**Terms of Reference for End of Project Evaluation**

**Project Title**

***“Improving reproductive health and adhering reproductive rights of youths and their parents in the north of Bangladesh”***

1. Introduction and background

Sustainable Association for Taking Human Development Initiatives (SATHI) and Kindernothilfee.V. (KNH) are looking for an interested consultant/consultancy firm to conduct the end of project evaluation for the project titled ***“Improving reproductive health and adhering reproductive rights of youths and their parents in the north of Bangladesh.”***The project takes place in the district of Mymensingh, Upazilas Haluaghat (4 Unions: Jugli, Bhubankura, Haluaghat and Gazirvita) and Dhobaura (3 Unions: Ghoosh Gaoan, Dakshin Maijpara and Baghber).The official implementation start has been 01.09.2015. The project will probably be implemented until 30.09.2019. The implementing partner of this project is SATHI, the funding partners are the German based non-governmental organization Kindernothilfee.V. (KNH) and the German Ministry for Economic Cooperation and Development (BMZ).

The project is in its last months of implementation and thus, the evaluation should answer questions raised by the project staff, beneficiaries, facilitators and further stakeholders.

The two objectives of the evaluation is ***to enable the project’s beneficiaries and the governmental stakeholders in sustaining and up-scaling their engagement in Reproductive Health and Rights and to enable SATHI and KNH in upgrading project implementation strategies and methods.***

Specific questions in the evaluation will be guided by three Criteria for Evaluating Development Assistance of the Organization for Economic Cooperation and Development (OECD) which is: Effectiveness, Impact and Sustainability.The evaluation will not be able to assess the relevance and efficiency of the entire project.

The evaluation should be conducted between March 2019 and August 2019 in above mentioned unions. Additionally, a final report must be submitted by May 15, 2019.

User of the evaluation results are all stakeholders of this project.

2. Brief description of the project

The project has been initiated and proposed by SATHI to KNH based on a problem and needs analysis:

The rate of early marriages is 35.4% in the targeted project area. This leads to school drop-outs and early pregnancies. Only 47% of all young people complete the seven years of primary school. Among the girls, only 23% complete primary school.

Adolescents (10-17 years) and youths (18-25 years, unmarried) have hardly any knowledge about reproductive health, preventive health care and contraceptives. This leads to an increased risk of unwanted pregnancies, life-threatening abortions and STIs. In addition, the reproductive health services provided by government health facilities are inadequate.

There are 27 government health facilities in the project intervention area (12 in Haluaghat and 15 in Dhobaura).

Nonetheless health care services in the project intervention area are insufficient. Because of limited budgets, rural health facilities lack the required medicines, skilled staff and medical equipment. Skilled medical personnel prefer not to work in remote areas, so positions in the medical centres remain vacant. As a result the health facilities do not open on the proposed hours, and the local people lack trust in the public health sector. The communities are unaware of the quality standards for health facilities that the government has defined. Therefore they are unable to claim their right to quality health services.

66% of all girls are married between the age of 14 and 18. As a result, very young girls become pregnant whose bodies are not yet fully developed. The risk of an injury of the reproductive organs, birth traumata or babies with low birth weight is high. The situation is aggravated by the chronic malnutrition of adolescent girls (iron, iodine and vitamin A deficit). The maternal death rate is 5.8 per 1,000 live births in adolescent mothers. In comparison, it is 4.5 per 1,000 live births in women aged over 20.

Additionally, births in the targeted project area traditionally take place at home. TBAs working in the villages lack knowledge about possible birth complications and are able provide limited assistance only. These women also carry out abortions, sometimes with life-threatening consequences. The TBAs learned from their elders. Knowledge is normally passed on verbally, because most of the women are illiterate. In every village there are several TBAs.

Adolescents who reach the reproductive age are not informed in this regard, whether in their families, in schools or health centres. On the contrary, when adolescents turn to a health centre and ask for contraceptives or have a sexual disease, there is no privacy at all – not even a room where they could talk to an expert confidentially.

Early marriages are a consequence of poverty and traditional family structures. This increases the number of early pregnancies and school/training drop-out rates.

Following project strategies have been implemented until today:

Social structures were set up by means of a SHG approach so adolescents/youths can make their own choices regarding reproductive health while their parents support them in their decision-making. Child rights issues were dealt with and what it means to safeguard and claim them, and what kind of rights violations are looked upon as “normal” by society. The simple fact that these topics were tackled provides the ground to understand what difficulties and challenges exist and that they can only be solved in a joint effort. After all, solutions can only be identified after the silence is broken.

