

[3] Existing literature suggest that pregnancy is associated with increased iron demand, and therefore, increase the risk of iron deficiency anaemia among mothers. Anaemia among mothers leads to lowered iron stores in their new-born baby. Hence, it becomes an inter-generational cycle of malnutrition.

concept will initially be implemented in pilot mode in one district at sub-district level with scale up to other districts in the State being the overall vision.

27. **Project goal**: The proposed intervention seeks to establish a replicable and demonstrable model for improving infant and young child feeding practices which could help in preventing malnutrition.

28. **Project Outcomes**: The project will lead to the following outcomes:

    i. Establishing a replicable, efficient demonstrable and '*Operationally effective*[4]' model, that ensures a nutritious and affordable THR to PLWs, infants and young children in a sustainable way
    ii. Improved nutritional knowledge, awareness and behaviours amongst caregivers, adolescents, PLWs, AWWs and other stakeholders on exclusive breastfeeding, complementary feeding, anaemia and key nutrition related behaviours.
    iii. Reduction in prevalence of malnutrition in children between 6 to 36 months of age

29. **Project Outputs:** The project will achieve the following outputs:

    i. Production of the age-appropriate, nutritious, fortified and diversified THR in the production center
    ii. Supply of age-appropriate, nutritious, fortified and diversified THR to the AWCs and distribution of nutritious THR from the AWCs to the children (aged 6-36 months) and PLWs.
    iii. Adherence to quality assurance mechanisms and standard operating procedures (SOP) on the total production process including fortification.
    iv. Appropriate storage of THR at all levels – production center and AWC level.
    v. Increased capacity of the state government officials trained for monitoring, procurement, production and distribution of the nutritious THR.
    vi. Increased capacity of the WSHGs in terms of entrepreneurship, financial literacy, leadership etc. required for the efficient production of THR and functioning of the production unit.
    vii. Increased acceptability and consumption of the improved, age-appropriate, nutritious, and fortified take-home rations delivered to young children and PLW with aim of preventing and addressing malnutrition.

30. **Project Components:** The core project components therefore include:

[4] Operational model will be called effective and replicable if- a) No gap in in the supply of nutritious, diversified and fortified THR to the AWCs, b) no break in the distribution of nutritious, diversified and fortified THR in the AWCs c) quality assurance mechanisms are effectively functional, d) there is acceptability for the nutritious, diversified and fortified THR e) monitoring of THR distribution, and consumption is streamlined, f) Standard operating procedures on fortification adhered to, g) Storage is proper. The agency should further propose methodology to define and assess the operational effectiveness. A replicable model should have capacities of officials/stakeholders built; government is capable and ready to take over the project; and government's intention to sustain and scale-up the project is strong.

A. **Supplementary Nutrition:** Under this component, the project partners including the women from the WSHGs will work towards improving the quality of the THR served to children between six to 36 months of age and PLWs. For further details please refer to ***Annexure 1***.
B. **Improved Care and Nutrition Practices:** A well planned, coordinated across sectors and thought through SBCC strategy will be implemented to ensure appropriate utilization and demand for nutrition services and appropriate decisions and behaviours by caregivers and individuals. The SBCC will also focus on gender equity, which is a key influencer of food intake, by emphasising elimination of any discriminatory practices in child feeding and against women and girls in the family. For further details on this component, please refer to ***Annexure 2***.

31. **Implementation Modalities:** The core components will be implemented via establishment of THR production unit for the production of quality and nutritionally age-appropriate THR, organization of sensitization workshops, capacity building of grassroots functionaries of various departments including that of DWCD, development of improved supplementary rations, development of training modules and other information, education and communication materials, supply chain management and quality assurance and control as appropriate through need based hiring of vendors. Principles of project implementation have been detailed out in ***Annexure 3***.

32. **Project location**: In discussions with the GoR, and based on some criterion[5], Jaipur is the choice of the project district for the pilot.

33. According to the NFHS-4, in Jaipur, 72 percent of children under six months of age are exclusively breastfed; solid or semi-solid foods and breastmilk were added to the diets of 42 percent children between 6-8 months of age, about 2.8 percent children between 6-23 months of age receive an adequate diet and among the children under the age of five, an estimated 13 percent are wasted, 36 percent are stunted, and 25 percent are underweight. Furthermore, approximately 27 percent of women aged 15 to 49 years suffer from anaemia; the prevalence being 30 percent during pregnancy. Around 23 percent of women are reported to have low BMI (too thin for their height).

    Jaipur is the most populous district of the Rajasthan. For administration and development, the district is divided into thirteen sub-divisions. For the purpose of the implementation of rural development projects/ Schemes under Panchayati Raj System, the district is divided in the 13 Panchayat Samitis (Blocks). There are 11 statutory towns in Jaipur. **Pilot project would be implemented in five blocks of Jaipur, that is Jaipur I, Jaipur II, Jaipur III, Sanganer City and Rural Sanganer.** Map of Jaipur has been annexed (***Annexure 4***). Details of the ICDS beneficiaries of Jaipur (***Annexure 5***) and list of ICDS beneficiaries in the project area of Jaipur (***Annexure 6***) has been annexed.

[5] Jaipur district has high prevalence of malnutrition (stunting, wasting, underweight and micronutrient deficiencies). It also has presence of project partners, other UN agencies and non-governmental organization (NGOs). Availability of existing infrastructure, mechanisms to ensure streamlined roll-out of the project interventions; and pro-active district administration with willingness to make a real change in the nutrition scenario is an added-advantage in Jaipur. Being the state capital, project would have better visibility and eventual scale-up throughout the State. Besides, Jaipur has also been recommended by the DWCD, GoR.

34. **Project duration**: The project duration will be three years starting from the date of signatures on the memorandum of understanding and letter of agreement between WFP and GoR: (i) Preparatory phase: six months (ii) Implementation phase: 24 months (iii) Hand-over including development of plans for scale-up: six months. Detailed of the activities to be conducted in each of the three phases have been mentioned in the ***Annexure 7***.

35. **Key Project Stakeholders**: The key departments of the Government of Rajasthan that WFP shall liaison under the umbrella of this project include the Department of Women and Child Development). Role and responsibilities of the GoR and WFP have been enlisted in ***Annexure 8***.

4. Evaluation Approach

4.1. Scope

36. This is a decentralized evaluation of the entire pilot project on IYCN through the ICDS scheme in Jaipur District of Rajasthan during 2020-2023. This evaluation is commissioned by WFP India CO and will cover the tentative period from November/2020 to November/2023.

37. As part of this evaluation, the tentative broad study parameters which would be evaluated are presented in the Results Framework (below table). The evaluation team is recommended to use the suggested parameters, but should not limit to these parameters. The evaluation team should formulate and suggest additional study parameters based on the project objectives.

Table 2: Results Framework along with Study Parameters

OBJECTIVES	ACTIVITIES	OUTPUTS	OUTCOMES
• Establishing a replicable, efficient demonstrable and '*Operationally effective*[6]' model, that ensures a nutritious and affordable THR to PLWs, infants and young children in a	• Up-gradation of existing equipment for production of a nutritious THR • Capacity building of the staff responsible for production • Supply chain management • Quality assurance and control • Regular monitoring along with required assessments and studies on shelf life etc before the product is	**Systemic Level** • Quantity (in kgs) of age-appropriate, nutritious, fortified and diversified THR: (a) produced in the THR production center; (b) supplied to the AWCs; and (c) distributed from the AWCs to the children (aged 6-36 months) and PLWs. • Number of AWCs: (a) supplied with nutritious THR; and (b) distributing nutritious THR • Frequency of monitoring of THR distribution (in a quarter) • Number of quality assurance (QA) mechanisms and standard operating procedures (SOP) on the total production process including fortification in place • Quantity (in kgs) of THR stored appropriately at all levels – production center and AWC level	**Systemic Level** • Percentage of required age-appropriate, nutritious, fortified and diversified THR regularly produced in the THR production centre • Percentage of AWCs distributing nutritious, diversified and fortified THR to the beneficiaries in a timely manner **Community and Individual Level** • Percentage of WSHGs exhibiting improved

[6] Operational model will be called workable and replicable if- a) No gap in in the supply of nutritious, diversified and fortified THR to the AWCs, b) no break in the distribution of nutritious, diversified and fortified THR in the AWCs c) quality assurance mechanisms are effectively functional, d) there is acceptability for the nutritious, diversified and fortified THR e) monitoring of THR distribution, and consumption is streamlined, f) Standard operating procedures on fortification adhered to, g) Storage is proper. The agency should further propose methodology to define and assess the operational effectiveness.
A replicable model should have capacities of officials/stakeholders built; government is capable and ready to take over the project; and government's intention to sustain and scale-up the project is strong.

sustainable way	rolled out for consumption by the ICDS beneficiaries.	• Number of the state government officials trained for monitoring, procurement, production and distribution of the nutritious THR. • Number of trainings or technical assistance provided to the government officials on monitoring, procurement, production and distribution of the nutritious THR. **<u>Community and Individual Level</u>** • Number of WSHGs[7] trained/assisted[8]. • Number of intended beneficiaries receiving and consuming nutritious, diversified and fortified THR - Boys/girls/PLWs	entrepreneurship, financial literacy, and leadership. • Percentage of intended beneficiaries showing improved consumption and acceptability of the nutritious, diversified and fortified THR - Boys/girls/PLWs.
• Improved nutritional knowledge, awareness and behaviours amongst caregivers, adolescents, PLWs and other stakeholders	• Developing SBCC materials and pre-testing SBCC materials among target audience segments • Capacity building of staff for effective implementation of SBCC campaign • Implementing the SBCC campaign with partners • Monitoring and improvising	**<u>Community and Individual Level</u>** • Number of frontline functionaries trained on nutrition counselling skills • Number of caregivers of children (dis-aggregated by boys and girls), adolescent girls, PLWs, AWWs and community members who received adequate information of exclusive breastfeeding, complementary feeding, anaemia and key nutrition related behaviours.	**<u>Community and Individual Level</u>** • Percentage of caregivers of children (dis-aggregated by boys and girls), adolescent girls, PLWs, AWWs and community members exhibiting adequate knowledge of exclusive breastfeeding, complementary feeding, anaemia and key nutrition related behaviours.

