PLAN INTERNATIONAL

(Terms of Reference)

Final Evaluation for Born on Time, a public-private partnership dedicated to prioritizing the prevention of preterm birth

1. About Plan International

Founded over 80 years ago, Plan International is one of the oldest and largest children's development organizations in the world. Plan International plays an important role in mobilising children, communities and civil society organisations to claim the rights of children and achieve agreed upon local development priorities, towards a commitment to ensuring the wellbeing of children in support of the United Nations Convention on the Rights of the Child (UNCRC). Plan International is independent, with no religious, political or governmental affiliations, and with a vision of a world in which all children realize their full potential, in societies that respect people's rights and dignity.

Plan International works in fifty-two developing countries across Africa, Asia and the South America. Another twenty-one countries of Plan International raise funds to support these efforts. In 2015, Plan International worked with eighty-four million children in 85,280 communities. Plan International's Global Strategic Goal is to reach as many children as possible, particularly those who are excluded or marginalized, with high-quality programs that deliver long-lasting benefits. Children are at the heart of everything the Plan International does.

Plan International started its operation in Bangladesh in 1994. Presently under country strategy IV, Plan International Bangladesh is implementing programmes in six thematic areas: health, education, child protection, WASH, youth engagement and employment, and disaster risk management and climate change.

2. Project Background

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.* At 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 district 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 in Bangladesh

Indicator	Bangladesh[1]
Live births	3,110,000
Under 5 mortality per 1000 live births	30
Neonatal mortality per 1000 live births	17
Still birth rate (per 1000 total births)	25
% of U5 death due to prematurity	19%
% of neonatal deaths due to prematurity	30%
Preterm birth rate per 100 live births	19
Deaths from complications of preterm births	26,600
Antenatal Care (ANC) attendance (4 visits)	31%
Skilled birth attendance	33%
Maternal Mortality Rate (MMR) per 100,00 live births	173

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;
- 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 (e.g 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

[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)

- Supporting increased knowledge and evidence on approaches to prevent and care for preterm births through research initiatives.

In Bangladesh, the project works in six Upazilas in the Rangpur district: Pirgani, Gangchara, Kaunia, Mithapukur, Pirgachha and Taragonj

Every year in Bangladesh, 604,000 babies are born too soon and 23,600 children under five die due to direct preterm complications. In addition, the preterm birth rate in Bangladesh is 19% (babies born <37 weeks), the low birth weight rate (babies born <2,500g) is 22%, and annually, 22,000 babies are born before 28 weeks gestation.[2] 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),[3] 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 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).[4]

3. Assessment Focus

3.1 Overview of the Request for Proposal

A project baseline household survey and health facility assessment were 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 to lead data collection in Bangladesh for the Final Evaluation.

The Consultant will serve as the Country Study Lead (CSL) for the Final Evaluation in Bangladesh. In addition to working closely with Plan International, the CSL will work in partnership with a Global Consultant, who will serve as the lead coordinator for the final evaluation across the three implementing countries.

The CSL will be primarily responsible (with support and oversight from the Global Consultant) for contextualizing tools to the Bangladesh context, enumerator training, qualitative and quantitative data collection, quality assurance, data entry transcription, field report and local results sharing. While data analysis will be primarily the responsibility of the Global Consultant, the CSL will provide some support for data analysis. Report writing will be the responsibility of the Global Consultant.

3.2 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:

[2] Every Preemie Scale Bangladesh Country Profile (updated May 2019): https://www.everypreemie.org/wp-content/uploads/2019/07/Bangladesh_7.5.19.pdf
[3] 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.
[4] Bangladesh DHS, 2014.

- Assess the BOT project's performance vis-a-vis the *DAC (Development Assistance Committee of OECD) 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. Scope of work

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:

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 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

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

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 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?

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. Methodology

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

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.

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5.1 Data Collection Methods

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 13-18, 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.

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.

The household survey, health facility assessment and adolescent survey were developed and piloted at baseline.

5.2 Quantitative Methods

The sampling methodology will be developed by the Global Consultant in consultation with Plan International.

Given the geographic coverage of the project, it is expected that the household survey will be conducted using a random multi-stage cluster sampling methodology to ensure cost-effectiveness and efficiency in survey implementation. This is similar to the methodology employed at baseline. 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. No specific sampling strategy is expected to be applied to ensure proportionate distribution of male and female index children. 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 interviews with male partners be conducted in 90% of eligible households.

Health facilities will be selected from the same clusters where the household survey is being undertaken. Facilities outside of these clusters may be selected to reach the desired sample size. 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.

Adolescents for the adolescent survey will be identified through the project's adolescent groups. The sample of adolescents will also be drawn from the groups formed in the clusters where the household survey is being undertaken.