In line with the SHG approach, adult groups were formed to combat the underlying problem, the high levels of poverty, to improve the status of families and enhance the development opportunities for the next generation. Self-managed saving activities, the establishment of a health fund and rights-centred campaigns targeted at government authorities strengthened the mothers of the adolescents / youths, while poverty were addressed by income-generating activities.

In a holistic approach adolescents and youths discussed their problems and identify solutions in groups of same-sex peers. The other project activities made sure that they got support from their communities. Adolescents and youths who are not interested in obtaining knowledge at first can thus be carried away by their peers.

By dealing with problems openly and drawing up a Child Protection Policy in the adult groups, silence regarding right violations were broken and joint solutions were identified among the persons affected and their communities.

In addition, with the help of capacity-building and of representatives from the informal and formal health sector and the education sector, more families were accompanied in an individual manner. Thanks to the establishment of Public Private Partnerships between government health facilities and community representatives the project contributed to improving reproductive health services in the area.

The objectives of the project, including the key output, outcome, and impact indicators are the following:

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| **Overall goal (impact):** The project contributes towards achieving the MDGs 3 “Promote gender equality and empower women”, 4 “Reduce child mortality”, 5 “Improve maternal health”, and 6 “Combat HIV/Aids, malaria and other diseases”. |

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| **Project aim (outcome)** The adolescents/youths and adults increasingly claim their right to quality reproductive health services. This will improve maternal and newborn health and lower the rate of early pregnancies. |

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| **Objectives (output)** | **Indicators** (if possible also with a quantity structure) | |
| **At project start** | **Plan (goal)** |
| 1: Adolescents/youths and their parents are aware of their right to reproductive health and have access to quality health services. | The actual situation is estimated at 45%, while this number refers to the knowledge that people in Haluaghat and Dhobaura have on preventive and follow-up care for pregnant women. The data are from the 2012 UNICEF report on multiple indicators from a survey. The exact data will be established through a baseline study. | % (35% above the baseline) of adolescents and youths have knowledge of reproductive health and STIs and how to protect themselves. This knowledge strengthens their decision-making abilities and contributes to reducing the number of STIs, unwanted and early pregnancies.  % (35% above the baseline) of the community members are aware of existing health care services, in particular those related with family planning, treatment of STIs, maternal and newborn health care and have access to such services. Because of a better accessibility and quality of the medical care provided by government health facilities risks to maternal and newborn health are minimised. Adolescents and youths have been empowered to actively assert their reproductive rights. |
| 2: The 154 villages have qualified staff for counselling, education and care from the informal health sector. These people are working in close relationship with personal from the public health sector. | According to reports from community members almost none of the TBAs has sufficient medical knowledge.  Currently there are no CHVs. | 154 CHVs and 154 TBAs (one per village each) support the community members in all matters related with reproductive health and have been adequately trained. Thus the families can rely on services based on academic medical standards. Earlier on, a part of the counselling provided by traditional helpers was harmful or completely useless.  % of the community members rely on the counselling and support of CHVs and TBAs and put their correct medical recommendations into practice.  % (30% more than in Baseline) of pregnant women deliver in public health facilities after receiving counselling from traditional birth attendances (referral system).  % (20% more than in Baseline) of pregnant women visit regularly public health facilities during and after pregnancy on advice given by the traditional birth attendances (referral system). |
| 3: The 7 Union Committees have built networks with 20 health facilities and campaign for quality reproductive health services (PPPs). | Currently there are no PPPs. | % (50% above the baseline) of the Union Committees have good linkage with existing health facilities and lobby successfully for reproductive health issues and quality services; as a result health care in the region is improved. The 7 Union Committees have concluded MoUs with the 20 health facilities and agreed on joint efforts to improve health care. Thus the Union Committees are able to defend the right to quality health services and exert pressure on the management of health facilities and political stakeholders. |
| 4: The existing 27 government health facilities are able to provide quality services to the population in accordance with academic medical standards. | Currently only 33% of the community clinics are operating.  These data stem from the 2014 and 2015 Haluaghat and Dhobaura Upazila Health Bulletins. The main reason is that medical positions are vacant and the budgets are too low to buy medicines and equipment. The exact data will be established in a baseline study. | % (40% above the baseline) of the 27 government clinics provide services to the population in the field of reproductive health. The community develop trust in the public health sector. |

***TARGET GROUPS***

Adolescents (aged 10-17) and youths (aged 18-25, unmarried) – altogether 3,300 persons from poor households. It was planned to form 100 girls’ groups (with a total of 2,000 girls) and 65 boys’ groups (with a total of 1,300 boys). The 165 groups will be formed in the 154 villages.

