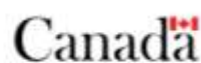
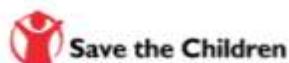




A public-private partnership dedicated to prioritizing the prevention of preterm birth

2020 FINAL PROJECT EVALUATION

TERMS OF REFERENCE



1.0 OVERVIEW OF REQUEST FOR PROPOSAL

The Consultant(s) will serve as the lead coordinator for the Final Evaluation of Born on Time (BOT), an MNH/SRHR project implemented in Bangladesh, Ethiopia and Mali. A project baseline survey was conducted in 2016-2017, followed by a midterm Quality of Care (QoC) study and rapid qualitative assessment in 2018-2019. Nearing the end of the project, the Born on Time consortium is now seeking a qualified consultant(s) to coordinate a multi-country Final Evaluation of its three implementing countries, in partnership with Country Study Leads (CSLs).

The Consultant(s) will be responsible for overseeing all aspects of the Final Evaluation, including: technical oversight of local CSLs; study design and methodology; enumerator training, data collection and quality assurance; data entry, transcription and analysis; and report writing. The main objective of the consultancy is to produce three individual country evaluation reports, and one summary report, for use by BOT consortium members, project implementers, partners, stakeholders, and donors.

2.0 PROGRAM OVERVIEW

Born on Time is a public-private partnership focused on prioritizing the prevention of preterm birth. This CAD\$30 million initiative brings together expertise and resources from World Vision Canada, Plan International Canada, Save the Children Canada, the Government of Canada and Johnson & Johnson. Working closely with local governments and stakeholders, the partners are working to improve newborn survival, with a focus on preventing preterm birth in high risk areas of **Bangladesh, Ethiopia and Mali** over five years (2016-2020). The initiative specifically addresses risk factors that can lead to preterm birth: Lifestyle, Infection, Nutrition and Contraception (LINC). Now in its fourth year of implementation, BOT is conducting a series of interventions that work towards the following intermediate outcomes:

1. Improved availability of quality, gender-responsive/ adolescent-friendly maternal, newborn and reproductive health services to prevent and care for preterm births among adolescent girls and women of reproductive age (WRA);
2. Increased utilization of quality, gender-responsive/adolescent-friendly maternal, newborn and reproductive health services to prevent and care for preterm births among adolescent girls and WRA;
3. Enhanced utilization of evidence-based, gender-specific information on preterm birth data for decision-making at various levels of the health system

Born on Time's ongoing activities and expected outcomes are closely linked to and supported by both national and global policies and strategies related to maternal and newborn health (MNH), sexual and reproductive health (SRH), and gender equality and empowerment of women and girls for the achievement of better MNH/SRH outcomes. At a global level, the project contributes to outcomes under Sustainable Development Goals (SDGs) 3 and 5, as well as to efforts guided by the 2016-2030 *Global Strategy for Women's, Children's and Adolescents' Health* and the 2014 *Every Newborn Action Plan*. And at a country level, the project's activities support the national MNH/SRH

policies, strategies and sector plans of the Governments of **Bangladesh, Ethiopia** and **Mali** respectively.

In order to reach the most vulnerable populations within each country, BOT has targeted the sub-national regions with some of the highest rates of newborn death; these include the Rangpur division of Bangladesh; the Amhara region of Ethiopia; and the Sikasso region of Mali. Across these project locations, BOT aims to reach over 2 million direct beneficiaries, through various SBCC interventions and by equipping and building the capacity of 10,000+ health care providers and 1,030 health facilities.

Table 1: Maternal, perinatal and child health indicators for BOT implementing countries

Indicator	Bangladesh ¹	Ethiopia ²	Mali ³
Live births	3,110,000	3,579,000	758,000
Under 5 mortality per 1000 live births	30	55	101
Neonatal mortality per 1000 live births	17	28	33
Still birth rate (per 1000 total births)	25	30	32
% of U5 death due to prematurity	19%	15%	1112%
% of neonatal deaths due to prematurity	30%	26%	30%
Preterm birth rate per 100 live births	19	12	12
Deaths from complications of preterm births	26,600	23,100	9170
Antenatal Care (ANC) attendance (4 visits)	31%	32	43%
Skilled birth attendance	33%	28	67%
Maternal Mortality Rate (MMR) per 100,00 live births	173	401	562

2.1 BOT CONSORTIUM

World Vision Canada, Plan International Canada and Save the Children Canada have a history of working in Public-Private Partnerships (PPP) for innovative financing and collaborative initiatives, including MNCH, HIV/AIDS, child protection and education projects. For Born on Time, World Vision Canada serves as the consortium lead, with Plan International Canada and Save the Children Canada as implementing partners. Implementation of BOT activities in the target countries has been divided between the three consortium partners: World Vision leads implementation in the Amhara region of Ethiopia; Save the Children leads implementation in the Sikasso region of Mali; and Plan International leads implementation in the Rangpur division of Bangladesh.

To address challenges and promote positive behaviour change with regards to LINC factors, towards the prevention of preterm birth, activities implemented across the consortium include:

- Training and capacity building of facility-based health care providers to deliver gender-responsive, adolescent-friendly, comprehensive MNCH and SRHR services, including family planning, referrals, and supply chain management;

¹ Source: WHO MNCAH platform (2018) except live births, deaths from complications of preterm births and preterm birthrate (from the Every Preemie SCALE, May 2019)

² 2016 Ethiopia DHS Survey, Countdown 2030 Ethiopia country profile, Ethiopia MNCAH platform

³ Sources: 2018 Mali DHS Survey; *Every Preemie Scale*, 2017 country profile; Mali national MNCAH platform.

