**Terms of Reference (TOR)**

for

Baseline Survey of the project ‘’Improving Physical and mental Health of children and adolescents as well as elderly people in Teknaf Upazila, Cox’s Bazar, Bangladesh”

1. **Background:**

GK has been active in Cox's Bazar district since the 1990s. In addition to its extensive programme activities in the area of humanitarian support for Rohingya refugees from Myanmar, which have been greatly expanded since 2017. The first cooperation between GK and Action Medeor took place in 2019. The project, which lasted a total of eight months. It was subsequently continued for a further ten months by other donors - Hungary Helps Agency, Secours Populaire Français , and Medico International. The pilot phase of the project approach was to improve the health situation of a target group of elderly persons as well as children within the Baharchara Union in Teknaf Upazila, Cox's Bazar has been successfully implemented. This was confirmed during project visits by the Action Medeor consultant (monitoring) and an externally conducted evaluation. The contact and exchange between both organisations has remained very close since the cooperation in 2019. The present project proposal represents a joint follow-up project. For this purpose, the project approach, which has proven to be promising, is to be expanded and intensified.

1. **The project location:**

Fifteen communities in Baharchara Union of Teknaf Upazila in Cox’s Bazar district.

1. **The direct target group consists of:**
* 1,500 older (60+), particularly vulnerable people who benefit through their participation in self-help groups and through the various health promotion and health education activities.
* Priorities or selection criteria for participants are: extremely low and irregular household income from casual labour, virtually no productive resources; households affected by chronic food shortages; poor housing conditions (substandard building materials, sanitation and household goods); households headed by women (widowed, separated, divorced or with a disabled husband or family member).
* 150 most vulnerable older people to be enrolled in kitchen gardening activity.
* 4,000 children and young people (between 7 and 16 years old) will have the opportunity to build social capital, improve their health and nutrition knowledge, use life skills through participation in the *Shishu Parishad* groups.
* Special attention in the selection of participants is given to the inclusion of school drop outs and children affected by child labour, children and young people with disabilities and/or limitations.
* 3,000 mothers who are given the opportunity to participate in *Uthan Baithak* (Courtyard) sessions on health and nutrition session, prevention of non-communicable diseases, contribute to improving health and future prospects of their children and families by making changes in their everyday’ s behaviour.
* Nine local community mobilisers and two health facilitators, who receive extensive training during the project period and take this knowledge back to their communities.
* Antenatal check-up and referral of 1500 pregnant mothers are indirect beneficiaries of the project.
1. **Situation of the targeted population:**

 In the project area, the physical and mental health conditions of the local population are precarious. The state social security system lacks massive resources and coverage. Therefore, especially the elderly population groups in rural, marginalised areas are affected by extreme poverty, social isolation and lack of health care.[[1]](#endnote-1)

The needs of the target groups (elder population, children and young people) are to strengthen social solidity. Knowledge about general health and health prevention, especially in the context of non-communicable diseases, is low in the target population. Cox's Bazar district is also heavily affected by the ongoing humanitarian crisis in the context of the Rohingya refugees. The overall fragile and insecure social environment, characterised by a lack of resources, puts children and young people in particular at a disadvantage, so that their mental and physical health is affected in the long term and they are deprived of positive development prospects for their future.[[2]](#endnote-2)

1. **Objective of the Baseline Study:**
* Identify the current status against relevant indicator to monitor and tracking the progress; and
* Establish a benchmarks for impact evaluation.
1. **Impact matrix:**

The impact matrix is given as annex - 01

1. **Deliverables from Consultant:**
* Finalize the methodology, data collection tools and content of the study in consultation with GK – Action Medeor project representatives within 7 business days of signing the agreement;
* Test field tools and finalize input integration and share final tools GK – Action Medeor team;
* Presentation of the first draft of the report within 20 days of signing of the agreement;
* Final report within 7 working days after by including input from all stakeholders (15 - 20 pages without annexures, cover page, table of contents including dataset in excel format, etc.,
1. **Selection criteria of the consultant:**

A Combination of marks on essential qualification plus the technical proposal (rated 65%) and financial price (rated 35%) will be used as selection criterial of the consultant.

The applicant consultant should have the following essential qualifications-

* Postgraduate degree in social science or public health with minimum 10 years of experience in participatory research and program development in the areas of gerontological social services, child development, community health care and social capital, and life skills.
* Sound skills and expertise in quantitative and qualitative approaches and methods.
* A proven record of writing a comprehensive report in English.
* Speaking and understanding of local language will added value.
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1. **Reporting:**

The consultant will report to the Program Coordinator.

