CARE INTERNATIONAL IN SOUTH SUDAN

TERMS OF REFERENCE (TOR) FOR MICs CONSULTANCY IN TORIT OF EASTERN EQUATORIA STATE, SOUTH SUDAN

Background

CARE is a humanitarian non-governmental organization committed to working with poor women, men, boys, girls, communities, and institutions to have a significant impact on the underlying causes of poverty. CARE seeks to contribute to economic and social transformation, unleashing the power of the most vulnerable women and girls.

CARE's operations in South Sudan dates back to the early 1980s, focusing on emergency and disaster relief to the conflict affected populations. Currently, CARE South Sudan works in four States, Unity, Jonglei, East Equatorial and Upper Nile States, addressing both humanitarian and recovery/development needs. In development/recovery programming, CARE South Sudan focuses on four broad areas namely Gender and Protection, Food security and Livelihoods, Nutrition and *Health.*

Introduction to the project

The project to be evaluated is an integrated project which is of Health, Nutrition and Gender Based Violence (GBV). CARE South Sudan' approach to this project is through utilizing mobile clinics and strengthening of community capacity by targeting the most vulnerable in remote, hard-to-reach areas with high concentrations of IDPs and vulnerable health care, nutrition services targeting cases of severe acute malnutrition (SAM) and Gender Based Violence (GBV). The mobile teams provide Integrated Community Case Management (ICCM) services for communicable diseases, basic Sexual and Reproductive Health (SRH), an expanded program on immunization (EPI), integrated Community-Based Management of Acute Malnutrition (CMAM), and GBV response and referral. Moreover, the mobile teams also work with community volunteer counterparts for integrated health and nutrition, and for GBV and conduct outreach activities. As part of this component, CARE works with a network of Community Nutrition and GBV Volunteers (CNGV), and form Women and Girl Friendly Spaces (WGFS). CARE engages women, girls, boys, men, community leaders, and people with disabilities to ensure that activities do not undermine the communities' ability to rebuild and develop resilience strategies. The intervention is designed as a short-term emergency response to the disruption in public health services, and the deterioration of the nutrition status of the conflict-affected population in former Eastern Equatoria state after the July 2016 crisis. The mobile outreach services to remote areas are designed to complement and supplement health and nutrition services currently provided through static health facilities and Outpatient Therapeutic Program (OTP) sites by Government and other NGO/UN actors.

Project Name	Emergency Health, Nutrition and GBV Response Assistance in South Sudan
Project Location	Imotong State (former Eastern Equatoria): • Torit , Ikoto, Lopa Lafon Counties
Project Goal and Outcomes	Respond to the humanitarian needs created or exacerbated by the July crisis, by providing essential health and GBV response/prevention services, as well as life-saving nutrition support for IDP and host community in South Sudan, focusing on women, girls, children under five and PLW. i. Increased access to lifesaving treatment of common illnesses, including complications for children (6-59 months), as well as trauma and violence-related injuries, including GBV ii. Increased access to lifesaving treatment of acute malnutrition, with complications for children (6-59 months) iii. Vulnerable IDP and HC women and girls have increased access to life-saving protection, health, case management, psychosocial support (PSS) services, and improved multi-sectoral and community-based protection
Target Population and beneficiaries.	Total Number of People Affected in the Target Area: **414,820** conflict affected individuals Total Number of People Targeted (Individuals): **82,964** conflict affected IDPs and HC Total Number of IDPs Targeted (Individuals) as subset of above: **43,141** IDPs
Estimated life of Project	One Year (16st June, 2017 to 31st, May, 2018)

Scope of the evaluation

Under the overall supervision of the project manager and MEAL Officer, the MICS Consultant (MC) will support and provide guidance to CARE in the preparation, implementation and completion of the MICS survey in the counties of Torit, Ikotos and Lopa-Lafon. The MC will take lead in the Survey Coordination during survey planning, questionnaire design, sampling, training, fieldwork, data processing, data analysis, dissemination and archiving, ensuring that MICS protocols and recommendations are followed at all times. The MC will communicate effectively between CARE Torit field officer and Juba Country office, responding promptly to MICS related needs and issues as they arise

This project is responding to the humanitarian needs created or exacerbated by the July crisis, by providing essential health, nutrition and GBV response/prevention services, to support IDP and host community in South Sudan, focusing on women, girls, children under five and PLW.

