Terms of Reference for Mid-Term Evaluation Data Collection, Management, Analysis, and Reporting
SCOPE RMNCH South Sudan Midterm Evaluation:
LQAS, Health Facility Assessment, Key Informant Interviews, and Focus Group Discussions
February-August 2022

Introduction

The Strengthening Community Health Outcomes through Positive Engagement (SCOPE) Program is a New Partnership Initiative (NPI) cooperative agreement funded by the U.S. Agency for International Development (USAID). SCOPE aims to address key drivers of child and maternal morbidity and mortality at the community level in four priority countries (Haiti, Kenya, Malawi, and South Sudan) to contribute to the ultimate goal of ending preventable child and maternal deaths (EPCMD) within a generation. SCOPE is being implemented by World Relief (WR) and through a sub-grant partnership with Christian Connections for International Health (CCIH), who, through Christian Health Associations (CHAs), manages networks of large faith-based health/hospital systems in the project countries.

SCOPE is motivated by a vision of self-reliant countries equipped with technical capacity and tools at the lowest levels of the health system to reduce preventable maternal, newborn and child deaths. **Our objective is to make it easier for mothers and caretakers to adopt healthy behaviors and seek necessary care by shifting cultural, social and behavioral norms and expectations about family planning, maternal care, newborn care, and child health and nutrition.** By design, SCOPE is working through and with the collaboration of faith actors and key community members to do this work to improve service utilization at the community level. SCOPE also seeks to ensure that quality and accessible community health services are available for all mothers and children by working closely with the Ministry of Health (MOH) and the community-based cadres of health workers in each country.

The four countries engaged in the SCOPE project are USAID priority countries and represent a diversity of geographic, political, and cultural backgrounds. They are strategically important to realize the goals of preventing child and maternal deaths as they are major contributors to maternal and child mortality and the unmet need for family planning (FP). The SCOPE project's strategic objectives are: 1) to increase utilization of reproductive health services for women of reproductive age, and 2) to increase utilization of primary health care services by children under five years.

SCOPE's program started in October 2019, focusing on startup in each of the four countries in the first program year (October 2019 – September 2020). The SARS-2-COVID pandemic delayed many startup processes. The SCOPE baseline assessment took place between August and October 2020.

Overview of Intervention Design

Community health is a critical part of the primary care continuum to address people's health needs. Extending preventive, promotive, and curative health services into communities is critical for ensuring access to high-quality primary care. Community health can be defined in many ways, but for the purposes of this project, our definition includes the following:

- Health promotion and service delivery activities that occur primarily outside of a health facility
- Community health workers (CHWs) as one, but not the only, delivery channel

- Linkages to a broader multi-sectoral community system through faith-based channels (such as temples, mosques or churches) and community groups (such as Care Groups, Savings Groups, Couples Groups)
- Demand for health care, including activities that community members undertake as agents of their own health using social accountability mechanisms (community scorecards)

SCOPE is delivering interventions in the following technical areas:

