CARE International in Sudan

BHA Project: Multi-sectoral and integrated humanitarian assistance for the conflict displaced and most vulnerable populations in East and South Darfur- Sudan

(15 September 2022 – 15th September 2024)

Scope of Work (SoW) of the project final evaluation

Background:

Approximately 14.3 million people in Sudan will need humanitarian assistance in 2022, 30% of the entire population[1]. As of November 2021, there were over 3 million IDPs in Sudan, the majority of them (~1.75 million) in the Darfur region as a result of the conflict that started in nearly two decades ago in 2003. Despite substantial assistance in the Darfur region over the past decade, there continues to be a significant need as many areas remain prone to conflict and climate shocks. This proposed intervention will provide integrated, sustainable, and lifesaving WASH, health, and nutrition services to crisis-affected and vulnerable host community members and IDPs in East and South Darfur.

Since April 2023, fighting between Sudan's Rapid Support Forces (RSF) and the Sudanese Armed Forces (SAF) has displaced over 1.8 million people2 and has affected 24.7 million people who are in urgent need for humanitarian assistance3. The conflict has taken an extreme toll on urban areas, including localities in Khartoum and South Darfur states, where people are living in 'extreme' or 'catastrophic' humanitarian condi-tions4. IOM reports the majority of IDPs are from Khartoum state (69.3%).

WASH; East and South Darfur have chronic WASH needs due to the protracted nature of the crisis and the high number of IDPs and refugees. The key drivers of WASH needs are the deepening economic crisis; lack of investment in already-weak and aging WASH services; poor knowledge, attitude, and practices related to lack of community governance of WASH infrastructure in rural areas; huge disparities amongst the rich and poor; and climate change. Additionally, high rates of undernutrition in both states are associated with poor WASH services. The current fighting has severely affected water treatment and supply centers in Khartoum and other urban areas where the majority are not currently functional and waste disposal services are not available.

Health: Sudan remains prone to disease outbreaks, including cholera, chikungunya, dengue, malaria, and measles. Childhood immunization rates are in decline across the country. Additionally, during 2021, the availability of emergency medicines declined steadily, reaching 43% compared to 57% during 2020. With recent violence, approximately 70% of health facilities across Khartoum are no longer functioning.

Nutrition: The overall number of people in need of nutrition support in Sudan has increased by 8.8% from 2021 to 2022 (3.9 million people), mainly children under-five and pregnant and lactating women. East Darfur and South Darfur have catastrophic levels of acute malnutrition. The overall number of people in need of nutrition support in Sudan has increased, as shown by the S3M (2018-2023) survey conducted on 2018, the survey shows high prevalence on malnutrition in Sudan as general. In South Darfur Global Acute Malnutrition (GAM) is estimated at 23.8%, SAM is estimated at 6.2% and in Kass child GAM is estimated at 12.6%, SAM at 2.4%. In East Darfur GAM is estimated at 39.8%, and SAM is estimated at 17.9: in Bahar Al Arab GAM 35.1% and SAM at 16.5% and in Sheria GAM at 39.0%; and SM is estimated at 22.6%. Due

[1] Data for this section comes from OCHA. December 2021. *Humanitarian Needs Overview Sudan 2022*.
[2] **IOM Response Overview: Sudan crisis and neighboring countries. 17 May 2023.**

[3] **OCHA. Sudan Situation Report. 28 May 2023.**

[4] **Ibid.**

to the current crisis, there has been an estimated 30% increase in the number of children with acute malnutrition in the affected areas.

Project goal: The goal of the project is ***"To reduce the suffering and build the resilience of the most vulnerable IDP and host populations in Khartoum, East and South Darfur through integrated WASH, health, nutrition and multipurpose cash-based humanitarian assistance"***.

Theory of Change (ToC) (statement): The project's Theory of Change (ToC) draws on evidence from CARE's long-term experience in Khartoum, East and South Darfur implementing humanitarian and development programs, as well as promising practices and lessons learned from recent interventions in the target areas.

IF vulnerable communities and IDPs have access to sustainable, integrated, and high-quality WASH, health, and nutrition services THEN host communities and IDPs will have reduced suffering and increased resilience and well-being.

