Section II: Schedule of Requirements

eSourcing reference: RFP/2020/18214

MCCT Baseline Survey - Kachin State

I. LIFT Background

The Livelihoods and Food Security Fund (LIFT) is a multi-donor fund set up in 2009, marking its ten-year anniversary last year. LIFT aims to strengthen the resilience and sustainable livelihoods of poor households by helping people to reach their full economic potential. This is achieved through increasing incomes, improving the nutrition of women and children, and decreasing vulnerabilities to shocks, stresses and adverse trends.

LIFT is a significant actor in Myanmar's development. To date, over 14.5 million people in 82 per cent of Myanmar's townships have benefitted from LIFT's programmes. From January 2019, LIFT has been guided by a new five-year strategy that puts 'leaving no one behind' at the centre and will in particular focus on social inclusion and cohesion, increased support to areas affected by conflict, bringing displaced people into LIFT's development programmes and working with Government at all levels on targeted policies that achieve gains in these areas.

LIFT has received funding from altogether 16 international donors since it was established. The current donors are the UK, the European Union, Switzerland, Australia, the United States of America, Canada, New Zealand, Norway and Ireland. For more details, visit www.lift-fund.org.

II. Introduction to the MCCT Programme

The Ministry of Social Welfare, Relief, and Resettlements (MSWRR), through the Department of Social Welfare (DSW), will launch a Maternal and Child Cash Transfer (MCCT) programme in Kachin State during the fiscal year 2020/2021. The overarching objective of the MCCT Programme is to improve nutritional outcomes for all mothers and children in Kachin State during the critical first 1,000 days period from conception until the child's second birthday. The Livelihood and Food Security Fund (LIFT) supported the MSWRR to implement the MCCT programme in Chin State starting from 2017. LIFT supported the cost of the baseline survey as well as the cost of operations and cash transfers for the first two years of the programme. In 2019 the MSWRR assumed full responsibility for implementation. From 2018, the programme has expanded in Rakhine State and Naga Self- Administered Zone, and in 2019, in Kayin and Kayah states. LIFT supported baseline surveys for Kayin and Kayah states, as well as operational costs for two years[1].

DSW has requested support for the baseline survey for the MCCT programme in Kachin State. The baseline is required to provide a basis for measuring and evaluating the outcomes and impact of the programme over time as well as providing an opportunity to develop skills and capacity within DSW to be able to carry out baselines in the future. As the MCCT Programme implementation is expected to commence with the first cash transfer in June or July 2021, LIFT aims to complete data collection in March/April 2021 (TBC) and the entire Baseline Survey report finalised by June/July 2021.

The following Terms of Reference outlines the major components of the baseline survey as well as the processes to complete the survey.

III. Background of the Programme

The overarching objective of the MCCT Programme is to improve nutritional outcomes for all mothers and children in Kachin State during the first 1,000 days from conception until the child's second birthday. At the

[1] The MCCT programme has also started in Shan State and Ayeyarwady Region in 2020, supported by the World Bank Group.

programme level, the specific objective is to ensure that pregnant women and mothers have improved practices on maternal nutrition, infant and young child feeding (IYCF), hygiene, and health-seeking behaviours during the first 1,000 days.
The MCCT programme will provide universal coverage for all pregnant women and children under two years of age in Kachin State. The benefits of the programme will include regular nutrition education, accompanied by a cash transfer of MMK 15,000 per month.

The MCCT programme in Kachin State will promote improved nutrition outcomes for pregnant women and young children in line with the National Social Protection Strategic Plan (NSPSP) and the Multi-Sector National Plan of Action for Nutrition (MS-NPAN). It will also serve as an opportunity to validate the design of a nationally-led nutrition cash transfer programme whereby the cash transfer is closely linked with SBCC strategies to address suboptimal nutrition practices.

This process will strengthen the capacities of the Department of Social Welfare and other authorities and stakeholders as identified, to lead and coordinate the expansion of social protection coverage for the most vulnerable children and families in Myanmar.

