TERMS OF REFERENCE FORMAT

(INSTITUTIONAL CONSULTANCY CONTRACTS) unicef

Title of the assignment	Evaluation of Community Mobilisation Volunteers (CMV) Network on Improving the Knowledge, Attitudes, Behaviours, and Practices (KABP) of the Rohingya and Host Communities
LTA Number	N/A
Purpose	The purpose of the evaluation is to generate evidence on what worked and what did not work and to document lessons on the Community Mobilization Volunteers (CMVs) network on Knowledge, Attitudes, Behaviours, and Practices (KABP) of the Rohingya and Bangladeshi host communities to inform UNICEF and partners future C4D interventions in humanitarian settings.
Location	Rohingya camps and host communities in Teknaf and Ukhia upazilas, Cox's Bazar district
Estimated Duration	1 September 2020 – 31 January 2021
Reporting to Technical Supervisor of this assignment	Chief SPEAR Section / Research & Evaluation Specialist, SPEAR
Estimated Budget	$ 100,000.00
Grant Number & Expiry Date	SM189910 – 13/21/2021

1. Background and rationale:

According to the Inter Sector Coordination Group (ISCG) Situation Report of August 2019, there are a total of 911,566 Forcibly Displaced Myanmar Nationals (FDMNs) in Cox's Bazar who fled Myanmar since 25 August 2017 due to extreme violence and atrocities. Among them 914,998 Rohingyas[1] have been identified in camps according to the Refugee Repatriation and Relief Commissioner (RRRC) UNHCR registration exercise (including 34,172 registered before 31 Aug 2017). Of these, 54 per cent are children under 18 and 19 per cent are under 5 years. Fifty-two per cent of the Rohingya refugee population is female. No detailed data is available on disability, with UNHCR estimating that four per cent of the population faces some sort of impairment. In addition to that, 5,812 Rohingyas are estimated to be in host communities in Ukhia and Teknaf upazilas as per Needs and Population Monitoring (NPM) round 15. From the baseline 2018 to midline 2019, there is an increase in the levels of awareness of communities on the services to access e.g. 7% to 22% increase in the levels of awareness on the IFCs and 78% to 84% on the health centers and other key services have shown an increase of levels of awareness on services among the communities. The evaluation will be guided by human rights instruments or policies, including child rights and gender equality.

Population breakdown: Rohingya refugees

Age	Male	Female
Under 5	9.4%	9.3%
5-11	11.3%	10.7%
12-17	6.8%	6.7%
18-59	18.8%	23.3%
Over 60	1.7%	1.9%

Multi sectoral rapid assessments conducted by ICSG highlight that majority of new Rohingya arrivals have little knowledge of how to access services or are not aware of services available or provided to them. The assessments have also recognized the gaps in the outreach to the affected new arrivals and referrals, including major language gaps as well as the need for creation of mechanisms to receive, orient and refer communities to relevant services, and record their feedback and grievances. The Rohingya community are in constant need of consistent and complete information on child and adolescent care at household

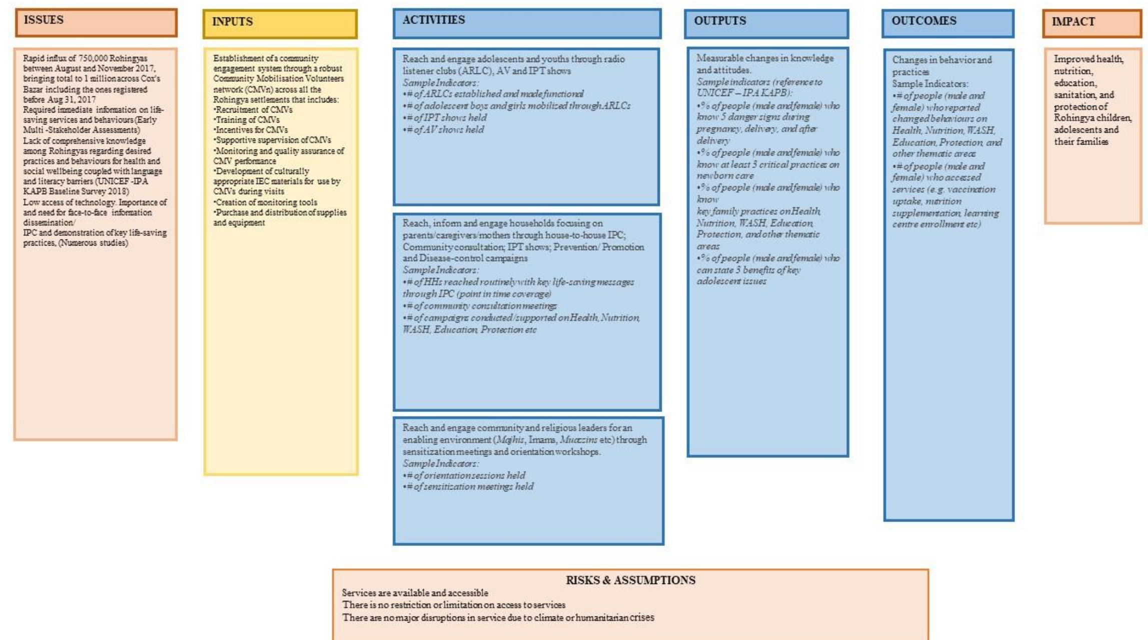
[1] Data as of 30 September 2019, the latest update provided. A full verification exercise was undertaken, but the results not yet published.

level, handling supplies and relief commodities (such as medicine and other life-saving behaviours and protective practices). Systematic and regular communication is also required to quell rumours and promote social cohesion among the new and previous arrivals as well as host population to avoid conflict in the settlements.