1. Reproductive health and family planning
2. Maternal and newborn health
3. Child health

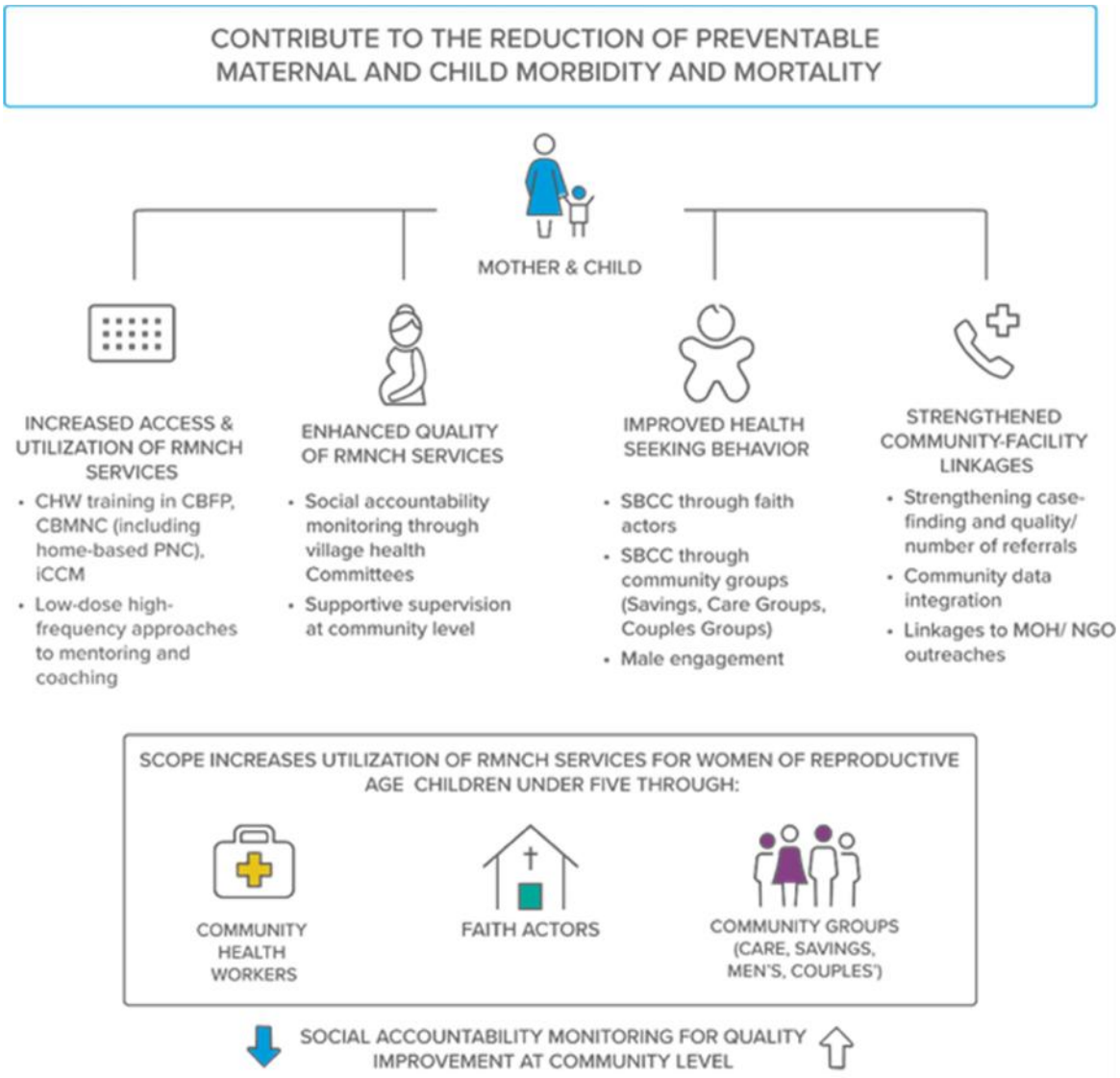


Figure 1: Overview of Intervention Design

Reproductive Health and Family Planning

FP increases maternal and child survival through healthy timing and spacing of pregnancy (HTSP) and by helping women and couples plan pregnancies during the healthiest time within a woman's reproductive

life cycle. A main objective of SCOPE is to increase the utilization of reproductive health services for women of reproductive age through community-based family planning.

Community-based family planning (CBFP) brings FP information and methods to women and men where they live rather than requiring them to visit health facilities. This approach increases access to and choice of contraceptive methods in underserved areas through a variety of channels, including CHWs and referrals to other providers of FP such as community depots, pharmacies, and the private sector. Community level access is key to accomplishing the goal of making the full range of modern FP methods available at the last mile. This approach requires a significant level of community ownership, because of the links between FP and many social norms, and because faith-based actors can either be a driver of or a barrier to acceptability of FP methods. The prevention of unintended pregnancies, especially amongst high-risk groups, is an important part of improving maternal newborn and child health (MNCH) outcomes. Lastly, integration of FP messages across the continuum of care during antenatal and postpartum periods, is also key to SCOPE's program activities.

Maternal and Newborn Health

Informed by findings from community-based maternal and newborn health (MNH) programs, SCOPE is implementing evidence-based interventions that directly address the major drivers of maternal and newborn mortality. Community Health workers (CHW) have been trained to conduct health promotion visits at the household and community level. This includes training on interpersonal communication (IPC), educational tools, job-aids, and appropriate adult education techniques to encourage pregnant women and family members with timed and targeted messages for routine antenatal care during pregnancy, safe motherhood and birth preparedness for delivery, and postpartum care including essential newborn care (ENC) practices with an emphasis on how to identify and manage emergencies if they occur.