- Provision of supplies, equipment and job aids to support service delivery;
- Training and capacity building of community health workers on gender-responsive and adolescent-friendly service provision, including SBCC;
- Strengthening community based systems and structures in order to create an enabling environment to reduce the high burden of preterm birth;
- Awareness raising at the community level, to increase knowledge and promote behavioral change on risk factors for preterm births (e.g. uptake of family planning services (i.e. promoting birth spacing), and prevention of child, early and forced marriage (CEFM)), facilitate appropriate referral systems, and to promote ANC visits through CHWs door-to-door counseling , community groups (i.e. group session with women, mothers-in-law, influential leaders, men, adolescent girls and adolescent boys) and mass information and communication methods (radio spots, public/community gatherings/events, etc);
- Empowering women and girls to access gender-responsive/adolescent-friendly MNH/SRH as well as engaging men and boys as active partners of change for gender equality and improved MNH/SRH support for women and girls;
- Strengthening health governance and information management towards evidence-based decision making and responsive action planning; and
- Supporting increased knowledge and evidence on approaches to prevent and care for preterm births through research initiatives.

2.2 BANGLADESH

Every year in **Bangladesh**, 604,000 babies are born too soon and 23,600 children under five die due to direct preterm complications.⁴ In addition, the preterm birth rate in **Bangladesh** is 19% (babies born <37 weeks),⁵ the low birth weight rate (babies born <2,500g) is 22%,⁶ and annually, 22,000 babies are born before 28 weeks gestation.⁷ When considering the LINC factors related to preterm birth, health-related issues and gender-based barriers, the following are prevalent challenges for pregnant women and adolescent girls in **Bangladesh**: a lack of maternal rest, heavy workload, intimate partner violence (IPV),⁸ and exposure to indoor air pollution; Urinary Tract Infections (UTIs), which are the highest reported problem during pregnancy; inadequate dietary diversity, low maternal height and/or maternal weight; child, early and forced marriage (CEFM), early

⁴ Every Premie Scale Bangladesh Country Profile (updated May 2019): https://www.everypreemie.org/wp-content/uploads/2019/07/Bangladesh_7.5.19.pdf;

⁵ Chawanpaiboon, Vogel et al. Global, regional and national estimates of levels of preterm birth in 2014: a systematic review and modelling analysis. *Lancet Glob Health*. 2019. Data sourced from WHO, Global Preterm Birth Estimates: see: <http://ptb.srhr.org/>

⁶ Every Premie Scale Bangladesh Country Profile (updated May 2019): https://www.everypreemie.org/wp-content/uploads/2019/07/Bangladesh_7.5.19.pdf

⁷ *Ibid.*

⁸ It should be noted that the BOT consortium does not classify intimate partner violence as a “lifestyle.” Intimate partner violence is classified as a “maternal stressor” linked to preterm birth, as “it has been hypothesized that physical and psychological stress acts through inflammatory pathways involving maternal cortisol to cause premature birth.” For more information, see WHO, *Born Too Soon* (2012), pg. 39 – 40.

sexual debut and early pregnancy (i.e. 30% of adolescent ages 15-19 have begun child bearing, and the median age at first marriage among women in Rangpur is 15.3 years).⁹

2.3 ETHIOPIA

In Ethiopia, an estimated 3,148,388 babies are born each year; 12% are born too soon,¹⁰ and preterm births account for 11% of all under-five deaths. Additionally, approximately 95,000 newborns die each year in Ethiopia and preterm birth complications are responsible for 26% of these deaths. Saving premature babies is critical to achieving Ethiopia's goal of reducing under-five mortality. When considering the LINC factors related to preterm birth, the following are prevalent challenges for pregnant women and adolescent girls in Ethiopia:¹¹ near ubiquitous use of solid fuel for indoor cooking, alcohol consumption; intimate partner violence; heavy workload, malnutrition, anemia and underweight status, especially among adolescent girls; early sexual debut and childbearing, limited birth spacing practices, and unmet need for family planning particularly among young adolescents (i.e. adolescent birth rate is 71 births per 1000 girls; and demand for FP is satisfied among only 35% of girls ages 15-17).

2.4 MALI¹²

Mali has a preterm birth rate of 12 per 100 live births;¹³ in the Born on Time intervention area of Sikasso, the preterm birth rate is even higher at 13.1 per 100 live births. Over half of the preterm births in the Sikasso region (61.5%) occur in the five health districts targeted by the project. As of 2017, preterm birth accounted for 30.0% of the neonatal mortality rate in Mali (35 per 1,000 live births) and 11.8% of the U5M rate (106 per 1,000 live births). Many of the risk factors linked to preterm birth are prevalent across Mali and include lifestyle factors, health-related issues, and gender-based barriers, specifically: heavy workload, intimate partner violence; and increased risk of infection from HIV or other STIs particularly in polygamous unions; widespread risk of malaria, with strong insecticide-treated bed net (ITN) coverage and moderate uptake of intermittent preventive treatment (IPTp) among pregnant women; anemia among WRA 15-49; high prevalence child, early and forced marriage, early pregnancy and a low contraceptive prevalence rate (at 20.1% in Sikasso).

3.0 EVALUATION OBJECTIVES

The overall objective of the **Final Evaluation** is to conduct a robust and objective study in order to assess the project's performance vis-à-vis expected outcomes within the Performance Measurement Framework (PMF), and vis-à-vis the *DAC Criteria for Evaluating Development Assistance*. More specifically, the objectives of the study are to:

⁹ Bangladesh DHS, 2014.

¹⁰ Lancet, 2018.

¹¹ The following observations and associated data points are sourced from the Ethiopia Demographic and Health Survey, 2016.

¹² All figures in this sub-section are sourced from the Mali Demographic and Health Survey 2018: <https://dhsprogram.com/what-we-do/survey/survey-display-517.cfm>.

¹³ Healthy Newborn Network: <https://www.healthynewbornnetwork.org/resource/database-global-and-national-newborn-health-data-and-indicators/>.