[7] WSHG who would set-up the THR production center

[8] Training or assistance provided to the WSHGs in terms of entrepreneurship, financial literacy, leadership etc. required for the efficient production of THR and functioning of the production unit.

38. In addition to the above parameters, based on the request from the Government of Rajasthan, following parameters would also be measured during pre and post intervention among the children (aged 6-36 months) in the project and comparison area.

    - Anthropometric status of the children in the target age group – Percentage of children who are wasted, stunted and underweight (dis-aggregated by boys and girls)

- Hygiene and health practices among the caregivers of children (dis-aggregated by boys and girls) at the household levels, PLWs, adolescent girls, community and others.
- Morbidity patterns among the beneficiaries - Percentage of children (dis-aggregated by boys and girls)who were ill in last 15 days (prior to survey)

39. In order to understand the existing situation, during baseline following context-specific information would be gathered:

Systemic Level

- On-going practices of the production, supply and distribution of the THR
- To identify issues and gap (if any) such as leakages of the THR in the current practices

Community and Individual Level

- The on-going practices by the WSHG
- On-going behaviours, key influencers around exclusive breastfeeding, complementary feeding, and other nutrition related aspects among the caregivers of children (dis-aggregated by boys and girls), AWWs, and others.
- Consumption pattern of THR including intra-household consumption pattern, especially between girls and boys, sharing of THR between male and female members,
- Cooking and eating practices of THR distributed under ICDS to the targeted children (dis-aggregated by boys and girls) and their caregivers.

4.2. Evaluation Criteria and Questions

40. **Evaluation Criteria** The evaluation will apply the international evaluation criteria of Relevance, Coherence, Effectiveness, Efficiency, Impact, and Sustainability.[9] Gender Equality and empowerment of women (GEEW) should be mainstreamed throughout.

41. **Evaluation Questions** Allied to the evaluation criteria, the evaluation will address the following key **questions**, which will be further developed by the evaluation team during the inception phase. Collectively, the questions aim at highlighting the key lessons and performance of the intervention in improving infant and young child nutrition, which could inform future strategic and operational decisions.

Table 3: Criteria and evaluation questions

Criteria	Evaluation Questions
Relevance	To what extent the nutritional and SBCC intervention activities, were appropriate to the target population – PLWs, children (boys and girls), AWWs, community members and others?

[9] For more detail see: http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm and http://www.alnap.org/what-we-do/evaluation/eha

	To assess the appropriateness of the initiative in relation to the policies and programs of the governments of India, Rajasthan and local entities in the districts of Jaipur.
Coherence	To what extent the nutritional and SBCC intervention activities are compatible with other nutritional interventions for children (dia-agg, PLW, adolescent girls in India, Rajasthan and specifically in Jaipur?
Effectiveness	To what extent project activities achieved its objective of establishing a replicable, efficient, demonstrable and 'Operationally effective' model, that ensures a nutritious and affordable THR to PLWs, infants and young children in a sustainable way? Were the same level of improvements were achieved among boys, girls, SCs and STs? To what extent intervention led to achieving its objective of improving the nutritional knowledge, awareness and behaviours amongst caregivers, adolescent girls, PLWs and other stakeholders? Were the same level of improvements were achieved among SCs and STs? To what extent intervention led to improving the capacities of the WSHGs in terms of entrepreneurship, financial literacy, leadership etc. required for the efficient production of THR and functioning of the production unit and other stakeholders?
Efficiency	Were the project interventions cost-effective? To what extent nutritional (production, supply and distribution of improved THR) and SBCC intervention activities were implemented in the timely manner?
Impact	To what extent, significant changes (if any) were achieved in the **production and distribution** of nutritious, diversified and fortified THR to the beneficiaries? To what extent, significant changes (if any) were reached in the **consumption and acceptability** of the nutritious, diversified and fortified THR ? Were the changes in the consumption and acceptability similar among boys and girls? Explore what factors were responsible for the change. To what extent, significant changes (if any) were attained in the key nutrition **awareness, behaviours and practices** among the targeted groups?
Sustainability	To what extent the intervention activities and benefits are likely to be sustained in the project area? To what extent is the state readiness to sustain and scale-up the intervention in other parts of the state?

4.3. Data Availability

42. The main sources of information available to the evaluation team are detailed project proposal, Letter of Understanding to be signed between WFP and GoR, Note for Records of the meeting and field visits of WFP in Rajasthan. A list of documents, which could be referred by the evaluation team has been annexed (***Annexure 14***).

43. Concerning the quality of data and information, the evaluation team should:

    a. assess data availability and reliability as part of the inception phase expanding on the information provided in section 4.3. This assessment will inform the data collection.

    b. systematically check accuracy, consistency and validity of collected data and information and acknowledge of any limitations/caveats in drawing conclusions using the data.

4.4. Methodology

44. A suggestive methodology has been provided in this section. It is expected that the methodology will be further refined by the evaluation team during the inception phase. It should:

- Employ the relevant evaluation criteria mentioned above Relevance, Coherence, Effectiveness, Efficiency, Impact and Sustainability.
- Demonstrate impartiality and lack of biases by relying on a cross-section of information sources (stakeholder groups, including beneficiaries, etc.). The selection of field visit sites will also need to demonstrate impartiality.
- Using mixed methods (quantitative, qualitative, participatory etc.) to ensure triangulation of information through a variety of means.
- Apply an evaluation matrix geared towards addressing the key evaluation questions taking into account the data availability challenges, the budget and timing constraints.
- Ensure through the use of mixed methods that women, girls, men and boys from different stakeholders groups participate and that their different voices are heard and used.
- Comparison of the findings of the baseline evaluation with the endline evaluation would provide the critical insights on the performance of the project.
- Mainstream gender equality and empowerment of women, as above.

45. The relevant data will be acquired at appropriate level by using mixed methods (quantitative and qualitative) to ensure triangulation of information through a variety of means.

46. WFP proposes a **quasi-experimental cross-sectional design**. As part of evaluation, hired evaluation team will conduct the following:

    - baseline evaluation towards providing an in-depth analysis of the baseline situation in the operational area to support benchmarking of key performance indicators, facilitating operational planning and establishing basis for evaluation on completion of the project.

- undertake an evaluation of the performance of project at end-line against established benchmarks at baseline, including gender and age dis-aggregations.

47. A comparison area with socio-economic and other background characteristic similar to project area would be matched and selected as the comparison. The comparison area would not receive any intervention, but it has been proposed that the baseline and also the endline study would be administered to it to measure the same variables as those of the intervention block. It would be preferred to select comparison area from the same district, but not geographically neighbouring to the project blocks. It is assumed that blocks with close proximity with the project area might have spill-over of project activities. Map of Jaipur in which project area has been highlighted has been annexed (***Annexure 4***). Following the baseline study, the intervention would be rolled out in the project area.

A. Desk Review:

48. Review of records of the documents such as THR registers, birth registers maintained by AWW, THR records etc. of the AWCs and some of the government documents would be done. In addition, agency would review all the project related documents. The agency will also need to look at other data sources available such as most recent studies, reports of joint review mission and other reports provided by the project staff/authorities.

49. Desk review on all the existing SBCC strategies, evidences of key nutrition-related behaviours, communication materials (IPC, mass media, outdoor media) on infant and young child feeding practices would be conducted.

B. Quantitative Survey

a) Caregivers of Children:

50. In order to measure the change of consumption of nutritious THR on the beneficiary children, children aged 6-36 months would be identified from the register maintained by AWWs in the project area or birth records and would be examined in terms of their anthropometric measurements.

51. The quantitative survey would be conducted among the caregiver of children (6-36 months) to assess the THR consumption pattern, acceptability, morbidity profile of children, awareness levels, behaviour, decision-making, health services provided at AWC, their beliefs, self-efficacy and social norms & other determinants of their current behaviours and practices related to complementary feeding and accessing AWC services etc. Socio-economic characteristics, health and hygiene practices at the household level would also be collected. To measure changes, which could occur due to project interventions, sample size should be statistically adequate to identify and measure those changes.

52. From the project and comparison areas samples would be identified using the Probability Proportional to Size (PPS) methodology, which means panchayats/nagar-palikas with higher number of AWCs would contribute higher number of samples as compared with panchayats/nagar-palikas with lesser number of AWCs. From each sample AWCs, children (6-36 months) would be randomly selected from the registers

maintained by the AWWs. Sample of children would have equal representation of male and female children. Sample children will also have equal representation of all ages (6-36 months). Samples from the project and comparison area would be selected in proportion to the rural and urban composition of the project area. Using structured questionnaire, information would be collected from the caregivers of 700 sample children from the project area and another 700 sample children belonging to the comparison area. Details of calculation of sample size is in ***Annexure 9.***

b) KAP Survey of Women – related to pregnancy, feeding practices and lactation:

53. In order to assess the consumption of THR, awareness-levels, women's knowledge, belief, self-efficacy, social norms/determinants of her behaviour, practices and various other components of SBCC and project related activities among the pregnant and lactating women, during baseline and end line, women who have given birth in the last 6 months would be investigated from the intervention and comparison areas. Rationale for identifying women who have given birth in the last 6 months is that at the point of end line evaluation, this cohort of women would have exposure to the fortified THR and SBCC components during pregnancy and lactation. Women who have given birth in the last 6 months would be examined during baseline and end line evaluation.