Parents of the adolescents/youths – altogether 4,260 persons formed in adult groups. 3,080 women will join a total of 154 female groups. In addition there will be 59 male groups with a total of 1,180 participants.

***FACILITATORS***

Community Health Volunteers (CHVs): A total of 154 local CHVs trained, representing one village in the project area each. Traditional Birth Attendants (TBAs): The 154 TBAs – one per village –trained in the same issues as the CHVs. Informal health service providers (traditional village doctors and pharmacists): 154 representatives of the informal health sector trained in adequate reproductive medicine and child rights issues. Theatre groups: With the help of drama groups, awareness raised among the communities. 100 persons from the project villages will be trained in this regard.

Teachers: 60 (female and male) teachers from 12 secondary schools in the project underwent training to understand how important it is for adolescents to know of reproductive health and the universal rights of children. 200 community clinic management committee members from 20 local government health facilities trained. 40 Government Health Workers trained to use their newly acquired skills in the government health facilities.

***A baseline study was conducted and a monitoring framework established (enclosed as annex 1).*** Quarterly data are collected and analysed for providing evidence of the project activities and for steering of the entire project.

3. Purpose of the evaluation

The main purposes of this evaluation are

* **to enable the above mentioned target groups and facilitators to sustain and scale up their engagement in Reproductive Health and Rights.**
* **to support SATHI and KNH in upgrading project implementation strategies and methods.**

The evaluation will not be able to assess the relevance and efficiency of the project.

The key users of the evaluation and their results will thus be the project’s target groups and facilitators in the project area, SATHI, KNH and the German Federal Ministry for Economic Cooperation and Development (BMZ).

The evaluation results will be shared with the project’s beneficiaries and facilitators of the project.

For this reason a youth-friendly sharing mode has to be developed and maintained by the evaluators.

Confidentiality of data and context sensitivity are pre-conditions in conducting the evaluation and sharing the results.

4. Specific Question for the evaluation

SATHI has collected questions from the stakeholder groups of this project, in particular the Self-Help-Groups, the Union Committees, the Youth Forums, the PIs, the Health Volunteers, the Governmental health officials at local and Upazila level, the project staff and of SATHI management. A copy of the questions in Bangla can be submitted on request to the interested applicants.

Based on above mentioned collection three specific questions have been chosen for this evaluation. It is expected that to each questioner commendations and learnings are provided in order to support the main purposes of the evaluation. Recommendations and learnings should be compiled in the report in specific sections.

1. **In how far have the strategies applied been effective to reach the project outcome?**

The proposed project outcome was that the adolescents/youths and adults increasingly claim their right to quality reproductive health services. This will improve maternal and newborn health and lower the rate of early pregnancies. The proposed strategies and methods for achieving this are mentioned above.

Expectation regarding the answer is the following:

1. An analysis to what extent project objectives have been achieved,
2. An analysis of the interdependencies of the actual project outcome and the implemented strategies, methods and main tools on the different levels: outcome, use of outputs and outputs.    
   The discussion needs to cover each component of the applied strategy, methods and tools and demonstrate the causal relation to reaching the outcome. Evidenceshouldbeprovided.
3. The potential of all strategies, methods and tools to provoke the above mentioned outcome and use of output,
4. The particular attractiveness of the applied strategies, methods and tools for the related target groups/facilitators/stakeholders to follow up on the outcome,
5. The level of independent actual utilization of learned strategies, methods and tools by the target groups/facilitators/stakeholders themselves to follow up on the outcome and other issues they would like to tackled.
6. **In how far has the project contributed towards changing power relations and changing structures?**

The project focuses on Reproductive Health and Rights. Rights-based interventions challenge the predominant power relations and structures within families and communities. The structures include governmental and non-governmental organisational groupings/institutions and include among others policies and practices.

Expectation regarding the answers is the following:

1. A discussion on the power relations and structures within the families.

- Are the seat present more favourable for children, marginalised or vulnerable persons to enjoy and protect their rights compared to project start?

- If yes, what is the extent of change? What is still lacking?

Criteria expected to be used among others are knowledge, attitudes and practices.

Particular interests are the handling of tabooed subject matters and the advancement of girl’s interest.

1. A discussion on the power relations and structures within the communities including their various groupings/institutions.

- Are the seat present more supportive to realise and protect Reproductive Health and Rights, Child Rights, Women’s Rights, Rights of persons living with disabilities compared to project start?

- If yes, what is the extent of change? What is lacking?

Criteria expected to be used among others are knowledge, attitudes and practices.

Particular interests are the handling of tabooed subject matters and the advancement of girl’s interest.

Evidence should be provided for each criterion, and between females and males of different age groups.