- Assess the BOT project's performance vis-a-vis the *DAC Criteria for Evaluating Development Assistance*: relevance, effectiveness, efficiency, impact and sustainability. Furthermore, this evaluation of the project's performance should:
 - Assess the BOT project's achievements vis-à-vis intended outcomes, referencing baseline results
 - Assess the BOT project's achievements in addressing social and gender equality dimensions and barriers related to: access to health services, use of health services, and LINC factors
- Assess the efficiency of the BOT consortium, and examine the extent to the consortium partnership and innovation contributed to the results obtained
- Review best practices in project implementation, and subsequently generate specific recommendations for each country and/or across the project to guide future program management and design
- Explore unintended outcomes of BOT activities, or successes that stem from the project expanding beyond its original scope

Born on Time consortium members (World Vision, Save the Children, and Plan International staff in Bangladesh, Ethiopia, Mali and Canada), implementing and technical partners, and donors (Global Affairs Canada, Johnson & Johnson) will be the major users of the evaluation results. In addition, key stakeholders in project countries such as government line ministries/departments, partner NGOs, local authorities, and communities are interested parties of the findings.

4.0 SCOPE OF THE FINAL EVALUATION

4.1 STUDY SCOPE

In order to achieve the evaluation purpose and objectives, the Final Evaluation will include primary and secondary data collection to assess progress against all indicators included in the BOT PMF, as well as to respond to the Evaluation Criteria listed in Section 4.2 below (*Relevance, Effectiveness, Efficiency, Impact and Sustainability*).

Indicators for **expected outcomes** in the BOT project include:

4.1.1 INTERMEDIATE OUTCOME INDICATORS

- % of mothers, and percentage of babies, who received PNC within two days of childbirth
- % of live births attended by skilled health personnel
- % of WRA who attended ANC at least four times during pregnancy by skilled provider
- % of WRA who were relieved of labour-intensive work in the months before delivery
- % of pregnant women that take recommended number of iron supplements during pregnancy
- % of WRA sleeping under insecticide-treated bed nets during pregnancy
- % of WRA who are currently using a modern method of contraception
- Extent to which facilities use data to track performance in maternal and newborn health services
- Extent to which local-level plans integrate preterm and gender-specific information

4.1.2 IMMEDIATE OUTCOME INDICATORS

- Extent to which health facilities have achieved gender-responsive standards in providing MNH/SRH for WRA
- Extent to which health facilities have achieved adolescent-friendly standards in providing MNH/SRH for WRA
- Extent to which health facilities have achieved quality standards in providing ANC services for WRA
- % of adolescents, WRA and their male partners that were highly satisfied with facility-based MNH/SRH services
- % of health facilities that utilize environmentally safe waste disposal methods
- % of health facilities providing screening for UTI during ANC
- % of facility-based HCPs who knew at least 2 key standards of gender-responsive and adolescent-friendly service provision
- % of facility-based HCPs who knew at least 4 risk factors for preterm birth
- % of women who were visited by a community health worker for prenatal counseling at least once in each trimester during their last pregnancy
- % of CHWs who knew at least 2 key standards of gender-responsive and adolescent friendly service provision
- % of CHWs who knew at least 4 risk factors of preterm birth
- % of WRA and male partners who know at least 2 danger signs during the continuum of care
- % of WRA and their male partners who know at least 4 risk factors for preterm births
- Average level of knowledge of WRA and their male partners on key gender equality messages related to MNH/SRHR
- % of male partners who consider a husband to be justified in hitting or beating his wife
- % of WRA who received a high level of support from their male family members for the utilization of MNH/SRH services
- % of WRA and their male partners who report equitable decision making power within the household in relation to seeking health care information and services for WRA or their newborns
- % of leadership positions in organized community groups occupied by women members
- % of CHC that have action plans for healthy pregnancy, delivery and care for the newborn that are gender-responsive and adolescent-friendly
- Extent to which facilities regularly maintain records, including preterm related data
- % of facilities that are sharing data, including preterm related data and sex-disaggregated data, with government stakeholders
- Extent to which preterm related data and best practices are disseminated at local, national and global levels

4.1.3. GENDER EQUALITY INDICATORS

Questions exploring the following topics related to **gender equality** are also expected to be included in the Final Evaluation, with analysis by age and sex of respondents:

- Marital status of respondents

- Type of support provided by male partner to WRA during, before and after childbirth
- Distribution of decision-making between WRA and their partners
- Women’s skills/abilities and opportunities related to making community-level decisions
- Male partners’ level of support towards their female partners’ participation in community groups/committees, assumption of leadership roles in those fora, as well as in community level decision making
- Level of decision-making/participation of women in committees, and associated barriers
- Distribution of productive and reproductive labour between WRA and their partners
- Attitudes towards intimate partner violence

4.2 EVALUATION CRITERIA

The following key questions will guide the Final Evaluation’s assessment of the project against the *DAC Criteria for Evaluating Development Assistance*.

- **Relevance:** *The extent to which the project was suited to the priorities of the target beneficiary group(s), stakeholders, and to the donor.*
 - To what extent are the outcomes of the project still valid to project stakeholders and beneficiaries (i.e. WRA (15-19 and 20-49), male partners, children and families; community members; health care providers; government officials; etc.)?
 - Was the project relevant to the needs of these beneficiaries, as identified at project the inception/design stage?
 - Were the project approaches and methodologies appropriate to the respective socio-cultural and institutional context(s)?
 - Were the implemented activities and achieved outputs of the BOT project consistent with the intended impacts and effects?
- **Effectiveness:** *The extent to which the project attained its outcomes.*
 - To what extent were the outcomes achieved?
 - How did the project contribute to the achievement of these outcomes?
 - How have the project’s implementation strategies, tools, unique partnerships and innovations contributed to project results?
 - What were the major factors influencing the achievement or non-achievement of the outcomes?
- **Efficiency:** *The extent to which the project used the least costly resources possible in order to achieve desired results, considering inputs in relation to outputs.*
 - Were resources effectively utilized?
 - Were outputs achieved on time and on budget?
 - What were the strengths, weaknesses, opportunities and threats to the project implementation process?
 - Did the project activities overlap and/or duplicate other similar interventions, funded nationally and/or by other donors?
 - To what extent did the project collaborate with consortium, national and sub-national partners and stakeholders (technical, advocacy, funding, etc.) to achieve results?