C. Qualitative Survey of AWWs, WSHGs, adolescents, Government officials, community leaders and other stakeholders:

54. In-Depth Interviews (IDIs) would be conducted among the various stakeholders. IDIs would allow in understanding the knowledge and practices on appropriate complementary feeding and nutrition including anaemia and other micronutrient deficiency disorders and to assess the distribution-pattern, acceptability etc. of THR among the PLWs, targeted children and their caregivers. Further, IDIs would help in understanding knowledge, belief, self-efficacy and practices of PLWs, caregivers, adolescents and others around determinants of their behaviour, practices-enablers and barriers for service delivery, especially counselling for triggering adoption of optimal behaviours in families. An attempt to assess the systems related determinants would also be made through IDIs. IDIs would be conducted among the members of the WSHG to assess their capacities in terms of financial literacy, entrepreneurship, leadership, decision-making etc. which are important for the efficient functioning of the THR production center.

D. Anthropometric assessment of Children:

55. A sample of around 300 children aged 6-36 months will be drawn and information collected shall include age, feeding practices, recent morbidity, weight in kilogrammes (to the nearest 1/10 kg) and recumbent length (< 24 months) or height (24-36 months). This information will be used to calculate the following z-scores using Epi-Info: weight-for-height, height-for-age, and weight-for-age. Children with z-scores below -2.00 SD will be classified as being wasted (whz < -2.00 SD), stunted (haz < -2.00 SD) or underweight (< -2.00 SD). The prevalence of child malnutrition in the project areas will be compared to a sample from pre-selected comparison areas to assess the change in nutritional outcomes between baseline and endline evaluation. All child health and nutrition analyses will be presented disaggregated by age and sex.

56. The following mechanisms for independence and impartiality will be employed trough the

    Set-up of an **Evaluation committee** (EC), which would be a temporary committee to facilitate meeting the impartiality provisions of the Evaluation Policy, ensuring due process in evaluation management. The EC oversees the evaluation process, by making decisions, giving advice to the evaluation manager and clearing evaluation products submitted to the Chair for approval.

    Constitution of **Evaluation Reference Group** (ERG) at the start of decentralized evaluation and for its entire duration. The ERG supports the relevance, independence and impartiality of the evaluation. The ERG is comprised of key evaluation stakeholders such as official from the government of Rajasthan, experts of nutrition and quasi-experimental evaluation. This composition ensures that a sufficiently broad base of expertise is available for the specifics of the subject under evaluation. External membership especially from government increases the relevance, ownership, credibility and utility of the evaluation, as well as helping minimize bias. Government would contribute to each and every stage of evaluation.

57. The following potential risks to the methodology have been identified.

    - Available literature suggest that THR distributed under any government' food based safety net targeting of the 0-3 year-olds has limitations: (a) irregularity in obtaining the quota (due to dependence on an adult for coming to the center) and (b) possibility of sharing the food with other members of the household or not completing the entire meal as they are not under the surveillance of the ICDS worker once they get back home. Under such circumstances, assessing the impact of the nutritious THR in terms of anthropometric measurement of beneficiary children might be challenging.
    - Duration of the exposure to the intervention needs to be long enough to reflect the impact of the consumption of nutritious THR on the nutritional status of the beneficiary children of all the age-groups.
    - Other factors such as food intake, health status also have effect on the nutritional status of children.

4.5. Quality Assurance and Quality Assessment

58. WFP's Decentralized Evaluation Quality Assurance System (DEQAS) defines the quality standards expected from this evaluation and sets out processes with in-built steps for Quality Assurance, Templates for evaluation products and Checklists for their review. DEQAS is closely aligned to the WFP's evaluation quality assurance system (EQAS) and is based on the UNEG norms and standards and good practice of the international evaluation community and aims to ensure that the evaluation process and products conform to best practice.

59. DEQAS will be systematically applied to this evaluation. The WFP Evaluation Manager will be responsible for ensuring that the evaluation progresses as per the DEQAS

Process Guide and for conducting a rigorous quality control of the evaluation products ahead of their finalization.

60. WFP has developed a set of Quality Assurance Checklists for its decentralized evaluations. This includes Checklists for feedback on quality for each of the evaluation products. The relevant Checklist will be applied at each stage, to ensure the quality of the evaluation process and outputs.

61. To enhance the quality and credibility of this evaluation, an outsourced quality support (QS) service directly managed by WFP's Office of Evaluation in Headquarter provides review of the draft inception and evaluation report (in addition to the same provided on draft TOR), and provide:

    a. systematic feedback from an evaluation perspective, on the quality of the draft inception and evaluation report.
    b. recommendations on how to improve the quality of the final inception/evaluation report.

62. The evaluation manager will review the feedback and recommendations from QS and share with the team leader, who is expected to use them to finalise the inception/ evaluation report. To ensure transparency and credibility of the process in line with the UNEG norms and standards[1], a rationale should be provided for any recommendations that the team does not take into account when finalising the report.

63. This quality assurance process as outlined above does not interfere with the views and independence of the evaluation team, but ensures the report provides the necessary evidence in a clear and convincing way and draws its conclusions on that basis.

64. The evaluation team will be required to ensure the quality of data (validity, consistency and accuracy) throughout the analytical and reporting phases. The evaluation team should be assured of the accessibility of all relevant documentation within the provisions of the directive on disclosure of information. This is available in WFP's Directive CP2010/001 on Information Disclosure.

65. Evaluation Agency will require to follow all the DEQAS norms and will have to address the comments of all the reviewers satisfactorily.

66. As anthropometric assessment of children would be conducted in this evaluation, the technical proposal submitted by the evaluation agency should also highlight the safety protocols, especially in view of the COVID-19 situation.

67. All final evaluation reports will be subjected to a post hoc quality assessment by an independent entity through a process that is managed by OEV. The overall rating category of the reports will be made public alongside the evaluation reports.

[1] UNEG Norm #7 states "*that transparency is an essential element that establishes trust and builds confidence, enhances stakeholder ownership and increases public accountability*"

5. Phases and Deliverables

68. The evaluation will proceed through the following phases. The deliverables and deadlines for each phase are as follows:

69. Baseline evaluation would take place from April 2021 to August 2021. Inception phase would commence around 15th April, 2021.

Time Plan:		**Baseline evaluation**																	
S. No	**Baseline evaluation related specific tasks**	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14**	**Week 15**	**Week 16**	**Week 17**	**Week 18**	**Week 19**
1	Inception meeting, development of tools, submission of inception report																			
2	Desk Review																			
3	Reviewing and extending the analysis plan																			
4	Finalization of Inception report																			
5	Data Collection																			
6	Data Entry, Cleaning and Analysis																			
7	Key findings presentation (PowerPoint)																			
8	Draft Evaluation Report (ER)																			
9	Quality assure the draft ER																			
10	Finalize Evaluation Report (ER)																			

70. End line evaluation would be conducted in 2023. Preparatory work of the end line would commence after the implementation of the project for around 20-22 months, which would be in January – March, 2023. Inception phase would commence around 15th March, 2021. Time plan and deliverables of end line are presented in the below table.

Time Plan:		**Endline evaluation**																	
S. No	**Baseline evaluation related specific tasks**	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14**	**Week 15**	**Week 16**	**Week 17**	**Week 18**	**Week 19**
1	Inception meeting, modification of tools, submission of inception report																			
2	Desk Review incl. Review of project documents																			
3	Reviewing and extending the analysis plan																			
4	Finalization of Inception report																			
5	Data Collection																			
6	Data Entry, Cleaning and Analysis																			
7	Key findings presentation (PowerPoint)																			
8	Draft Evaluation Report (ER)																			
9	Quality assure the draft ER																			
10	Finalize Evaluation Report (ER)																			

71. Post-finalization of the evaluation report, dissemination and follow-up with relevant stakeholders and users of the evaluation would be conducted. The WFP Commissioning Office management respond to the evaluation recommendations by providing actions that will be taken to address each recommendation and estimated timelines for taking those actions.

6. Organization of the Evaluation & Ethics

6.1. Evaluation Conduct

72. The evaluation team will conduct the evaluation under the direction of its team leader and in close communication with Dr. Divya Tiwari (Monitoring and Evaluation Officer and Deputy Head of Evidence and Results Unit, India CO, WFP). The team will be hired following agreement with WFP on its composition.

73. The evaluation team will not have been involved in the design or implementation of the subject of evaluation or have any other conflicts of interest. Further, they will act impartially and respect the code of conduct of the evaluation profession.

74. Evaluation team would follow the evaluation schedule in ***Annexure 12*** (See evaluation timeline template). Baseline evaluation would take place from January 2021 to August 2021 and end line evaluation would be conducted in 2023.

6.2. Team composition and competencies

75. The evaluation core team is expected to include Team Leader (Senior person), nutrition expert, SBCC expert, gender expert, and field managers. Core evaluation team would be of 5-7 members. To the extent possible, the evaluation will be conducted by a gender-balanced, geographically and culturally diverse team with appropriate skills to assess gender dimensions of the subject as specified in the scope, approach and methodology sections of the ToR. At least one team member should have WFP experience.