Project's indicator **Table of Project indicators.docx**

Table 1. Geographic Area and Population Coverage

State	County	Payam	Number of House Hold	Total Household Members
E.Equatoria	Ikwotos	Ikotos, Chahari, Chorokol	17,262	120,834
	Torit	Hiyala/Imatari, Murahatiha	20,339	142,373
	Lopa/Lafon	Imuluha, Lohobohobo, Harilo, Bule, Brugilo, Adeba, Ugwil and Marguna	21,648	151,536
Total			**59,249**	**414,820**

Purpose, Objectives, and Rationale

Multi Indicator Cluster Survey (MICS) to assess the outcome and impact of the program across the various sectors. It will also target populations' needs across a range of indicators including beneficiary knowledge, attitude and practices (KAP) that cover SGBV, Health and nutrition. These surveys will be used to measure results at the outcome and impact levels and are calibrated to specific vulnerabilities and resilience capacities relevant to the context. The MIC survey is intended to be conducted between the 12-27 July 2018.

The *objectives* of the evaluation are as follows:

- To assess the relevance and effectiveness of the project.
- To assess the efficiency of the project implementation
- To assess the results achieved throu8gh the project.
- To ascertain the sustainability of the project's impact even after funding
- To assess the outcome and impact of the program across all sectors (Health, Nutrition, Protection)
- To test the beneficiary knowledge, attitude and practices on health, nutrition, FSL and protection
- To provide data to CARE and partners to inform programming
- To document lessons learnt for improvement of future programming

Evaluation questions

The specific evaluation questions will be in the final evaluation TOR but broadly the questions will address the following broad areas of inquiry:

i. Have the right things been done? (relevance, effectiveness)
ii. Have things been done well? (efficiency, effectiveness)
iii. What results have been achieved? (effectiveness, impact, cost/effectiveness)
iv. How do the results compare with an alternative intervention to achieve the same objective? (relative effectiveness, impact, cost/ effectiveness)
v. How could things be improved or done better in the future?
vi. What has been validated or disproven about the program theories of change, and what adjustments are needed to our assumptions and hypotheses to achieve the impact goal?
vii. Are the results achieved through the project sustainable?

Intended Users

The evaluation findings and processes will be used and shared by relevant stakeholders. The following table outlines the expected communications in sharing the findings of this evaluation. (i.e. reports, presentations, etc.), the purpose of the communications, as well as the intended users.

Table 3. Communication and Reporting Plan

Communication Format	Purpose of Communication	User	Person Responsible	Timing/Dates	Notes
Email and phone	Keep informed about evaluation progress	CARE	Consultant	During development of tools	Review of evaluation tools
Progress report	Reporting the progress in data collection	CARE	Consultant	Daily, during data collection	Reports to the Project manager and Area Manager
PowerPoint presentations	Present preliminary findings	CARE	Consultant	First draft	In a meeting
Submission of soft/hard copy data	Submission of data sets for archiving	M&E unity	Consultant	After data analysis	In a meeting
Final report	Submission of final report for approval	PQDM and M&E	Consultant	After the draft report presentation	In a meeting

Approach and Methodology

The MICS will take a randomized control approach and data collection method will include both qualitative and quantitative methods. The contractor will be responsible for defining and carrying out the overall evaluation approach. This will include specification of the techniques for data collection and analysis, structured field visits and interactions with beneficiaries and the evaluation team. Evaluation tools, methodology and findings should be reviewed and validated with various stakeholders and approved by the evaluation manager at CARE.

See examples, here.

Primary Data

The collection of primary data will involve mostly mix methods, especially questionnaires, FGD, KII and secondary data reviews. To answer the Key Evaluation Questions, data will be collected using randomized sampling method, with an appropriate sample taken from the target population of 82,964.

Some of the key stakeholders that must be targeted through the primary data collection include:

- Households of beneficiaries
- Individual women and men
- Children 6-17 years
- Children under five
- Health workers
- Government officials
- CSO/NGO partners

The data collection process will include: Focused group discussions, key informant interviews, individual questionnaires using both paper and computer aided software. A pre-test will be done to the questionnaires before use. This will be done by random sample of individuals and households within the geographic scope of the project.