The evaluation should focus on measuring the achievement of the designed indicators shown in below table.

More information about measuring the indicator can be found in the Indicator_Handbook_March_2021.docx

Project objective and sectors indicators

Purpose1	Provision of integrated, sustainable, and lifesaving WASH, health, and nutrition services to crisis-affected and vulnerable host community members and IDPs in **Khartoum,** East and South Darfur.
Sector I	**WASH**
Sub-sector Name	**Water supply**
Indicator W01	Number of individuals directly utilizing improved water services provided with BHA funding.
Indicator W02	Number of individuals gaining access to basic drinking water services as a result of BHA assistance.
Indicator W03	Average liters/person/day collected from all sources for drinking, cooking, and hygiene.
Indicator W04	Percent of water user committees created and/or trained by the WASH activity that are active at least three (3) months after training.
Indicator W05	Percent of water points developed, repaired, or rehabilitated that are clean and protected from contamination.
Sub-sector Name	**Sanitation**
Indicator W06	Number of individuals directly utilizing improved sanitation services provided with BHA funding.
Indicator W07	Number of individuals gaining access to a basic sanitation service as a result of BHA assistance.
Indicator W08	Number of basic sanitation facilities provided in institutional settings as a result of BHA assistance.
Indicator W09	Percent of households targeted by latrine construction/promotion activity whose latrines are completed and clean.
Indicator W10	Percent of excreta disposal facilities built or rehabilitated in health facilities that are clean and functional.

Sub-sector Name	Environmental Health
Indicator W11	Number of individuals receiving improved service quality from solid waste management, drainage, or vector control activities (without double counting).
Indicator W12	Average number of community cleanup/debris removal events conducted per community targeted by the environmental health activity.
Indicator W13	Average number of vector control activities conducted per community targeted by the environmental health intervention.
Sub-sector Name	**Hygiene promotion**
Indicator W14	Number of individuals receiving direct hygiene promotion (excluding mass media campaigns and without double-counting).
Indicator W15	Percent of individuals targeted by the hygiene promotion activity who know at least three (3) of the five (5) critical times to wash hands.
Indicator W16	Percent of households targeted by the hygiene promotion activity who store their drinking water safely in clean containers.
Sector II	**Health**
Sub-sector Name	**Health Systems Support**
Indicator H01	Number of health facilities supported.
Indicator H02	Percent of total weekly surveillance reports submitted on time by health facilities.
Indicator H03	Number of health facilities rehabilitated.
Indicator H04	Number of health care staff trained.
Sub-sector Name	**Basic Primary Health Care**
Indicator H05	Number of outpatient consultations.
Indicator H06	Number of Community Health Workers (CHW) supported (total within activity area and per 10,000 population).
Indicator H07	Number and percent of deliveries attended by a skilled attendant
Indicator H08	Number and percent of pregnant women who have attended at least two complete antenatal clinics.
Indicator H09	Number and percent of newborns that receive postnatal care within 3 days of delivery.
Indicator H10	Number of cases of sexual violence treated.
Indicator H11	Number of consultations for communicable disease.
Indicator H12	Number and percent of community members who can recall target health education messages.
Indicator H13	Number of mothers with children under-five who can identify three or more health danger signs, that need an urgent referral of the children to the nearest health facility.
Indicator H14	Number of women health group established and trained on GBV and awareness raising.
Sub-sector Name	**Pharmaceuticals and other medical commodities**
Indicator H15	Number of individuals trained in medical commodity supply chain management.