76. The evaluation core team will be multi-disciplinary and include members who together include an appropriate balance of expertise and practical knowledge in the following areas:

- Expertise and experience of in evaluating effectiveness of infant and young child feeding programmes as well as good understanding of the ICDS, especially around take home rations. .
- Expertise in evaluation design and statistical analysis using statistical software. Must also have experience in leading collection of child anthropometric data (age in months, weight in kgs and length/height in cms) and the use of Epi-Info to generate z-scores for analysis.
- Expertise in design and evaluation of social behaviour change communication campaigns, especially in the area of health and nutrition.
- Gender expertise / good knowledge of gender issues, especially around IYCF practices and nutrition as well as good understanding of presenting age and sex dis-aggregated findings in the report and gender specific sections in the report.
- All team members should have strong analytical and communication skills, evaluation experience and familiarity with Rajasthan.

- Field team members are required to have knowledge of oral and written language used in the Jaipur and English language is the expected language of the evaluation report.

77. The Team leader should be a technical expert of the evaluation subject. S/he should have leadership, analytical and communication skills. Team leader would be responsible for the overall management of the evaluation and to ensure the adoption of DEQAS guidelines.

78. The team members will bring together a complementary combination of the technical expertise required and have a track record of written work on similar assignments.

79. Team members will: i) contribute to the methodology in their area of expertise based on a document review; ii) conduct field work; iii) participate in team meetings and meetings with stakeholders; iv) contribute to the drafting and revision of the evaluation products in their technical area(s).

80. Field Team including young professionals who would be responsible for collecting quantitative data from the field would be gender-balanced. Field team members should have the prior 3-5 years experience and expertise of collecting field level data from PLWs, adolescents and caregivers of young children in Rajasthan. Knowledge of oral and written language used in Jaipur is required.

81. Field Team members who would be collecting the anthropometric data from the children should have appropriate qualification and 3-5 years' experience of collecting anthropometric data from children (aged 6-60 months). Further, they must undergo training before the start of field level data collection from children and would be adequately supervised while collecting the anthropometric measurements.

6.3. Security Considerations

82. Considering the COVID-19 situation, evaluation team including the data-collection team would adhere to all security and safety protocols of Government of India, Government of Rajasthan and the UN. Social distancing while collecting the data should be strictly followed.

83. COVID-19 related safety protocols would be strictly followed, while collecting anthropometric data from the young children. Anthropometric instruments for collecting the anthropometric measurements of the children have to be properly sanitized before taking the measurements from each child.

84. As an 'independent supplier' of evaluation services to WFP, the evaluation company is responsible for ensuring the security of all persons contracted, including adequate arrangements for evacuation for medical or situational reasons. The consultants contracted by the evaluation company do not fall under the UN Department of Safety & Security (UNDSS) system for UN personnel.

85. Consultants hired independently are covered by the UN Department of Safety & Security (UNDSS) system for UN personnel which cover WFP staff and consultants contracted directly by WFP. Independent consultants must obtain UNDSS security clearance for travelling to be obtained from designated duty station and complete the

UN system's Basic and Advance Security in the Field courses in advance, print out their certificates and take them with them.[10]

6.4 Ethics

86. Necessary permission from the Government of Rajasthan will be obtained before collecting data. Informed consent, as well as assent, as applicable, will be sought from all the study participants by the Evaluation Agency. All the information collected will be anonymized during analysis and reporting. Considering the COVID-19 situation, strict safety protocols would be strictly adhered while collecting anthropometric data from the young children.

87. The UNEG ethical principles of Integrity, Accountability, Respect and Beneficence would be integrated at each and every stage of evaluation[11].

88. Evaluation Team would respect the values of the beneficiary communities and would be sensitive towards the cultural, gender, ethnic and religious background of the study participants of this evaluation.

89. The Evaluation Team Leader should have the responsibility to ensure that ethical standards are considered throughout the evaluation process, and training provided to the field team involved in the survey.

7. Roles and Responsibilities of Stakeholders

90. **The WFP India Country Office:**

a- The WFP India Country office **Management (Director or Deputy Director)** will take responsibility to:

- Assign an Evaluation Manager for the evaluation: Divya Tiwari, Monitoring and Evaluation Officer & Deputy Head of Evidence and Results Unit, WFP India CO.
- Compose the internal evaluation committee and the evaluation reference group (see below).
- Approve the final TOR, inception and evaluation reports.
- Ensure the independence and impartiality of the evaluation at all stages, including establishment of an Evaluation Committee and of a Reference Group (see below and TN on Independence and Impartiality).
- Facilitate in discussions with the evaluation team on the evaluation design and the evaluation subject, its performance and results with the Evaluation Manager and the evaluation team
- Organise and participate in two separate debriefings/ validation workshop, one internal and one with external stakeholders
- Oversee dissemination and follow-up processes, including the preparation of a Management Response to the evaluation recommendations

[10] Field Courses: Basic; Advanced

[11] https://www.unodc.org/documents/evaluation/Guidelines/UNEG_Ethical_Guidelines_for_Evaluation_2020.pdf

b- **The Evaluation Manager**:

- Manages the evaluation process through all phases including drafting this TOR
- Ensures quality assurance mechanisms are operational
- Consolidates and shares comments on draft TOR, inception and evaluation reports with the evaluation team
- Ensures expected use of quality assurance mechanisms (checklists, quality support
- Ensures that the team has access to all documentation and information necessary to the evaluation; facilitates the team's contacts with local stakeholders; sets up meetings, field visits; provides logistic support during the fieldwork; and arranges for interpretation, if required.
- Organises security briefings for the evaluation team and provides any materials as required

c- **An internal Evaluation Committee** has been formed as part of ensuring the independence and impartiality of the evaluation [***Annexure 10***].

91. **An Evaluation Reference Group** has been formed, as appropriate. [***Annexure 11***]. The ERG members will review and comment on the draft evaluation products and act as key informants in order to further safeguard against bias and influence.

92. **The Regional Bureau:** When not the Commissioning Office, the RB will take responsibility to:
    - Advise the Evaluation Manager and provide support to the evaluation process where appropriate.
    - Participate in discussions with the evaluation team on the evaluation design and on the evaluation subject as relevant, as required.
    - Provide comments on the draft TOR, Inception and Evaluation reports. Support the Management Response to the evaluation and track the implementation of the recommendations.
    - While the Regional Evaluation Officer Yumiko Kanemitsu will perform most of the above responsibilities, other RB relevant technical staff may participate in the evaluation reference group and/or comment on evaluation products as appropriate.

93. **Relevant WFP Headquarters divisions** will take responsibility to:
    - Discuss WFP strategies, policies or systems in their area of responsibility and subject of evaluation.
    - Comment on the evaluation TOR, inception and evaluation reports, as required.

94. **The Office of Evaluation (OEV).** OEV, through the Regional Evaluation Officer, will advise the Evaluation Manager and provide support to the evaluation process when required. It is responsible for providing access to the outsourced quality support service reviewing draft ToR, inception and evaluation reports from an evaluation perspective. It also ensures a help desk function upon request.

95. **The DWCD, GoR** would provide advise, guidance and support to the evaluation process. Secretary of DWCD of GoR is a member of ERG. GoR would facilitate and support data collection at the field level during baseline and endline evaluation. GoR would review the preliminary findings of the baseline and endline evaluation.

Evaluation reports would be shared with GoR for their learning and decision making towards the scale-up of the project.

96. **Beneficiaries.** Government's ICDS scheme beneficiaries (pregnant and lactating women, adolescent girls, men, boys and girls), AWWS and members of WSHGs of this pilot project would provide the data and insights, which would be the most critical information for conducting the baseline and endline evaluation.

97. Communication and budget

a. Communication

98. To ensure a smooth and efficient process and enhance the learning from this evaluation, the evaluation team should place emphasis on transparent and open communication with key stakeholders. These will be achieved by ensuring a clear agreement on channels and frequency of communication with and between key stakeholders. ToR, preliminary findings and evaluation report would be shared with the partners for seeking their feedback and in an appropriate manner their feedback would be incorporated. Evaluation team would update the progress of evaluation in terms of development of tools, data collection, data entry, preliminary findings and report writing to the WFP on a weekly basis. Tools for collecting the data would be bi-lingual that is in English and in local language of Jaipur. WFP would inform the Government, donors and other partners about the progress of evaluation on a monthly basis. Evaluation team along with WFP would present the findings of the evaluation to the GoR.

99. As part of the international standards for evaluation, WFP requires that all evaluations are made publicly available. Following the approval of the final evaluation report, WFP India CO would share the evaluation report with the government, Cargill India (donor) and other partners. Final report would be uploaded on the WFP website. Dissemination workshop would be conducted to share the findings of the evaluation with important stakeholders. Video highlighting the process and findings of the evaluation would be developed and disseminated. WFP would be responsible for conducting the dissemination workshop and developing the video for wider dissemination of the findings of the evaluation. Evaluation team would be required to present the findings of evaluation during the dissemination workshop.

a. Budget

100. **Budget:** For the purpose of this evaluation, the budget will:

- Competitive procurement process ("Tender"), in which case the budget will be proposed by the applicant.

  Evaluation firms or agencies participating in the competitive procurement process, would be required to prepare and submit the budget or financial proposal, using the format for financial proposal provided as ***Annexure 15***. Budget should be provided separately for baseline and endline evaluation.