- **Impact:** *The positive and negative changes produced by the project, directly or indirectly, intended or unintended.*
 - What has happened as a result of the BOT project – either as intended or unintended, positive or negative?
 - According to beneficiaries, what difference has the project made in their lives?
 - How many people have been affected?

- **Sustainability:** *The extent to which the benefits (outputs, outcomes) of the project are likely to continue after donor funding has been withdrawn.*
 - What is the likelihood of continuation and sustainability of project outcomes and benefits after completion of the project?
 - What commitments (financial, human resources, etc.) have been made by stakeholders to maintain or improve results?
 - How will improvements in stakeholder knowledge, attitudes, capacities, etc., if observed, contribute to maintaining results?
 - To what extent is support available from the external environment to maintain or improve results?
 - What are the major external factors that may influence, positively or negatively, the sustainability of the project results?
 - To what extent has the project’s design, implementation, stakeholder management, etc. contributed to the sustainability of project results?
 - To what extent have the project exit strategies and approaches to phase out activities contributed and/or hindered the sustainability of results?

An assessment responding to these key evaluation questions is expected **for each BOT implementing country (3)**, as well as in summary for the BOT consortium overall. Key questions will be further adapted and prioritized by each country to reflect unique implementation modalities, contextual factors, local strategies and partnerships, and areas of programmatic interest.

5.0 EVALUATION METHODOLOGY

The **Final Evaluation** will be a summative evaluation, employing a non-experimental, mixed method design towards pre-post analysis.

To meet the stated evaluation objectives, assess project performance and respond to evaluation questions, quantitative analysis is expected to compare baseline (pretest) and endline (post-test) values with statistical rigour; and qualitative analysis should adequately complement and triangulate quantitative findings to assess BOT project contributions to observed outcomes.

5.1 DATA COLLECTION METHODS

As one of the specific objectives of the evaluation is to assess the effectiveness of the project, the Consultant(s) will measure the achievement of outcomes by comparing results to project baseline, and to some extent, midterm studies. The Final Evaluation will include the core components of:

- A **household survey**, wherein primary respondents are women of reproductive age (WRA), 15 – 49 years of age, with a live birth in the 24 months (index child) preceding the survey. In

households that meet this inclusion criteria, a questionnaire will also be administered to **male partners** who were present during the most recent pregnancy.

- A **health facility assessment** including interviews with key informants (health facility staff) on facility staffing and capacity, service provision, and data management; observations of facility infrastructure and supplies; and client exit interviews with adolescent girls and boys seeking SRH services, on satisfaction and service utilization.
- An **adolescent survey**, wherein primary respondents are adolescent girls and boys, ages 15 – 19, unmarried and nulliparous, who have participated in adolescent groups formed under the Born on Time project
- A **secondary data review**, including project monitoring data, health facility records, and local governance committee plans and records.

Additional inclusion or exclusion criteria may be introduced as appropriate for the context and/or unique programmatic elements in each BOT implementing country.

Additionally, the Consultant(s) will be expected to employ various **qualitative methods** in order to achieve the objectives of the evaluation, including assessment of the project vis-à-vis the *DAC Criteria*. It is expected that these will be participatory in nature and may include: focus group discussions; key informant interviews; etc.

The Consultant(s) is expected to propose additional data collection methods as appropriate for the objectives and scope of the Final Evaluation.

5.2 SAMPLING STRATEGY

The Final Evaluation is expected to employ a non-experimental design, towards pre-post analysis within the intervention area(s). For more information on the population of interest in the intervention area, see **Annex 1**. A representative sample is expected to be collected in each BOT implementing country for the household survey and health facility assessment.

5.2.1. HOUSEHOLD SURVEY

Considering the expansive geographic coverage of each of the BOT implementation areas in Bangladesh, Ethiopia and Mali, it is expected that the household survey will be conducted using a random multi-stage cluster sampling method to ensure cost-effectiveness and efficient survey implementation, as was done at baseline. It should be noted that translated household questionnaires have already been developed in each country, and piloted and used at baseline.

As the Final Evaluation will include a pre-post analysis, sample size estimates for the household survey should be determined using a power-based calculation, with the following formula:

$$n = D \frac{(Z_{\alpha} + Z_{\beta})^2 (P_1 (1 - P_1) + P_2 (1 - P_2))}{(P_2 - P_1)^2}$$

Here,

- D = design effect of 2¹⁴
- P_1 = the estimated level of the indicator at baseline (see Table 2)
- P_2 = the expected level of the indicator at endline (see Table 2)
- $Z_\alpha = 1.96$
- $Z_\beta = 0.84$

Further to this calculation, an additional 15 percent sample of households is expected to be included in the estimate to address non-respondents or incomplete questionnaires. The following table may inform the sample estimation for each country:

Table 2: Information for sample size estimation

Country	Suggested indicator ¹⁵	WRA, 15 – 49 years		
		Baseline Value	Endline value ¹⁶	Expected difference
Bangladesh	% of live births attended by skilled health personnel	67%	74%	7 percentage points
Ethiopia	% of WRA who are currently using a modern method of contraception	44%	51%	7 percentage points
Mali	% of live births attended by skilled health personnel	12%	20%	8 percentage points

It is expected the sample for WRA 15-49 will be proportionately distributed by age group: that is, for WRA 15-19 years and 20-49 years, respectively.¹⁷

In order to maintain a level of effort appropriate for male partners as a *secondary respondent* at sampled households, and acknowledging that eligible households may not have a male partner available at the time of this survey, we recommend that the target sample size for male partners be equivalent to 90% of the overall target for WRA, wherein interviews may be conducted with male partners (with a child under 24 months), at any eligible household.