UNICEF in collaboration with partners from the Communicating with Communities (CwC) Working Group (WG) and key Sectors – Health, Nutrition, WASH, Child Protection, and Education under ICSG, established several communication, social mobilization and community engagement interventions aimed at improving access of the affected population to key life-saving information, services and feedback mechanisms. These include Information Feedback Centres (IFCs), house-to-house interventions through a network of Community Mobilisation Volunteers (CMVs), radio programming, mass campaigns, and community dialogue sessions among others.

Since January 2018, UNICEF in partnership with Bangladesh Rural Advancement Committee (BRAC), has also additionally established a network of 1000 Community Mobilization Volunteers (CMVs) in Rohingya camps and host communities in Teknaf and Ukhia upazilas that are trained, incentivized and supervised to reach and engage households on a range of priority multi sectoral behaviours. Across all mobilisers, UNICEF is set to reach approximately 500,000 Rohingya people, with special attention for vulnerable groups including pregnant and lactating women, young children and adolescent boys and girls. As Rohingyas and host communities have expressed a need for more information[2], the importance of CMV network is high. The CMV network is jointly implemented by BRAC and UNICEF with a budget of over 3 million USD. Other technical partners include BBC Media Action, CCP-Johns Hopkins, Islamic Foundation and Bangladesh Betar. UNICEF has expanded the CMV network with increased number of volunteers (another 200) and extended working hours covering more households. Since the CMV network is a response to Rohingya emergency, there was no time to construct a theory of change. As such, a theory of change was constructed retroactively in consultation with UNICEF C4D team (Annex A).

Theory of Change(Annexure 1)



To measure progress of the above-mentioned UNICEF intervention, C4D Section in collaboration with SPEAR Section conducted Baseline and Midline surveys in 2018 and 2019 respectively. The Baseline Survey assessed the Knowledge, Attitudes, Practices, and Behaviours (KAPB) of the Rohingya and host communities and identified that the CMVs are the second most important source of information in the Rohingya camps. As a follow-up of the Baseline, a Midline Survey was conducted to compare the changes in KAPB levels in 2018 and 2019. A randomized saturation design was also implemented during the Midline to provide an exhaustive analysis of the impact of the CMV network.

[2] Internews, Information need assessment, Cox Bazar-Bangladesh, November 2017.

The original plan was for UNICEF to conduct an evaluation in the same target areas with the same target groups using the same sampling plan and methodologies. This evaluation was also expected to measure the impact of the CMV intervention on the life of CMVs. These CMVs are part of the Rohingya community and are not only receiving training on dissemination of key life-saving messages but also playing a leadership role in the community, which in turn is enhancing their interpersonal communication and leadership skills. BRAC had identified two to three potential candidates to be trained for each of the 200 additional CMV blocks, and UNICEF had randomly selected individuals who underwent rigorous training and capacity building. This randomization would allow UNICEF and BRAC to understand the effects of the CMV network so that informed decisions on the scope and scale of the CMV network can be taken.

However, due to the COVID-19 pandemic, the evaluation was halted before implementation. Given the profound impacts of the pandemic and the necessary response, an impact evaluation is no longer feasible in its original form. It has been over six months since the CMV intervention scaled down, and there have been a number of interventions provided in response to the COVID-19 crisis and other natural disasters. The purpose and objectives will largely remain the same, with some methodological changes necessary to accommodate the COVID-19 restrictions and impact.

Purpose

The purpose of the evaluation is to generate evidence on what worked and what did not work and to document lessons from the implementation of Community Mobilization Volunteers (CMVs) network on the Knowledge, Attitudes, Behaviours, and Practices (KABP) of the Rohingya and Bangladeshi host communities to inform future C4D interventions for UNICEF and partners in humanitarian settings.

Thus, this evaluation will be summative. The primary users for the findings of this evaluation are UNICEF C4D sector and other relevant sectors in UNICEF. Potential secondary users are UN agencies, Government of Bangladesh and CSO partners. The intended audience are those who work in humanitarian settings. Findings and recommendations from the evaluation are expected to become a reference document for the planning of evidence-based C4D interventions in humanitarian settings in the future.

Objective of the assignment:

The evaluation aims to assess the relevance, effectiveness, impact, efficiency, and sustainability of the CMV network. While the Midline survey set the foundation to monitor the impact on the KAPB of the Rohingya refugees and host communities, the evaluation will be an opportunity to conduct a broader assessment of the CMV network through the OECD-DAC criteria.