Indicator H16	Number of health facilities out of stock of any medical commodity tracer products, for longer than one week, 7 consecutive days.
Sector III	**Nutrition**
Nutrition Sector Indicator 1	Number of children under five (0-59 months) reached with nutrition-specific interventions through BHA.
Nutrition Sector Indicator 2	Number of pregnant women reached with nutrition-specific interventions through BHA.
Sub-sector Name	**Maternal Infant and Young Child Nutrition in Emergencies**
Indicator N01	Percent of infants 0-5 months of age who are fed exclusively with breast milk.
Indicator N02	Percent of children 6–23 months of age who receive foods from 5 or more food groups.
Indicator N03	Number of individuals receiving behavior change interventions to improve infant and young child feeding practices.
Indicator N04	Number of individuals receiving micronutrient supplements.
Sub-sector Name	**Management of acute malnutrition**
Indicator N05	Number of health care staff trained in the prevention and management of acute malnutrition.
Indicator N06	Number of supported sites managing acute malnutrition.
Indicator N07	Number and percent of individuals admitted, rates of recovery, default, death, relapse, and average length of stay for individuals admitted to Management of Acute Malnutrition sites.
Indicator N08	Number of Management of Acute Malnutrition sites rehabilitated.
Indicator N09	Number of individuals screened for malnutrition by community outreach workers.
Purpose 2	**Provision of multipurpose cash assistance to crisis-affected and vulnerable community members and IDPs in Khartoum and South Darfur**
Sector I	**Multipurpose Cash Assistance (MPCA)**
Sub-sector Name	**Multipurpose Cash**
Indicator M01	Total number of individuals (beneficiaries) assisted through multipurpose cash activities.
Indicator M02	Percent of (beneficiary) households who report being able to meet their basic needs as they define and prioritize them.
Indicator M03	Percent of beneficiaries reporting that humanitarian assistance is delivered in a safe, accessible, accountable, and participatory manner.
Indicator M12	Percent of (beneficiary) households reporting that all household members have access to an adequate quantity of safe water for drinking, cooking, personal and domestic hygiene.
Indicator M11	Percent of (beneficiary) households that report having minimum household items that allow all the following: comfortable sleeping, water and food storage, food preparation, cooking, eating, lighting, and clothing.
Indicator M13	Percent of (beneficiary) households having access to a functioning handwashing facility with water and soap at home and essential hygiene items including menstrual hygiene products.

Evaluation Purpose

The purpose of the end line evaluation is to learn from monitoring data and supplemental qualitative methods, as well as from end line data collection. During the end line evaluation, the purpose is to assess the extent to which the project was able to achieve its targets, the extent to which positive changes can be attributed to the project's activities, how contextual factors affected implementation and the connection between actions and outcomes, the barriers and facilitators to success, and lessons learned and recommendations for how to improve the success of similar projects in the future. The evaluation will provide evidence and learning that can be applied in future projects, and to the accountability of the project to its affected population and stakeholders. Specifically, the evaluation sets out to:

1. Establish if the project achieved its set targets according to the approved Indicator tracking tables and explain any deviations from established targets.
2. To assess the relevance, efficiency, effectiveness, impact/changes, and sustainability of the interventions
3. To assess how the program ensured inclusion of vulnerable and marginalized communities and engaged with affected population and communities.
4. To document lessons learned/best practices (what worked well, what did not work well, what can be improved - practices that worked well during the project period?) and provide evidence-based recommendations for similar future interventions.

Audience of the Findings

The main audience of the findings will be BHA, CARE, Sudan line ministries, CARE partners and other humanitarian organizations in Sudan and beyond as well as the targeted communities. Table explains the potential use of the results from the evaluation.

Audience	Use of Evaluation Findings
BHA	BHA will use the evaluation findings to promote the key results delivered and impacts observed to its constituency as part of BHA's effort in effective aid delivery in Sudan. Moreover, BHA can still use the evaluation findings to extract useful information to make informed decision and consider the evaluation as part of evidence of return for the resources invested in Sudan.
CARE	Evaluation findings and recommendations will be used for new programming in Sudan and follow up the status of recommendation and use the evaluation data as a final reference for next phase. Moreover, the learnings and best practices along with individual cases/success stories would be used to improve performance in the next phases.
Humanitarian Community in Sudan and beyond	Other stakeholders will utilize the findings for new programmes and plans at a broader cluster level, and as final data for next rounds of humanitarian interventions.
Community/Beneficiaries	The evaluation will engage the affected communities to confirm that the program's intended results resulted in benefits, validating how accountable the programme was to the affected people.