The sampling design should be finalized, and sample size estimation presented, by the Consultant(s) in the proposal; competitive proposals should also include an overview of the estimated *level of effort* (i.e. total # of household visits) and any specific strategies for achieving the target sample size for sub-groups, i.e. WRA 15-19 with a live birth in the last two years, male partners, etc.

Please see **Annex 1** for more information about the population of WRA in BOT intervention area(s).

¹⁴ While a design effect of 2 is recommended for multi-stage cluster surveys, exact DE may be calculated per country.

¹⁵ Indicators have been suggested according to expected differences between baseline and endline for coverage indicators monitored under BOT (see section 4.1.1) and accordingly, feasibility of / level of effort required to achieve sufficiently powered sample(s).

¹⁶ Endline values are estimated using project targets set in the BOT PMF.

¹⁷ Note: No specific sampling strategy is expected to be applied to ensure proportionate distribution of male and female index children.

5.2.2. HEALTH FACILITY QUESTIONNAIRE

A parallel, stratified random sample of health facilities is expected to be drawn from the same clusters¹⁸ where the household survey is administered, to ensure cost-effectiveness and efficient survey implementation. Here, strata will include *facility type*. Sample size estimates for the health facility questionnaire should be determined using the following formula:¹⁹

$$n = D \frac{(Z^2 * p * q) + ME^2}{\frac{(ME^2 + Z^2 * p * q)}{N}}$$

Here,

- D = design effect of 1.2
- Z² = square of normal deviate at the required confidence level; at 95% confidence, ∴ 1.96² = 3.84
- ME = margin of error, 15%
- p = proportion of facilities with the attribute of interest, estimated at 50% for maximum effect
- q = 1 – p
- N = population size (number of health facilities in the sampling frame)

The sampling design should be finalized, and sample size estimation presented, by the Consultant(s) in the proposal. Please see **Annex 1** for further information on health facilities in BOT intervention area(s).

As noted in Section 5.1, qualitative client exit interviews will be conducted with nulliparous adolescent boys and girls, ages 15 – 19 years, on their utilization of and satisfaction with facility-based SRH services. Sampling size estimations for adolescent client exit interviews should be presented by the Consultant(s) in the proposal.

5.2.3. ADOLESCENT SURVEY

A parallel, multi-stage random sample is expected to be drawn from the same clusters²⁰ where the household survey is administered, to ensure cost effectiveness and efficient survey implementation. It should be noted that translated adolescent questionnaires have already been developed in Mali and Bangladesh, and piloted and used at the beginning of the project. Sample size estimates for the adolescent survey should be determined using the following formula:

$$n = D \frac{z^2 p(1-p)N}{ME^2(N-1) + z^2 p(1-p)}$$

Here,

- D = design effect of 2
- Z = standard variate at a given confidence level, i.e. 95 percent
- ME = margin of error, 5%

¹⁸ If required, additional near-by facilities may be selected to achieve the target sample size.

¹⁹ WHO Service Availability and Readiness Assessment (SARA), Implementation Guide, 2015, Chapter 2, *Annex 1: Calculating the sample size for SARA*.

²⁰ If required, additional near-by adolescent groups may be selected to achieve the target sample size.

- p = proportion of respondents with the attribute of interest, estimated at 50% for maximum effect
- $q = 1 - p$
- N = population size (adolescent group members)

The sampling design should be finalized, and sample size estimation presented, by the Consultant(s) in the proposal. It is recommended that separate samples be drawn for male and female participants. Please see **Annex 1** for further information on BOT adolescent group membership.

5.2.4 QUALITATIVE METHODS

As a means of ensuring an in-depth understanding and context to the data gathered through quantitative means, and to gather the perspectives, attitudes and lived experiences of beneficiaries, the Consultant(s) is expected to make use of various qualitative techniques such as: focus group discussions (FGD), key informant interviews (KII), in-depth interviews and case studies, among others.

It is expected that qualitative methods will be conducted using a non-random, purposive sampling method, towards data saturation in the overall intervention area for each BOT implementing country; and that for the purpose of overall efficiency in survey implementation, this purposive sample may be drawn from the same clusters where the household survey is administered, when appropriate.

Focus group discussions are expected to be conducted with the following respondent groups:

- Adolescent girls, 15 – 19; currently pregnant or with a child <2 years of age
- Adult women, 20 – 49; with a child <2 years of age
- Male partners, 15+; married; with a child <2 years of age
- Elder women (i.e. mothers-in-law, etc.)
- Adolescent girls, 15 – 19; unmarried; nulliparous
- Adolescent boys, 15 – 19; unmarried; nulliparous

Key informant interviews are expected to be conducted with project stakeholders including, but not limited to:

- Facility-based health care providers
- Community health workers
- Religious and traditional leaders
- Community leaders, including women leaders
- Local government officials
- Health governance committee members
- Project implementing partners
- Project staff

Any additional qualitative methods should be proposed, sampling design for all qualitative methods should be finalized, and sample size estimations should be presented, by the Consultant(s) in the proposal.

5.2.5. SECONDARY DATA

In order to meet the evaluation objectives and respond to all evaluation criteria (Section 4.2), the data from the following secondary sources is expected to be collected:

- Project documentation
- Health facility records
- Local governance committee plans and records
- National health management information systems (HMIS)
- Community health worker registers

Additional secondary data sources may be recommended by the Consultant(s) in the proposal.