Specific objectives:

a. Assess the extent to which the CMV network led to changes in knowledge, attitudes, behaviours and practices (KABP) of both the Rohingya and host communities including, children, adolescents' girls and boys, pregnant and lactating women and young children; and to the extent possible, determine contribution to the changes among Rohingya to the program.
b. Assess the extent to which the CMV network led to changes in capacities of CMVs, including personal/technical skills regarding key life-saving messages, interpersonal communication (IPC), community engagement, and leadership skills.
c. Assess the relevance, efficiency and sustainability of the program.
d. Assess the extent to which human rights approach, equity and gender equality were integrated and addressed in programme implementation.
e. Identify and validate lessons learned, good practices and examples and efforts that enhanced programme implementation and provide actionable recommendations

Scope of the evaluation

The evaluation will cover the timeframe of the CMV network from the end of 2017 to present in all Rohingya camps and all host community villages in Ukhia, Teknaf and Pekhua. The stakeholders to be covered by the evaluation will include a broad range of age groups in Rohingya refugees and host communities such as adults, the elderly, and adolescents of both sexes, as well as pregnant and lactating women and young children. Local community leaders (e.g., *imam*, *moazzin*), service providers (e.g., teachers, health service providers, information service providers) camp leaders (*majhi*) both male and female, and representatives of vulnerable groups such as the disabled community will also be covered. CMVs, community mobilisation managers, and programme organizers will be covered. The assessment is planned to start in September 2020 for a period of three months. The scope of the evaluation will be further assessed and refined during the evaluability assessment in the inception phase.

2.3 Evaluation questions

The evaluation will be informed by the OECD-DAC criteria of relevance, effectiveness, efficiency, impact and sustainability. In addition, gender and human rights will also be addressed.

The evaluation will seek to answer, but not limited to, the following questions corresponding to the criteria. The bidding team can

suggest changes to the evaluation questions in the proposal, as long as it clearly mentions how the original question is being captured and the reasoning behind the changes.

Relevance/Appropriateness

- To what extent was the CMV network relevant and responsive to the needs and priorities of the Rohingyas and host communities, including those most vulnerable (adults, the elderly, and adolescents of both sexes, as well as pregnant and lactating women and young children)?
- To what extent was the program aligned and responsive to relevant human rights (including child rights and gender) global, regional and national legal and policy frameworks?

Effectiveness

- To what extent did the CMV network lead to changes in the knowledge, attitudes, behaviours and practices (KABP) of the Rohingya refugees and their host communities? How has this been affected by COVID-19?
- To what extent did the intervention contribute to equitable participation and benefits to various groups (adults, the elderly, and adolescents of both sexes, as well as pregnant and lactating women and young children)?
- To what extent did the CMV network lead to changes in capacities of CMVs including personal/technical skills regarding key life-saving messages, interpersonal communication (IPC), community engagement, and leadership skills?
- What enabled or hindered the achievement of outcomes?

Impact

- What was the perceived and measurable impact of the different CMV intervention approaches, as implemented in 2019, on KAPB among the Rohingya refugees living in the camps?
- Did the programme lead to any positive or negative unintended results?
- To what extent was gender and human rights (including child rights) advanced as a result of the CMV programme?
- Was there any evidence of or perceived spillover effects of the programme into non-programme areas? If so, was there evidence of the main change factors being spilled over?

Efficiency

- What was the cost-effectiveness of the programme in terms of inputs to outputs?
- What were the factors affecting the pace and quality of implementation (i.e., high CMV dropouts) and how could these have been better mitigated?
- To what extent were the outputs (i.e., number of households reached; number of consultations held; please see Theory of Change for sample output indicators) delivered in reference to quality standards and timeliness?
- To what extent was the allocation of resources in the program appropriate to the beneficiaries and the most vulnerable groups (mothers and their children, people with disabilities)?

Sustainability

- To what extent were sustainability considerations built into programme implementation, in terms of recruitment, training and retention of CMVs, among others?
- To what extent have the beneficiaries sustained the good behaviours and practices after the end of the intervention?
- To what extent have or can the achieved results been/be replicated or integrated into policies, strategies, and programmes?

Please note that these questions need to be answered for the Rohingya and host communities separately as much as possible. Given the necessary methodological changes, an evaluability assessment matrix should be developed outlining how each of these evaluation questions will be addressed methodologically and to what degree will the findings be conclusive, based on the methods and data access and availability.

3. Duty station: Cox's Bazar, Bangladesh.

4. **Indicative assignment dates:** 1 September 2020 – 31 January 2021

5. Methodology:

Note: The selected firm will have access to the datasets (including raw data) from the previous surveys. UNICEF, as the proprietary, reserves the right to the ownership of all data.

The evaluation will use both quantitative and qualitative methodologies and gender, equity and human rights principles will be mainstreamed through the evaluation. The evaluation team is expected to develop this further during the evaluation process and ensure the evaluation is gender responsive. Evaluation should ensure disaggregation of data e.g. by sex, age, disability etc.

Evaluation design. The agency/institution/consultant will propose the most appropriate design in line with ToC and addressing the proposed evaluation questions, which will be subject to review by UNICEF. The theory of change (Annex A) should be the guiding framework for the evaluation. A randomized saturation design was implemented in the Midline for the purpose of conducting an impact evaluation of the CMV network. Given the current context and inability to conduct a RCT-based impact evaluation, the approach and methodology should include, but not limited to, the following:

1. A detailed mixed methods approach based on sampling similar to the baseline and midline quantitative surveys, with complementary qualitative methods to narratively explain the changes observed and address each evaluation question;
2. A quality assurance plan for all remote data collection processes, analysis and training of field staff, as relevant;
3. A data triangulation plan taking stock of all relevant data sources available as identified during the evaluability assessment;
4. An evaluability assessment matrix.

For reference, Annex B presents a detailed summary of the midline methodology, including the randomized saturation design, quantitative and qualitative data collection method, sampling strategy, respondents and sample sizes.