Initial estimates of sample sizes have been developed for this TOR. While they are subject to change, they should serve as guidance for developing the proposal, timeline and budget.

Tool	**Respondent type**	**Estimated sample size**[5]	**Length of survey**
Household survey	WRA 15-49 with a live birth within 24 months, Male partners	1400 WRA, 1260 male partners	60-90 minutes for WRA 30-45 minutes for male partners
Health facility assessment	Key informants at project supported health facilities, Client exit interviews with adolescent boys and girls seeking SRH services	31 facilities Minimum 12 exit interviews	60-90 minutes for health facility assessment 45 minutes for exit interview
Adolescent survey	Girls and boys, ages 13-18, nulliparous, who participated in adolescent groups formed under the project	340 girls 340 boys	45 minutes

5.3 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 is expected to make use of various qualitative techniques such as: focus group discussions (FGD), key informant interviews (KII), among others.

[5] Sample sizes are estimates only and will be finalized in conjunction with the Global Consultant. The actual sample may vary by +/- 10%

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 (approximately 3-6 FGDs per group):

- 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
- Adolescent girls, 15 – 19; unmarried; nulliparous
- Adolescent boys, 15 – 19; unmarried; nulliparous

Approximately 15-20 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 and leaders
- Health Administrators
- UH&FWC Management Committee members
- Project implementing partners
- Project staff

5.4 Secondary Data Review

In order to meet the evaluation objectives and respond to all evaluation criteria, 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. Expected competency

Plan International Bangladesh is looking for a consultant experienced in conducting quantitative and qualitative data collection for MNCH/SRHR programs. Both institutions and individuals are eligible to apply for this assignment. 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
- Experience in administering household surveys, health facility assessments and qualitative tools for health programs

- Should have clear understanding on the challenges of administering data collection in rural and remote health facilities and communities.
- 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
- Extensive experience performing gender analysis
- 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 the project locations and any related cultural, political, or religious sensitivities relevant to the completion of this assignment
- Excellent writing and communication skills in English
- Demonstrated experience developing mobile data collection tools, including proficiency in software platform programming, training and management, is preferred

7. Deliverables and timeframe

The Country Study Lead (CSL) will work closely with the Global Consultant to deliver the Final Evaluation for the project. The key responsibilities and deliverables expected from the CSL 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:
    - Based on suggested methodology and sampling methodology detailed worked plan with key milestones.
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    -
    - A detailed overview of considerations regarding *gender equality* and *child protection / safeguarding* throughout the study, and especially during field work
    - A section on risk assessment during data collection and mitigation strategies.
- **Data collection tools**:
    - Review of data collection tools used at baseline and midterm, and provide modifications and contextualization as necessary to ensure accurate data is collected.
    - Support the Global Consultant with the development of *new* data collection tools required to meet the study objectives
    - Development of mobile / ICT-based data collection tools, if needed
- Recruit data collectors, translators, field supervisors and other required roles for the data collection
- Ensure any required ethics approvals are obtained on time
- Provide enumerator training with support from the Global Consultant, including any refinement of tools as required during the training
- Pilot and test all data collection tools with WRA, male partners, and other respondent groups as appropriate, capturing learnings and refining tools for field work
- Oversee data collection, provide supervision and perform spot-checking to ensure quality data
- Ensure data collection activities are gender responsive, adolescent friendly and respect child safeguarding principles

- Data verification, data entry, data cleaning and production of clean, raw datasets for the Global Consultant; incorporate feedback from the Global Consultant and Plan as required
- Transcribe qualitative data recordings (verbatim) and undertake contextual translation for all qualitative interviews (FGDs, KIIs, etc.)
- Support or provide input on preliminary analysis, emerging themes, and contextually appropriate interpretation for qualitative analysis
- Provide feedback on the draft country-level report
- Support the presentation and dissemination of results to partners and stakeholders in Bangladesh

The Global Consultant will be responsible for the overall management, study design and methodology, technical oversight and report writing. Specifically, the roles and responsibilities of the Global Consultant supporting this work are to:

- Orient the local study teams
- Develop the project methodology and sampling strategies
- Review and revise existing data collection tools and work with the CSL to contextualize tools as necessary
- Develop data collection and management protocols, including considerations for inclusive, gender responsive and adolescent friendly field work and child safeguarding
- Provide oversight and quality control during data collection process
- Verify, process and analyse all quantitative and qualitative data
- Draft the final evaluation report, including country specific reports and a summary chapeau report
- Present findings to BOT partner staff and stakeholders

For all the responsibilities identified above, the Consultants will work in collaboration with BOT country office staff and Canada-based staff as appropriate.

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.