IV. Kachin State Context

Kachin State, located in the northern part of Myanmar, borders China, India, and Myanmar's Shan State and Sagaing Region. With a population of 1,689,000 people (36 per cent living in urban areas) Kachin State is rich in natural resources including minerals, hydropower, and timber, in addition to vast areas of productive agricultural and agro-forestry land. However, the history of intensive, long-standing conflict between the Government of Myanmar and Ethnic Armed Organisations (EAOs), as well as among EAOs and the presence of a multitude of militias, coupled with large scale illegal production of opium and heroin as well as other illegal activities (gambling, smuggling, etc.), have adversely affected socio-economic development in the states despite their tremendous potential. Kachin has a higher than average poverty level at 28.6 percent compared to the national level of 25.6 percent.[2] Protracted conflicts have impeded economic development and caused large displacement of populations. As of January 31, 2020, there were 138 internally displaced people (IDP) sites in Kachin State, with a total of 97,322 IDPs.[3] Many of the displaced (about 40 per cent) were in areas outside of government control with limited humanitarian access.

The lack of livelihood opportunities is a major challenge for internally displaced people in camps and host communities in government- and non-government-controlled areas (GCAs and NGCAs). Several communities rely solely on humanitarian and development aid to survive. This perpetuates a lack of nutrition and food security and increased protection risks as internally displaced people take more significant risks seeking work and access to food markets. Livelihood challenges are a significant problem in Kachin State and are closely related to many other social problems. These challenges can be a result of unemployment, underemployment, displacement or the struggle to earn sufficient income from farming or other traditional livelihoods. Kachin ranked fourth among all states in a vulnerability index developed following a countrywide review of census data by the Myanmar Information Management Unit (MIMU) and the Humanitarian Assistance and Resilience Program (HARP) in June 2018. An estimated 988,300 persons, or 60 per cent of the population in Kachin State, had some form of vulnerability concerning housing materials, education/educational attainment, safe sanitation, drinking water, child dependency, availability of identification cards and/or direct exposure to conflict during the period analysed.

In Kachin State, **36 per cent of children under five years old are stunted**, an indicator of chronic malnutrition, according to the 2015-2016 Myanmar Demographic Health Survey (DHS). The rate of wasting is relatively low in both government- and non-government-controlled areas, with only four percent of children aged below five affected by wasting or acute malnutrition. Dietary adequacy in the first 1000 days for pregnant and breastfeeding women, young children, adolescent girls and the wider population is challenging to achieve among internally displaced people and host communities, as a result of poverty, a lack of income, rapid price rises and limited access to market, recently exacerbated by the COVID-19 pandemic.

Tensions between the Government of Myanmar and Ethnic Armed Groups continues in Kachin and northern Shan State, with parties to the conflict participating in the on-going peace processes and complex governance negotiations. An MCCT programme in Kachin State will need to take into account that some areas are under

[2] MIMU 2018
[3] CCCM-Camp Coordination and Camp Management Cluster

the authority of the government, others under the authority of an ethnic armed organisation and many with a combination of these. An MCCT programme, starting with the baseline, will need to have a deep understanding of the context, be sensitive and responsive to that context, be able to operate in that context while not contributing to or fuelling drivers of the conflict, and aim to contribute to the drivers of peace. Management of associated risks, ensuring dialogue with and engagement of all key stakeholders and ensuring good communication and access to information will be critical. The MCCT programme will need, in particular, to engage with the ethnic health organisations (EHOs) and civil society organizations.

V. Purpose of the Consultancy

The consultant(s) or firm will conduct the baseline study in Kachin State for the MCCT Programme. The primary purpose of the baseline study is to collect information on the current nutritional status, practices and context for the mothers and children in Kachin State that relate to the expected objectives of the MCCT programme. The baseline findings will serve the following additional purposes, among others:

- To provide a benchmark to measure the MCCT programme effect A comparative analysis of the baseline findings and eventual end line will enable programmers and policymakers to measure changes in the MCCT outcomes.
- To inform programme adjustments in design and implementation, both in the short term (i.e., Kachin State) and in the longer-term (i.e., scale-up). The baseline will support the finalisation of the M&E plan, including the targeting, monitoring and reporting on the MCCT programme. Regarding the programme design, the baseline will provide a deeper understanding of the context, which will ensure the programme is sensitive, responsive, and adopts a do no harm approach.
- The participation of the DSW staff across the critical stages of the baseline study will strengthen the capacities of DSW staff to conduct future surveys independently.