- WFP, as an Agency of the United Nations, is exempt from the payment of taxes by reason of the UN privileges it enjoys. Financial proposal should, therefore, be free of all taxes and other levies.
- Based on the background calculation, estimated budget for conducting this evaluation is around USD 80,000. **As this would be competitive procurement process, thus the estimated budget for conducting this evaluation would be removed from the ToR, before floating it externally for seeking the bids.**

Annexure 1 - Improving the quality of take-home rations distributed through the Integrated Child Development Services (ICDS) scheme

Background

The first 1,000 days of a child's life starting from gestation till two years after birth is a unique period of opportunity when the foundations for optimum health and development across the lifespan are established. The health and well-being of a pregnant and lactating woman is directly connected to the growth and health of her infant. The right nutrition and care during the 1,000-day window influences the child's growth and development, reduces disease risk as well as protects the mother's health.

Impact of poor nutrition early in life has lasting effects that can transcend generations, as a malnourished woman gives birth to malnourished children, who in the absence of nutritional interventions, are likely to grow up and further perpetuate the cycle by giving birth to malnourished children. Impaired cognitive development may lead to a child being at higher risk for poor school performance and low skilled employment later in life, which, in addition to the healthcare costs of malnourishment, translates into a huge economic burden for countries.

According to the National Family Heath Survey-4 survey, an estimated 18 percent of babies are born with a birth weight lower than 2.5 kg. The feeding practices of only 9 percent of breastfed children aged six to 23 months, meet the minimum standards for all Infant and Young Child Feeding (IYCF) practices and among the children under the age of five, an estimated 21.0 percent are wasted, 38 percent are stunted, and 36 percent are underweight. Furthermore, 53 percent of women aged 15 to 49 years suffer from anaemia, around 23 percent of women are reported to have low BMI (too thin for their height) and 11 percent of have a height below 145cm.

Focusing on the critical period of first 1,000 days, which is often referred to as the "window of opportunity", can prevent the serious and irreparable damage caused by hunger and malnutrition in children. Take Home Rations (THR) in India, under the ICDS Scheme, are provided to children (six to 36 months old) as well as pregnant and lactating women and have the potential to address nutrition gap during this critical period. However, for the THR to be effective, it is required that a quality, nutritious and age appropriate product is seamlessly delivered to the beneficiary.

The Project

Considering that THR provides supplementary nutrition coverage to the crucial 1000 days' period, piloting a nutritionally appropriate take home ration for the ICDS beneficiaries.

Piloting a nutritionally appropriate take home ration for the ICDS beneficiaries

There is variation in the production modalities amongst states with respect to take home rations. In some states, the production and delivery of take-home rations is outsourced to the private sector while in some states it is locally produced by women's self-help groups and delivered by government hired transport agents to the Anganwadi Centres.

Amongst the many issues plaguing THR in the country, the most glaring include the poor quality of the product leading to non-consumption of the product as desired and often times use of the THR for animal feed on account of quality issues. As part of the project, WFP will study the composition of the existing THR in place, work out a revised composition for the product aligned to global guidance and then roll out the same in the state identified for the project. The improvement in the quality of take-home rations may include but not be limited to fortifying the product, adding milk powder to the composition, reducing the sugar content of the product, taste enhancements.

WFP will work with government stakeholders to assess the existing systems and propose any revisions in consultation with the relevant authorities. The following activities will be undertaken under the project

(i) Up-gradation of existing equipment for production of a nutritious THR
(ii) Capacity building of the staff responsible for production
(iii) Supply chain management
(iv) Quality assurance and control
(v) Regular monitoring along with required assessments and studies on shelf life etc before the product is rolled out for consumption by the ICDS beneficiaries.

Source: Project document drafted by the Nutrition Unit (Project Team) of India CO, WFP

Annexure 2 - Improving care and nutrition practices in the community through Social Behaviour Change Communication (SBCC)

Background

Nutritional outcomes such as stunting, wasting including overweight and obesity and various nutritional practices such as breastfeeding, complementary feeding, cooking and eating are a reflection of knowledge and behaviours. Improving nutrition nearly always requires behaviour change. Although human behaviour is complex and highly contextual, evidence-based Social Behaviour Change Communication (SBCC) can effectively improve nutrition. SBCC is globally recognized as one of the essential actions to change social norms and improve nutrition-related behaviours in any setting. Further, SBCC is not only about changing beneficiary behaviours but also focusses in equal measure on changing the behaviours of the frontline workers who help deliver the programme services.

Global evidence on SBCC suggests the following:

(i) using not one, but multiple SBCC approaches together, is important. For instance, using both interpersonal and media approaches are more effective than using one or the other alone
(ii) SBCC is better when it is context-specific, with a combination of specific activities and channels designed to resonate with audience segments
(iii) SBCC is more effective when targeted messages reach intended audience segments more frequently – more exposure leads to greater change

The Project

In view of the above, WFP in collaboration with other project stakeholders proposes to develop and roll out a Social Behaviour Change Communication campaign focussing on appropriate infant and young child feeding practices, varying nutritional requirements at key physiological periods of life, dietary diversity, healthy eating and feeding practices etc. These messages will be delivered to different groups (mothers, fathers, care givers, adolescents etc) in the community through a variety of approaches to work towards improving knowledge, attitudes and eventually practices for improved nutrition. This project component also ties in well with the component on improving take home rations and will work towards ensuring uptake and consumption of the take home rations in the appropriate target groups.

Project activities

The project activities will be implemented across different phases namely formative, development, programming and monitoring.

The different activities in the phases include:

(i) Conducting formative work to gather context-specific information about on-going behaviours, key influencers etc. This formative work will be undertaken as part of the overall project baseline but with specific questions focussed around SBCC. The formative phase will help in defining the SBCC objectives and channels.
(ii) Drafting creative briefs from formative work to develop SBCC materials and pre-testing SBCC materials among target audience segments
(iii) The SBCC will be delivered through government platforms and will therefore require capacity building of staff for effective implementation of SBCC campaign
(iv) Implementing the SBCC campaign with partners
(v) Monitoring Phase and improvising
(vi) Evaluating the effectiveness of the intervention to inform the handover of this model to the government

Source: Project document drafted by the Nutrition Unit (Project Team) of India CO, WFP

Annexure 3 - Principles of project implementation

The project will be implemented with the following understanding:

Alignment to government vision: The vision of the Government of India, and state governments, on malnutrition as expressed through the POSHAN Abhiyaan will be the overall guiding principle for the implementation of the project. All activities under the project will be undertaken in alignment to that vision as well as in coherence with existing guidelines issued around the same.

Support to government systems: Activities will be geared towards supporting and strengthening government structures, schemes and systems for reducing malnutrition, particularly at state, district and sub-district level.

Innovation: Though guided by the POSHAN Abhiyaan and implemented in alignment to it, the project will look at exploring innovative options and strategies for its implementation.

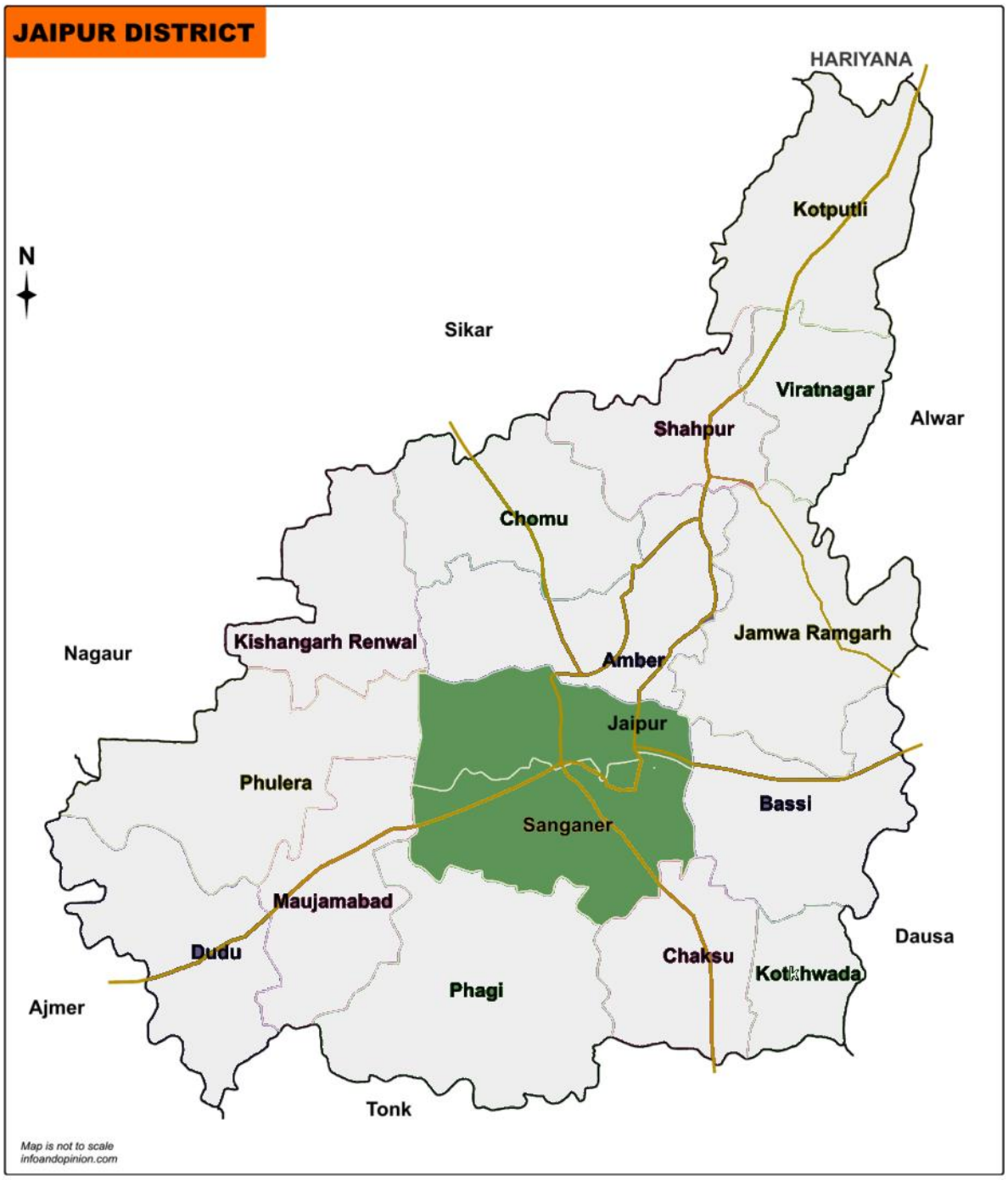
Partnership: Partnerships will be key to the success of the implementation of the project. The project will be implemented in close collaboration with other development partners, UN agencies and field-based NGOs. All efforts will be made to learn from their successes and to take into consideration the challenges met by them in the design of the project.