Methods for data collection

Data collection method will include both quantitative and qualitative methods demonstrating inclusion of key stakeholders at various levels, including the data collection tools and appropriate qualitative and quantitative methods to be used. Quantitative and qualitative data collection should happen in parallel, based on exiting data from baseline and midline.

In principle, the same data collection tools need to be used to ensure comparability, where possible Slight modifications may be necessary given the change to remote data collection techniques and to explore any topics that raised concern at baseline and midline or to better understand the CMV network and other C4D interventions.

Against this back-drop, the evaluation will employ the following mixed methods, and given the delay and current context changes, evaluators are encouraged to carry out a stakeholder mapping to update and ensure inclusion of stakeholders that may have been missed out in this ToR:

A. Quantitative Survey
   - People from different age groups from Rohingya refugees and host communities including adults, the elderly, and adolescents of both sexes, as well as pregnant and lactating women and young children.

B. Key Informant Interviews (KIIs)
   - Community leaders (Imam/Moazzin)
   - Service providers (teachers/health/information providers)
   - Camp leaders (e.g., majhi) and host community leaders (e.g., chairman, member)

C. Community Mobilization Volunteers / Community Mobilization Managers / Programme Organizers / Focus Group Discussions (FGDs)
   - People from different age groups from Rohingya refugees and host communities, including adults, the elderly, and adolescents of both sexes, as well as pregnant and lactating women and young children.

D. In-Depth Interviews (IDIs)
   - People from different age groups Rohingya refugees and host communities, including adults, the elderly, and adolescents of both sexes, as well as pregnant and lactating women and young children.

Sampling Methodology and Sample Size

Even though the RCT design is not possible, in order to ensure comparability between baseline, midline and the current summative evaluation, intervention participants (at 50% treatment and 100% treatment) should be surveyed and if possible, some control participants as well. There will need to be a robust replacement strategy proposed given the expected large degree of internal mobility and hardship to trace and find the same households. The size of the qualitative work should allow information to come decision-makers, leaders, and community members, from men and women, adolescent boys and adolescent girls of different age ranges. For both methods, names and contact numbers of community members and leaders and CMVs will be provided to the evaluation team.

Methods for data analysis

The agency/ institution/consultant is required to propose a detailed Data Analysis Plan for both the KABP findings, as well as for the impact on CMVs themselves. KABP data needs to be presented separately for host and refugee communities.

Evaluability assessment matrix: The firms are requested to present a preliminary evaluability assessment matrix that shows how different methods will be used to answer each of the evaluation questions proposed.

Budget and evaluation schedule: The agency/institution/consultant will be required to provide a detailed budget and timeframe to accompany the submission. The overall duration of the project should not be more than 14 weeks, completing the final approved report by 31 January 2021. A detailed and realistic project schedule/work plan should be included, indicating timing of activities, results and regular reporting, as required.

Limitations. The agency/institution/consultant will need to take into consideration and provide workable solutions to the following challenges and possible limitation of the evaluation:

1. The separation of knowledge, attitudes, and behaviours/practices pre- and post-COVID-19 pandemic and recall bias expected.
2. The high degree of internal mobility in the sample group, high attrition rate, and hardship to trace and find the same households.
3. The inconsistency of saturation level for treatment levels due to high degree of internal mobility. Additionally, the scenario of the camps may have changed (with major relocations, restructuring and renaming of camps, among others), which may contribute to the difficulty of maintaining the saturation level.
4. The lack of baseline data on the skills of CMVs, as the CMV intervention had started by the time the baseline survey was conducted. The CMVs have gone through a series of training and capacity development activities over the period of time and after the programme as well.

Norms and standards guiding the evaluation

This evaluation will be held to the highest standards employed by UNICEF for the conduct of evaluations and research. This means it will abide by the following:

- United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation in the UN System, 2016
- Ethical Guidelines for UN Evaluations
- UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis

The final report is expected to meet the UNICEF-adapted UNEG Evaluation reports standards as well as benchmarks used in UNICEF's Global Evaluation Reports Oversight System (GEROS).

Ethical considerations. It is expected that the proposal will include a section on the expected ethical and methodological challenges and issues that the evaluation will need to overcome. The institution/consultant will also be responsible for getting IRB ethical clearance. IRB ethical clearance is needed before quantitative and qualitative data collection, and the proposal should include a clause on how to deal with remote data collection as well as interviewing adolescent boys and girls in humanitarian settings. The IRB approval letter will need to be attached in the annexure of the final report. The proposal will need to spell out how the UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis will be followed/met, rather than only mentioning that the evaluation will abide by them. In the past, the research design and methodology for the baseline and midline were approved by the IRB.

Gender and Human Rights. Evaluation approach and data collection and analysis methods will be human rights based, including child rights based and gender sensitive. All data will be disaggregated by sex, age and ability level. The agency/institution/consultant is expected to abide by the UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation, and the UN-SWAP Evaluation Performance Indicator.

6. Work schedule:

The consulting team will refine the proposed timeframe and expected products in the inception report.