Expected limitations, challenges and mitigations:

Limitation/Challenge	Mitigation measures
The targeted states are currently inaccessible due to the impact of the ongoing war on travel.	• The selected consultant/firm will work remotely, while the MEAL team in South Darfur and East Darfur will assist in collecting data in the field. • Local partner in Khartoum will lead the data collection under supervision of MEAL team. • The team leaders in the states will receive the necessary orientation and training from the consultant before conducting the data collection. • Utilize Kobo toolkit to gather quantitative data in order to improve precision and facilitate prompt data entry into the system.
The challenges in Khartoum state include a lack of communication and unavailability of CAE staff. Additionally, using mobiles for data collection is difficult	• Have good coordination with authorities in the different sites • Assess the situation during data collection and find alternative methods for collecting data in Khartoum state. • Involve local partners and volunteers to collect data using hard copies, which can be transferred to Kobo later.
The absence of the consultant in the field may have a negative impact on the collection of high-quality qualitative data.	• recruiting individuals who are highly skilled and experienced in data collection, specifically for gathering qualitative data using methods such as Focus Group Discussions (FDGs) and Key Informant Interviews (KIIs). • Continuous follow up with team in the field to ensure accuracy of data collected and do required improvement.
The three states being targeted are now under the authority of the Rapid Support Forces (RSF)	• Significant level of cooperation across all stages of the evaluation process, and ensure getting the approval for each stage.

Scope of the evaluation:

Geographical coverage: The final evaluation will take place in the project implementation areas in eleven localities distributed in three states as below;

State	Localities
East Darfur	Assalaya, Abu Karinka, Bahar Al Arab, Ad Du'ayn, Sheria, and Yassin
South Darfur	Beliel, Gerida, and Kass localities and East and South Jebel Mara areas
Khartoum	Jabal Awlia and Umbada localities

Evaluation Type

The end line evaluation for this project will be a performance evaluation that follows a pre-post design using mixed-methods data collection and analysis approaches.

The evaluator will apply the OECD/DAC criteria to assess the relevance, efficiency, effectiveness, and sustainability of the BHA project. The key evaluation questions include:

Relevance: *Is the intervention doing the right things?*	• Were interventions appropriate and effective for the target group based on their needs? • Which target groups and individuals were reached by the interventions? • How effective was the targeting approach in achieving the activity goal?
Effectiveness: *Is the intervention achieving its objectives?*	• To what extent do the activity's interventions appear to have achieved their intended outputs and outcomes? • To what extent do project intervention improved beneficiaries access WASH Health and Nutrition services.
Efficiency: *How well are resources being used?*	• How were problems and challenges managed? • To what extent have the activity's interventions adhered to planned implementation schedules? • What was the level of efficiency and timely delivery of the goods or services?
Sustainability: *Will the benefits last?*	• To what extent did the activity take advantage of other USG and non-USG investments in the same target areas to facilitate linkages with complementary services, layering with earlier investments, and implementing an exit strategy? • To what extent did the activity align and integrate with host government social protection strategy/policy/service delivery? • Was the activity able to end operations at the close of the award without causing significant disruptions in the targeted communities?

Evaluation design and methodology

The evaluation is expected to employ a "mixed methods approach" that combines quantitative and qualitative techniques. The evaluation is expected to involve boys/girls, men/women, partners and stakeholders, field visits, and review of program document and program data. Data collection techniques may include desk reviews, key informant interviews, focus group discussions, satisfaction survey and observations. The team leader is expected to give due attention to the methods employed at baseline used to benchmark the performance of tracked outcome indicators. The survey will incorporate both qualitative and quantitative components, using, but not limited to, the following key data collection methods:

1. Desk review of project documents and other background documents like project proposal, log frame, assessment reports, etc
2. Survey to collect quantitative indicators that cannot be assessed through secondary data
3. Semi structured interviews with key informants and other community groups such as women and youth groups
4. Focus group discussions with target women, girls, men, and boys, as well as community leaders.
5. Observations from the field – basic service provision, natural environment, community institutions, livelihoods activities, etc.

Any limitations to obtaining and verification of program data as well as to the methods and analysis should be clearly documented in the report. All efforts should be made to capture gender disaggregated data.