***Gender transformative approaches for change in nutrition status*:** A sound gender analysis will be undertaken to assess the underlying factors and norms practiced in the communities that are inhibiting the healthy practices. Efforts will be made to specifically address the issues based on the gender analysis through the strategies for capacity building and SBCC. Some of the known factors such as the children of non-anaemic/well-nourished and healthy mothers are less likely to be malnourished imply the need for simultaneous work towards improvement of mother's nutrition. Also, taking into consideration the social norms and increasing participation of women in economic activities, it is imperative to involve men in the care practices. The inequalities would be addressed, taking into consideration the specific needs of the communities and sensitization of the service providers through its integration in all project strategies.

Scale-up: The project though implemented in a district with some elements being implemented at sub-district level should ultimately inform scale-up throughout the State along with relevant policy change as appropriate at National level. A crucial success factor will be the close involvement, from the onset, of the state-level authorities in developing and implementing the project with its various activities and pilots.

Source: Project document drafted by the Nutrition Unit (Project Team) of India CO, WFP

Annexure 4 - Map of Jaipur, Rajasthan – project area has been highlighted in green



Annexure 5 – Details of the ICDS beneficiaries in Jaipur district

कार्यालय उपनिदेशक महिला एवं बाल विकास विभाग, जयपुर

कमरा नम्बर 206 कलेक्टेट,जयपुर दूरभाष नम्बर 0141–2209042,E-mail :-ddicdsjaipur206@gmail.com

S. No.	NAME Of Project	total no.of awc	total no. Of 6month to 3 year beneficiary		total no. Of 3 to 6 year beneficiary		praagnent and lactating women	adolsent girl	total no. Of beneficiary
			B	G	B	G			
1	Amer	158	1094	1030	978	1086	1399	0	5587
2	Bairath	174	2041	2040	1392	1392	1374	0	8239
3	Bassi	316	3513	3389	1981	2044	3867	0	14794
4	Chaksu	246	960	910	1365	1420	1618	0	6273
5	Dudu	176	1452	1442	1239	1255	1891	11	7290
6	Mozmabad	162	1975	1952	1182	1203	2131	0	8443
7	Govindgarh	214	1186	1171	1150	1138	1703	0	6348
8	Govindgarh II	179	1429	1387	837	886	1203	0	5742
9	Jaipur I	156	700	693	1224	1230	1633	0	5480
10	Jaipur II	199	545	507	1724	1713	836	0	5325
11	Jaipur III	201	1438	1471	1929	2068	3204	37	10147
12	Jalsu	177	1031	993	1053	1078	1513	0	5668
13	Jamva Ramgarh	272	1700	1629	1713	1922	3152	0	10116
14	Jhotwara	174	1098	1005	762	877	1419	2	5163
15	Kotputali	197	1569	1476	1511	1409	2215	0	8180
16	Phagi	233	1178	1118	1204	1279	2005	4	6788
17	PAOTA	148	1309	1324	1012	1059	1733	0	6437
18	Sambher	271	3309	3294	1692	1726	3476	0	13497
19	Sanganer R	190	810	790	794	864	1735	0	4993
20	Sanganer City	196	832	875	1248	1453	1987	2	6397
21	Shahpura	215	2076	1962	1451	1538	1878	0	8905
total		4254	31245	30458	27441	28640	41972	56	159812

Source: DWCD, Jaipur, GoR

Annexure 6 - List of ICDS beneficiaries in the project area of Jaipur district, Rajasthan

BLOCK	No. of AWC	6 month-3 years Children		3-6 years Children		Pregnant /Lactating Women	Adolescent girls
		Boy	Girl	Boy	Girl		
Jaipur 1	156	700	693	1224	1230	1633	0
Jaipur 2	199	545	507	1724	1763	836	0
Jaipur 3	201	1438	1471	1929	2068	3204	37
Sanganer R	190	810	790	794	864	1735	0
Sanganer City	196	832	875	1248	1453	1987	2

Source: DWCD, Jaipur, GoR

Annexure 7 - Details of the phases of the project

In the preparatory phase (November, 2020 to April, 2021), the project will be discussed and agreed with Government counterparts and other stakeholders at the State level through a series of workshops to understand existing interventions already in place as well as the progress made in the State in the nutrition space. This phase foresees setting up of various collaborative platforms and review mechanisms for the project such as the Technical Advisory Group (TAG); agreement on the collaborative project with clearly delineated roles and responsibilities of the various partners and the government formalised, as well as taking up all activities needed for rolling out the project such as hiring of necessary staff, vendors and conducting an in-depth assessment n depth assessment will be undertaken in each of the states to identify 'gaps' and 'opportunities' for addressing nutritional security, involving understanding the needs on the ground, assessment of government policies (including ensuring coordination among relevant Departments in the State), conditions for private sector participation, identification of existing models/approaches including by the private sector or other actors.

In the implementation phase (May, 2021 – May, 2023), a series of sensitization meetings will be organized across sectors at the district level to help functionaries of other sectors and schemes understand various background factors leading to malnutrition and their possible role in addressing the same. These sensitization meetings will also lead to the development of workplans for each of the sectors- the component on IEC material and SBCC of the work plan will be implemented through this project. These sensitization meetings will be conducted under the overall leadership of the multi-sectoral platform formed at the State and district level- this platform will also regularly meet to review the progress and the action taken on the workplans developed.

For the improvement of quality of the THR, the project partners will either work with existing producers /suppliers of THR (usually companies or self-help groups - SHG) or possibly organize women in to forming self-help groups. SHG may be supported with investments and the composition of the THR will be agreed with the TAG formed for the project. For the children partaking in the hot-cooked meals at the AWC- the staple provided in the meal will be fortified by supporting the fortification-process well integrated in the supply-chain of the ICDS. While the supplementary nutrition is being improved, all efforts will also be undertaken to improve the quality of the service delivery through the AWCs by use of appropriate technology, capacity building of the workers, support and monitoring to ensure inclusion of all vulnerable households. Action will be undertaken to ensure that the AWCs are converted into place in the villages where the community wilfully converges for its nutritional needs. Improved nutrition is ultimately the responsibility of the household and individual. The AWC will focus on Social Behaviour Change Communication (SBCC) activities for awareness and better nutrition behaviours and increased uptake and utilisation of the supplementary nutrition.

Finally, in the hand-over and scale-up phase (June, 2023 – November, 2023), each project component will be handed over to the Government to sustainably implement in the given geography as well as to expand to other geographies. This phase foresees

transfer of knowledge, tools and the necessary wherewithal needed to implement such a project. The hand-over and scale-up phase sees the role of the project partners being gradually limited and focussed on technical assistance alone and implies full involvement of government partners from the onset.

Annexure 8 - Role and responsibilities of the GoR and WFP

Below roles and responsibilities are based on the Letter of Understanding which would be signed by the GoR and WFP.

Role and responsibilities of the Government of Rajasthan (GoR)

Formation of a technical advisory group: DWCD shall set up a technical advisory group consisting of the relevant departments (Women and Child Development, Human Resource Development, Tribal Area Development, Rural Development, Food and Public Distribution) from within the Government, subject experts and WFP to oversee and facilitate the implementation of the project and call for regular bi-annual meetings of the same. The organizational expenses of the technical advisory group will be borne by WFP.

Timely approvals and facilitatory support: DWCD along with other concerned departments of GoR shall be responsible for providing timely approvals to activities envisaged in the project proposal including facilitatory support required to conduct need-based research such as project evaluations, acceptability studies on the THRs.

During the setting up and period of the THR pilot, GoR shall also facilitate, road permits for smooth transportation of the equipment procured for production of the THR from the respective suppliers to the SHG site.

Procurement of THR from WFP supported self-help groups as well as timely payments: DWCD shall ensure procurement of the take home rations on a regular basis from the WFP supported THR production units as well as make timely payments for the THR procured to ensure continuous functioning of the WFP set-up unit.

Project Coordination and liaison support: To support this partnership, DWCD will identify a project manager already looking after ICDS/THR production operations in the state for regular dialogue, discussion and day to day follow-up activities. These officers would provide support and would be wholly responsible for project implementation, supervision and coordination and liaise with a designated officer from WFP.

DWCD through the above-mentioned officer will also provide necessary coordination and liaison support as required with the Department of Rural Development, Tribal development etc.