6.0 PURPOSE AND OBJECTIVES OF THE CONSULTANCY

The Consultant(s) will serve as the lead coordinator for the three-country Final Evaluation of the BOT project, and will be responsible for overall management, study design and methodology, technical oversight Country Study Leads (CSLs), supervision of data collection and entry/transcription, analysis of all data, and report writing.

Specifically, the roles and responsibilities of the Consultant(s) are to:

- Orient local study teams in each of the three (3) BOT implementing countries
- Review project documents including but not limited to: Logic Model, Performance Measurement Framework, Project Implementation Plan (PIP), Gender Equality Assessments, Gender Equality Strategy, project reports, baseline and midterm study reports, research reports, etc.
- Determine sampling strategies and sample sizes
- Review and revise existing data collection tools, and develop new data collection tools as required
- Develop data quality protocols to guide data collection / entry, including spot checking protocols;
- Work with BOT partner Country Offices, and CSLs, to obtain necessary ethics approvals
- Submit an Inception Report, including full study protocol(s), ethics approvals, field work plans, and risk mitigation strategies
- Support and jointly facilitate enumerator trainings
- Lead data collection for various qualitative methods, as strategic and appropriate
- Provide technical oversight of CSLs for data collection, including quality control, supervision and spot-checking, either in-person or remotely;
- Provide oversight to ensure that all study activities are gender-responsive, adolescent-friendly, and respect child safeguarding principles
- Verify, process and analyze all raw data;
- Write draft and final evaluation reports, incorporating feedback from BOT partners

- Present findings to BOT partner staff and stakeholders (in Bangladesh, Ethiopia, Mali and Canada), either in person or remotely

For responsibilities listed above, the Consultant(s) will work in collaboration with BOT Country Office staff and Canada-based staff as appropriate.

6.1 Country Study Leads (CSLs)

Three (3) local study firms/consultants will be hired to conduct the Final Evaluation in each BOT implementing country. Recruitment and direct management of the CSLs will be the responsibility of BOT Country Office teams in Bangladesh, Ethiopia and Mali, respectively. The Consultant(s) will provide “dotted line” management and technical oversight of CSLs, with support from BOT partners.

The specific roles and responsibilities of CSLs are to:

- Review project documents specific to the BOT implementing country, including but not limited to: Logic Model, Performance Measurement Framework, Project Implementation Plan (PIP), Gender Equality Assessment, project reports, sustainability plans, baseline and midterm study reports, research reports, etc.
- Collaboratively develop an overall sampling strategy and field work plan at household, facility and community levels
- Review, contextualize and translate all data collection tools
- Ensure that all necessary ethics approvals are obtained on time, as per country guidelines
- Recruit translators, enumerators, field supervisors, data entry operators, and transcribers, ensuring gender balance as appropriate
- Pilot all data collection tools with WRA, male partners, and other respondent groups as appropriate prior to enumerator training
- Prepare and conduct enumerator training with support from the Consultant(s)
- Oversee data collection, supervision and spot-checking, with in-person and remote support from the Consultant(s), providing continuous updates on progress of field work activities
- Ensure that all data collection activities are gender-responsive,²¹ adolescent-friendly, and respect child safeguarding principles
- Oversee data entry as per agreed upon software and data entry protocols established
- Review raw data to ensure quality and consistency, and take corrective actions
- Transcribe and translate all qualitative data (focus group discussions, interviews, etc.)
- Support and provide feedback to the Consultant on preliminary analysis, emerging themes, and contextually appropriate results interpretation
- Review and provide feedback on the draft country-level Final Evaluation report(s)
- Ensure all training materials, original data collection forms, and hard copies of raw data are maintained and submitted to each respective organization with the final dataset

²¹ i.e. ensures that all voices and perspectives from respondents – regardless of age or gender – are equitably heard; ensures that information is treated confidentially; ensures that the process of engagement in the evaluation is inclusive, respectful, culturally appropriate and empowering; etc.

- Liaise with the Consultant(s), BOT Country Office, and Canada-based BOT consortium staff for technical support throughout the process, and integrate feedback provided

For responsibilities listed above, the Consultant(s) will work in collaboration with BOT Country Office staff and Canada-based staff as appropriate. In particular, support from Country Office staff will include but is not limited to: providing orientation documents; refining and prioritizing evaluation questions; securing necessary approvals for field work; reviewing inception reports and field work plans; reviewing and validating data collection tools; recommending key informants; training local study teams on local Child Protection/Safeguarding and Gender Equality policies and practices; advising on logistics for field work; participating in the study as key informants on the project; and validating preliminary findings.

7.0 DELIVERABLES AND TIMELINES

The key deliverables expected from the Consultant(s) for this assignment are as follows:

- Review all relevant documents, studies, and other data sources regarding MNCH/SRHR issues relevant to each of the three countries, particularly baseline and midterm studies
- Produce a detailed **Inception Report** including the following:
 - Overall study design and sampling methodology, building on the approach(es) utilized in the baseline and midterm studies
 - Detailed work plan that includes all tasks by the Consultant(s) and team members, and incorporating overall study timelines
 - Reviewed and finalized data collection tools
 - Detailed plan and timelines for enumerator training, tool piloting, and field work in all three countries
 - A detailed overview of considerations regarding *gender equality* and *child protection / safeguarding* throughout the study, and especially during field work
 - A detailed analysis plan for quantitative and qualitative data
- **Data collection tools**, including:
 - Review of data collection tools used at baseline and midterm, with modifications and contextualization as necessary to ensure accurate data is collected.
 - Development of *new* data collection tools required to meet the study objectives
- **Data Collection and Management Protocol** for local study teams, including considerations for inclusive, gender responsive and adolescent friendly field work, and a **Code Book**, as appropriate for newly developed and/or revised data collection tools.
- **Analysis** of all quantitative and qualitative data in accordance with the evaluation objectives listed above, for all three countries, including critical analysis of the data through statistical treatment and triangulation with other sources and literature review.
- **Draft and final Evaluation Reports**,²² including: one report for each of the three BOT implementing countries; and one summary “chapeau” report with key findings for the project overall.