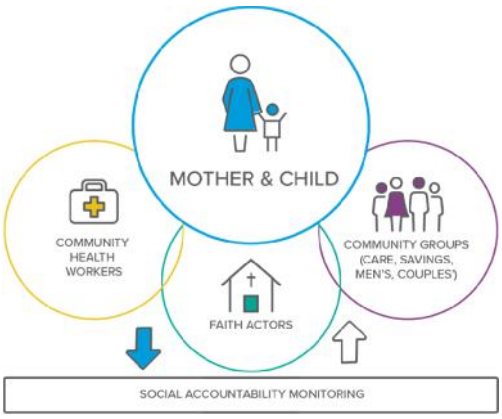
Child Health

The World Health Organization estimates that most of the world's remaining 6.6 million annual child deaths could be prevented with known interventions. Addressing the principal causes of child mortality after the newborn period—pneumonia, diarrhea, malaria and malnutrition—and improving the quality of community and facility-based care for infants and young children is key to reducing post-neonatal child mortality. SCOPE has trained CHWs and other community volunteers to teach caregivers to identify signs and symptoms of pneumonia, diarrhea, malaria and malnutrition, to identify children in need of immediate referral in South Sudan, Malawi and Kenya to assess and treat children with uncomplicated pneumonia, diarrhea and malaria.

Intervention Delivery Platforms

The SCOPE project uses the following three delivery mechanisms at the community level to implement interventions that impact the health of mothers and children, as illustrated in the graphic below (Figure 2). Each country is implementing a contextualized intervention package that considers existing MOH policies and strategies, health worker cadres at the community level, supervision and monitoring efforts already in place, and other related investments being made by USAID and other donors. The project is strengthening and leveraging faith actors, community groups and CHWs as frontline implementers of SBCC interventions for FP/MNCH and service delivery, as appropriate with specific national guidelines in each country.

Figure 2: Technical Delivery Platforms



Faith Actors

Faith communities and faith leaders play crucial gatekeeping and influencer roles in the success of community-based work in developing countries.[1] However, faith communities often lack the necessary skills and information to engage in helpful ways on health issues. Existing cultural and religious practices can also contribute to or further exasperate the issues that lead to poor health outcomes for the mother and child. Faith communities can even be the drivers of misinformation; thus creating barriers that prohibit people from visiting clinics, receiving vaccinations, or using birth spacing methods. The influence of faith communities and faith leaders is an essential component of efforts to address early marriage, combat harmful traditional practices, establish equitable treatment for women and girls, and overcome the stigma around male involvement in RMNCH. In South Sudan, World Relief has trained a total of 364 faith leaders in family life education who are currently cascading the lessons in communities.

Community Groups

Care Groups: Global evidence[2] has shown the effect of the Care Group (CG) Model for improved maternal and child survival outcomes. A CG is composed of 10-15 volunteer mothers who meet regularly for social behavior change communication (SBCC) and related skills building. Each volunteer mother shares short, simple lessons through home visits to 10-15 of her neighbors in nearby households. CGs reach target households with SBCC and link households to the maternal and child services they need. SCOPE project staff provide technical support to the CG Volunteers through training, supportive supervision and regular meetings. The CG volunteers report on child illnesses, death and pregnancy and provide referrals to MOH-appointed/approved CHWs who can feed vital information into existing health information systems. In some countries, the CG model has been modified to fit local contexts. By extending the reach of the CHWs and MOH all the way down to the household level, SCOPE is ensuring that even the most vulnerable members of the community know how and when to access services.

Savings Groups: Access to financial services—in addition to the range of other daunting economic challenges rural households face—stands as a significant barrier to achieving health outcomes, especially in times of medical emergencies. Even though services may be free within public sector facilities, a family may not have transportation to get to a facility for the birth or illness of a child, or to buy drugs or other auxiliary medical products needed for quality care. *Savings for Life* (SFL) is WR's model for Savings Groups. *SFL* empowers rural families—some of the most vulnerable in these communities—

by providing them with a savings and loan solution. Through *SFL*, 15-25 individuals form savings groups. Group members learn about basic money management, time management, and group management. Additionally, they help other members set money aside for health-related emergencies. SCOPE will leverage existing Savings Groups (or form new ones where none exist) to increase economic and financial resiliency for women of reproductive age, pregnant women and families of children under five. This work has not yet begun.