The **four stages of the consultancy** are**:**

SURVEY DESIGN: Develop the baseline evaluation design including sampling strategy and capacity building plan for DSW staff, to be carried out in Kachin State;

IMPLEMENTATION: Implement the baseline survey, including conducting village interviews, a representative population-based household survey including anthropometry, and key informant interviews;

DATA PROCESSING: Conduct data processing and produce data tabulations;

ANALYSIS & REPORTING: Analyse the data and draft a final study report for Kachin. Produce one briefing paper on Kachin State MCCT, to be reviewed with DSW before dissemination.

Scope of the study
The firm will conduct the state-wide baseline study in all but one or two townships of Kachin State where security issues exist. It is the responsibility of the firm to seek and employ feasible methods, such as, for example, through local partners, for collecting data in non-government-controlled areas.

Stakeholders
Ensuring inclusiveness, ownership and accountability among MCCT stakeholders is an integral part of the monitoring and evaluation of the interventions. The consultant or firm should map the primary and secondary stakeholders, and their engagement in the evaluations process from the design/planning, conduct and follow-up of the evaluation. The firm may employ various mediums or strategies to engage the broad ranges of the stakeholders throughout the evaluation process and can form stakeholder groups to allow continued dialogue during the evaluation.

VI. Survey Design and Methodology

PART A: Survey Design

To detect programme impact, the baseline and end-line survey should be designed to include a treatment and comparison group. The identification of an effective comparison group is particularly challenging because the MCCT program is based on the principle of universality, where all eligible women will receive the cash transfer (all pregnant women at the time the program starts).

Thus, applicants are to suggest ways to construct an effective comparison group for example a regression discontinuity design or using propensity scores from a group in a similar area. Importantly, the choice of a suitable approach to measuring the counterfactual would be a key criterion for assessing the suitability and viability of the technical proposals. Hence, the firm will require demonstrating knowledge and experience in quasi-experimental designs relevant for this study.

The contractor must design and execute all aspects of a representative, population-based household survey. This includes developing a sampling plan, questionnaire, and field procedures manual; recruiting and training enumerators, supervisors and anthropometrists to administer the questionnaire and take anthropometric measures; piloting and refining the questionnaire; arranging logistics for data collection; supervising data collection; ensuring data entry, cleaning, tabulation, and analysis; and report writing.

As part of the design process, the consultant(s) should conduct a desk review of existing survey reports and context analysis to ensure the design follows a conflict-sensitive approach. The indicators and data collection instruments which were used for the Chin, Kayin and Kayah baselines should be reviewed and revised as necessary.

Data Collection Methods

The baseline survey will consist of three main modules:

1) Village profiles, to cover village level assets and conditions
2) A Township profile which may include key informant interviews with health and other service providers and a township analysis of the data.
3) A representative, population-based household-level data collection module

1. Village Profile

The contractor will complete a profile for each village included in the household survey, identifying and documenting village characteristics and assets through a series of key informant interviews with village leaders and other stakeholders. They may also involve group discussions with various sub-groups in a sample of the selected villages. The village profile format will be developed in consultation with DSW and LIFT.

Within the Village Profile, topics of enquiry may include:

- Number of and distances to nearby markets and education and health facilities
- Presence of community committees, including Village Health Committees
- Presence of community volunteers, including auxiliary midwives and community health workers
- Access and quality of water and sanitation facilities and markets;
- General agricultural practices, particularly vegetable and livestock production
- Main livelihood strategies of the population

2. Township Profile

A township profile should be completed for each township where data is collected. The township profile may include:

- Township description; population, governance and administration
- Key informant interviews with representatives from DSW and MoHS and other key stakeholders
- Key Results:
    - Demographic overview
    - Stunting and wasting results and key nutrition indicators (consistent across all profiles)
    - Access to health and nutrition services (antenatal care, postnatal care, facility delivery, treatment of moderate and severe acute malnutrition, immunisations, etc.)
    - Water and Sanitation

- General agricultural practices, particularly vegetable and livestock production
- Main livelihood strategies of the population

The structure of the township profiles will be established during the design phase.