The team leader is expected to refer to the OECD-DAC criteria, the Sphere Standards and BHA guidelines on Evaluating Humanitarian Actions.

Evaluation Approach

An independent external team leader has responsibility for the evaluation. Because of challenging travel conditions, the external team leader will be working remotely. The CARE MEAL team will provide support to the leader throughout data collecting. The team leader will assess the tools utilized for the baseline survey and make any necessary modifications.

For more accuracy and easy transferring data, quantitative data will be processed digitally using kobo toolbox. Team leader will be responsible from upload the household questionnaire to the Kobo system and provide training to the field team and enumerators. Additionally, he/she will do data analysis and generate the evaluation report. The CARE MEAL team will assist in collecting data in the field on behalf of the team leader due to the challenges of traveling to the specific states and localities.

The evaluation process will involve active participation from the project's local partners, namely JMCO, SADO, NAHA, and SHOA. The evaluation team will gather information from the respective staff of these partners, who will serve as key informants. Additionally, a project staff member from each partner in the states will be involved in the data collection process in the field.

Secondary Data Analysis and Desk Review

The selected team leader will do secondary data analysis and a thorough examination of all project documents and reports in order to provide a foundation for reviewing and updating data gathering tools. Furthermore, project documentation and other reports will be utilized to assess the progress made on monitored output indicators and record the extent to which the interventions have met their predetermined targets. The review will offer potential justifications for any deviations from the established goals. CARE will provide the team leader with the essential project documentation and strategy documents to enable the evaluation. The desk review will also assess the degree of accomplishment of planned actions and the level of achievement of the established targets.

Mixed-methods Performance Evaluations: for this project CARE will conduct a performance evaluation which consist of both quantitative and qualitative data collection, which are systematically integrated. A final, mixed-methods performance evaluation must integrate a comparison of baseline and end line quantitative data, as well as a qualitative study. The qualitative study should be designed to explore issues identified in the quantitative results and answer evaluation questions that are beyond the scope of the quantitative survey (e.g., sustainability, management, etc.). Where possible, mixed-methods performance evaluation should pull from other sources of data including different project reports.

Population-based survey (PBS):

A population-based survey (PBS) will be conducted to assess changes in outcome indicators on access to safe drinking water, hygiene practices, access to safe and recommended latrines as well as access to optimum health services as these services are targeting the whole community. The PBS will follow a two staged sampling technique as detailed in the BHA M&E guidance document. The first stage of sampling will be the selection of villages from a sampling frame of all targeted villages in the catchment areas of targeted HFs that are also receiving WASH services from the program. The first stage will employ probability proportional-to- population size (PPS) sampling to select villages to be enumerated. The second stage of sampling will include the systematic random sampling of households from the selected villages. Focus Group Discussions and Key Informant Interviews. Sample size for the PBS will be based on the proportion of households targeted by the WASH program that are collecting all water for drinking, cooking, and hygiene from improved water sources.

Focused group discussions will be conducted with a number of groups to tease out and document community perceptions, areas of strength and areas of improvement in the different interventions under the project. Focused group discussions will be conducted with community members and community structures such as the water management committees and community development committees. Key

Informant interviews will be conducted with line ministry management, local authority representatives, cluster-coordinators and community leaders to document the interventions' strengths and gaps in technical designs, coordination and implementation especially considering timeliness, sequencing and soundness of the interventions.

Sample size determination and sample distribution:

This evaluation will use Glenn. I., 2002 method to determine the sample size, for more accuracy, sample size will be calculated separate for each state. The identified sample size will be distributed proportionally to different localities and locations.

Glenn. I., 2002 method to determine the sample size.

Sample size **(n) =** Total **HHs (N) / (1+N*r²) (**r is a margin of error (degree of accuracy).

