Introduction

Mercy Corps' (MC) PROCOMIDA Program (Community Food Diversification Program for Mother and Child) requires the services of a Consultant Firm to perform a Final Evaluation (FE). The objective of this activity is to measure actual impacts and results as compared to goals and to identify constraints that have influenced the ability to achieve these goals. PROCOMIDA is a six year Title II Food Security Program that started in July 2009, funded by United States Agency for International Development (USAID) under agreement number AID-FFP-A-09-00005, and seeks to improve nutritional status and health of women and children vulnerable to food insecurity in Alta Verapaz.

PROCOMIDA efforts consist of three main components:

Food component: The program is expected to increase availability of staple food through commodity distributions (rice, pinto beans and vegetable oil as the household ration) for the participating families, and micro-nutrient rich food\(^1\) (as the individual ration) to target participants (pregnant women, lactating mothers and children between 6 and 24 months of age). Together with the promotion of local nutrient rich food and implementation of recipe demonstrations, food availability and diet diversity is expected to increase for the whole family and specifically children under two years of age. In coordination with the other two components, the ultimate aim is to improve the health and nutritional status of children under two; specifically preventing chronic malnutrition which can cause irreversible physical and cognitive retardation during the critical window of development (conception to two years of age).

Health component: PROCOMIDA works with Non-Government Organizations (PSS\(^2\)) and Ministry of Health’s (MOH) health units to establish and/or strengthen community structures organized to improve the provision of culturally and technically appropriate health services. This is expected to result in improved access to preventive and curative health services and more mothers and children using these services.

Care component: Through its Behavior Change Communication (BCC) strategy and nutrition training, the program is expected to empower mothers and other caregivers to adopt best practices, including seeking health services.

As a Preventing Malnutrition in Children under 2 Approach (PM2A) program, PROCOMIDA has an important research component, which is coordinated with FANTA-III\(^3\) and IFPRI\(^4\). In order to simultaneously address the essential underlying causes of under-nutrition, the PM2A approach delivers a package of health and nutrition interventions required for preventing child under-nutrition.

PROCOMIDA has two objectives:

1. Pregnant and lactating women, children under two and malnourished children under five in program areas have improved and sustainable health and nutrition status.

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\(^1\) Corn Soy Blend (CSB), lipid based nutrient supplements (LNS) or micronutrient powder (MNP).

\(^2\) Prestadoras de Servicios de Salud, Local NGOs that implement health services

\(^3\) Food and Nutrition Technical Assistance Project, phase III, executed by FHI360. See www.fantaproject.org

\(^4\) International Food Policy and Research Institute, see www.ifpri.org
2. Health care service providers at community and municipal levels have improved service quality and delivery.

The program initiated interventions in 713 communities in Alta Verapaz, through 211 Convergence Centers (CC). A Convergence Center is a community level health structure used by Health Service Provider NGOs that covers approximately 1,000 persons. The program has gone through different stages of expansion, reaching at one point 357 CCs and 1,166 communities, covering 50% of all convergence centers in the department. At the time of the final evaluation, the program is planning to maintain a presence in 217 CCs.

As mentioned above, IFPRI is implementing research in the program, consisting of Formative Research, Process Evaluation and a Longitudinal Impact Study. Before program implementation started, 120 CCs were randomly selected for the study from a set of 240 CCs initially identified by Mercy Corps. These 120 were divided into six different research arms, including one control group (20 CCs per arm). The differences between the non-control research arms within the program is the ration size (see table 1); all other program interventions are the same, except for the control group, where the program has no interventions at all. IFPRI also conducted the Baseline Study for the program in these 120 CCs.

Table 1. Ration types in the program.

<table>
<thead>
<tr>
<th>Research Arm</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D (LNS replaces CSB)</th>
<th>E (MNP replaces CSB)</th>
<th>F (No intervention (control))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CCs in research</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Ration Type</td>
<td>Commodity</td>
<td>Kg</td>
<td>Kg</td>
<td>Kg</td>
<td>Kg</td>
<td>Kg</td>
</tr>
<tr>
<td>Individual</td>
<td>CSB</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>LNS</td>
<td>MNP</td>
</tr>
<tr>
<td>Family</td>
<td>Rice</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Beans</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Veg Oil</td>
<td>1.85</td>
<td>0.925</td>
<td>0</td>
<td>1.85</td>
<td>1.85</td>
</tr>
<tr>
<td>TOTAL (KG)</td>
<td>15.85</td>
<td>10.93</td>
<td>4</td>
<td>11.85</td>
<td>11.85</td>
<td>0</td>
</tr>
</tbody>
</table>

The IFPRI longitudinal impact study measures the differences in impact between the different rations and the control, but does not measure the indicators that PROCOMIDA is required to report to USAID/Food for Peace (FFP). Hence, the program will conduct its own external final evaluation.

Evaluation Objectives

The purpose of the final evaluation is to evaluate the performance of PROCAMIDA in targeted populations and to assess relevance, effectiveness, impact and sustainability of the program. This implies evaluating the program's achievements in meeting the goals and objectives of the program and indicator targets set against baseline values and the control.

5 A department is the geographical and administrative first level division within the country.
The final evaluation is expected to evaluate the theory of change of PROCOMIDA through establishing plausible links between program activities, outputs, and immediate and long term outcomes. It will also assess how well the program achieved these results, and draw lessons for improvement of future Title II Development Food Assistance Programs (DFAPs) or similar future activities. More specifically, the evaluation is to:

1. **Determine the results of the program.**
   The evaluator(s) will be expected to analyze quantitative and qualitative data on outputs, outcome and impact indicators collected through a population-based mixed-method study, program monitoring reports, annual results reports, standard program questionnaire and all other reports produced by the program. Outcomes refer to the effects of the more immediate tangible benefits (i.e. improved health-seeking behaviors), while impacts refer to changes in the lives of targeted communities and rural households (e.g. improved food security, improved health and nutrition, improved resilience of targeted households to cope with shocks and natural disasters affecting food security, etc.). The observable changes in communities, in relation to the baseline and established objectives, should have resulted directly from program activities.