3. A representative, population-based household survey module

Sampling design: Given the importance of being able to make statistically-sound conclusions of MCCT outcomes and impact (based on the key indicators selected), the sampling approach must provide an acceptable level of confidence and degree of precision in the results. The design should be sufficiently robust to allow comparisons over time – before and after MCCT, across all areas where MCCT will be implemented.

The sample size, confidence levels, power and margins of error should be proposed in the sample design with adequate justification. As the project aims to cover both urban and rural areas, both urban wards and rural villages are expected to be sampled in both government and non-government controlled areas. The sample size will be determined based on the proposed design, taking into consideration that the MCCT is a universal programme for all pregnant and breastfeeding women with children under two years. The total population of Kachin is 1,689,000 people; certain areas, however, may not be accessible for security reasons.

Questionnaire design: Household level data collection will involve formal household interviews using a closed-ended questionnaire, which on average should take about two hours to complete, including the anthropometric and MUAC (mid-upper arm circumference) measurements.

Areas of enquiry likely will include, but are not limited to:

- Demographic factors (including family size and composition, age of household members, occupation, education levels, school attendance, etc.)
- Birth registration
- Nutrition, including correct knowledge, food intake, and anthropometric and MUAC measures of both pregnant women and mothers and children up to five years old
- Food security
- Childhood illnesses
- Health and hygiene-related knowledge and practices
- Access to and use of health services
- Access to and use of water and sanitation facilities
- Household employment and income sources, including migration and remittances
- Household expenditure
- Coping strategies
- Time use of mothers
- Household assets (including housing, livestock, equipment, consumer items, and transport)
- Poverty
- Women's empowerment, including women's role in decision making

A list of the specific indicators that may be measured in the baseline survey is included in Annex A. At the start of the consultancy, the contractor will confirm and adapt as necessary the final indicators to measure in the baseline survey in consultation with DSW and LIFT.

To ensure alignment with previous studies in other regions, it is recommended that the questionnaire for Chin and Kayin/Kayah be adapted and amended, as may be appropriate, to address specific contextual issues that are relevant for Kachin. The contractor must ensure that any changes to the questionnaire are highlighted and discussed with LIFT and DSW. The finally agreed questionnaire should then be developed in English and ensure accurate translation in local languages in which the survey will be conducted and then back-translated to English. The contractor must ensure that questions follow established questionnaire design principles and international standard formats wherever possible. Each page of the questionnaire should include the same unique identifier to ensure accurate data entry and enable the linking of different datasets. The contractor must ensure that the questionnaire is piloted and adjusted accordingly before the start of data collection.

Anthropometric Measurements

For the anthropometric component, the contractor will ensure that an anthropometry expert properly trains the recruited enumerators in anthropometry. The training will include instructions on how to take measurements on height and weight for children up to two years (lying down) and two years up to five years (standing up), and pregnant women and women with children under five years of age, and standardisation testing of trainees' measurements. Also, the anthropometry expert will provide oversight and feedback to the enumerators in the field for at least a portion of the data collection period. In the survey, each measure must be repeated multiple times by at least two enumerators, and all values must be recorded. An average of the values is to be used in the analysis. Using WHO's Anthro software to convert anthropometric data into Z-scores is recommended.

Referral protocols for children who are identified with severe acute malnutrition will be developed to ensure those who need it reach adequate care and treatment. LIFT will provide the equipment necessary for accurate anthropometric measurement, including Shorr Boards, Seca scales, and MUAC measuring tapes.

Capacity Building:
The contractor is expected to work with a team of DSW survey staff to ensure full involvement and skills development of key DSW staff to build capacity in survey design, data collection and supervision. This is with the intention that in the future DSW will be able to carry out the full implementation of the end-line survey with perhaps support for analysis and reporting. In addition, this process will strengthen the DSW's skills to lead future baseline surveys.