**Payment Schedule:**

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| **Sl** | **Deliverable** | **Payment Schedule** |
| 1 | Finalize the methodology, data collection tools and content of the study | 20% |
| 2 | Completion of assignment and acceptance of the study  | 80% |
|  | **Total** | **100%** |

1. **Institutional Arrangement:**
* The interested consultant must submit
	+ - a technical proposal - maximum of 3 pages including the table of contents; the proposal or technical offer will be rated 65%;
		- a financial proposal - the price offer will be rated 35%.

a CV;- will be used to justify section 8 above;

* + - COVID-19 immunization certificate.
* Team membership will not exceed two. If this is the case, both CVs are required. The proposed team membership cannot be changed without an acceptable justification from the management of GK.
* The project will deploy nine Community Mobilizers for full-time data collection under the direction of a consultant, at no charge to the consultant. However, the consultant will be responsible for training community mobilizers for 3 - 5 days (as required) with the consultant's cost.
* The consultant will cover travel, accommodation, food cost etc of his/her, team member and data collectors. All related cost to be reflected in the financial proposal.
* GK shall deduct the applicable income tax and VAT under the law of the country (which is approximately 25% plus or minus of the amount payable).
* The proposal should be **submitted by 5 PM of September 30, 2022.** The proposal will be accepted only by email (Anisur Rahman <anisurrahman673@gmail.com>) and in PDF format (signed scanned copy) with the subject line "Hiring a Technical Consultant to Conduct Base Line Study". GK is expected to have commissioned the study by the end of September 2022.
* A shortlisted consultant may be interviewed prior to awarding the task. GK retains the right to accept or reject any or all application without stating any reason or anything.

**Annex - 01**

**Impact Matrix**

**Overall objective of the project:**

The project contributes to improving the physical and mental health of particularly vulnerable groups (children and elderly people) in Teknaf Upazila, Cox's Bazar, Bangladesh.

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| **Project goal****(Outcome)** | **Indicators** (possibly plus quantity structure) |  |
| Output value (quantitative & qualitative) | Target value (target) (quantitative & qualitative) |  |
| The health and living conditions of children and older people in 15 rural host communities in Cox's Bazar have improved.  | *Older people*The state social security system in Bangladesh is severely lacking in resources and coverage. Therefore, especially the elderly population groups in rural, marginalised areas are affected by extreme poverty, social isolation and lack of health care. *Children*Due to the suspension of birth registration between 2017 and 2020 in Cox's Bazar, there are no accurate statistics on the number of children born since then. No or delayed registration denies children access to state health care and education. Knowledge about the necessity and negative consequences of not registering children is low among the population. In addition, the administrative process is often avoided because of the costs involved (transport, fees). The fragile and insecure social environment (high rate of child labour, experience of violence, low school attendance, low level of education within the village communities, etc.) particularly disadvantages children and adolescents, so that in the long term their mental and physical health is impaired and they are deprived of positive development prospects for their future.  | *Older people*90 % of the older people in the target group rate their health and wellbeing[[3]](#footnote-1) as improved at the end of the project. *Children*Knowledge and awareness of the relevance of birth registration has increased within the target group and the proportion of children officially registered at birth has increased by 10% within the Baharchara Union at project end. Within the target group of children and adolescents, 90% rate their well-being[[4]](#footnote-2) as improved at the end of the project.  |  |