2. **Determine the effectiveness and relevance of programmatic activities and alternative implementation approaches.**
   The evaluator is expected to examine, as systematically and objectively as possible, how well the program attained its overall goal and strategic objectives and whether the achievements were efficient and relevant to participating communities and individuals. Focus may be placed on, but not limited to: education sessions, recipe demonstrations, community health commissions, mother leaders, household action plans, home gardens, strengthening of local PSS.

3. **Evaluate the extent to which the program’s cross-cutting themes have been addressed and integrated.**
   The program identifies three major cross cutting themes: community participation, gender and environment.
   Generally, Social Behavior Change (SBC) is considered another cross cutting theme for Title II programs. In PROCOMIDA’s case, SBC is considered a core component and interventions were developed specifically around it. A variety of indicators have been defined from program design to measure its results.

   a. **Community participation**
      The final evaluation is expected to assess to what level community participation has been strengthened. Some of the key questions are:
      i. To what degree have existing community structures (COCODE, women groups, water boards, religious groups and others) been strengthened?
      ii. The program has introduced “new” community structures, such as Mother Leaders, Community Growth Promotion Teams and Community Health Commissions. How well have they been integrated in already existing and formal community structures?

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6 Efficiency, as defined in ISO 9001-2008: a relationship between results achieved (outputs) and resources used (inputs). Efficiency can be enhanced by achieving more with the same or fewer resources. The efficiency of a process or system can be enhanced by achieving more or getting better results (outputs) with the same or fewer resources (inputs).
7 Household Action Plans assist families to identify their conditions and practices in and around the house. It is also used as a reminder of the key BCC messages promoted by the program.
8 Community Development Counsel, official representation of the municipality at community level.
9 Although these institutions are part of the MOH community level health structures and were not designed or invented by the program, they have not been widely implemented and at community level are considered as new.
iii. Are these introduced community structures sustainable?
iv. Are members of these structures recognized as leaders and respected?
v. How have the pre-existing community structures been changed by the program? Was this positive? Is the change sustainable?
vi. How well do the priorities identified by PROCOMIDA match with those identified by the community?
vii. Do community members feel they have more support now than before the program?

Additional questions will be defined together with the consultant.

b. Gender
The consultant will be expected to evaluate how well the program has addressed and integrated its gender cross-cutting theme, specifically in the following domains:

- Knowledge, beliefs, perceptions
- Participation and leadership
- Mobility

Although the program was designed before the USAID Gender Integration Report, several of its interventions are focused on empowering women in these domains (BCC sessions, Mother Leaders, food preparation demonstrations, Household Action Plan, Community Health Commissions, Community Growth Promotion Teams, Community Health Emergency Plan and others).

The program promotes behavior change in different gender related aspects, such as:

- Women’s ability to recognize the functioning of their own body and danger signs at different stages
- Empower women to participate in decision making in the family with regards to health and nutrition
- Raise awareness in women to actively improve family diet diversity, with special emphasis in pregnant or lactating women and children between 6 and 24 months of age, using locally available high nutritious food.
- Promote kitchen gardens to improve autonomy regarding access to diversified food, empowering women to make diet decisions for the whole family.
- Strengthen women leadership mainly through institution of Mother Leaders, who are now recognized leaders in their communities. In some cases, Community Health Commissions are comprised entirely of women.

Through the quantitative surveys, some aspects regarding gender will be measured, such as: number of prenatal control visits to the health center; percentage of women who give birth in a health facility; and percentage of women with adequate post natal care.

Mercy Corps expects the final evaluation to answer also the following key questions:

i. Do women feel more respected within their homes?
ii. Do women feel more respected within the community?
iii. Are women more included in community health activities and structures?
iv. Do women feel confident in making decisions regarding their children’s and their own health and nutrition?
v. Are men taking women’s opinion into consideration in health and nutrition issues?
vi. Has access to transport improved for women? Is it easier to attend health visits at the health centers?

vii. How well are women represented in the introduced community structures?
viii. How many women have implemented kitchen gardens? Are these gardens sustainable? Do they consume the produce?
ix. Has the program caused any unexpected negative gender impacts?
x. What could the program have done to address more specifically gender issues?

c. Environmental issues
Since the program has no agriculture, WASH or livelihoods interventions, environmental issues are mostly related to improved environments that support health and nutrition (for example essential hygiene practices and food safety practices). The principal information source for this cross-cutting theme is the ESR and PERSUAP, complemented with the following key questions, which will be complemented in conjunction with the consultant, to be answered through the final evaluation:
i. Have all potential hazards of program intervention been identified and addressed correctly?
ii. Has the program implemented adequate monitoring activities to measure mitigation and prevention mechanisms?
iii. Has the program implemented activities that reduce the environmental impact of community and household activities? Are these activities sustainable?

The effectiveness of the integration of these cross-cutting themes in daily program activities and its impacts at community level, as well as lessons learned, will be of great assistance when designing future projects.