Couples Groups: Joint decision-making and increased couple communication around fertility intentions—including the number of children, spacing and timing of children—have proven effective at increasing contraceptive use[3]. Couple-focused interventions are a potentially valuable strategy to address communication and conflict management challenges and accelerate progress towards achieving reproductive health goals.[4] WR's program model for couple strengthening, *Families for Life,* promotes gender equality, couples' communication, and intolerance for gender-based violence through an innovative, locally-designed curriculum implemented in couples' groups. Existing couples' groups that local volunteers run will be leveraged and expanded to address fertility awareness, birth spacing, and joint decision-making for FP, based on evidence that increased spousal communication has positive effects on contraceptive use. This work will begin in Year 3 of the project.

Community Health Workers

Building on WR's years of experience working with CHWs, SCOPE project will work with the MOH and CHAs to train, equip, support, and mentor CHWs, including *Agent de santé communautaire polyvalent* (CHW) in Haiti, Community Health Volunteers (CHVs) and Community health extension workers (CHEWs) in Kenya, health surveillance assistants (HSAs) and Community Based Distribution Agents (CBDAs) in Malawi, and in South Sudan, SCOPE Project will work with SCOPE Health Promoters (SHPs), OPEN (local NGO), CHDs (County Health Department) and MOH . This work is underway in all countries.

In South Sudan, SCOPE has adapted a "Low Dose High Frequency" (LDHF) capacity strengthening approach for CHWs, proven successful for facility-based clinical health workers in RMNCH.[5] The LDHF approach, facilitated by CHW supervisors (usually clinical staff), includes a shorter hands-on training focused on adult-learning training approaches rather than a purely didactic training in a classroom environment. A series of regular mentoring/coaching sessions which includes practicing of SBCC skills, case scenarios, role-plays, and learning games is planned for the intervention arm. This training methodology is being piloted and studied in three Payams (Madebe, Ibba Centre, Manikakara) in Ibba County and one Payam (Maridi Central) in Maridi County, in Western Equatoria State, South Sudan to test the study objectives using a quasi-experimental (non-equivalent control group) design utilizing both qualitative and quantitative data collection methodologies to explore the differences between two groups of SCOPE CHWs.

Social Accountability Monitoring

Helping citizens engage with their local governments for improved accountability has become a significant interest of scholars and practitioners of international development over the past decade and is increasingly viewed as a critical part of addressing governance and scale.[6] Knowing that health systems issues that affect availability, quality, utilization and sustainability of health services are often impediments to quality and access to care, SCOPE will use social accountability monitoring to address quality of care. This work will begin in Year 4 of the project.

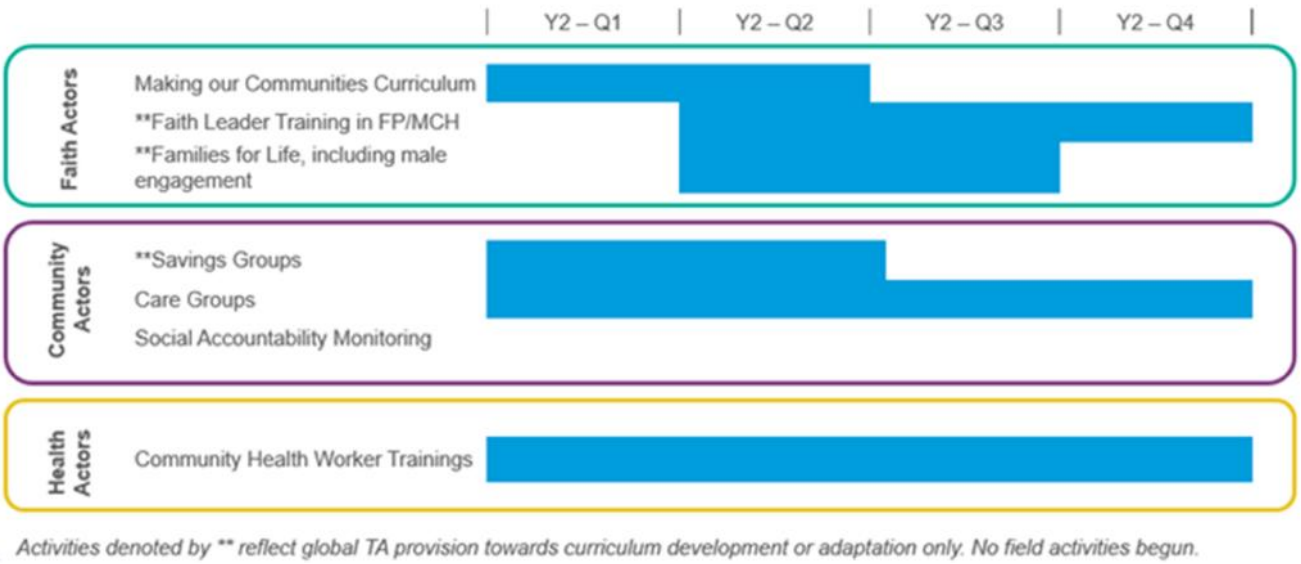


Figure 3: Field Activity Roll Out

Scope of Work for the Consultancy

The consultancy includes accurate sampling, data collection, data cleaning, data analysis, and reporting as outlined in full below. The methods for data collection include:

- Lot Quality Assurance Sampling (LQAS) of women of reproductive age, men in partnership with women of reproductive age, and community health workers for comparison to the baseline and the future endline, with population weighting. The survey indicators are listed in the table below, and the questions and tabulation rules are based on and adapted from the UNICEF MICS (Multiple Indicator Cluster Surveys) tools (https://mics.unicef.org/) and the Knowledge, Practices and Coverage Survey tool (https://coregroup.org/wp-content/uploads/2020/03/KPCFieldGuide_Sept03-2.pdf) as well as Indikit (https://www.indikit.net/). Community health worker questions are a custom design interview. Some of the indicators will show program outcomes, coverage, and/or quality. Data will also be used for decision making by program managers and supervisors.
- Rapid Health Facility Questionnaire and Field Visit guide has been developed, and a purposive sample of health facilities in the project areas will be visited to complete the questionnaire.
- Key Informant Interviews, to be conducted using the semi-structured questionnaire with a purposive sample of faith leaders and supervisory CHWs.
- Focus Group Discussions, to be conducted with mothers supported by the SCOPE program, male partners of mothers supported by the SCOPE program, and SCOPE community-based volunteers.

Below is a table of indicators for which data will be collected.

Increase utilization of reproductive health services for women of reproductive age		
MEL #	**INDICATOR**	**DEFINITION**
MEL 1	Modern Contraceptive Prevalence Rate amongst women of reproductive age in the target population	**Numerator**: Number of women of reproductive age married or in union who are currently using (or whose partner is using) a modern

		contraceptive method at a particular point in time **Denominator:** Number of women of reproductive age who are married or in union
MEL 2	Percent of the population in target geographic areas who are married or in union who report discussing family planning with their spouse in the past year	**Numerator:** Number of men and women who are married or in union who report discussing family planning with their spouse in the prior year **Denominator:** Number of men and women who are married or in union
MEL 5	Percent postpartum mothers of children ages 0-23 months counselled on birth spacing and postpartum contraception options	**Numerator:** Number of women who had a live birth in the reference period who were counseled on birth spacing and contraceptive options within the first 6 weeks after delivery **Denominator:** Number of women with alive birth in the same reference period
Increase frequency and quality of maternity care		
MEL #	**INDICATOR**	**DEFINITION**
MEL 7	Percent women in the target population with children 0 to 23 months attended at least 4 times for antenatal care during pregnancy	**Numerator:** Number of women ages 15 to 49 with live births who attended ANC four or more times during most recent pregnancy **Denominator:** Total number of women with live births within the reference period (for survey) or Number of pregnant women registered
MEL 8	Percent of births in health facilities to women with children 0 to 23 months in the target population	**Numerator:** Number of births reported by women ages 15 to 49 with live births in the reference period **Denominator:** Total number of live births
	Percent of live births with skilled birth attendants to women with children 0 to 23 months in the target population	**Numerator:** Number of live births attended by skilled health workers, as reported by women ages 15 to 49 with live births in the reference period **Denominator:** Number of live births in the sample
MEL 12	Percent of women in the target population with children 0 to 23 months receiving postpartum care from a skilled health provider within two days of childbirth	**Numerator:** Number of women ages 15 to 49 with a live birth in the reference period who had a postnatal check by a health provider during the first 2 days after giving birth **Denominator:** Number of women with a live birth in the reference period
Increase frequency and quality of newborn care		
	INDICATOR	**DEFINITION**
MEL 10	Percent of newborns born to women in the target population with children 0 to 23 months receiving immediate breastfeeding within one hour of birth	**Numerator:** Number of infants who were given breastmilk within the first hour of birth **Denominator:** Number of live births in reference period