Secondary Data

The process, retrieving existing documents and data, will include: a desk review of existing literature including the project/program/initiative proposal, reports, formative research, implementation plans, M&E data, MIS system data, formal policy documents, official statistics, and other relevant quantitative and qualitative secondary data that will support the evaluation implementation strategies. Information will be provided to the external evaluation team as per the proposed evaluation schedule.

Deliverables

1. Daily and weekly Progress Report of activities, describing activities undertaken during the week and highlighting problems met and solutions put in place to mitigate them;
2. Presentations of evaluation tools and review.
3. Draft survey report (PowerPoint presentation)
4. Final survey report with annexes.

Final Report Requirements

The external evaluator is accountable to maintain the requirements for the content, format, or length of the final report, overall quality and approved timelines. They will produce a comprehensive report that assesses the achievements, relevance, coherence, coverage, effectiveness, efficiency, outputs and early outcomes of Emergency Health, Nutrition and GBV project so far, and provide prioritized recommendations to maximize results. To simplify this process, CARE has developed a evaluation report template that can be modified to meet the needs of all project, programs, and initiatives.


Evaluation Report Template

The report must include:

- **A Title:** A title that conveys the name of the project, location, implementation period, as well as the main impact or key finding of the report.
- An **executive summary that focuses both on process as well as impact** (except for baseline evaluations where we would not expect to see impact data) that is no more than 2 pages in length and is formatted so that it can be printed as a stand-alone 2-pager about the project.
- **A display of impact early in the report, including 3-5 key impacts/findings:** What changed because of the program? What happened in the world, and why did it matter? This are the most significant accomplishments, supported by solid evidence. Each impact should be written as one or two sentences. **Talk about impact early on the report** so that the audience does not have to read the entire report before seeing evidence of change.
- **3-5 key lessons learned:** These should be short, actionable, and the most important aspects of what the program/analysis found. They need to be relevant and new for people outside of the direct program.

- **3-5 bullets describing how the project got to impact/3-5 recommendations**: It is important to have non-jargon descriptions of what a project did to get to impact. These are highlights of the most effective, relevant, and scalable approaches and tools. If this is an analysis and not an evaluation, then this section should be 3-5 key recommendations for what the project/program/initiative should do based on your findings.
- **Shareable Evidence:** Clearly separate evidence collected by the external evaluation from the conclusions and recommendations must be submitted along with the final report. Sources of all evidence must be identified and conclusions must be based only on evidence presented in the report, and recommendations must directly correspond to the conclusions.

For a list of other optional final evaluation deliverables, click here.

Data Disclosure

The external evaluator should deliver, at minimum, all files including: quantitative data sets (raw and refined products), transcripts of qualitative data and others in an easy to read format, and maintain naming conventions and labelling for the use of the project/program/initiative and key stakeholders.

All documents should be compliant with the following conditions (see data format requirements**):**

- All the data generated from this survey and its associated materials shall remain the property of CARE South Sudan country office and shall be achieved in accordance to its policies.
- CARE requires that the datasets that are compiled or used in the process of external evaluation are submitted to CARE when the evaluation is completed.
- **Data must be disaggregated by gender**, age and other relevant diversity, etc.
- Datasets must be anonymized with all identifying information removed. Each individual or household should be assigned a unique identifier. Datasets which have been anonymized will be accompanied by a password protected identifier key document to ensure that we are able to return to households or individuals for follow up. Stakeholders with access to this document will be limited and defined in collaboration with CARE during evaluation inception.
- In the case of textual variables, textual datasets or transcripts please ensure that the data is suitable for dissemination with no de-anonymizing information **UNLESS** these are case studies designed for external communication and suitable permission has been granted from the person who provided the data. In these circumstances, please submit, with the case study, a record of the permission granted, for example a release form[1].
- Where there are multiple datasets (for example both tabular and textual datasets) identifiers must be consistent to ensure that cases can be traced across data lines and forms.
- CARE must be provided with a final template of any surveys, interview guides, or other materials used during data collection. Questions within surveys should be assigned numbers and these should be consistent with variable labelling within final datasets.
- Formats for transcripts (for example: summary; notes and quotes; or full transcript) should be defined in collaboration between CARE and the external evaluator at the evaluation inception
- In the case of tabular datasets variable names and variable labels should be clear and indicative of the data that sits under them. Additionally, the labelling convention must be internally consistent and a full codebook/data dictionary must be provided.
- All temporary or dummy variables created for the purposes of analysis must be removed from the dataset before submission. All output files including calculations, and formulae used in analysis will be provided along with any Syntax developed for the purposes of cleaning.