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| **Sub-target**s **(output)** | **Indicators** (possibly plus quantity structure) |  |
| Output value (quantitative & qualitative) | Target value (target) (quantitative & qualitative) |  |
| 1**.Community mobilization:** Structures to strengthen the social cohesion of vulnerable groups have been established within all 15 village communities. These group structures (self-help groups for the elderly, children's and youth groups) are active and strengthened for their long-term continuation.  | There are no active self-help structures for/by older persons at village community level. There is currently no initiative to push for the establishment and guidance.Group programmes for children and young people exist only sporadically and are often linked to schools. Children outside of these fall through this social net. The effects of the covid 19 pandemic have further weakened (everyday) and social structures.Children and young people are unable to act as role models for their peer group and younger children due to their own poor starting situation (high youth unemployment, few training opportunities, etc.). So far, no multipliers have been trained at the level of children and youth in the project communities.  | By the end of 2022, 150 self-help groups for older people (60+), each with at least 10 members, have been established and are holding monthly meetings. At least 160 *Shishu Parishads,* each with about 20-25 members, have been established by the end of 2022 and have successfully passed the two-month formation phase. 90 % of the 320 participants of the *Lifeskills* training can pass on knowledge on life skills to their peer group through the independent continuation of Shishu Parishad group meetings.  |  |
| **2 Health knowledge and (preventive) health behaviour** is strengthened in the 15 village communities and especially among the target groups (older people and children and young people**)**. . | *Older persons* Knowledge about general health prevention, especially in the context of - partly age-associated - non-communicable diseases is low in the target group of older persons and their relatives. Complaints are ignored for a long time and early, effective treatments are prevented. *Children and young people*Knowledge on health issues is insufficient at community and household level. Only XY% of children can name basic principles in WASH and personal hygiene. Mothers as the main caregivers for children and older persons do not have sufficient knowledge about specific needs and requirements of the respective age group. This concerns, for example, the appropriate age-appropriate care and support for young children. In adolescence, girls and boys are often not or not sufficiently educated or informed about puberty and sexual and reproductive health. In most cases, the women of the households are also responsible for the care of elderly relatives. Specific knowledge about the handling, needs and requirements are low within the local population. There are no information or counselling services for caring relatives.  | *Older persons*90 % of older people participating in self-help group activities have integrated at least XY[[5]](#footnote-3) number of preventive health behaviours (e.g. exercise, nutrition, screening) into their daily lives. XY% of the interviewed relatives of older persons state that they are better informed about the needs of older persons and that they have improved their (preventive) health knowledge. *Children and young people*90% of children and young people who have participated in *Shishu Parishad* activities have integrated at least XY6 of preventive health behaviours into their daily activities.  90 % of the participants (mothers; caregivers) of the *Uthan Baithak* sessions can name at least X to Y6 measures (e.g. age-appropriate healthy nutrition, cognitive support, use of preventive medical check-ups and vaccinations) to improve and support the physical and mental development of their children. % of caregivers of older people implement at least X to Y6 of the recommended instructions/advice (e.g. age-appropriate healthy diet, motor and cognitive exercises).  |  |
| 3. access to (low-cost) health care is increased through the combination of low-threshold transport and community-based interventions (Connecting people to services). | *Information situation*XY % of the village population cite the lack of information about services (performance, location and costs) as (access) barriers to health care. *Transport*XY%6 of the village population state that seeking health care services is specifically avoided/prevented due to the barrier factor of transport/transport costs. *Utilisation* Due to ignorance and misinformation about health care options, access barriers such as lack of time, transport and financial resources, medical consultations are not sought despite symptoms and complaints. Access to needed medicines is difficult, especially for the target group of older people (availability & affordability). In particular, continuous access to medicines for chronic, non-communicable diseases is not available for the population in the project area.   | *Information situation*80 % of the village population state that they are informed about current health care and treatment services that are accessible to them. *Transport* By the end of 2022, a pilot concept for a financially sustainable and cost-effective transport system (from the village communities to the health facilities) could be established. By mid-2024, this has been established in practice. Spatial distance is no longer cited by villagers as a crucial barrier to accessing health care. *Utilisation*Within the 35 months, a total of at least 15,000 medical consultations were used in the context of the project activity at village level. At the end of the project, more than 80% of the target group of older persons confirm that they can obtain prescribed medication (availability and affordability). The RDF set up is managed by local structures (community clinics and their community group) and is financially stable due to constant demand.  |  |
| 4. advocacy: At the local level (Union) as well as at the upazila and district level, concerns identified as relevant by the target group were raised with the relevant government agencies. | So far, there are no targeted and regularly used communication and exchange formats between the project's target groups and the local *Union Parishad* responsible for them. Within the village communities, problems, challenges and also rights of the elderly and children receive little attention. The issues are neither discussed in public nor specifically addressed through campaign days. The two population groups (children and older people) lack support formats to make their concerns heard actively and with reach. The issues (basic rights, social security, health care) are not discussed at the village community level and consequently not effectively raised at the administrative/governmental level.  | At least 16 monthly meetings have taken place between *Shishu Parishad* and *Union Parishad during* the project period. 80% of the children and young people are satisfied with the meetings. Their concerns could be demonstrably raised. Representatives of the government and NGOs etc. took part in the annual campaign days on the rights of children and the elderly. Issues such as the right to (free) access to medicines and health care in old age, as well as the fundamental rights of the elderly and children, have demonstrably been addressed and discussed by competent bodies.  |  |

1. Based on: https://www.wvi.org/development/publication/development-assets-profile-dap [↑](#endnote-ref-1)
2. Based on: https://www.wvi.org/development/publication/development-assets-profile-dap [↑](#endnote-ref-2)
3. Based on: Health Outcome Tool (Source: HelpAge International) [↑](#footnote-ref-1)
4. Based on: https://www.wvi.org/development/publication/development-assets-profile-dap [↑](#footnote-ref-2)
5. Target value is specified after evaluation of the baseline [↑](#footnote-ref-3)