4. Examine the potential sustainability of established mechanisms and activities.
The evaluation team should determine the likelihood of continuation of goods and services provided by the program as well as the continuation of adoption of behavioral and systemic changes promoted by the program. Such as the degree to which community based groups (e.g. Health Commissions, Mother Leaders) and activities will continue with viable operations and so forth. The evaluation team must review how well the program created the demands for goods and services and the communities' willingness and ability to pay for the services and what has been done to ensure continuous supply of the goods and services after the end of PROCOMIDA. The evaluation also needs to establish whether other local organizations or government institutions, whose capacity has been built by the program, will provide some continuation of the services once the program interventions have completed. Finally, the evaluation is expected to identify and document any external factors that may influence or have influenced sustainability of program interventions.

5. Identify key lessons learned and best practices for replication.
The evaluator is also expected to draw key lessons learned (positive and negative) in the past six years MC and partners have been implementing the program. The evaluator should document best practices for replication in future Title II and other programs. Areas of interest may include BCC strategy, Community Health Commissions, Mother Leaders and others.

Key evaluation questions for each of the above objectives are included below. An additional list can be found in annex 1.
Since IFPRI is measuring impacts between research arms, this FE is not required to compare results between research arms. However, to take advantage of the existing control group, final evaluation results of the intervention area will be compared to them.

Study Context

The program is organized around two pillars. The first pillar focusses on direct interventions with the population to improving health and nutrition knowledge and practices through training sessions, recipe demonstrations and household visits. For this pillar the program has designed a BCC strategy with training materials. Through anthropological and formative research, key messages were defined and flipcharts designed around them. The program provides monthly training sessions to participant mothers that consist of education sessions - based on adult training techniques - recipe demonstrations with locally available nutrient-rich food combined with donated food, household visits and ration distribution.

The second pillar is centered on health and nutrition focused institutional strengthening. The first level of institutional strengthening is at the community level, where community health commissions are strengthened in management of a community health fund, handling and distributing of centrally repackaged monthly food rations, as well as health and nutrition best practices. At this level, the program is also initiating specific interventions with the community health volunteers (CHV) and traditional birth attendants (TBA) in order to improve community knowledge of danger signs of maternal, newborn and child health and emergency actions. The second level of institutional strengthening focuses on the NGO health providers. MOH, through its Extension Coverage Program (PEC), contracts local NGOs to provide basic health services in the more remote areas, through the Convergence Centers (CCs). These NGOs, known as PSS, have Basic Health Teams (EBS)10 in charge of providing health services in the CCs. EBS receive training from program staff, as well as the PSS office staff. The PSS also receive a sub-grant from PROCOMIDA to hire additional personnel and cover operations and program costs in order to improve their services. Additionally, CCs have been provided with new anthropometric equipment. The third level of institutional strengthening focuses on the MOH, mainly at the departmental and area division levels, strengthening the coordination with the NGOs and supporting training of field staff. The program also assists in providing materials to the departmental MOH (such as growth cards) to be distributed in the health regions, with priority to the program intervention area.

PROCOMIDA’s mid-term evaluation and IFPRI’s Process Evaluation, both conducted in 2012, provided the program with some findings and recommendations that are being addressed by the program through an Improvement Action Plan that includes the following strategies:

- Involve TBAs in the program’s training and outreach
- Improve the capacity of NGO health providers for growth monitoring
- Prepare specific training/reference materials at the community level (Mother Leaders, TBA and CHV)
- Provide more focus on community based growth monitoring and promotion
- Condense and prioritize BCC messages and the training process
- Ensure a special focus on complementary feeding for children between 6 and 24 months
- Provide reminders for key messages and behaviors to mothers and families

The program has also developed a sustainability plan that identifies the activities and skills to be transferred and a strategy for the transfer process.

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10 *Equipos Básicos de Salud*
Evaluation objective 1 will be measured through quantitative surveys and will collect data for the relevant indicators that are reported to the donor through the Indicator Performance Tracking Table (IPTT, see sample in Annex 2) and will compare findings with baseline values in order to determine the final results.

A survey at the household level will measure the following aspects that also were measured at baseline:

General data:
- Family composition
- House conditions

Impact Indicators:
- Anthropometry in children under 5 years of age (WfH, HfA, WfA).
- Household Dietary Diversity Score (HDDS)

Monitoring Indicators:
- Mother knowledge in health and nutrition good practices and danger signs (pregnancy, birth, new born, infants, children 6-23 months of age)
- Pre- and Post-natal health practices (number of pregnancy controls, post natal checkup)
- Child feeding practices (IYCF, including exclusive breastfeeding)
- Preventive mother and child health practices (hygiene)
- Illness and health seeking behavior (diarrhea and ARD identification and action)

At the CC level, two additional surveys will be conducted, which also were measured at baseline:
- CC survey, capturing services provided, infrastructure and supplies
- Health worker knowledge in health and nutrition best practices and danger signs

The program requires the consultant to measure the following topics in addition to the IPTT indicators:
- Household Action Plan, including implementation of home/kitchen gardens
- User satisfaction survey of health provider services at CC

The following correlations are expected to be measured and compared between baseline and final evaluation, as well as program communities and control group:
- Average household dietary diversity score (HDDS) and percent of children 6-24 months with minimum dietary diversity
- Average HDDS and percent of mothers demonstrating increased nutritional knowledge
- Percent of children 6-24 months with minimum dietary diversity and percent of mothers demonstrating increased nutritional knowledge
- Percent of children 0-6 months exclusively breastfed and percent of mothers demonstrating increased nutritional knowledge
- Percent of mothers receiving minimum recommended antenatal care and percent of mothers receiving minimum recommended postnatal care