1. **What type of benefit and which level of outcome are likely to continue after the project is finalised?**

- What will likely to continue?

- What determination of actors will ensure the continuation?

- What circumstances will ensure the continuation?

- What is recommended to ensure the continuation?

The recommendations should be specific, measurable, realistic and feasible within the coming three to five years for the communities including their various groupings/institutions and the above mentioned target groups of the project. The implementation of the recommendations should preferably be possible with own resources and capacities of the community groupings and institutions, and governmental stakeholders. The recommendations should take into consideration specific content of above mentioned collection of questions.

5. Scope of the evaluation

The evaluation should evenly take place in all implementation sides.

Target group of the evaluation could includeadolescents and youths (individuals, within their groups and forums, Parents of the adolescents/youths (individuals, as groups – SHG, UC, PI), Community Health Volunteers (CHVs), Traditional Birth Attendants (TBAs), Informal health service providers (traditional village doctors and pharmacists), Theatre groups, teachers and headmasters, community clinic management committee, Government Health Workers, UP Chairman and members, Standing Committee, project staff, SATHI management.

The evaluator/evaluation team is requested to suggest the sampling size to be representative and gender disaggregated. Further to this adult and youth participation needs to be considered, whereby adults for female are understood as married women and youth female to be understood as unmarried girls and young women.

6. Methodology

Based on the baseline survey, the project has developed a monitoring framework and has quarterly surveyed on the indicators. This data source can be used. Furthermore, the evaluator/evaluation team is requested to suggest a feasible approach, methodology and the sampling size to be representative.

The methodology should be participatory, youth friendly and maintain privacy. It should provide space that the individual beneficiary, the beneficiaries groups, the Union Committees, the PI can reflect on the past and take own decisions for the future.

Gender, age clusters, project side disaggregation as well as the triangulation of different data sources are required.

7. Deliveries

The expected deliverables in accordance with the timeframe on **section 10** are as follows:

1. Inception Report with evaluation data collection tools to be discussed with SATHI and KNH Germany (if needed via skype talk).
2. Data/Information collection from target groups of the evaluation.
3. Draft one of the evaluation report within 10 working days after the data collection has been done.
4. Presentation and validation of the evaluation results in a validation meeting with SATHI and KNH Bangladesh and a couple of representatives of the target groups within 10 working days after the data collection has been done.
5. Revised report (draft two) incorporating findings from the validation meeting within 5 working days after the validation meeting.
6. Final report – one electronic copy (pdf-file) and three hard copies within 10 working days of receipt of comments on the revised report from SATHI and KNH Germany.
7. Jointly with SATHI staff a one-day sharing session for the target groups and facilitators of the project.

The evaluation report is expected to be written in English, DINA 4 and the expected structure is as follows:

* **Cover page** (Title of the evaluation, the date of the evaluation, recipient’s name, name(s) of the evaluator(s) involved)
* **Table of Contents**
* **List of Acronyms**
* **List of Charts, Table or Figures**
* **Executive summary** [Stand-Alone, about 5 pages, summary of report. This section may not contain any material not found in the main part of the report]
* **Main Part of the Report**
  + *Section 1:* Introduction/Background and Purpose: [Overview of the final evaluation. Covers the purpose and intended audiences for the evaluation and the key questions as identified.]
  + *Section 2:* Evaluation Approach and Methods: [Brief summary, Additional information, including instruments should be presented in an Annex]
  + *Section 3:* Findings: [This section, organized in whatever way the evaluator(s) wishes, must present the basic answers to the key evaluation questions – unequivocal and for each research question - , i.e. the empirical facts and other types of evidence the evaluator(s) collected including the assumptions]
  + *Section 4:* Conclusions: [This section should present the evaluator(s)’ interpretations or judgements about its findings]
  + *Section 5:* Recommendations: [This section should make it clear what actions should be taken as a result of the evaluation for its basic purpose. Recommendations must be relevant to practice and implementation oriented]
  + *Section 6:* Lessons Learned: [In this section the evaluator(s) should present any information that would be useful to people who are designing / managing similar or related new or ongoing projects in the country or could be adopted elsewhere. Other lessons the evaluator(s) derive from the evaluation should also be presented here.]
  + *Section 7:* References
* **Annexes** [These includes supplementary information on the evaluation itself; further description of the data collection/analysis methods used; data collection instruments; summaries of interviews; statistical tables, and other relevant documents]

The final evaluation report is expected to give an unequivocal statement of findings and conclusions in relation to the questions to be addressed, as specified in the terms of reference.