Recruitment and training of enumerators and supervisors:
The Contractor is expected to recruit, and train experienced survey enumerators and supervisors or to partner with an organisation who can provide this service. The contractor can subcontract enumerators and supervisors who should be trained in how to properly administer the informed consent portion of the questionnaire and each question with its possible response categories, and recommend best practices for conducting interviews. In addition, the trainees should know the roles and responsibilities of survey field staff, data quality assurance procedures, and ways to solve potential problems. Within the training sessions, enumerators and supervisors should practice administering the questionnaire and checking and correcting questionnaires for accuracy and completeness. As part of the training materials, and to serve as a reference guide, the contractor is expected to provide the enumerators and supervisors with field procedure manuals.

Enumerators and field supervisors who speak local languages where needed should ideally be recruited and trained separately. If this is not feasible, the contractor is expected to recruit, train, and supervise translators in locations where experienced enumerators who speak the needed local languages are not available.

Preparing and formatting electronic version: Electronic data collection should be used with the contractor responsible for carefully preparing and formatting the electronic version of the questionnaire. This must be checked and tested prior to enumerator training and piloting. The contractor must ensure that the devices are functional in rural areas and must describe their strategy for ensuring continued use given electricity shortages and lack of mobile phone connection.
The contractor will develop a data dictionary or codebook that includes the definitions of all variables created and describes how they were derived.

The analysis of survey data will include descriptive statistics, frequency and percentage distributions, cross-tabulations and the appropriate significance tests. Data are to be disaggregated by sex where relevant.

The contractor will propose a data treatment and analysis plan that details:

- Identification of the software to be used for all steps of data entry, cleaning, and analysis
- Specification of how and when data will be entered into and how double data entry will be conducted
- Descriptions of data quality checks and tests within the database
- Planned data analyses, stating which statistics and significance tests will be used
- Indicator tabulation plan and data dummy tables

The draft plan will be reviewed by DSW and LIFT and adjusted as required.

Data Quality Assurance

The contractor is expected to develop and implement standard operating procedures to ensure the quality of data in all phases of the study, including design, data collection, data entry and collation, data analysis, and reporting of the results. Such procedures should include but are not limited to, conducting both routine and random checks. For quantitative data, the standard data quality criteria of validity, reliability, accuracy, integrity, completeness and timeliness should be applied. For qualitative data, the standard data criteria of trustworthiness should be applied, which includes credibility, transferability, dependability, and confirmability. The contractor is to include a data quality assurance plan in the baseline survey Inception Report.

VII. Deliverables

The evaluation period is estimated for six months from 1st January 2021 to 31st June 2021.
The consultant(s)/firm should submit the deliverables according to an agreed-upon timeframe. A suggested timeframe is included in the following table.

Deliverables	Details	*Suggested Activities for selected deliverables*	Estimated Timeframe
Part A: Survey Design Phase			
A1. Approvals & permits	Obtain all required approvals and permits related to data collection from human subjects and logistics of study implementation, health and accident insurance, salary and taxes for all data collectors. Coordinate with DSW to support government approvals of relevant any documents Evidence of approvals submitted before LIFT granting permission to commence data collection activities.		Before commencing data collection activities (January 2021[4])
A2. Work plan	The work plan must specify details for critical tasks, planned outputs, and timelines with dates, resource needs, and responsible persons.		One week after commencement of the contract. (January 2021)
A3. Baseline Survey design workshop	A. Organise, develop materials for, and conduct a one-day workshop, either virtual or in country (depending on the situation) in English that brings together the contractor and subcontractor (if relevant), DSW staff, LIFT and others as deemed appropriate. B. The purpose is to glean information from programme implementation about survey sampling and fieldwork logistics planning, clarify		Two weeks after commencement of the contract (January 2021)