The sector indicators will be measured with a margin of error of 5%. The total number of samples for each sector will be allocated respectfully among the states depending on the number of beneficiaries in these sectors in the three states. The table below shows the sample size for each sector:

Sample distribution y sectors

Sector	Total target	Sample size at 5% margin error
WASH	758,510	400
Health	560,455	400
Nutrition	210,707	399
MPCA	9,660	384
Total		**1583**[5]

The whole sample will be allocated to the three states in proportion to the distribution of targeted beneficiaries in each sector. Therefore, the samples will be distributed to the states as follows:

Samples distribution per state and sectors

Sector	Total sample size	SD	ED	KH
WASH	**400**	192	184	23
Health	**400**	189	200	11
Nutrition	**399**	205	167	27
MPCA	**384**	131	0	253
Total	**1583**	**718**	**551**	**314**

Data Collection Tools and Procedure

The team leader and CARE will work closely together to update and develop the evaluation tools. The PBS surveys will to a larger extent adopt the baseline tools but with a few updates considering any new information required that was not needed or missed at baseline. FGDs and KIIs tools will be developed with the guidance of the team leader and considering evaluation questions/ matrix. All questionnaires and tools will be translated to Arabic and deployed in Arabic. CARE will hire and train enumerators and supervisors for collecting primary data. Quantitative data will be collected digitally through mobile phones using kobo toolbox.

[5] The total sampling include over lapping, and do not give number on individuals as many people were reached through different sectors

Data Collection and Quality Assurance

The team leader will be responsible for ensuring data quality throughout the collection period. Prior to data collection, training will be provided to enumerators on the tools and field visit procedures. Survey, FGDs and KIIs tools will be pre-tested prior to the actual data collection to identify challenging questions and internalizing the questions. At field site, CARE MEAL team will conduct spot-checks and review completed questionnaires for completeness and accuracy. Every morning before data collection begins, enumerators will be given feedback on issues identified from the submitted or completed questionnaires. The final completed questionnaire will be signed off by the enumerators, supervisors, and MEAL officers.

Data Analysis and Report Writing

Quantitative primary data will be entered onto Kobo-collect online system. The external independent team leader will be responsible for data analysis and compiling the final report. Qualitative data will be analysed following content analysis methods or equivalent approaches.
In general. The methodology should be designed to mitigate against the numerous risks and challenges in the context, which will be discussed in more detail during inception phase, Finally, the consultant will be seeking to work to the principles of evaluation. Specifically, and not outlined/specified elsewhere in this scope of work.

- ***Independence:*** measures should be put in place to prevent bias.
- ***Usefulness:*** final findings must be articulated clearly and in a way that maximizes the potential for these findings to inform decision-making.
- ***Representativeness:*** final should strive to include a wide range of beneficiaries, including from different genders, age groups, ethnic groups, and locations (e.g., urban, and rural) as relevant to the project.
- ***Gender and protection sensitivity:*** final must be gender and protection sensitive and also, where possible, ensure to assess the intended or unintended effects of the project on gender roles and responsibilities and power relations. At the same time, the final must assess the protection risks that faced the target groups from men, women, boys, and girls.

CARE Tasks

In order to make the evaluation assignment successful and deliver expected activities within the deadline and high quality, the evaluation shall undertake the following key tasks:

- Facilitate meetings with key project staff of CARE, CARE management, and/or other stakeholders.
- Consolidate feedback on data collection tools from program quality team and finalize draft data collection tools to be tested.
- Facilitate training for the enumerators who will pre-test the data collection tools. If necessary, make final adjustments to data collection tools in consultation with the program quality team.
- Collect data from a representative sample of individuals from the target groups and key project relevant stakeholders using household questionnaires, key informant interviews (KII) and Focus Group Discussions (FGDs)
- Transcribe FGDs/ KIIs interviews.
- Organize and conduct training for enumerators focusing on data collection tools, methods, and overall field data collection process.

Individual Consultant/Firm Tasks

- Write the inception report including finalizing the evaluation methods and present it to the respective program quality and project team members.
- Review of baseline tools and update it as required.
- Upload of the quantitative tool in kobo collect system.
- Orientation of MEAL team in the field on the different tools and data collection strategy.
- Conduct data analysis Report writing and submission of first draft report.
- Presentation of findings and recommendations to and validation by key stakeholders.
- Finalize the report incorporating feedback and submission of final report.

There should be adequate female representation and participation throughout the data collection process. Where necessary, especially in rural areas, focus group discussions should be conducted separately for men and women and by data collectors of the respective genders. This arrangement will provide an opportunity for women to participate and share their insights and ideas freely.