MEL 11	Percent of newborns born to women in the target population with children 0 to 23 months who received postnatal care within two days of childbirth in SCOPE-supported programs.	**Numerator:** Number of newborns who receive postnatal care during first two days after childbirth. **Denominator:** Number of live births in the same reference period
	Percent of mothers of children 0-23 months who know at least 3 danger signs for newborn care	**Numerator:** Number of mothers ages 15 to 49 who report at least 3 danger signs for newborn care. **Denominator:** number of live births in the same reference period
Improve CHW coverage and performance		
	INDICATOR	**DEFINITION**
MEL 3	Percent of target population households assisted by CHWs reporting they have been provided FP information, referrals, and/or services during the year	**Numerator** Number of households surveyed who report that they have been provided FP information, referrals, and/or services in the last year **Denominator:** Number of households surveyed
MEL 14	Percent of target population households who received at least one visit from a CHW in the last three months	**Numerator** Number of households who received a visit from a CHW who provided health information, services, or referrals in the 3 months preceding **Denominator:** Number of households surveyed
MEL 15	Percent of target population households that completed the referral at the health facility (referral completion) in the last year	**Numerator:** Number of HHs referred by a CHW to a health facility who were received at the health facility **Denominator:** Number of HHs referred by a CHW to the health facility
MEL 16	Percent of SCOPE-supported CHWs who received supervision/coaching/mentoring in the last three months.	**Numerator:** Number of CHWs who received at least one visit from a supervisor during the reporting period. **Denominator:** Number of CHWs trained and deployed
CONTEXT 1	Percent of CHWs with all the key stock commodities in the last reporting period	**Numerator**: Number of CHWs who did not report a stockout of key supplies (as defined by country program) in the reporting period **Denominator**: Number of CHWs deployed

The table below lists the groups to be sampled and corresponding indicator groupings

TABLE 1: CLIENT–SURVEY CONTENT GROUPINGS	
GROUP	**SURVEY CONTENT**
Women of Reproductive Age	Exposure to messages about MNCH, gender, and FP Attitudes and gender norms about and use of modern contraceptives Experiences with CHW home visits and referrals Health care seeking

Men who are partners of Women of Reproductive Age	) Exposure to messages about MNCH, gender, and FP) Attitudes and gender norms about and use of modern contraceptives) Health care seeking
Group 1: Women with child 0 – 23 months	) Exposure to messages about MNCH, gender, and FP) Attitudes and gender norms about and use of modern contraceptives) Birth preparedness, antenatal care) ENC) Care seeking for sick newborn) Experiences with CHW home visits and referrals) Health care seeking
Group 2: Woman with child 24 – 59 months	) Exposure to messages about MNCH, gender, and FP) Attitudes and gender norms about and use of modern contraceptives) Care seeking for sick child) Experiences with CHW home visits and referrals) Health care seeking
Group 3: Community Health Workers	) Family planning information) CHW Supervision) CHW commodities
Health Facility Questionnaire	) Referral completion) Skilled birth attendance

The proposed catchment areas for the survey and the samples will comprise:

TABLE 1: CLIENT–SURVEY CONTENT GROUPINGS	
GROUP	**LOCATIONS/SUPERVISION AREAS**
Women of Reproductive Age	) Project Area 1 Ibba (Madebe, Ibba Centre, Manikakara)) Project Area 2 Maridi (Maridi Central Payam)
Men who are partners of Women of Reproductive Age	) Project Area 1 Ibba (Madebe, Ibba Centre, Manikakara Payams)) Project Area 2 Maridi (Maridi Central Payam)
Group 1: Women with child 0 – 23 months	) Project Area 1 Ibba (Madebe, Ibba Centre, Manikakara Payams)) Project Area 2 Maridi (Maridi Central Payam)
Group 2: Woman with child 24 – 59 months	) Project Area 1 Ibba (Madebe, Ibba Centre, Manikakara Payams)) Project Area 2 Maridi (Maridi Central Payam)
Group 3: Community Health Workers	) Project Area 1 Ibba (Madebe, Ibba Centre, Manikakara Payams)) Project Area 2 Maridi (Maridi Central Payam)
Health Facility Questionnaire	) Project Area 1 Ibba (Madebe, Ibba Centre, Manikakara Payams)) Project Area 2 Maridi (Maridi Central Payam)

Description of the Context

The Midterm Evaluation shall be conducted in the three Payams (Madebe, Ibba Centre, Manikakara) in Ibba County and one Payam (Maridi Central) in Maridi County, these counties are located in Western Equatoria State in South Sudan where the SCOPE Project is being implemented.