²² A suggested Table of Contents will be provided by BOT Consortium at the beginning of the assignment.

7.1 TIMELINES

The consultancy is expected to commence in February 2020, with field-based data collection to begin in June 2020. All data collection must be completed by the end of July 2020; and the final report must be submitted to and approved by World Vision Canada on behalf of the BOT consortium by November 1st, 2020.

The Consultant(s) selected to complete this assignment will be responsible for the deliverables specified in the table below:

Table 3: Final Evaluation Consultancy - Deliverables and Timelines

Deliverable	Timeline
Contract awarded	February 14, 2020
Orientation for local study team(s) and document review	February 2020
Detailed inception report	March 2020
Complete ethics approvals	April 2020
Final inception report, including tools	April 2020
Pre-test, translation and back-translation of tools	April – May 2020
Enumerator Training	April – May 2020
Data Collection	June – July 2020
Frequency Tables, and samples of completed qualitative instruments (i.e. translated and coded transcripts)	August 2020
Submission of all hard and soft copies of (cleaned) data collected	September 2020
Draft country evaluation reports (three total, one for each country)	October 2020
Final country evaluation reports, incorporating feedback from BOT consortium members in Bangladesh, Ethiopia, Mali and Canada	October 2020
Draft global summary report, summarizing key findings from the three country reports	October 2020
Final global summary report, incorporating feedback from BOT consortium members in Canada	November 1, 2020

*Grey denotes deliverables led by CSLs but *supported* by the Consultant(s)

8.0 QUALIFICATIONS OF THE CONSULTANT(S)

Born on Time partners are looking for an experienced, multi-disciplinary team of consultants with experience in designing and conducting evaluations for MNCH/SRHR programs in developing country contexts. Both institutions and individuals are eligible to apply for this assignment. However, in the case of a group of consultants who are not associated with an institution, the Born on Time consortium would only sign the agreement with the lead consultant. The *team* should have the following qualifications:

- Master's degree or higher in International Development, Public Health, Gender Studies and/or other Social Sciences, Statistics or related fields (CVs required);

- Minimum 10 years' experience in administering studies, collecting data and producing quality evaluation reports, preferably for international non-profit organizations and/or multilateral agencies, and previous experience coordinating multi-country studies is mandatory
- Extensive experience in assessing health outcomes in developing contexts
- Extensive experience assessing gender equality outcomes
- Extensive experience performing gender analysis
- Demonstrated experience in designing project evaluations including proven experience in sound sampling, mixed methods approaches, tool development, enumerator training, quality assurance, etc.
- Experience using participatory and gender-responsive techniques in data collection, with demonstrated experience in data collection with vulnerable children and adolescents strongly preferred
- Demonstrated experience in quantitative and qualitative analysis
- Knowledge and experience with MNCH and SRHR issues (including adolescent health), policies and service systems, particularly in developing country contexts
- Familiarity with the social-cultural contexts of each of the three BOT implementing countries and any related cultural, political, or religious sensitivities relevant to the completion of this assignment
- Excellent writing and communication skills in English and French are mandatory (sample of work and references required)²³
- Ability to travel to any of the three BOT implementing countries in support of the study, as required and feasible within the study plan

9.0 APPLICATION PACKAGES AND PROCEDURES

Qualified and interested parties are asked to submit the following:

1. **Letter of interest** in submission of a proposal (in the form of an email), to: Marie Bettings, Marie_Bettings@Worldvision.ca. Letter of interest should be submitted on or before **end of business day (EST) December 13th, 2019.**
2. **Questions or clarifications** related to the RFP, if necessary, to: marie_bettings@worldvision.ca. Questions should be submitted on or before **end of business day (EST) December 13th, 2019.**
3. Detailed **technical proposal** (maximum 20 pages) clearly demonstrating a thorough understanding of this Terms of Reference and including the following:
 - a. Description of methodology, including: sample size with detailed calculations (based on information available); and a detailed description of any new data collection tools proposed, including topic areas and example questions.

²³ In case the Team Lead is not fluent in French, he/she needs to add a team member with comparable/relevant experience as the Team Lead (minimum 5 years), who is fluent in French. This team member will be expected to run the data analysis and report writing for the Mali evaluation.

- b. Demonstrated previous experience in mixed methods studies, project evaluations, and other qualifications outlined in this RFP
- c. Proposed management of local study teams and field work
- d. Considerations for child protection and safeguarding, gender and adolescent friendliness throughout the study
- e. A proposed timeframe detailing activities and a schedule/work plan (including a Gantt chart)
- f. Proposed approaches to data analysis, in response to overall objectives (see Section 3.0) and evaluation criteria (see Section 4.2)
- g. Team composition and level of effort of each proposed team member, including language skills of team members
4. A **financial proposal** with a detailed breakdown of costs for the study:²⁴
 - a. Itemized consultancy fees/costs
 - b. Estimated travel expenses to support the study in the three BOT implementing countries, as appropriate
 - c. Itemized administrative expenses
5. Curriculum Vitae(s) of all proposed team members outlining relevant experience
6. Names and contact information of three references who can be contacted regarding relevant experience
7. A copy of at least two previous reports of similar work undertaken on: a) studies on MNCH/SRHR, and/or b) final multi-country project evaluations
8. A Consulting Firm profile (if applicable).

The expected total contract value for this assignment is CAD\$150,000 – \$200,000.

The proposal will be scored on both technical (methodology) and financial (budget) aspects. Complete applications should be submitted electronically through COUPA, World Vision Canada's online procurement platform. All candidates who submit a Letter of Interest will receive detailed information on how to set-up an account.

Closing date for submission of the application package is end of business day (EST) on January 17th, 2020.