	Deliverable	Items covered/Included	Time frame	Payment schedule
1	Inception Report and presentation	- An inception report including o Work plan and budget, **including IRB clearance** and travel and meeting schedules o Evaluability assessment matrix o Details of methodological design and sampling methodology o Copies of the data	10 days of signing the Contract	First payment (20%)

		collection tools o Plan for data analysis - Power Point presentation of issues covered in the inception report at an inception meeting.		
2	Pre-test report	- Field work pre-test of data collection tools completed - Copies of the finalized data collection tools (translated) - Finalised enumerator's, and supervisors' manuals	20 days after acceptance of inception report	Second payment (20%) to be made on submission of pre-test report before field work
3	Fieldwork	- Field data collection of both quantitative and qualitative to be completed within 6 weeks of acceptance of the inception report. Quantitative and qualitative data collection should happen in parallel.	6 weeks	
4	Fieldwork report	- Fieldwork report outlining o Completed field notes o Finalised questionnaires o Details of persons met, documents reviewed and discussions held	1 week after 2 weeks of fieldwork	Third payment (30%) to be made after submission of the fieldwork report
5	Data analysis	- Quantitative data entry, data cleaning and data analysis performed - Qualitative data fully transcribed and analysed	3 weeks after submission of fieldwork report	
6	Draft Final Report and PowerPoint presentation	- Findings, results, and recommendations represented in a comprehensive report - PowerPoint presentation of the results	In week 10	
7	Final Report	- Soft copy of the Report incorporating all comments, fully formatted, edited and finalised to a professional printable standard - Hard copy of the report - All completed data collection instruments - The cleaned computer data files - All qualitative data transcripts	14 Week of signing the Contract	Fourth payment (30%) to be made on submission of final report and PPT presentation
8	Dissemination	- Dissemination of findings through a stakeholders meeting and brownbag presentation. - Reader-frieldy policy brief	After completion and acceptance of final report	

Evaluation Dissemination Plan/Communication Plan

The final report will be followed by a participatory dissemination workshop, where the key stakeholders will take part in finalizing the recommendations of the report. This presentation will include maximum 10 slides in the key findings, followed by the initial

recommendations that will be presented for discussion.

A reader-friendly policy brief that summarized the key findings, conclusions and recommendations of the evaluation needs to be produced. The firm can choose the format, but it is expected that innovative formats such as infographics or an ebook are used for enhanced readability.

7. **End products**

1. Inception Report: Within 10 days of signing the contract, an inception report that presents the proposed evaluation design, methodology, sampling, data collection tools, ethical considerations work plan, deliverables, and deadlines will be submitted. The tools and analytical methods used should explicitly consider gender, human rights and equity dimensions. An evaluation matrix that includes the evaluation questions and maps these to the tools and specific questions in the tools, as well as respondent groups is expected. IRB clearance needs to be included in the workplan. The inception report should present the proposed content of the final report following the GEROS reporting standards. The institution/consultant will make a PowerPoint presentation of issues covered in the inception report at an inception meeting.
2. A Pre-test report covering revised tools, revised protocol will be submitted at the end of researchers' training and pre-testing of tools conducted within 20 days after acceptance of the inception report.
3. Fieldwork: The field data collection of both quantitative and qualitative shall be completed within 8 weeks of acceptance of the inception report. Quantitative and qualitative data collection should happen in parallel.
4. Fieldwork report: Within 1 week after completion of fieldwork the institution/consultant should submit a report outlining the status of implementation of the evaluation and problems encountered (during fieldwork, etc.); a meeting will be convened for this purpose and preliminary findings will be shared.
5. A draft final report: Within 2 weeks from the acceptance of the fieldwork report, a draft final report that adheres to the GEROS reporting standards documenting the findings of the entire evaluation should be submitted. The report needs to show a clear flow from objectives and purpose of the evaluation, evaluation questions, methods and tools used to collect and gather information, analytical approach, findings, conclusions and recommendations. Recommendations are expected to be presented and discussed with the reference group. A PowerPoint presentation of the results will be presented and discussed with the reference group. Special attention to be taken to the discussion of the recommendations.
6. Final report. Within 14 weeks from the signing of the contract the institution/consultant should submit a final report that incorporates comments and inputs given to the draft final report and that adheres to the GEROS reporting standards. The report needs to show a clear flow from objectives and purpose of the evaluation, evaluation questions, methods and tools used to collect and gather information, analytical approach, findings, conclusions and recommendations. The report should aim for conciseness, readability, and visual appeal. Additionally, all data files, data completed tools must be submitted to UNICEF.
7. Dissemination workshop. A participatory dissemination workshop will be held, where the key stakeholders will take part in finalizing the recommendations of the report. This presentation will include maximum 10 slides in the key findings, followed by the initial recommendations that will be presented for discussion. A reader-friendly policy brief that summarized the key findings, conclusions and recommendations of the evaluation needs to be produced. The firm can choose the format, but it is expected that innovative formats such as infographics or an ebook are used for enhanced readability.

The inception report and draft evaluation report will be shared with the evaluation reference group for feedback.

UNICEF Bangladesh reserves the right to ensure the quality of products submitted by the external evaluation team and will request revisions until the product meets the quality standards as expressed by the joint ERG.

8. **Supervisors and management of the assignment:**

The evaluation will be managed by Chief of SPEAR Section and Research & Evaluation Specialist, SPEAR. SPEAR Section will provide technical support while C4D Section in UNICEF Cox's Bazar Field Office will provide coordination support, such as engagement with sectors to identify areas and stakeholders for inclusion in the evaluation, coordination with the implementing partners, and updates with field level/camp level to facilitate the implementation and dissemination of results. A designated focal point will be responsible for convening, coordinating and supporting the evaluation.