Goal of the Midterm Program Evaluation

The overarching goal of the Midterm Program Evaluation is to understand the intermediate effects of the SCOPE interventions in each country, assess if pre-determined targets have been achieved for key grant performance metrics in each country, and determine what actions should be taken going forward to maximize the effectiveness of the interventions. Of interest to the team are intermediate outcomes in focus behaviors, including intermediate shifts in social and behavioral norms related to FP and MNCH. Of note, the SCOPE team is also monitoring a) direct client exposure to messages on FP/MNCH and b) direct client experiences with SCOPE-supported community volunteers. At this stage of field activities, assessment of direct client exposure and experiences will provide the most useful information for SCOPE technical and field staff as we track project coverage, changes in intermediate outcomes, and changes in other health-related behaviors.

We will use mixed methods during this evaluation to assess the direct client experiences and the intermediate effects of the SCOPE interventions at the household and community level. For the midterm evaluations, quantitative methodologies will look at direct client dose/exposure to messaging on FP/MNCH, quality of CHW and CGV delivery, and direct client responsiveness to the interventions. The midterm survey is designed to examine steps in the results framework that precede the main measures of interest, such as intermediate shifts in social and behavior norms that have been promoted through the Care Group, CHW and Faith engagement activities.

The evaluation will also measure behaviors and social norms that *Families for Life (FFL*), *Savings for Life* (*SFL)*, and Social Accountability Monitoring interventions seek to influence, change in PY3, to provide a reference point for PY4 and beyond. It is anticipated that taken together the baseline, midterm program evaluations and the endline will provide the SCOPE project with an illuminating time-series data for RMNCH related behaviors, social norms and key outcome level performance indicators that should enable constructive review and adaptation of WR's core RMNCH approaches.

Objectives

There are three primary objectives of the midterm program assessments are:

1. Assess changes in key intermediate MNCH and FP relate behaviors in SCOPE direct clients and analyze against pre-determined indicator targets
2. Assess direct client exposure to the MNCH, FP and gender programming and messages.
3. Drawing on the findings of the assessments above, make recommendations for program improvement and/or adaptation.
    a. Describe aspects of intervention delivery platforms that are working well and what needs to be strengthened
    b. Despite challenges, document SCOPE project achievements to date

Consultancy Deliverables

The goal of the consultancy is to conduct the complete mid-term evaluation with the following deliverables:

- Sampling Framework Review and Finalization: Utilizing guidance from World Relief Technical Team and the SCOPE Country level team, finalize a sampling frame for review. Respond to questions from reviewers, and prepare as a final. This process should result in a country specific protocol that is approved and in place no later than April 6, 2022.
- Contextualize Data Collection Tools: Review the global tools and make any changes needed in the English versions to speak to the context of the country where the survey will be implemented. Examples of contextualization may include: tweaking responses to match titles or language used locally to mean the same things, etc. These changes should be made in track changes. Consultants should also review the proposed skip patterns. After this review in Word, the Global and country level tools for ODK will be shared for final review. This process should result in final data collection tools no later than April 8, 2022.
- Translate, back translate, and test tools: using the final version of the data collection tools, the Consultant will oversee a process of translation, back translation, and testing of the tools. This must be completed no later than April 21, 2022.
- Database for Data Entry and Analysis: The Consultant will present a database, formatted in preparation for data entry and appropriate indicator analysis for review no later than April 21, 2022. ***Data entry must be through ODK on tablets provided by WR; the database will be cloud-based in ONA.
- Kick-off Meetings: Facilitate a country level briefing with World Relief staff and community-level meetings, as needed, to introduce the midterm evaluation process and procedures to stakeholders. This will take place no later than April 28, 2022.
- Contract/hire personnel for data collection: The Consultant is responsible to recruit and hire enumerators and leads for the collection of quantitative and qualitative data, including the LQAS survey with guidance from World Relief (WR will provide the consultant any information in regards to the cost for enumerators, vehicle hire and accommodation), health facility visits, focus group discussions, and key informant interviews. The training for these enumerators will take place no later than May 6, 2022.
- Conduct Data Collection: In accordance with the Midterm Evaluation Protocol and agreed sampling frame, conduct data collection. During the data collection exercises, consultants may be observed by WR staff. Complaints or questions about data collection from WR or community-level partners must be documented and addressed to the satisfaction of WR and community-level partners. Data security and management is the responsibility of the consultant but must be done with regard to best practices for protection of individually identifiable data or sensitive information. Data collection should begin in May 2022 and should be completed no later than June 16, 2022.
- Quantitative Evaluation Reporting: Calculate average coverage values for all survey indicators for the supervision areas mentioned. These values will serve as new benchmarks for donor indicator and internal target setting for each indicator for the coming year. Consultants should prepare reports that align with guidance from the MCHP guide at this link and the KPC guidance in this manual. Raw data