[4] please note the month is just indicative and will depend on the time of contracting this consultancy

	indicators, and discuss the proposed data collection plan. C. LIFT will fund the attendance of LIFT-related participants and provide the meeting venue or the necessary virtual arrangements; however, the contractor will bear the cost of its travel and attendance.		
A4. Survey Inception Report	The inception report should include descriptions of the following: A. Study design and the specific data collection methods to be conducted B. Sampling design C. Drafts of the survey and qualitative data collection instruments, including the village profile format and interview guide and household questionnaire D. Data analysis plan E. Data quality assurance plan ensuring appropriate oversight and supervision throughout the study and efficient use of personnel and resources F. A logistics and management plan and schedule, including a detailed schedule of village visits The inception report is subject to LIFT's review and approval	● Review relevant documents, including the operations manual and those relating specifically to MCCT in Kachin State. ● Agree on key indicators and means of information collection for each, through discussions with DSW, LIFT and other key stakeholders. ● Develop sampling methodology to represent all townships and villages where the MCCT will be implemented in the Kachin States (in consultation with DSW and LIFT); ● Draft the questionnaire and KII guide (if required for Township Profile), develop the anthropometric survey methodology, and revise the village profile format to meet the needs of the baseline, with input from DSW and LIFT ● Translate the English draft of the questionnaire into the languages required for each ethnic/language group in the sample; ● Include an analysis of the operating environment to demonstrate a conflict-sensitive approach to the survey design ● Recruit and train survey interviewers (enumerators), with particular attention to the use of appropriate languages; ● Field test the questionnaire (covering each language), the village profile, and the anthropometric survey tool, as well as the methodology to select villages, households and respondents, and make	Three weeks after commencement of the contract (January 2021)

		revisions to tools and methods as required; ● Develop a detailed survey implementation plan and schedule for covering all townships and villages, supervising field teams and ensuring high-quality completion of all necessary questionnaires and village profiles before leaving each village.	
A5. Training curriculum, including field procedure manuals for data collectors	Draft training agenda, session plans and materials for enumerators, supervisors, interviewers, and anthropometrists, for LIFT to review and approval		Four weeks after commencement of the contract (February 2021)
A6. Final versions of all data collection instruments . Includes pilot and pre-test reports.	Final versions of data collection instruments, including the pilot and pre-test, after they have been: A. Translated into required local languages and back-translated into English B. Piloted and pre-tested Data collection instruments are subject to LIFT's review and approval		Five weeks after commencement of the contract (February 2021)
Part B: Data collection			
B1. Fieldwork progress report	Provide progress against the schedule of village visits and highlights problems or issues faced, which should include discussions on revisions to the survey implementation plan, if any. It is estimated that data collection may take from 30 to 35 days, but will depend on the length of the questionnaire, the sampling plan, and the number of enumerators and whether the data collection can take place simultaneously across the townships.	● Commence field work and supervision of field teams; ● Review progress against the survey implementation plan, and make revisions as required; ● Raise any important issues or problems with DSW and LIFT and address them accordingly.	The end of each week of data collection

B2. Fieldwork completion report	A. A summary of dates, locations and completed data collection efforts, issues faced that may affect the reliability/accuracy of data, and any actions taken. B. All hard copies of questionnaires and village profiles must be carefully ordered, completed, and legible for the next phase of the survey, data entry and tabulation. All hard copies of questionnaires and village profiles will ultimately remain the property of LIFT.	● Complete field work ensuring all household questionnaires and village profiles are complete, and data is ready for tabulation. ● Draft the survey completion report and submit with all household questionnaires and village profiles to LIFT.	One week after the completion of data collection (May 2021)
Part C: Data processing			
C1. Data treatment and analysis plan	A. Specification of how and when data will be entered and how to double data entry will be conducted B. Descriptions of data quality checks and tests within the database C. Planned data analyses, stating which statistics and significance tests will be used D. Indicator tabulation plan and data dummy tables	● Agree with DSW and LIFT on the choice of database for data entry and analysis (this should be a common, affordable Windows-based database or statistics package); ● Design the database structure and fields, with appropriate validation rules and data entry forms, etc.; ● Develop methods to ensure data accuracy; ● Develop appropriate codes (as required) in consultation with DSW and LIFT ● Recruit and train data entry personnel (if required), supervise data entry and backup.	Six weeks after the commencement of the contract (February 2021)
C2. Data Processing completion report	A. Data entry is anticipated to be completed within two weeks after completing data collection. The choice of database/survey analysis software should be agreed with	● Complete data processing, data cleaning, and data checking using tablets; ● Draft the data entry completion report; ● Submit soft copies of database and all copies of questionnaires and village profiles in good order to LIFT.	Two weeks after completion of data collection (May 2021)