A Reference Group comprised of key stakeholders from the government and other partners will be set up from the onset of the evaluation to provide quality assurance to the deliverables. The Reference Group will be consulted on each key milestone of the evaluation (i.e., inception report and draft report) and will give feedback on the deliverables of the evaluation. Evaluation results will also be presented and validated by the Reference Group. Chief of SPEAR will have the accountability of accepting each deliverable.

9. **Payment schedule:** First payment: 20% upon approval of the Inception Report and PPT presentation Second payment: 20% upon approval of the pre-test report Third payment: 30% upon approval of the fieldwork report Fourth payment: 30% upon approval of the Final Report along with PPT presentation
10. **Qualifications or specialized knowledge/experience required for the assignment:** **Qualification and experience of the institution:** Given the complexity of the assignment, it is anticipated that this evaluation is conducted by a reputable agency with expertise in experimental and quasi-experimental impact evaluation designs, especially randomized saturation, designs in humanitarian / emergency settings. The evaluation team should comprise a maximum of 5 team members, including at least the following: Lead Evaluator (international consultant), one subject matter expert (international or national consultant) and one National Consultant. Given the country context, it is important that the evaluation team be gender-balanced (also in leadership roles) and that at least one of the team members has expertise on gender. **Qualification of Team Leader**: • Background in Public Health, Development Economics, Social Science and/or another related discipline/s • Expertise and proven substantial experience of at least 15-20 years in social research, with at least 8 years of experience in qualitative and quantitative research methods (with focus on household surveys) including analysis and synthesis • Proven experience conducting evaluations, particularly in the context of a humanitarian crisis setting • Proven expertise with experimental and quasi-experimental impact evaluation designs, especially randomized saturation designs • Demonstrated understanding of Social and Behaviour Change Communication (SBCC) and demonstrated skills in assessing Knowledge, Attitudes, Practices, and Behaviours in an emergency context • Expertise in gender, equality and human rights, including child rights programming, monitoring and evaluation. • Experience working in emergency setting, preference would be given who has previous working experience in Rohingya camps. • Has field level data collection resource pool who have at least 5 years of experience • Must be able to work/operate legally in Bangladesh **Qualifications of Team/Team Composition** • Selected firm/agency should recruit a Team Leader who will possess at least 5-7 years of experience in action research, SBCC research, various methodological study designs, and evaluations • The Team Leader has experience in managing a diverse team in emergency setting

Routing for approval of the ToR

Routing for approvals	Name	Signature & Date
Prepared by Technical Supervisor of the assignment	Andee Cooper Parks, Research & Evaluation Specialist, SPEAR, UNICEF Bangladesh	Andee C. Parks 14 October 2020
Reviewed & endorsed for approval by Chief of SPEAR	Mekonnen Woldegorgis, Chief, SPEAR, UNICEF Bangladesh	14 October 2020
Procurement Review by Chief of S&P/Procurement Manager	Srikanth Srinivasan, Chief of Supply and Procurement, UNICEF Bangladesh	14.10.2020
Reviewed & endorsed for approval by Chief of Requesting Section/Field Office	Ezatullah Majeed, Chief of Field Office, UNICEF Cox's Bazar.	15/10/2020
Approved by Deputy Representative for program/Chief of Operations for Operations	~~Veera Mendonca, Dep. Representative/OIC Dep Rep~~. Dara Johnston, OIC Dep Rep	Dara Johnston. 15 Oct 2020

Annex A: Theory of Change for the CMV Network

ISSUES	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	IMPACT
Rapid influx of 750,000 Rohingyas between August and November 2017, bringing total to 1 million across Cox's Bazar including the ones registered before Aug 31, 2017 Required immediate information on life-saving services and behaviours (Early Multi -Stakeholder Assessments) Lack of comprehensive knowledge among Rohingyas regarding desired practices and behaviours for health and social wellbeing coupled with language and literacy barriers (UNICEF -IPA KAPB Baseline Survey 2018) Low access of technology. Importance of and need for face-to-face information dissemination/ IPC and demonstration of key life-saving practices. (Numerous studies)	Establishment of a community engagement system through a robust Community Mobilisation Volunteers network (CMVs) across all the Rohingya settlements that includes: - Recruitment of CMVs - Training of CMVs - Incentives for CMVs - Supportive supervision of CMVs - Monitoring and quality assurance of CMV performance - Development of culturally appropriate IEC materials for use by CMVs during visits - Creation of monitoring tools - Purchase and distribution of supplies and equipment	Reach and engage adolescents and youths through radio listener clubs (ARLC), AV and IPT shows *Sample Indicators:* • *# of ARLCs established and made functional* • *# of adolescent boys and girls mobilized through ARLCs* • *# of IPT shows held* • *# of AV shows held* Reach, inform and engage households focusing on parents/caregivers/mothers through house-to-house IPC; Community consultation; IPT shows; Prevention/ Promotion and Disease-control campaigns *Sample Indicators:* • *# of HHs reached routinely with key life-saving messages through IPC (point in time coverage)* • *# of community consultation meetings* • *# of campaigns conducted /supported on Health, Nutrition, WASH, Education, Protection etc* Reach and engage community and religious leaders for an enabling environment (*Majhis*, Imams, *Muezzins* etc) through sensitization meetings and orientation workshops. *Sample Indicators:* • *# of orientation sessions held* • *# of sensitization meetings held*	Measurable changes in knowledge and attitudes. *Sample indicators (reference to UNICEF – IPA KAPB):* • *% of people (male and female) who know 5 danger signs during pregnancy, delivery, and after delivery* • *% of people (male and female) who know at least 3 critical practices on newborn care* • *% of people (male and female) who know key family practices on Health, Nutrition, WASH, Education, Protection, and other thematic areas* • *% of people (male and female) who can state 3 benefits of key adolescent issues*	Changes in behavior and practices Sample Indicators: • *# of people (male and female) who reported changed behaviours on Health, Nutrition, WASH, Education, Protection, and other thematic areas* • *# of people (male and female) who accessed services (e.g. vaccination uptake, nutrition supplementation, learning centre enrollment etc)*	Improved health, nutrition, education, sanitation, and protection of Rohingya children, adolescents and their families