Capacity building and awareness creation: DWCD will conduct capacity building of the Anganwadi workers during the scale-up phase of social behaviour change component of the project while WFP will support training of trainers for the roll out. The training and IEC material for the same will be developed in collaboration with WFP. Printing of the training modules for the scale-up phase of the project will be the responsibility of the GoR.

Project monitoring and reporting: DWCD, GoR shall share with WFP, information collected through its regular monitoring mechanisms on the number of beneficiaries reached through the improvised THR, tonnage of THR produced and distributed, number of units set up for production of THR through provision of mechanized units

and training of relevant staff during the course of the pilot and scale-up phase of the project on a monthly basis.

The GoR shall agree to flexibility in the reporting system for any mid-term modification in order to facilitate WFP in making changes in the reporting format to make these more THR context friendly. WFP may seek other food, nutrition and health related reports, which GoR may furnish from time to time.

Support WFP project partnerships: Participate and attend multi-stakeholder platform discussions set up by WFP and its partners.

Continuation of the purpose of the project: DWCD, GoR will continue and scale-up the basic purpose of the project i.e. provision of a quality THR for children between 6-36 months of age receiving the same from ICDS at its own cost after assistance from WFP once the demonstration phase is handed over.

Roles and responsibilities of WFP:

Resourcing the project: WFP will ensure availability of necessary financial resources for the provision of technical assistance to the THR production unit in Banswara, setting up the THR production unit in an agreed district as well as SBCC activities in the pilot phase of the project.

Procurement: WFP will procure the equipment needed for production of THR through its internal procedures for setting up and running the demonstration unit for production of fortified blended foods.

During the pilot, WFP will work with the identified SHG/s for procurement of raw materials such as wheat, fortificant etc along with packaging needed to produce a quality take home ration. To support the implementation of various activities in the project, WFP through its internal procedures may procure the services of other partners.

In the scale-up phase, WFP will support the self-help groups in the procurement of the fortificant, raw materials and mechanized fortification units through technical support and related documentation as need be and appropriate.

Undertake need based research: WFP will commission a series of studies such as shelf life, acceptability, economic viability etc as a precursor to the roll out of a quality THR through the unit.

Provision of technical support and assistance: WFP will engage on a regular basis with the identified self-help group in Banswara with a view to strengthen its functioning and expand its coverage. The role of WFP will be to support the set-up of a quality THR production unit with technical support and input to the SHG in all aspects.

Development of quality control protocols: During the period of the THR production demonstration unit, WFP will undertake responsibility of setting up quality control and assurance protocols both at the production site and through the engagement of the services of an independent laboratory. Reports of the analysis will be used to undertake corrective action in case so needed.

During the scale-up phase, WFP will develop a quality control protocol and support instituting systems in place to support GoR in ensuring delivery of safe and good quality fortified blended foods to children between 6-36 months of age.

Project coordination: For effective coordination, project supervision and support towards up-scale, WFP will appoint one Project coordinator (Nutrition) based at the district identified for the pilot in Rajasthan. WFP would also designate project focal staff at the Country office in New Delhi, who would provide regular guidance and support to the project coordinator for day to day implementation and problem resolution.

The project coordinator and WFP focal staff would regularly visit the project implementation sites to monitor the production, quality and distribution of THR under the ICDS programme. WFP focal staff would also maintain a close contact with beneficiaries to assess compliance as well as the relevant state departments to share progress and feedback from time to time.

Capacity building and awareness creation: WFP will support capacity building of the staff at the THR production unit on systematic production, fortification, quality control and food handling/safety.

Towards supporting the scale-up of fortification of nutri-mix, WFP will create a master pool of trainers at the State level who are capacitated on various aspects of THR production and will be able to in turn conduct cascade training for all the women self-help groups engaged in THR production identified in consultation with the government.

WFP will support the development of appropriate training material towards the above.

WFP will also undertake capacity building of anganwadi workers in counselling parents on consumption of the THR while supporting development of specially designed information, education and communication material and other communication strategies highlighting the need and importance of quality complementary foods for young children. WFP will also develop communication strategies and material for sensitizing other members of the community on nutritional requirements at key vulnerable phases of life.

Project monitoring: WFP will intensely monitor the project during the phase of the demonstration unit and report to the government on quantity of THR produced and distributed etc.

WFP will also monitor the scale-up phase of THR production through self-help groups at either district/block level to ensure that the government expected activities are on track.

Partnerships: Work with partners to sensitize and build capacity of private sector on nutrition related issues including setting up of multi-stakeholder platforms.

Annexure 9: Sample size calculation

The following formula may be used to calculate the required sample size for indicators expressed as a percentage or proportion. Note that the sample sizes obtained are for each survey round.

$$\mathbf{n = D\ [(Z_\alpha + Z_\beta)^2 * (P_1\,(1 - P_1) + P_2\,(1 - P_2))\ /(P_2 - P_1)^2]}$$

n = required minimum sample size per survey round or comparison group

D = design effect (assumed in the following equations to be the default value of 2)

P_1 = the estimated level of an indicator measured as a proportion at the time of the first survey

P_2 = the expected level of the indicator either at some future date or for the project area such that the quantity (P_2 - P_1) is the size of the magnitude of change it is desired to be able to detect

Z_α = the Z-score corresponding to the degree of confidence with which it is desired to be able to conclude that an observed change of size (P_2 - P_1) would not have occurred by chance (α - the level of statistical significance), and

Z_β = the z-score corresponding to the degree of confidence with which it is desired to be certain of detecting a change of size (P_2 - P_1) if one actually occurred (β -statistical power).

Z_α and Z_β have "standard" values depending on the reliability desired. Note that the higher the percentage, the more sure the program will be of measuring accurate results.

Suppose an increase of 10 percentage points in the proportion of caregivers of children exhibiting proper awareness levels is to be measured. Assume further that at the time of the first survey, about 50 percent of caregivers were believed to be having proper awareness levels. In this case, P_1 = .50 and P_2 = .60. Using standard parameters of 95 percent level of significance (α) and 80 percent power (β), values of Z_α = 1.645 and Z_β = 0.840 are chosen. Inserting these values in the above formula yields the result of 606 caregivers per survey round.

Accounting the non-response rate, sample size would be around 700

Annexure 10 Membership of the Evaluation Committee

- Mr. Bishow Parajuli (Chair) – Country Director, WFP India CO
- Mr. Eric Kenefick – Deputy Country Director, WFP India CO
- Ms. Yumiko Kanemitsu – Regional Evaluation Officer, WFP Regional Bureau Bangkok
- Ms. Pradnya Paithankar – SDG Manager, WFP India CO
- Dr. Shariqua Yunus Khan- Head of Nutrition Unit, WFP India CO
- Dr. Abhay Kumar – Head of Evidence and Results Unit, WFP India CO
- Dr. Divya Tiwari – Evaluation Manager, Deputy Head of Evidence and Results Unit, WFP India CO

Purpose of formation of EC: The overall purpose of the internal evaluation committee is to ensure a credible, transparent, impartial and quality evaluation process in accordance with WFP Evaluation Policy 2016-2021. It will achieve this by supporting the evaluation manager (EM) in making decisions through the process, reviewing draft evaluation deliverables (TOR, Inception Report and Evaluation Report) and submitting them for approval by the CD/DCD who will be the chair of the committee.

Responsibilities of the Evaluation Committee: During planning phase, the EC will decide the contracting method, well in advance to enable the evaluation manager to plan for the next phase of the evaluation. Further, the EC reviews, provides comments and approves the Terms of Reference, budget, evaluation team, and inception and evaluation reports, while also supporting management of the evaluation.

Annexure 11 - Membership of the Evaluation Reference Group

- Mr. Eric Kenefick (Chair) –Deputy Country Director, WFP India CO
- Secretary, Department of Women and Child Development, Government of Rajasthan
- Mr. Thomas Forissier - Director Programs, Asia, Alive and Thrive (IYCF Expert)
- Ms. Yumiko Kanemitsu – Regional Evaluation Officer, WFP Regional Bureau Bangkok
- Ms. Britta Schumacher – Senior Nutritionist, WFP Regional Bureau Bangkok
- Mr. Stuart Coupe, Evaluation Consultant, WFP Regional Bureau Bangkok
- Mr. Simone Lombardini, Evaluation Specialist, WFP Head Quarters Rome
- Dr. Shariqua Yunus Khan- Head of Nutrition Unit, WFP India CO
- Dr. Abhay Kumar – Head of Evidence and Results Unit, WFP India CO
- Dr. Aradhana Srivastava - Gender Officer, WFP India CO
- Dr. Divya Tiwari – Evaluation Manager, Deputy Head of Evidence and Results Unit, WFP India CO

Purpose of formation of ERG: The overall purpose of the ERG is to support a credible, transparent, impartial and quality evaluation process in accordance with evaluation standards. ERG members review and comment on various documents such as evaluation Terms of Reference, inception and evaluation report. The ERG members act as independent experts in an advisory capacity, without management responsibilities. Responsibility for approval of evaluation products rests with the Chair of the Evaluation Committee.

Tasks: The ERG is expected to play a valuable role in ensuring the quality and utility of the evaluation outputs, the ERG will ensure and support the relevance, independence and impartiality of the evaluation. The specific tasks include-

i. Review draft TOR for the evaluation and provide feedback.

ii. Review and comment on the Inception Report.

iii. Review and give feedback on the draft evaluation report. Specifically focusing on accuracy, compliance and on quality and comprehensiveness of evidence base against which the findings are presented, and conclusions and recommendations are made. Attention should also be given to ensure that the recommendations are relevant, targeted, realistic and actionable.

iv. Finally, the ERG also will actively engage in dissemination of final evaluation report and provide input to management response and its implementation (as appropriate) by concerned stakeholders.