Deliverables and Timeframe

The timing of the evaluation is expected to start in July 2024 – preparatory activities included and be completed data collection by 20th August 2024 with the delivery of the final report in 10th September 2024. Hence, the duration of the assignment is up to a maximum of 64 days. The important timeline for the key deliverables and milestones presented in the table below:

#	Key Deliverable/Milestones	Expected Level of Effort	Responsible	Deadline
1	**Preparation Phase**			**25th July 2024**
	• Develop detail SOW. • Share with PQ team and TAs with request for review and feedback. • Develop field plan and share with MEAL officers for implementation. • Identify and appoint an international individual consultant for data analysis and writeup.	10 days	CARE MEAL	
2	**Inception Phase**			**20th August 2024**

	• Contract signing & Inception meeting
	• Desk review of relevant project documents
	• Development and submission of an inception report for the evaluation including:
	  ○ Clear methodology, sample size and sampling strategy.
	  ○ Tools development, review, translate to Arabic loading into KOBO and testing.
	• Incorporate comments and Final submission of approved inception report.
	• Logistic planning.
	• Hiring of enumerators.
	• process and finalize al required permeations from HAC and other institutions
		8 days	Consultant and CARE	

3	**Data Collection Phase**			**20 September 2024**
	• Conduct actual data collection.	10 days	CARE MEAL	

	• Data entry, cleaning, and organization • Share clean data with consultant			
4	**Data management, analysis, and interpretation**			**30 September 2024**
	• Review data, share comments with CARE MEAL team for any missing data. • Clean SPSS/ R datasets • Clean FGDs/ KIIs transcripts • Complete data analysis, interpretation for both quantitative and qualitative data • Conduct data visualization.	7 days	Consultant	
4	**Evaluation reporting Phase**			**20 October 2024**
	• Draft evaluation Report and submitted for review. • Review report and comments shared with consultant. • Presentation (validation workshop) to Evaluation Technical working group including Project partners. • Final Report along with clean evaluation data submitted	5 days	Consultant	
5	**Dissemination and Documentation**			**15 November 2024**
	• Share the final evaluation findings with CARE for documentation as well with USAID for record and reference. • Document management plan for evaluation recommendations. • Profile and Document research activities	NA	CARE Sudan; CARE USA	

The evaluation report shall not exceed a maximum of 35 pages (excluding annexes). The evaluation report will be in English and submitted as an electronic copy (both PDF and MS Word format). The draft and final reports will have the following structure at a minimum.

- **Title of evaluation:** Title must identify the type of evaluation, identify what was evaluated, avoid acronyms
- **Abstract:** Abstract of no more than 500 words briefly describing the evaluation questions, intervention evaluated, methods, and key findings. Brief caption describing the cover image with photographer credit
- **Table of content:**
- **Acronyms**
- **Executive summary:** includes
    - Evaluation purpose and evaluation questions
    - Background
    - Evaluation questions, design, methods, and limitations
    - Findings, conclusions, and recommendations
- **Evaluation purpose and evaluation questions:** includes
    - Evaluation purpose
    - Evaluation questions

- **Background:** provide brief background information on the strategy, intermediate result, project, activity, or intervention evaluated. This should include country and/or sector context; the specific problem or opportunity the intervention addresses; and, where available, the development hypothesis, theory of change, or simply how the intervention addresses the problem. It may also include other relevant background information, such as any changes that have occurred since the intervention started, a description of the beneficiary population, and the geographic area of the intervention.
- **Evaluation methods and limitations:** This section should provide a detailed description within one to three pages of the evaluation methods, why they were chosen, and their strengths and limitations. If more space is needed, additional detailed information on the methods should be provided in an annex.
- **Findings:** Findings are empirical facts based on data collected during the evaluation and should not rely only on opinion, even of experts.
- **Conclusions:** Conclusions synthesize and interpret findings and make judgments supported by one or more specific findings.
- **Recommendations:** They are specific actions the evaluation team proposes be taken by program management that are based on findings and conclusions. The reader should be able to discern what evidence supports the conclusions and recommendations.