RISKS & ASSUMPTIONS

Services are available and accessible
There is no restriction or limitation on access to services
There are no major disruptions in service due to climate or humanitarian crises

Annex B: Randomized Saturation Design from midline[3]

Quantitative Method
Issues addressed

- Knowledge: The study surveys Rohingya refugees and the host communities to determine their level of knowledge of: newborn care, management of communicable diseases (e.g. diarrhea), Water, sanitation and hygiene (WASH), Infant and Young Child Feeding Practice, harmful practices (e.g. child marriage) where and how to access services (e.g. information), education, and healthcare.
- Attitudes: The attitudes and perceptions of Rohingya refugees and host communities about the importance of education, availability and quality of essential services (e.g. education), information, and healthcare, etc.
- Practices and Behaviours: People's self-reported practice and behaviour related to new-born care, breastfeeding, care of young children, WASH, etc.

Respondent identification strategy, sample size and sampling distribution:

As mentioned above, the primary objective of this study is to assess the true picture of the KAPB status on life-saving behaviour in the Rohingya camps as well as the host communities. As such, the primary objective of the sampling was to draw a representative sample of the Rohingya and host communities. Within the Rohingyas, the sampling ensured the representation of and distinction between those receiving direct service from the CMVs and those who are not.

In all households, our respondent selection protocol was to survey either the mother/father (aged 18 years and above) of the youngest child in the household (aged five years or below).

Based on the team composition (14 male enumerators and 28 female enumerators) where male enumerators surveyed male respondents only and female enumerators surveyed only female respondents, instruction was given to survey 67% female and 33% male respondents. As we expected to get variation in ages naturally, we did not put an emphasis on surveying different ages across respondents. Also, it was important that we survey caregivers of children who make all children related decisions (e.g. whether to vaccinate,), and thus limited ourselves to surveying the parent of the youngest child.

In the quantitative survey, we interviewed 2,540 respondents from 283 randomly selected blocks in the camps. For midline, we followed a randomized saturation design across 283 blocks. We provided the intervention in three saturation levels. For one group, the CMVs provide direct service to all the Rohingyas in these blocks, (100% saturation level) for second group the CMVs provide direct service to half of the Rohingyas in these blocks (50% saturation level) and the third group received no direct service from the CMVs (0% saturation level). In each block, we randomly selected 9 respondents or 2540 in total. In the host communities, we randomly selected 37 villages, and, in each village, we randomly selected 18 respondents or 666 respondents in total. It is important to mention that not providing intervention to all households did not compromise ethical considerations of the delivery of intervention. The CMV intervention by UNICEF had already planned to cover partial population in the camps and IPA only decided on the dispersion design of this planned coverage of households. The research design and methodology was also approved by the IPA Institutional Board of Review (IRB). A table showing sampling distribution for the KAPB study is outlined below.

[3] Extracted from the midline report by Innovations for Poverty Action (IPA).

Survey coverage and target groups

Target Area	Rohingya camps and all the villages in Ukhia and Teknaf
Target Groups	Households in Rohingya refugee and host communities
Age Groups	Males and females aged 18 and above

Sample Allocation Designation Number

Designation	Number
Number of sample refugee camps	7
Camp sample size	2540
Block sample size	283
Respondents per block	9
Host community sample size	666
Village sample size	37
Respondents per village	18

Sampling Plan

We implemented a new randomized saturation design in the midline. The advantage of a randomized saturation design is that it allows to identify a set of estimates: not only can the researcher identify the usual intention-to-treat effect and the spillover effect on the non-treated, but can also observe spillover effects on treated units, and understand how the intensity of treatment drives spillover effects for the treated and untreated.27 The following saturation design was followed for doing the impact evaluation study of the Community Mobilization Volunteers (CMVs) network.

We followed a randomized saturation design for the following saturation treatment arms.

- No saturation condition (Z=0.0): No CMV visits any of the households in these refugee blocks.
- Mid saturation condition (Z=0.5): CMVs visit 50% of the households in these blocks.
- Full saturation condition (Z=1): CMVs visit 100% of the households in these blocks.

For all the blocks in the seven camps, the above saturation conditions were randomly assigned. We had initially randomized saturation across 362 blocks. However, BRAC was able to maintain the saturation levels for 283 blocks out of 362 blocks. For the study, we are only considering the blocks where saturation levels were maintained. (See limitations)

In order to draw a sample that was representative of the Cox's Bazar Rohingya population and the host community, we proposed the following sampling method:

Refugee camp sampling

Random Walk Sampling Strategy

- There will be nine households selected from each block.
- Randomly select three starting points in the block using the Kish grid method29.
- Send enumerators to those 3 starting points.
- First respondent household: The enumerators interview the closest household to the starting point.
- After this interview, the enumerator spins a pen on a piece of paper and follows the road that goes in the direction closest to where the pen is pointing.
- Second respondent household: Interview the 5th household that you walk to, counting households on both sides of the street.
- Third respondent household: After finishing the second interview, continue in the same direction if possible, and interview the 5th household that you walk to, counting households on both sides of the street.