	LIFT & DSW before data entry commences. B. All household questionnaires should be carefully and individually numbered to coincide with an index number in the database. LIFT may choose to undertake independent random checking of the accuracy of data against the original questionnaires and village profiles before paying for this output C. The baseline survey and results shall be the intellectual property of UNOPS LIFT and shall not be used or communicated in any way without the prior permission of UNOPS LIFT.		
C3. Data tabulation report	A. Data tabulation report consists of the frequencies, percentages and cross-tabulations for all significant variables and indicators, with measures of statistical error or significance where appropriate. The report includes all tables and charts, which are carefully numbered and labelled, accompanied by a soft copy of the database queries/tables with corresponding numbers. B. No explanatory text is required at this stage.	● Develop basic frequency and two way tables (cross tabulations) for all major variables with measures of statistical error or significance where appropriate. ● Discuss with DSW and LIFT any additional tabulations required[5]; ● Develop charts for some parameters based on discussion with the above; ● Draft a report that includes all tables and charts that have been developed (text descriptions not required but all tables and charts to be clearly titled and numbered); ● Provide soft copies of the database including all queries, tabulations and charts with corresponding numbering to the tables and charts in the written report to LIFT.	Two weeks after completion of data entry (May 2021)
Part D: Analysis and reporting			

[5] LIFT will consult with DSW and communicate their suggestions to the contractor.

D1. Draft study report	An outline of the report is to be agreed to by LIFT, prior to drafting the report	• Conduct more detailed analysis of survey data including cross-tabulations; • Incorporate the findings of the village profiles and KIIs to help explain findings and trends; • Examine differences between treatment and comparison areas; • Provide soft copies of the revised survey database including all queries, tabulations and charts with corresponding numbering to the tables and charts in the written report; • Conduct a workshop on the study's major findings and take record of feedback and suggestions from participants.	Three weeks after completion and LIFT's acceptance of the necessary data tabulation report (May 2021)
D2. Briefing to major stakeholders	A. The formal briefing should include relevant content of the study report, including findings, conclusions, lessons and recommendations. B. FMO will provide the venue, but the contractor must bear the cost of their travel and lodging.		TBD
D3. Final study report	DSW and LIFT will provide feedback on the draft study report within three weeks of receipt. The final study report should incorporate LIFT's feedback and feedback from the briefing. By the end of the study, the contractor will also provide LIFT with soft copies of the following: A. Raw data set B. Data dictionary and codebook for quantitative analysis C. Syntax and output for analysis D. Final dataset including cleaned data & transformed variables E. Transcribed qualitative data	• Revise the draft report incorporating stakeholders' written feedback and feedback from the workshop; • Provide soft copy of the revised survey database including new queries, tabulations, charts etc.	TBD. Ideally, completed within two weeks of receiving stakeholders' feedback (June 2021)

	F. Codebook for qualitative data analysis G. Revised survey database including the queries, tabulations, charts, etc.		
D4. Briefing Papers	● Propose to LIFT a structure and outline for briefing paper based on findings of the baseline study to inform policy and programme. ● Share draft briefing paper for approval with LIFT ● Finalise briefing papers for publication ● Present these briefing papers at a dissemination forum or to stakeholders (TBD)	● In consultation with LIFT, propose a structure and outline for a briefing paper to present the findings of the baselines in order to inform programming and policy. ● Develop first draft based on the agreed outline and share for approval ● Provide finalised briefing paper for Kachin.	Briefing Papers submitted 2 weeks after the submission of the final survey report (July 2021)

VII. Timing

The firm/ contractor is expected to commence in January 2021 - June 2021 (6 months). That duration of the contract is inclusive for completion of all baseline activities, including field survey work, data processing, tabulations, and the draft report should be completed by 31st May 2021.