Annexure 12 Evaluation Schedule

Evaluation schedule for baseline evaluation is as following:

	Phases, Deliverables and Timeline	Key Dates
Phase 1 - Preparation		**Up to 9 weeks**
	Desk review, draft of TOR and quality assurance (QA) using ToR QC	18 Jan – 10 Feb 2021
	Sharing of draft ToR with outsourced quality support service (DE QS)	11-13 Feb, 2021
	Review draft ToR based on DE QS feedback	19th-21 Feb, 2021
	Circulation of TOR for review and comments to ERG,RB and other stakeholders	18th Jan- 24 Feb, 2021 (2 weeks)
	Review draft ToR based on comments received	18th-24 Feb, 2021
	Submits the final TOR to the internal evaluation committee for approval	24 Feb, 2021
	Sharing final TOR with key stakeholders	24 Feb, 2021
	Selection and recruitment of evaluation team	(3 weeks)
Phase 2 - Inception		**Up to 7 weeks**
	Briefing core team	15th March 2021
	Inception mission in the country (if applicable)	N.A.
	Draft inception report	16th-22nd March, 2021
	Sharing of draft IR with outsourced quality support service (DE QS) and quality assurance of draft IR by EM using the QC	23rd-30th March, 2021
	Revise draft IR based on feedback received by DE QS and EM	31st-5th April, 2021
	Submission of revised IR based on DE QS and EM QA	
	Circulate draft IR for review and comments to ERG, RB and other stakeholders	6th-13th April, 2021
	Consolidate comments	
	Revise draft IR based on stakeholder comments received	14th-18th April, 2021
	Submission of final revised IR	
	Submits the final IR to the internal evaluation committee for approval	
	Sharing of final inception report with key stakeholders for information	

Phase 3 – Data collection		**Up to 3 weeks**
	Briefing evaluation team at CO	19th April, 2021
	Data collection	20th April - 19th May, 2021
	In-country Debriefing (s)	20th May, 2021
Phase 4 - Analyze data and report		**Up to 11 weeks**
	Draft evaluation report	21st May - 11th June, 2021
	Sharing of draft ER with outsourced quality support service (DE QS) and quality assurance of draft ER by EM using the QC	12th June, 2021
	Revise draft ER based on feedback received by DE QS and EM QA	19th June - 25th June, 2021
	Submission of revised ER based on DE QS and EM QA	
	Circulate draft ER for review and comments to ERG, RB and other stakeholders (list key stakeholders)	11th June- 30th June, 2021
	Consolidate comments	
	Revise draft ER based on stakeholder comments received	30th June – 10th July 2021
	Submission of final revised ER	
	Submits the final ER to the internal evaluation committee for approval	
	Sharing of final evaluation report with key stakeholders for information	
Phase 5 - Dissemination and follow-up		**Up to 4 weeks**
	Prepare management response	11th July – 30th July, 2021
	Share final evaluation report and management response with OEV for publication	5th August, 2021

As the end line evaluation would be conducted in 2023, thus the tentative dates would be decided in consultation with government in year 2023. Broad evaluation schedule for end line evaluation is as following.

	Phases, Deliverables and Timeline	Key Dates
Phase 1 - Preparation		**Up to 9 weeks**

	Desk review, draft of TOR and quality assurance (QA) using ToR QC	(3 weeks)
	Sharing of draft ToR with outsourced quality support service (DE QS)	(3 days)
	Review draft ToR based on DE QS feedback	(3 days)
	Circulation of TOR for review and comments to ERG,RB and other stakeholders	(2 weeks)
	Review draft ToR based on comments received	(1 week)
	Submits the final TOR to the internal evaluation committee for approval	
	Sharing final TOR with key stakeholders	
	Selection and recruitment of evaluation team	(3 weeks)
Phase 2 - Inception		**Up to 7 weeks**
	Briefing core team	(1 day)
	Inception mission in the country (if applicable)	(1 week)
	Draft inception report	(1 week)
	Sharing of draft IR with outsourced quality support service (DE QS) and quality assurance of draft IR by EM using the QC	(1 week)
	Revise draft IR based on feedback received by DE QS and EM	(1 week)
	Submission of revised IR based on DE QS and EM QA	
	Circulate draft IR for review and comments to ERG, RB and other stakeholders	(2 weeks)
	Consolidate comments	
	Revise draft IR based on stakeholder comments received	(1 week)
	Submission of final revised IR	
	Submits the final IR to the internal evaluation committee for approval	
	Sharing of final inception report with key stakeholders for information	
Phase 3 – Data collection		**Up to 3 weeks**
	Briefing evaluation team at CO	(1 day)
	Data collection	(3 weeks)
	In-country Debriefing (s)	(1 day)
Phase 4 - Analyze data and report		**Up to 11 weeks**
	Draft evaluation report	(3 weeks)
	Sharing of draft ER with outsourced quality support service (DE QS) and quality assurance of draft ER by EM using the QC	(1 week)
	Revise draft ER based on feedback received by DE QS and EM QA	(1 week)
	Submission of revised ER based on DE QS and EM QA	
	Circulate draft ER for review and comments to ERG, RB and other stakeholders (list key stakeholders)	(2 weeks)
	Consolidate comments	
	Revise draft ER based on stakeholder comments received	(2 weeks)
	Submission of final revised ER	

	Submits the final ER to the internal evaluation committee for approval	
	Sharing of final evaluation report with key stakeholders for information	
Phase 5 - Dissemination and follow-up		**Up to 4 weeks**
	Prepare management response	(4 weeks)
	Share final evaluation report and management response with OEV for publication	

Annexure 13 Acronyms

- AWC: Anganwadi Centers
- AWW: Anganwadi Worker
- BMI: Body Mass Index
- CO: Country Office
- DEQAS: Decentralized Evaluation Quality Assurance System
- DWCD: Department of Women and Child Development
- EB: Executive Board
- EC: Evaluation committee
- EQAS: Evaluation Quality Assurance System
- ERG: Evaluation Reference Group
- GEEW: Gender Equality and empowerment of women
- GoR: Government of Rajasthan
- HH: Household
- HQ: Headquarter
- ICDS: Integrated Child Development Services
- IDI: In-Depth Interviews
- IPC: Inter Process Communication
- IYCN: Infant and Young Child Nutrition
- M&E: Monitoring and Evaluation
- MoU: Memorandum of Understanding
- NFHS: National Family Health Survey
- OBC: Other Backward Classes
- OEV: Office of Evaluation
- PLW: Pregnant and Lactating Women
- PPS: Probability Proportional to Size
- QS: Quality Support
- RB: Regional Bureau
- RG: Results Group
- SBCC: Social Behaviour Change Communication
- SC: Scheduled Castes
- SOP: Standard Operating Procedures
- SPSS: Statistical Package for Social Sciences
- ST: Scheduled Tribes
- THR: Take Home Ration
- TOR: Terms of Reference
- UN: United Nations
- UNDSS: UN Department of Safety & Security
- UNEG: United Nations Ethical Guidelines
- WFP: World Food Programme

- WSHG: Women's Self-Help Groups

Annexure 14 List of Documents

Below list provides the list of documents which could be referred by the Evaluation Team:

Project Documents:

- Detailed Project Proposal,
- Field visits of WFP in Rajasthan
- Letter of Understanding to be signed between WFP and GoR
- Note for Records of the meeting

Other Documents:

- Baseline Assessment for fortification of Nutrimix in Selected panchayats of Wayanad Kerala. A project of Government of Kerala and World Fod Programme. 2017
- Census (2011), Primary Census Abstracts, Registrar General of India, Ministry of Home Affairs, Government of India
- Endline Assessment for fortification of Nutrimix in Selected panchayats of Wayanad Kerala. A project of Government of Kerala and World Fod Programme. 2021
- International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), India, 2015-16: Rajasthan. Mumbai: IIPS.
- International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), India, 2015-16: India. Mumbai: IIPS.
- International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), India, 2015-16: Jaipur. Mumbai: IIPS.

Annexure 15 Template for Financial proposal

Budget Estimate (Submit separately for baseline and end-line evaluation)					
Budget Items	**Unit Costs (INR)**	**No. of Units**	**No. of Days**	**Total Costs (INR)**	**Comments**
A. Direct Support Cost					
A.1 Project Personnel					
Analyst					
Coordinators					
Enumerators					
Supervisors					
Anthro technician					
Expert					
Trainner					
Sub-total					
A.2 Daily Allowance –(Food, Accommodation, Incidentals, etc.)					
Coordinators					
Enumerators					
Supervisors					
Anthro technician					
Trainers					
Drivers including transportation cost					
Sub-total					
A.3 Travel[++]			No.of trip		
Coordinators					
Enumerators					
Supervisors					
Trainers					
Drivers (if any)					
Sub-total					
B. Other Direct Cost					
B.1 Training					
Rent of location					
Food					
Sub-total					
B.2 Data entry and validation					
Data entry					
Data validation					
Sub-total					
B.3 Materials & other services					

Developingquestionnaire					
Translation & Replication of questionnaires					
Stationary (training kit)					
Printing of questionnaires & reports					
Sub-total					
B.4 Miscellaneous / Other Costs					
Sub-total					
TOTAL					
C. Indirect Support Costs / Overhead Cost (if any)					
Sub-total					
GRAND TOTAL					

Please don't include any cost of software and hard ware or vehicles etc. It is assumed that the agency already owns such technical equipment/facilities.