(including field notes) from the quantitative data collection will be submitted to World Relief as part of the project finalization, and the complete digital raw data set should also be available to World Relief Malawi as soon as data is entered. Final KPC report document will be based on the guidelines given in the KPC field guide report chapter and comprise two sections:

- A table with breakdown of indicators scores in similar format to the baseline report to allow for estimation of progress, including a population weighted average coverage for the project areas. Analysis, discussion and comparisons should be based on these results and form the bulk of the KPC report.
- Confidence intervals need to be calculated and presented for all average coverage survey indicator results throughout the report.

For all targeted districts, the KPC data analysis will help assess community needs, public health priorities and the level of access to health services by the population. The quantitative data should be cleaned and made available to World Relief by June 30, 2022 and report first drafts due no later than August 10.

- Qualitative Evaluation: Focus group discussion, key informant interview, and health facility visit questionnaire data should be cleaned, analyzed, and reported in a narrative report that describes key themes, challenges, lessons learned, and recommendations. This narrative report can be a chapter in a longer report including the quantitative data. This report is due no later than August 10, 2022.
- Review and Finalization of Reports: The Consultant is expected to participate in reviews and revisions of the reports, and to answer queries or requests for additional data analysis. The Consultant will prepare the final report for presentation to the donor, with copy-editing, formatting, and photos, in the time period between August 10 and September 30, 2022.
- Presentation of Midterm Country Data: In September 2022, together with the World Relief country team, prepare a presentation of the midterm evaluation data and support the facilitation of a meeting at national (and, as needed, subnational levels). The Consultant's role in this meeting or workshop may vary from presenter to support roles, preparing materials, depending on the requests of the World Relief office.

General Requirements

The Consultant must be able to demonstrate experience with producing similar deliverables and activities and must provide at least two references for this work, to be contacted by World Relief (COUNTRY) technical staff. Examples of previous similar work should be linked or attached to the application. Applicants are requested to provide a letter outlining the ways that their firm meets the qualifications, a proposed plan for meeting the deliverables, and a proposed number of working days. There should also be a summary budget and a brief bio of each team member. The total application package (not including work samples) should not exceed 6 pages. Work samples should be an annex to the application. Qualifications for The Consultant include:

- Master's Degree or higher in a relevant field (e.g. Public Health) for the lead consultant.
- Extensive experience with baseline, midterm, and endline program evaluations and/or public health studies and applied statistics in developing countries.
- Extensive knowledge and experience using quantitative representative statistical sampling methodologies in general and LQAS in particular and preferably conducting KPC surveys in

developing countries.

- Extensive knowledge and experience implementing health facility field visits and assessments.
- Extensive knowledge and experience conducting focus group discussions and key informant interviews.
- Experience providing training for data collection with enumerators.
- Experience using data analysis software such as SPSS, STATA, Access or EPI info.

World Relief has sole ownership of all data and any findings shall only be shared or reproduced with the permission of World Relief. Please also note that the contents of the report will be analysed by World Relief's assigned staff, and final payment will be made only upon acceptance of final report by World Relief SCOPE leadership. A KPC survey report completeness checklist will be used to ensure report is complete and meets international standards.

Timeline

1. The assignment is expected to commence on **April 1, 2022**.
2. Consultants should estimate a **maximum number of working days of less than 120 days** in their applications, which includes preparation time, data collection in the field and deliverables as outlined above.
3. The final report must be submitted no later than **31 August 2022**.

Application Process

All interested/qualified experts/ expert firms are requested to submit their applications by close of business (16:30Hrs, CAT) on **Friday 25th March 2022** in tender box or sstenders@wr.org copying EMunyenge@wr.org. World Relief Office Hai Cinema next to MAF Office and Ministry of Water and Irrigation. The tender documents must be submitted on company letterhead and signed, stamped by the bidder and sealed envelope do not write or indicated your company name on the envelop only the RFQ no. (RFQ: WR-SSPT-2022-17) on envelop and subject. **It is highly recommended that all applications be submitted electronically**.