The offer must remain valid for no less than 120 calendar days after the deadline noted above.

²⁴ All financial proposals should indicate the currency used.

10.0 ETHICS APPROVAL AND DISCLOSURE/OWNERSHIP OF INFORMATION

Full ethical approval will be obtained before the study commences, if required.

All ownership and copyright for final data collected is held by respective BOT consortium members. It is understood and agreed that the Consultant(s) shall, during and after the effective period of the contract, treat as confidential and not divulge, unless authorized in writing by World Vision, Save the Children, and/or Plan International any information obtained in the course of the performance of the contract. Information will be made available for the Consultant(s) on a need-to-know basis. Any and all necessary field visits will be facilitated by BOT consortium partner staff.

11.0 SUPERVISION AND MANAGEMENT OF THE ASSIGNMENT

The Consultant(s) will be required to work closely with BOT staff, including technical working groups, as well as Country Office focal points to be identified at the beginning of the assignment. A communications protocol will be provided to the Consultant(s) at the beginning of the assignment to ensure that all BOT consortium stakeholders can remain appropriately informed throughout the evaluation.

The Consultant(s) will be directly accountable to the Born on Time Project Director, an employee of World Vision Canada.

12.0 RISK MANAGEMENT

The Consultant/s must take all reasonable measures to mitigate any potential risk to the delivery of the required outputs of this consultancy on time and meeting the expected quality. As such, applicants should submit a risk management plan that covers (at minimum):

- Key assumptions underpinning the successful completion of the assignment, anticipated challenges and estimates of the level of risk for each risk identified
- Contingency plans that will be put in place to mitigate against any occurrence of each of the identified risks

ANNEX 1: BORN ON TIME BENEFICIARY POPULATION, BY COUNTRY

Table 4: Estimated population of WRA in intervention areas, by age group

Country	Region	Sub-District/ Upazila	Target Population		
			Adolescent Girls, 15 - 19	Women, 20 - 49	Total WRA, 15 - 49
Bangladesh	Rangpur	Pigani	20253	77855	98108
		Gangchara	15649	60157	75806
		Kaunia	11968	46007	57975
		Mithapukur	26696	102622	129318
		Pirgachha	16461	63277	79738
		Taragonj	7487	28781	36268
		Total	98514	378699	477213
Ethiopia	Amhara	Dabat	11256	35969	47225
		Wogera	14560	46530	61090
		Chilga	16143	51586	67729
		Lay Armacho	8858	28305	37163
		West Belesa	10880	34768	45648
		Libo Kemkem	16396	52395	68791
		Este	15733	50276	66009
		Ebinat	12194	38966	51160
		Farta	12443	39763	52207
		Andabet	8972	28671	37643
		Yilmana Densa	16994	54305	71298
		South Achefer	9970	31859	41829
		North Achfer	15554	49704	65258
		Mecha	17942	57337	75279
		Dega Damot	11191	35762	46953
Total	199084	636197	835282		
Mali	Sikasso	Kadiolo	19,757	58,180	77,937
		Kignan	9,563	28,161	37,724
		Koutiala	47,412	139,618	187,030
		Niena	10,143	2,987	40,013
		Sikasso	40,085	118,040	158,125
		Total	126,960	373,869	500,829

Table 5: Population of adolescents (15 – 19) participating in Born On Time adolescent groups, by sex

Country	Region	Sub-District/ Upazila	Target Population					
			Female		Male		Total	
			Groups	Members	Groups	Members	Groups	Members
Bangladesh	Rangpur	Pigani	45	900	45	900	90	1800
		Gangchara	30	600	30	600	60	1200
		Kaunia	18	360	18	360	36	720
		Mithapukur	51	1020	51	1020	102	2040
		Pirgachha	27	540	27	540	54	1080
		Taragonj	15	300	15	300	30	600
		Total	186	3720	186	3720	372	7440
Ethiopia	Amhara	Dabat	35	420	15	180	50	600
		Wogera	35	420	15	180	50	600
		Chilga	35	420	15	180	50	600
		Lay Armacho	35	420	15	180	50	600
		West Belesa	35	420	15	180	50	600
		Libo Kemkem	35	420	15	180	50	600
		Este	35	420	15	180	50	600
		Ebinat	35	420	15	180	50	600

Country	Region	Sub-District/ Upazila	Target Population					
			Female		Male		Total	
			Groups	Members	Groups	Members	Groups	Members
		Farta	35	420	15	180	50	600
		Andabet	35	420	15	180	50	600
		Yilmana	35	420	15	180	50	600
		Densa	35	420	15	180	50	600
		South Achefer	35	420	15	180	50	600
		North Achfer	35	420	15	180	50	600
		Mecha	35	420	15	180	50	600
		Dega Damot	35	420	15	180	50	600
		Total	525	6300	225	2700	750	9000
Mali ²⁵	Sikasso	Kadiolo	24	240	24	240	48	480
		Kignan	9	85	9	85	18	170
		Koutiala	25	247	25	247	50	494
		Niena	14	126	14	126	28	252
		Sikasso	33	330	33	330	66	660
		Total	105	1028	105	1028	210	2056

Table 6: Number of health facilities receiving project interventions

Country	Region	Facility Type	# of facilities
Bangladesh	Rangpur	Upazila Health Complex	1
		Union Health & Family Welfare Centre (UH&FWC)	55
		Rural Dispensary (RD)	2
		Community Clinic	3
		Maternal and Child Welfare Centre (MCWC)	1
Ethiopia	Amhara	Hospital	14
		Health Centre	115
		Health Post	501
Mali	Sikasso	Centre de Santé Communautaire (CSCoM)	137
		Centre de Santé de Référence (CSRef)	5

²⁵ BOT implementation teams in Mali intentionally ensured an equal number of male and female members for adolescent groups within each district / community.