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

Deliverable	Timeline
Contract awarded	2nd week of February 2020
Orientation with Global Consultant and document review	3rd week of February 2020
Detailed inception report	4th week of March 2020
Complete ethics approvals	2nd week of April 2020
Final inception report, including tools	3rd week of April 2020
Pre-test, translation and back-translation of tools	April – May 2020
Enumerator Training	April – May 2020
Data Collection	June – 2nd week of July 2020
Submission of raw data and transcripts	July 2020
Support data analysis	September 2020

Deliverable	Timeline
Review draft country report	October 2020
Results dissemination	November 2020

8. Mode of payment

The payment will be made in three instalments:

Instalments	Percentage	Timeline
First instalment	30	After written acceptance of inception report by Plan International
Second instalment	30	After written approval of the satisfactory submission of the raw data and transcripts to Plan International
Final instalment	40	After written approval of the final report by Plan International

9. Evaluation criteria and scoring

Criteria	Score
Realistic workplan to address suggested methodology in considering country context	40
Relevant competency of team leader and team composition	40
Amount of budget and justification	20

10. Preparation and submission of proposal

The proposal will be divided into two parts and should be submitted in one zip folder. The technical part of the proposal should not exceed 20 pages without annexure. Necessary other documents would be added as annexure. The technical proposal will contain the followings:

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- Detailed timeframe with key milestones (including dates for submission of first draft, dissemination of findings and final report).
- Account of experience of conducting survey and employing proposed methods.
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- CVs of the team leader and key members of the study team which reflect relevant experience to conduct the study.
- Copy of VAT registration certificate (for consulting firm).
- Copy of valid TIN certificate and bank account detail.

The financial proposal should clearly identify, item wise summary of cost for the assignment with detail breakdown. The budget should not contain income tax as a separate head; it can be blended with the other costs as it will be deducted from the source. However, VAT can be mentioned in the budget as per government regulation. The organisation will deduct VAT and Tax at source according to the GoB rules and deposit the said amount to the government treasury. The consultant/consulting firm is expected to provide justified budget, which is consistent with technical proposal.

The technical and financial proposals should be submitted electronically to the email address: planbd.consultant.hiring@plan-international.org with subject line **Born On Time Project – Final Evaluation**. Proposal submitted to any other email account except this and in hard copy will be treated as disqualified. Submissions after the deadline **28 January 2020** will be treated as disqualified. The technical and financial proposal should be submitted in pdf format into one zip folder with a covering letter.

11. Penalty clause

The consultant/consulting firm is expected to provide services within period as well as submit the final report maintaining the quality as mentioned in section 7. If the quality is not maintained as mentioned in section 7, Plan International Bangladesh will deduct 5% of the total agreement amount. If for any reason, the consultant/consulting firm fails to deliver services within stipulated time, the consultant/consulting firm needs to inform Plan International Bangladesh without any delay in time with valid and acceptable explanation. Failing to this may evoke penalty clause at the rate of 1% for each day of delay.

12. Contact person

For any technical issue related to the study, please communicate Tamanna Sharmin, Manager, Research and Knowledge Management Specialist, to the following email ID: tamanna.sharmin@plan-international.org

13. Ethical Considerations

There will be nothing in the study which may be harmful for respondents regarding legal or medical ground. No one would be forced to provide information for the study. The objectives will be clearly explained to all the respondents of the study before gathering data from them. The evaluators will be abstained from collecting data from those who will deny or show any kind of disinterest in providing information. Thus, verbal/written consent of the respondents should be taken before collecting data. Confidentiality of data should be maintained and in the report name of the respondents should not be revealed.

14. Child Protection Policy

The consultant/consulting shall comply with the Child Protection Policy of Plan International Bangladesh. Any violation /deviation in complying with Plan's child protection policy will not only result-in termination of the agreement but also Plan will initiate appropriate action in order to make good the damages/losses caused due to non-compliance of Plan's Child Protection Policy.

15. Intended users of evaluation

The intended users of the study are Plan International Bangladesh and its implementing partner, LAMB; and BOT consortium members. Additional intended audiences may be project donors, including Johnson and Johnson and the Global Affairs Canada; and government partners, including Ministry of Health and Family Welfare, Bangladesh.

16. Bindings

All documents, papers and data produced during the assessment are to be treated as Plan International Bangladesh property and restricted for public use. The contracted consultant/consultant firm will submit all original documents, materials and data to country office of Plan International Bangladesh.

17. Negotiations

Once the proposals are evaluated, Plan International Bangladesh may enter into negotiation with one or more than one consultant/ consulting firm for final selection. If negotiations fail, Plan International

Bangladesh will invite consultant/consulting firm who had submitted the proposal and received the next highest score, for negotiating a contract. If none of the invited proposals led to an agreement a new Request for Proposals (bidding document) will be called for.

18. Disclaimer

Plan International Bangladesh reserves the right to accept or reject any or all proposals without assigning any reason what so ever.