[1] All release forms should be agreed in advance with CARE.

- We require that datasets are submitted in one of our acceptable format types.
- CARE must be informed of and approve the intended format to be delivered at evaluation inception phase. Should this need to be altered during the project CARE will be notified and approval will be needed for the new format.
- The external evaluator will be responsible for obtaining all necessary permissions, approvals, insurance, and other required permits needed for data collection. These include required permits related to data collection from human subjects, including necessary ethical review board approvals (ERB) and health and accident insurance for evaluation team members

Logistical Support:

Logistical support (access to official facilities including internet, documentation—printing, photocopying of tools etc.) will be provided by CARE

Note:

- The consultant is responsible to pay for any additional costs arising from personal negligence
- The consultant will be responsible of any tax or other fees related.
- The payments will be in one instalment after the completion of the task and submission of final acceptable report to CARE
- Please note that a partial payment hold-back will be in effect until a final report has been approved by CARE

Roles, Responsibilities, and the Evaluation Timeline

See examples, here.

During data collection and analysis, the primary roles of CARE program staff will be informants and reviewers. CARE staff may review and provide comments on data collection tools, instruments, and all other deliverables before they are finalized. CARE Staff must not collect primary data, or participate in translation, analysis, or interpretation of the data.

The following tables delineates the key roles and responsibilities of CARE Staff and the consultant during the evaluation process:

Table 5. Roles and responsibilities on evaluation team(s)

Person/Unit/Organization	Activity
MIC Consultant	**Overall technical lead, training, reporting and coordination**
Project Manager	Coordination and supervision, preliminary report, stakeholders briefing, data collection coordination and consultant field management
M&E Team	Technical supervision, data tools, methods sampling techniques
Project's Medical Officer	Field supervision and support to data collection
Torit Area Manager	Overall management supervision first approval of report
Health and Nutrition Manger	Technical guide and second approval of report
Project Team	Informants
Logistician	Logistical support
Procurement	Consultant Contract management
ACD-P	Final report approval

The following tables delineates the evaluation timelines and milestones during the evaluation process.

Table 6. Draft Evaluation timeline and milestones. *For an example of a completed evaluation timeline table,* click here.

Evaluation Activities	Week 1	Week 2	Week 3	Week 4	Week 5
Survey planning and Review of tools					
Travel					
Enumerators training					
Data collection and processing					
Data analysis and draft report					
Final Report submission					

The consultancy is estimated to take at most 20 working days

Budget

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A detailed budget to be provided by the consultant

Required External Response to Terms of Reference

A technical and cost proposal based on this Terms of Reference (ToR) is requested from the consultant or consulting firm. The proposal should contain:

1. Detailed plan of action for field work indicating staff-days required
2. Specific roles and responsibilities of the team leader, supervisory chain and other core members of the evaluation team.
3. Schedule of key activities preferably in a format such as a Gantt chart.
4. Detailed budget with justification. The external evaluation proposal should include a reasonable detailed budget to cover all costs associated with the evaluation. This should be submitted by major activities and line items for CARE's review and decision. This includes a break-down of the cost to the external evaluation team members, international and local travel, and in-country lodging and per diem. Other related costs that might be in the budget include expenditures for hiring local personnel (drivers, translators, enumerators and other local technical experts), translating reports, and renting meeting rooms for presentations/workshops.
5. Updated CV of Team Leader and other core members of the Evaluation Team
6. A profile of the consulting firm (including a sample report if possible)

7. Submission.

If you qualify please send your CV, and Technical proposal detailing survey methodology, work plan and budget. The Technical proposal with budget and CV should be send to Alex.Anyik@care.org. copying Robert.Amule@care.org and Geoffrey.Odongkara@care.org

Deadline for expression of interest is on 24th July 2018 before 3PM.