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11 IPTT indicators are divided into impact and monitoring indicators. Six monitoring indicators are reported through regular data collection by the program, all other indicators are measured through the final evaluation surveys. This is consistent with the baseline.
- Percentage of mothers with proper identification of childhood illness danger signs and percentage of children aged 6 – 23 months with respiratory diseases that received adequate treatment
- Percentage of mothers with proper identification of childhood illness danger signs and percentage of children aged 6 – 23 months with diarrhea that received adequate treatment
- Percentage of mothers demonstrating increased nutritional knowledge and percentage of children 6-59 months with (<-2 Z score W/H).
- Percentage of mothers demonstrating increased nutritional knowledge and percentage of children 6–59 months stunted (<-2 Z score H/A).
- Percentage of mothers demonstrating increased nutritional knowledge and percentage children 6 – 24 months with minimum dietary diversity
- Percentage of mothers that know danger signs of pregnancy and percentage pregnant mothers with pregnancy emergency plan.
- Percentage of children 0 – 6 months exclusively breastfed and percentage children 6-59 months stunted (<-2 Z score H/A).
- Average household dietary diversity score (HDDS) and percentage families with home gardens.
- Percent of children 6-24 months with minimum acceptable dietary diversity and percentage families with home gardens.
- Mothers’ attendance to training sessions (data provided by PROCOMIDA information system) and mothers knowledge: a) Percentage of mothers demonstrating increased nutritional knowledge; b) Percentage mothers that know the danger signs of pregnancy; and c) Percentage of mothers with proper identification of childhood illness danger signs.

These correlations will mainly support evaluation objective 1, but may support also objectives 2 and 4.

The FE will follow the quantitative survey instruments used for the baseline study, which were designed by IFPRI in close coordination with Mercy Corps. According to recent revisions by Mercy Corps, some questions have been slightly changed, specifically in the Spanish wording. Since actual data collection is done in Q’eqchí, it is important that the consultant will assure actual Q’eqchí language is comparable to baseline translations. Baseline instruments are available upon request for comparison. PROCOMIDA will provide assistance in the translation practices and Q’eqchí standardization to assure comparability with baseline.

In addition, qualitative data will be collected to assess:

- How has the program strengthened community health structures?
- Perception/opinion of participant mothers with regard to access to and quality of health services. (Do they feel access has improved? Do they feel the quality has improved? Do they feel confident going to the health services? Do they feel understood?)
- Perception/opinion of participant mothers with regard to their knowledge and attitudes towards health and nutrition. (Do they feel they know more? Do they feel they have changed their attitudes and practices? Were the changes difficult to adopt? Why? Was there resistance in their family to the changes?)
- Other impacts not measured through the IPTT, intended or unintended, positive or negative. Some examples are impacts in gender relations within families, as mentioned above, participation of other family members, strengthening of community structures (midwives, health commissions, mother leaders), strengthening of local NGO capacities (e.g.: organizational, financial) or other impacts that have not been identified.
For **evaluation objective 2**, the evaluation will assess the scope and compliance of the program’s processes, results and impacts as planned in the proposal and operational plans, as well as assess efficiency, sustainability, relevance, unintended outcomes, and plausible contributing factors. Multivariate analyses and qualitative information will be used to assess objective 2. Direct observations, focus group discussions, key informant interviews and other interactive methods will be used to collect information from beneficiaries, local partners, program staff, other Mercy Corps staff, donor representatives, partners, sub-country and district-level government officials, business operators and other stakeholders. In addition, the evaluation team will review existing documents to gain an in depth understanding about the program processes and performances. The evaluation team will interview vulnerable groups including, but not limited to women, youth and children to assess the effectiveness and relevance of programmatic activities and implementation approaches.

For **evaluation of objective 3**, the evaluation team will analyze qualitative information to measure how well cross-cutting themes have been integrated in the program. If the evaluation team identifies a priori certain quantitative data that is necessary but not available to measure gender integration, it should include these in the surveys. Quantitative data will be used to triangulate qualitative findings.

To evaluate **objective 4**, the evaluation team must review the sustainability/ exit strategy of PROCOMIDA. How well the strategy was implemented? To improve sustainability of practices promoted by PROCOMIDA, which goods and services must continue to be available and how the communities will continue to have access to these services? What the project has done to create demand for these goods and services and whether the community is willing to pay and able to pay after the end of PROCOMIDA.

In general, when measuring sustainability, the following questions should be kept in mind:

- What is the program participant's perception of sustainability?
- What is the perception of sustainability of stakeholders (e.g. Community Health Commissions, CHV, ECOPROC\(^{12}\), Mother Leaders, DASAV\(^{13}\), PSS, and SESAN\(^{14}\))? How effective is the sustainability action plan and how well it was implemented?
- To sustain the practices promoted by PROCOMIDA, which services and institutions must continue?
- What institutional and financial arrangements were made to sustain these services? How sustainable is the financing mechanism and what could be done to improve the sustainability of these services?
- What is the demand for these services\(^{15}\) in the community? What is the level of willingness of the community to pay for the services? Are these services affordable to the target group?
- What is the role of private sector in providing the services to support the practices promoted by PROCOMIDA? What is the likelihood of continued support from the private sector? How this can be strengthened?
- What strategies have been used to motivate volunteer workers to continue their work after the program finalizes?
- How likely will these strategies assure sustainability of these volunteer structures?
- What are the challenges that volunteers may face to be able to continue to do their work?

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\(^{12}\) Community growth promotion teams
\(^{13}\) Alta Verapaz MOH Health Area
\(^{14}\) Secretary of Food Security and Nutrition
\(^{15}\) Services needed to sustain the practices promoted by PROCOMIDA
To evaluate **objective 5**, the evaluation team will review program documentation, interview project staff, volunteers and other stakeholders to capture lessons learned – what has worked? What Mercy Corps should continue to do and what did not work? The lessons learned should be supported by data (evidence based). The evaluation team must show correlations between the approach/activity/tools/methods and the results to determine whether a practice can be labeled as a better/best practice.