Without annexes the report **should not exceed 40 pages!**

8. Evaluators Requirements and Selection

The evaluator or evaluation team is expected to have following knowledge, skills and experience:

The evaluator should be holder of a Master Degree in Public Health and/or Master Degree in social science related subjects. In case of an evaluation team at least the team leader should have a Master Degree.

The team needs to be gender balanced.

The evaluator or team leader brings along several years of working experiences in health interventions, economic and social empowerment of community groups and apex groups in Bangladesh or surrounding countries, in subjects such as Reproductive Health, Reproductive Rights, Child Rights, Public Health, Maternal and Newborn Health, Women’s Rights, Empowerment of deprived sections of society.

It is expected that the evaluator or evaluation team have experiences to apply participatory methods and tools for working with rural populations’ groups, technical competence and knowledge in the sectors to be looked into, and qualitative and/or quantitative evaluation methods.

Excellent English writing and communication skills and the ability to reflect and interpret the data collected for providing recommendations is imperative.

The evaluator or evaluator team will be selected based on the above mentioned criteria, *in particular a clear description of the suggested approach, methodology and tools* based on a written application and an interview by SATHI jointly with KNH.

Applications of representatives of other Bangladesh based NGOs or Bangla speaking consultant(s) from surrounding countries are welcomed.

9. Roles and responsibilities

SATHI as commissioning agency will support the evaluator or evaluation team with

* logistical arrangements incl. arranging for transport;
* arrangements for meeting the target groups of the evaluation
* the agreement between SATHI and KNH, interim reports, internal monitoring reports, meeting minutes, documents from SHGs/UC/PI/Clinic and so on. .

The evaluator /evaluation team has among others following particular roles and responsibilities**:**

* **The entire evaluation process management in line with the time schedule.**
* Weekly written information (e-mail) about the evaluation progress to SATHI management and KNH Bangladesh and Germany.
* Availability to feedback talks (also via skype) with SATHI management and KNH.
* Adherence to the codes of ethics, transparency, confidentiality, child protection, non-discrimination of any person and anti corruption of SATHI and KNH.

Additional details will be laid down in the engagement contract if any.

10. Timeframe

Anticipated timeframe for the evaluation

Selection of the evaluator /evaluation team and contracting: until beginning of March 2019.

Inception report submitted: until March 15, 2019

Discussion and fine planning of data collection: until March 30, 2019.

Data collection: April 2019

Validation meeting: between May 1-10, 2019

First report: May 15, 2019

Final report: July 15, 2019.

11. Mode of Payment

Payments are made at the following stages:

a) 30% on signing the contract

b) 30% on submission of the draft report

c) 40% on approval of the final report

12. Proposals

The interested consultant or consultant team is requested to apply with a written proposal/application

The proposal should include a technical and financial part.

The technical part should include

* Clear description of the consultant’s understanding of the project and the evaluation tasks, *the consultant’s suggested approach, methodology and tools* to be used.
* Description and quantification of the use of the instruments (e.g. how many individual interviews and with which groups of people; how many focus group discussions).
* Management of evaluation process.
* Clear dated work plan.

The financial part should include

* A calculation of the number of working days.
* Consultant’s daily rate including indication of any taxes.
* Total consultancy fees including clear indication of any taxes.
* Calculation of any additional costs incurred during the evaluation (if any)
* Validity period of quotation.

Note: Consultant must clearly elaborate on the division of tasks and of the team members (if any) proposed. The fee for each team member has to be mentioned.

Other required documents to include are

* The Consultant’s Curriculum Vitae– maximum 4 pages with references.
* Curricula Vitae of (lead) evaluator and his/her team members (if applicable). If the evaluator team are employees of a firm/organization/institution the additional documents have to be included: profile, physical address, telephone numbers, contact person of the firm/company; copy of registration and VAT certificate; names of Directors/Proprietors
* Documentation of any work previously conducted by the evaluator.
* Report of one reference evaluation conducted within the last three years.

Proposal documents including all required documents are expected to be submitted, duly signed as one, maximum two scanned pdf files only (max. 5 MB).

Hard copy proposal documents, duly signed, are only expected to be submitted, if invited to an interview.

Proposals clearly marked “Application for project evaluation”. Project title: Improving reproductive health and adhering reproductive rights of youths and their parents in the north of Bangladesh” should be sent via e-mail to following addresses

To: pm1.rhrp@gmail.com

Cc: sathicircular@agni.com; knh.bdesh@gmail.com; uta.dierking@knh.de

In case of questions, please contact the project manager Mr. Sakawat Hossain, Email: pm1.rhrp@gmail.com

**Deadline for submitting the proposal is February 15, 2019.**

Interviews for the selection of the evaluator /evaluation teams will take place in February 2019 in Dhaka.