Under the guidance of the team leader, herein referred to as the consultant, CARE will conduct data collection and meet all costs related to data collection. The consultant will lead the exercise remotely working closely with CARE MEAL team During the implementation of this assignment, the evaluation team shall respect the terms and conditions of CARE policies and procedures on code of conduct, data protection and copyright, etc. CARE branded templates will be used to compile the final report and other products developed from the evaluation. The title rights, copyrights and all other rights of whatever nature in any materials used or generated under the provisions of this consultancy will exclusively be vested with CARE Sudan. All products developed under this consultancy belong to the project exclusively, guided by the rules of the grant contract. The consultant will need prior written permission to use any information from this evaluation for publication or dissemination.

Required Competencies from the Individual Consultant

- Individual consultancy
- Advanced university degree (Masters / PhD) in International Development, Social Sciences, or any other related field with a minimum of 5 years of professional in international development and program evaluation.
- Demonstrated experience in assessments and/or evaluations of interventions on WASH, Health, Nutrition and Protection.
- Proven experience in data analysis, interpretation, and visualization
- Previous professional experience in Sudan/Africa is highly desirable.
- Excellent understanding of humanitarian and development issues.
- Advanced analytical and report writing skills.
- Proven and strong writing English language skills, with Arabic as a plus.
- Thorough understanding of different data collection methods.

Management of the consultancy and logistical support

The principal contacts for this consultancy will be the CARE Studies Evaluation Research and Learning coordinator. Under the guidance of the team leader, herein referred to as the consultant, CARE will conduct data collection and meet all costs related to data collection. The consultant will lead the exercise remotely and working closely with CARE MEAL team. During the implementation of this assignment, the evaluation team shall respect the terms and conditions of CARE policies and procedures on code of conduct, data protection and copyright, etc. The title rights, copyrights and all other rights of whatever nature in any materials used or generated under the provisions of this consultancy will exclusively be

vested with CARE Sudan. All products developed under this consultancy belong to the project exclusively, guided by the rules of the grant contract. The consultant will need prior written permission to use any information from this evaluation for publication or dissemination.

Application process:

The deadline for submission of applications and hiring an individual consultant is **20th July 2024** COB Sudan Time. All applications should include the following:

- **Cover letter** (maximum 1 page) stating the candidate's availability during the evaluation period and **updated CVs** of the main consultant, including **three references** with contact details.
- **Technical proposal**: Which should include **(i)** brief explanation about the consultant with particular emphasis on previous experience in this kind of work; **(ii)** profile of the consultant to be involved in undertaking data analysis and report writing of the evaluation, **(iii)** anticipated data analysis and interpretation plan; **(iv)** understanding of the TOR and the task to be accomplished, **(v)** proposed methods and approach to conduct the evaluation **(vi)** draft work plan for the assignment(data analysis, interpretation and report writing).
- **Financial Proposal**: Detailed budget that includes cost for data analysis, interpretation, visualization, software used and report write up.
- **One previous similar report,** relevant to the scope of work and deliverables indicated above for Donors like BHA, USAID, EU, ECHO etc. and conducted in Sudan or area.
- **Copy of firm's** legal documents (valid tax ID, commercial registration, etc.) and firm's profile.

Interested consultants should submit their applications through emails to:
Procurement: najat.ahmed@care.org & wala.yousif@care.org
SERL coordinator: Nasreldin.Saeed@care.org

Applications will be evaluated based on the following criteria:

- Technical experience and expertise
- Quality of proposal
- Cost-effectiveness of proposal (best value)
- Sample reports.

Please note: Technical proposal will be rated 60%, and the financial proposal will be rated with 40%.

Bids must include the following:

- Cover letter: stating candidate skill and experience suitable for the consultancy (max 1 page)
- Outline of evaluation framework and methods, proposed timeframe, work plan and budget (max 3 pages)
- CV and sample of similar assessments/research carried out previously.

All bids and proposals must be sent to:

sdn.procurementtender@careinternational.onmicrosoft.co and Cc: najat.ahmed@care.org.

More details: Please the following link for more information;
https://www.sudanbid.com/jobview.php?id=2267&s=

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