**Evaluation Methodology**

The final evaluation will require a mixed methods approach, which will be organized around the above mentioned evaluation objectives. The evaluation questions mentioned above and in Annex 1 are a minimum requirement; additional questions can be included in the proposal.

A population based quantitative survey, using a cluster sampling method, will collect data on key indicators to compare with the baseline values. A qualitative evaluation will employ a variety of qualitative primary data collection methods and tools including semi-structured in-depth-interviews, group discussions, key informant interviews, and direct observation to assess relevance, effectiveness, impact and sustainability of the program. Results from the quantitative survey will be used to identify specific issues to be addressed through the qualitative study. Hence, the quantitative data collection will take place before the qualitative study.

Mercy Corps encourages data collection through tablets. The effective use of tablets can greatly improve data quality and cut down data entry time. Whether it is through paper based or through tablets, the consultant will develop the data collection tools and validate them in the field for accuracy and functionality. The consultant will also design, develop and implement quality control methods to review collected data on a daily basis. The program requires the consultant to cross check data collected through spot checks by re-interviewing partial surveys of certain households.

Interviews and surveys with community members will be held in the local Q’eqchí language. For that purpose, the consultant will provide either a standardized Q’eqchí text for all tools, either on the Tablet or on paper, to be used by all surveyors/interviewers. Q’eqchí standardization will be approved by PROCOMIDA M&E staff, to assure consistency in questions with the baseline, mid-term and final evaluation. The consultant may utilize existing Q’eqchí translations of some of the quantitative questionnaires made by PROCOMIDA for its annual monitoring.

Following is a list of indicative methods for qualitative evaluation:

i. Desktop review of relevant documentation, including program proposals, monitoring and evaluation plan, baseline study report, program performance reports, midterm evaluation, assessments and studies, and other related documents as necessary. The team is expected to review all available field-level quantitative and qualitative data.

ii. Field visits to meet with direct beneficiaries, indirect beneficiaries and members of the target communities who did not benefit from the program at all. Use observation methods, interview and interactive methods and tools for data collection.
iii. Key informant interviews with beneficiaries, staff from USAID, awardees, and partner, host Government officials, and other agencies as appropriate.

The consulting firm/consultant must submit a qualitative study design including the following areas and seek approval from PROCOMIDA before starting the field work.

1. Topical Focus Areas
2. Criteria and strategy to select sample sites
3. Fieldwork Strategies
4. Criteria and strategy to select respondents
5. Data Management & Data Analysis
6. Data collection schedule

A quantitative survey design document, in Spanish, must be prepared and get approved by Mercy Corps PROCOMIDA and USAID Guatemala/FFP before the survey implementation.

1. The survey instrument used in the baseline survey should be the starting point. If there is a need for rephrasing any question, the consulting firm must add a question with revised statement instead of replacing an existing one. Changing a question will void the comparability. In consultation with PROCOMIDA staff and the USAID/Guatemala Mission, the consulting firm may add questions to the survey instrument.
2. The tools and methodologies should be finalized having concurrence from PROCOMIDA management and USAID Guatemala/FFP.
3. Field Procedure Manual: It is expected that the Consulting firm will develop a field manual to be used as part of the training materials for survey enumerators and supervisors and serve as reference material for staff in the field conducting the survey. The field manual should include instructions on how to sample dwellings within clusters, households within dwellings, and select individuals within households. The manual should also give recommended best practices for conducting interviews and dealing with specific challenging situations, e.g., households that refuse to participate, and provide a household and individual respondent non-response follow-up strategy. The manual should also describe the roles and responsibilities of the enumerators, supervisors, and other field staff and contain a detailed explanation of how to properly administer each question in the questionnaire.
4. The survey team is required to ensure statistically representative data collection within the household survey and anthropometric measurement with appropriate representation of the program as well as control locations.
5. For the anthropometric data collection, the Consulting firm must use international standard height boards and scales.

Study Size
The sample and the methodology for determining and selecting respondents will be defined by the consultant hired, under the supervision and approval of the program. The FE is expected to compare measurements with the baseline as well as the control group.

For the comparison with baseline, Mercy Corps is requesting a two staged sampling with all 100 program CCs as first (cluster) level and individual households as second level. For comparison with the 20 control groups, an additional sample is required. In this case the 20 CCs that receive Full Ration (with CSB) will be compared to the 20 Control Group CCs to measure impact and result attribution in a more reliable way. Sampling should follow USAID/FFP guidelines and minimum standards. It should also be comparable to the baseline sample framework, designed by IFPRI. The consultant must be able to prove that FE results can be compared to BL results. The sampling strategy must be shared with
The design document should include sampling strategy and sample size estimation, sampling frame and household listing, data treatment and analysis plan, training of enumerators and supervisors, field testing of the instruments, and oversight and quality control mechanisms. The consulting firm/consultant must specify the details of the sampling design in the survey design document in advance of field implementation. This document must include all of the following elements:

i. The principal indicators and associated target groups that will drive the sample size calculation for the entire survey.

ii. The consulting firm should show the equation used for this calculation and the parameters used in the equation, including the design effect assumed for the principal indicators driving the sample size calculation. The calculation should take into account statistical power. The final number of households/target groups will be calculated by identifying the largest affordable sample size between all identified indicators.

iii. The number of households to be sampled in order to achieve the desired sample size for the target group (assuming that households may contain more than one or no eligible members from the target group). The consulting firm should give an indication of how the base sample size will be adjusted to account for the number of households that need to be visited. Design effect should be used from the baseline survey data.

iv. The number of households to be sampled to account for anticipated household non-response. The Consulting firm should indicate by how much the number of households to be sampled will be pre-inflated to account for household non-response.