- If an enumerator finds some barrier that prevents them from proceeding before they've conducted three interviews: They should return to the initial starting point, begin walking in the opposite direction that they started in, and recruit the fifth households in their walk. Barriers include:
  - The road ends
  - There is some obstacle preventing passage
  - The enumerator reaches the edge of the block

Host communities sampling
In order to compare KAPB proportions between camps and the host community, we also added the host community in our sample. We randomly selected 37 villages, from Ukhia and Teknaf, and selected 18 households from each village using the same random walk sampling strategy.

The following are sampling steps for the host communities:

- Prepare a list of host community villages in Ukhiya and Teknaf in discussion with UNICEF. We construct this list considering refugee population/host population density or geographic distance from refugee camps.
- Randomly select 37 villages from the list.
- Using Random Walk Sampling Strategy, select 18 household from each village.
- We selected a total of 666 households from the host communities.
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Household substitution protocol: If the designated household is not available, we will go to the house immediately next door. For example, if the enumerator reaches the fifth household, but no one is home, they should proceed to the next household, that is, the closest household they can reach moving in the same direction, but not moving backward. During our survey 977 HHs were replaced as per the above protocol.

If an enumerator arrives upon a household that another enumerator interviewed as a part of this study, proceed to the next household, that is, the closest household they can reach moving in the same direction, but not moving backward. During our survey, this occurred 10 times.

Qualitative Method
Rationale of the qualitative study and issues addressed:

The major goal of the qualitative study is to gather in-depth information, perspectives, and identify underlying drivers related to life-saving/priority behaviours and practices. Specifically, the objectives of the study are:

- To understand the perceptions and attitudes of Rohingya refugees and their host communities about life-saving/priority behaviours and practices in areas such as health, hygiene, sanitation, maternal and newborn care, nutrition, and education;
- To understand the underlying drivers of and barriers to desired practices on hygiene, sanitation, maternal and newborn care, nutrition, and education of Rohingya refugees and their host communities;
- To understand access and obstacles to seeking/receiving information among the Rohingya refugees and their host communities as well as the motivation behind these factors;
- To analyze these perceptions and behaviours from a gender and social inclusion perspective;
- To learn how the Rohingya refugees and the host community members spend their time and who they interact with regularly.

Qualitative survey sample size and Distribution
Data was collected through three different methods: in-depth interviews (IDI) with Rohingya refugees of both sexes and of varying ages, key informant interviews (KII), and focus group discussions (FGDs) with adult Rohingya refugees of both sexes.

In-Depth Interviews (IDI): Twenty-four in-depth interviews were conducted among several segments of Rohingya refugees and host communities such as adults, the elderly, and adolescents of both sexes. IDIs provided us with comprehensive information on issues such as healthcare, sanitation, vaccination, hygiene, maternal and newborn care, breastfeeding, complementary foods, diseases, and education facilities. We were also able to identify some key desired behaviours and practices from the perspective of gender and social

inclusion. These interviews helped us map the daily life and social interaction patterns of respondents, and by proxy, the community.

Key Informant Interviews (KII): We conducted 12 key informant interviews on KAPB. To conduct KII, we selected key persons such as local community leaders (e.g. imam, moazzin), service providers (e.g. teachers, health service providers, information service providers), both male and female, camp leaders (majhi), and representatives of vulnerable groups such as the disabled community, wherever available. The aim of the KII was to account for the perspectives of service providers and leaders on relevant issues.

Focus Group Discussion (FGD): Shifting from individual in-depth interviews to group interviews, the FGD helped us reach consensus, verify consistency, and validate generalizations. The FGDs were conducted with adult members of the Rohingya and host communities. Given that younger adults may feel uncomfortable expressing their views in the presence of older adults, we have divided them into two age groups: ages 20 to 35 and ages 36 to 50. We also separate FGDs for men and women. In total, eight FGDs were conducted in both camps and host communities, with male and female members of the community in the two age groups separately. From the FGDs we gathered collective information on key desired behaviours related to hygiene, sanitation, education, maternal and childcare, and education. In the FGDs, we also learned about collective knowledge and perception on how households respond to and cope with shocks; this will be particularly interesting for the Rohingya refugees.

Sampling Plan
With the help of local organizations, participants for IDI, KII, and FGD were selected using a **purposive sampling method**.

In the qualitative study, we conducted 10 Key Informant Interviews (KIIs) with the leaders and service providers in these communities, 29 In-Depth Interviews (IDIs) with people from different age groups and genders and 3 FGDs to validate our findings using all the above-mentioned methods.

Distribution of Participants

Tools	Original	Targeted Group	No. of Participants
Key Informant Interviews	10	Community leaders (Imam/Moazzin)	2
		Service providers (teachers/health/information service providers)	6
		Camp leader (e.g. majhi) and host community leaders (e.g. chairman, member)	2
Tools	**Proposed/ Original**	**Targeted Group**	**No. of Participants**
In-depth Interviews	29	Female adult	26
		Male adults	3
Focus Group Discussion	3	Camp younger adult male	6-8
		Camp older adult male	6-8
		Camp younger adult female	6-8
		Camp older adult female	6-8