v. Geographic or other criteria for stratification. The Consulting firm should specify all stratification criteria and the total number of strata for all criteria.

vi. The number of stages of sampling to be used.

vii. Explanation of how the number of clusters and of households per cluster in the sample will be determined.

viii. Explanation of how individual members in a sample household will be selected for interview (this is particularly important for anthropometric indicators, questions related to women at reproductive age, questions related to infant and young child feeding practices and farmers).

ix. Definition of the clusters. The Consulting firm should use tables to show the number of clusters that will be selected for each stratum.

x. Explanation on the source of the information for the sampling frame, e.g. census lists or other national or internationally-sponsored surveys, such as the Demographic Health Surveys (DHS). The Consulting firm should indicate how reliable and recent the frame information is.

xi. A Probability Proportionate to Size (PPS) sampling mechanism should be used to randomly select the clusters. The Consulting firm should use the number of households per cluster as the size measure and include a table of size measure and another showing the final list of selected clusters along with their probabilities of selection.

xii. Indication that the Consulting firm will use systematic sampling to select dwellings within clusters. This implies that for the sampled clusters, a list of all households, with household identification and location indicated, within these clusters.
clusters must be obtained through either a preliminary pass on the cluster prior to interviewing or other existing sources.

xiii. A clear explanation how the two sampling methods (FE vs Baseline and FE vs Control Group) interact and how overlap is handled.

Data Analysis and Results Dissemination Plan

The consultant will present Mercy Corps with a data analysis and treatment plan that describes data cleaning and handling, indicator calculation, result tables (baseline values, end-line values, confidence levels, test of differences, levels of significance)

Data Treatment and Analysis Plan: The Consulting firm must prepare a data treatment and analysis plan to address the following elements:

1. Indication of how and when data will be entered into the database, as well as the software to be used for data entry. Double-data entry is required; If tablet or smart phone is used to capture data, name of the application and the strategy to double-check the data on a regular basis so that any inconsistencies can be identified immediately and corrective measures can be taken within a day;

2. Data quality checks and edits (data cleaning) planned to ensure logical consistency and coherence, as well as an indication of the software to be used;

3. Sampling weights to be included on the data file. The formulae used to calculate the sampling weights should be included as part of a data dictionary document. Different sampling weights will need to be calculated for separate analysis of each component (program vs control) and of the program level aggregate. Note that a household non-response adjustment should be made to the sampling weights as part of the final weighting system;

4. Indicator tabulation plan. Estimates should be produced for each stratum and for the overall level; Indication of which sub-groups, if any, for which the Consulting firm will produced estimators;
   i. To understand factors that explain the variation in change in stunting, household dietary diversity score, and minimum acceptable diet, multivariate analysis model must be specified and presented in the tabulation plan.
   ii. The Consulting firm should specify all intended bivariate and multivariate analysis in the tabulation plan;
   iii. Indication that confidence intervals associated with the indicators will be produced alongside the indicator estimates and that these will take into account the design effect associated with the complex sampling design. Additional statistical outputs are required for multivariate analysis, but should be provided in an appendix; and
   iv. Software to be used for data analysis and for conversion of anthropometric data into Z-scores.
   v. Description of methods for comparing the final survey data with the baseline survey data, and tests to be used to detect a population level difference at 95 percent level of significance.

For quantitative data collected via the household survey, the evaluation team will conduct descriptive, bivariate and multivariate analyses using the appropriate tests of statistical
significance. Comparisons between groups (program area and control group) are defined through bivariate analyses; the level of statistical significance associated with the difference between groups will be cited. Confidence intervals, p-values and other criteria used in hypothesis testing will be documented. Qualitative information will also be synthesized with supporting quotations, to highlight key points and conclusions. Qualitative information will provide insights to quantitative results and is expected to uncover why and how program activities led to varying levels of outcomes as well as unintended and unexpected results.

Initial findings from both quantitative and qualitative data collection and analysis will be presented in a one day debrief workshop attended by Mercy Corps staff and partner staff, defined by the program. Feedback from the workshop will guide the finalization of the second draft report that will be circulated to respective Technical support units of Mercy Corps and USAID FFP. Feedback from this will culminate in the final report. The consultant will lead sharing of findings and lessons learned in a formal presentation with Mercy Corps, the donor and government representatives both at central and regional level. Hard and soft copies will be provided to the donor and Mercy Corps. The final report is required to be presented both in English and Spanish. If Spanish language is a limitation for the reporting team, Mercy Corps can recommend translators.

**Evaluation Team Composition**

The core evaluation team will be external. In order to maximize learning and ownership of findings, program staff may accompany the process, but will not participate in the actual data collection. The selected external evaluation firm/team will have a lead consultant who will be responsible for coordinating other team members’ tasks, liaising with program staff and other potential interviewees for appointments, as well as ensuring that adequate resources are in place to have swift evaluation flow. The lead consultant will report to PROCOMIDA’s Chief of Party, who will provide relevant program documentation (prepared or requested). The selected external evaluation firm/team is expected to have strong expertise in both quantitative and qualitative program evaluation, specifically, evaluations of nutrition focused food security programs as well as technical aspects of nutrition and maternal/child health activities, such as growth promotion, BCC and young child and infant feeding practices. The lead consultant is also expected to have extensive Title II experience as FFP M&E requirements are stringent. The external evaluation team must have experience in a variety of settings and with a number of different people that will include members of staff, government officials, local government extension officers and community members in rural and urban environments.

At minimum, the evaluation team should include members with experience and expertise in agriculture and livelihoods, health, nutrition, anthropometry, behavior change communication, gender, and institutional strengthening. Teams with locally sourced members may stand a competitive advantage. The team leader will be required to prepare Scope of Work for team members and routinely manage member performance through table discussions and other communication means. PROCOMIDA’s TSU and M&E Managers will support the evaluation team to ensure access to existing program data, reports and documentation, setting up data collection with target households, partners and support with arranging meetings, focus group discussions and key informant interviews.

Direct supervision of all processes will be done by Mercy Corps’ Technical Support Unit Manager, in close coordination with the Monitoring and Evaluation Manager and other M&E staff, including data collection in the field.

**Location**
The evaluation will take place in the rural areas of Alta Verapaz, Guatemala, in the CCs where the program is implemented, in the four municipalities of Cobán, San Pedro Carchá, Cahabón and Lanquín. The evaluation will focus on the 120 CCs selected for the IFPRI research, which include 100 program CCs and 20 (non-program) control CCs.

**Schedule**

The consultant shall submit a detailed timetable as part of the proposal. The timetable will start the week after signing the contract and must include (below timeframes are approximate and only for reference):

- Online and onsite coordination for setting operational and programmatic details. Review of quantitative survey and qualitative instruments, provision and programming of surveying equipment (Tablets), recruitment of field staff and pilot to validate the instruments (lasting approximately three to four weeks)
- Training surveyors, including standardization and field practice. (Approximately three weeks)
- Data collection (approximately six to seven weeks)
- Data cleaning and quality control (two weeks)
- Analysis and reporting (six to seven weeks)
- Delivery of end products, including the survey report. (two weeks)
- Public presentation of final results to donor and partner organizations

All field work should be completed before the end of May 2015, when program interventions stop. This coincides with the period where baseline data was collected and is exactly within the scarcity season (March – July). The final FE Report is expected to be received not later than August 15, 2015.

**Field Logistics**

- The data collection will be conducted by local staff hired by the consultant, in digital form by using Tablets. It is expected that the consultant will provide data collection equipment, such as Tablets. Since this equipment can be used for different consultancies, the consultant is to state in their proposal a reasonable rental or depreciation cost for this item.
- The programming of the Tablets will be carried out using appropriate software for the equipment used, defined jointly with the consultant and the program.
- The consultant will define the assessment team, including number of field teams (enumerators, supervisors, editors, anthropometrists) according to the stipulated time for data collection and geographic coverage. It should take into account that data will be collected at two levels (family and CC/community) both quantitative and qualitative.
- The consultant will also provide a technical support team for the supervision and analysis, including (but not limited to) a statistician, sampling expert, food security expert, and nutritionist.
- Anthropometric data from all children under five years of age of sampled households will be collected. The program will provide anthropometric equipment (SECA infantometer, SECA height board, TANITA digital floor scale with tare) in excellent condition. The consultant can verify the quality of the infantometers and height boards and request replacements if necessary. In the case of the TANITA scales, it is expected that the consultant will pay for calibration in country with a qualified provider. Mercy Corps can assist with identifying and contacting such a provider. Anthropometric standardization is to follow Government of Guatemala MOH guidelines.
- Rigorous training of surveyors in data collection by the consultant’s technical staff is required. This should include field practice and anthropometric standardization.
PROCOMIDA’s technical staff will be present during the training and will provide feedback to the consultant and its technical team. The consultant is to present a solid training and standardization plan within four weeks of signing the contract.

- Surveys and interviews will be conducted in Q’eqchi. Field staff should be standardized in survey methods and the formulation of questions in Q’eqchi. The field staff, including enumerators, interviewers and supervising staff, must be 100% bilingual Q’eqchi and Spanish, subject to language assessment by PROCOMIDA staff.
- Field team should include sufficient supervisors/editors to oversee enumerators and interviewers and review all surveys before being delivered to the field coordinator.
- Consultant should describe the quality controls implemented throughout the process to ensure the accuracy of the information and the completion of the survey sample.
- Result tables will be determined jointly between the consultant and the program. The parameters used in the baseline will be taken into account.
- Data cleaning, statistical analysis and production of the final report is responsibility of the consultant.

Deliverables
1. Detailed study plan, including:
   - General methodology
   - Sampling framework
   - Formation of teams
   - Training and standardization plan, including but not limited to:
     - Survey training
     - Survey techniques
     - Q’eqchi standardization
     - Anthropometric standardization plan for enumerators.
   - Detailed schedule
   - Interaction and complementarity of quantitative and qualitative data collection
   - Field survey plan by municipality, CC and families to be surveyed. It should be noted that data collection will need to be done 7 days a week as the Household Diet Diversity Score indicator requires all seven days of the week to be represented in the data collection, since it is a 24 hours recall. The consultant may consider including short rest periods, provided it does not affect the final date for the field work and with approval from PROCOMIDA’s Technical Support Unit.
   - Quality control plan to ensure high quality of data
   - Other relevant items.

The plan should also identify who of the technical team will be in country and in what phases. It will also define the coordination efforts with PROCOMIDA during the process.

2. Quantitative and qualitative questionnaire instruments, developed with input from the MC PROCOMIDA team, as well as the quantitative and qualitative protocols for data collection and analysis.

3. Training and anthropometric standardization report at the end of the training process, including details of the standardization in Q’eqchi and anthropometric standardization report.


5. Final field report, including response rate, number of surveys per segment of the population, observations and issues, any other information necessary for the interpretation of the data.

6. Databases in a format suitable for use in common software for data analysis (SPSS). The databases will be accompanied by a dictionary of variables, including the name of each variable, label, type of variable, the values and labels (if it is a discrete variable) and method of calculation.
7. Presentation of preliminary results to the program technical staff and management to validate results.
8. Presentation of the final validated results in a formal meeting to the donor, national partners and other invitees.
9. Presentation of the final results to Food for Peace Washington.
10. Final report in both English and Spanish including, at a minimum:
   - Executive Summary (3 pages maximum)
   - Background
   - Evaluation Purpose (including methodology, with strengths and limitations identified)
   - Results by IR or objective (including description of key technical components: quality, results, successes and challenges
   - Other cross-cutting themes or programmatic review (commodity management, M&E, staffing/HR, financial management)
   - Recommendations

11. To comply with USAID’s Open Data Policy, USAID/FFP will host the data to USAID’s Open Data portal. To comply, the Consulting firm must submit the following:
   i. Raw data and the cleaned data files with all of the computed variables both in SPSS and CSV formats.
   ii. SPSS or STATA Syntax files and weighting files in Microsoft Excel
   iii. Submit a data dictionary - essentially a definition and description of any of the fields provided in the dataset
   iv. The Consulting firm must ask the respondent of the survey for their consent to release their birth dates and any other identifying information.

Requirements of the Proposal

- Global study plan, including a detailed schedule of above mentioned deliverables and description of proposed sampling methodology, complementarity of qualitative and quantitative methods, logistics and data analysis (software).
- Detailed budget, including at least the following items:
  o Wages (stating title, wage and number of employees for each position)
  o Lodging, meals and incidentals
  o International travel
  o Cost of local transportation (vehicles, fuel and related costs)
  o Other direct costs, including communication, safety, stationery, training,
  o Indirect costs
  o Taxes
  o Total cost
- Proposed Table of Contents of the final report
- Team composition and Curriculum Vitae of the evaluation team (CVs not required for enumerators)
- References and previous experience of the consultant in the field of maternal and child health and nutrition, especially Title II programs in the past 5 years.

Assessment of the Proposal

The proposal will be reviewed and final selection made by Mercy Corps based on the following parameters:

- Consistency of the proposal with these terms of reference
- Composition of evaluation team
- Sampling methodology
• Training and standardization plan
• Quantitative and qualitative methods proposed
• Expertise in similar assessments
• Past performance of the consulting firm for similar evaluations
• Methodology
• Clarity of the proposal
• Proposed Table of Content
• Economic proposal

Final selection of the consultant will require concurrence of USAID/FFP.
Annex 1. Sample Key Evaluation Questions

These questions are in addition to the evaluation questions defined in this Scope of Work and are optional.

1. To determine the outcomes and results of the program.
   - To what extent has the program achieved its set objectives and targets?
   - How have the program activities affected the direct and indirect beneficiaries' food security?
   - To what extent has the program promoted technologies and practices been adopted?
   - How have the program activities changed lives (improved food security, improved dietary diversity and health status of family members in targeted households, and others) of households in targeted communities?
   - Are there other unintended but important outcomes and results that have been realized in targeted communities as a result of program activities?
   - To what extent has the program improved the capacity of local health providers to providing goods and services to targeted households?
   - Do the stakeholders have a sense of ownership of the program? What are their views on program implementation and progress?
   - Are there any negative results or unintended consequences of the program that need to be addressed, and how?

2. To determine the effectiveness of programmatic activities and alternative implementation approaches, notably the shift to market facilitation.
   - Which interventions are most critical and/or effective in achieving project objectives and intermediate results? What lessons can be drawn from successful activities?
   - Is the level of effort among different interventions and activities relevant to the MCHN problems facing the community?
   - How efficient has the program been in attaining its goals and objectives?
   - What is the program status with respect to target outputs in terms of quantity, quality and timeliness? What factors impede or facilitate the production of such outputs?
   - Do the outputs contribute to the achievement of the strategic and intermediate objectives of the program?
   - Does the monitoring and evaluation system appropriately address the program’s objectives and indicator targets?
   - How effective was the technical assistance provided throughout the program? To what degree was the TA adopted among beneficiaries?
   - What aspects of the program were particularly effective and ineffective?

3. To evaluate the extent to which the program’s cross-cutting themes have been addressed and integrated.
   - How effective is the program at reaching women? What could be done to improve women’s participation?
   - What effect is the program having, if anything, on the livelihood of the women beneficiaries and their households?
• How has the program affected the gender based relationships in targeted households?
• Are beneficiaries adopting desired practices or behaviors? Which practices have beneficiaries been more inclined to adopt, and why? Are there certain groups within the population with lower rates of adoption and why?
• How can programs such as this one improve and increase its impact on these crosscutting activities or others on beneficiaries and their households?

4. To examine the potential sustainability of established mechanisms and activities.
• What systems or activities have been put in place to ensure sustainability? What mechanisms have been developed to maintain the infrastructures created or rehabilitated after the program end?
• Are program activities and technical assistance related to adoption of better practices sustainable, i.e., are participants likely to continue receiving TA after the program ends? Are pass-on activities going to continue after the program ends?
• To what extent will targeted beneficiaries continue to access long-term positive benefits after the program comes to an end?
• To what extent will other local or donor resources continue to be available to perform the activities the program now conducts that will require continuation after the end of the program?

5. To identify key lessons learned and best practices for replication.
• What improvements can be made to the design to improve results?
• What improvements can be made in the implementation of the program in order to improve results?
• What are the lessons learned in commodity management system?
• What are the main lessons that can be drawn from the program experience since its inception?
• In particular, what have been the main lessons learned regarding targeting and working with vulnerable households?
• What are the best practices in formulating, implementing, reporting, monitoring and evaluating a food security program that need replication in future Title II programs?
• What corrective actions are recommended regarding the design, implementation, reporting, monitoring and evaluation of the program?
• What actions are recommended to follow up or reinforce initial benefits from the program?