VIII. Team Composition and Qualifications

The team composition must reflect the multi-sectoral nature of the MCCT programme and include expertise in the following: design and implementation of population-based surveys, analysis of complex survey data, qualitative data collection and analysis. It is important for the team to have familiarity with maternal and child nutrition and social protection-related indicators. The firm/consultant(s) must also have at least 5 years experience in implementing large-scale household surveys; in particular nutrition, health and hygiene surveys – experience running extensive household surveys with an anthropometry element is required.

While the contractor may propose the composition of the team suitable to undertake the Consultancy in the time required, the following is an indication of the types of personnel deemed necessary. It is expected that most, if not all, data collection personnel will be recruited locally, and where relevant, have appropriate language capacities.

Previous experience in conducting similar surveys in Myanmar or other Southeast Asian countries is considered an asset. It is the responsibility of the firm/consultant(s) to conduct the necessary administrative processes, including to seek and obtain all required approvals and permits related to data collection from human subjects from Myanmar's Ministry of Health and Sports (MOHS).

Key Personnel:

1. Nutrition Baseline Survey Team Leader – This individual will serve as an experienced team leader and will be the primary point of contact between LIFT and the study team. S/he will have responsibility for the overall compilation and completion of the study report.
2. Social Protection Expert- to provide social protection technical guidance on designing, managing and coordinating the survey and analysis of the survey data.
3. Senior Nutrition Survey Specialist – will be responsible for providing nutrition technical guidance from designing, managing and coordinating the household survey and analysis of the survey data.
4. Senior Survey Statistician – will be responsible for statistical guidance from designing the study, including the suitable sample size, data processing and analysis of the survey data.
5. Nutrition Survey Trainer – This experienced trainer will oversee the training in anthropometry and advise on the collection of anthropometric data
6. Field Operations Manager – This individual will be responsible for planning, managing and supervising the household survey data collection in the field.
7. Data collection team for Kachin State

Other Personnel:

- Field Team Leaders/Supervisors
- Enumerators, with appropriate language skills
- Anthropometrists, with appropriate training, experience and language skills. It is preferable that the Anthropometry team be an independent group solely focused on ensuring the collection of quality data.
- Interviewers, with appropriate language skills
- FGD Facilitators, with appropriate language skills (if needed)
- FGD Rapporteurs, with appropriate language skills (if needed)
- Translators
- Database design expert (e.g., MS Access, SQL Server, SPSS)
- Data entry supervisors
- Data entry personnel

IX. Survey Management

LIFT will provide overall direction to the contractor, identify critical documents, and help refine a work plan, as well as arrange meetings with key stakeholders. LIFT will be the primary contact and communication channel for the baseline survey; however, DSW will supervise the process and approve deliverables, with the support of LIFT. If feasible, DSW may also select staff to participate in the survey process, including data collection. LIFT and DSW staff may be available for consultations regarding programmatic and technical issues, as needed.

The contractor is responsible for arranging other meetings and for making all logistical and administrative arrangements, such as vehicle rentals and drivers, lodging, workspace, computers, Internet access, printing and photocopying. The contractor is also responsible for transporting the data collection teams to randomly selected villages in Kachin State, keeping in mind the difficult travel conditions. Also, the contractor will be required to make its own payments, and cover the costs of producing the data collection instruments, the travel expenses of the field teams, and communications and reporting. All forms of Insurance and travel authorisations are the responsibility of the contractor.

X. Risk Management

The current and evolving COVID-19 context may affect the implementation of the baseline survey activities. The firm or consultant(s) should define strategies for implementation of the survey activities within the contractual period. The firm or consultant(s) should also describe financial strategies to ensure efficient use of funds in the likely event that the COVID-19 situation impacts survey activities.

The consultant(s)or firm should also define strategies to facilitate the process of approving the research documents or proposals with respective Government entities, including the Internal Review Board of the MoHS to avoid delays in conducting survey activities.

XII. Application Procedures and Evaluation Criteria

The application should consist of a:

1. Technical proposal that includes the following[6]:

   a) Firm/consultant(s) Information: Name of the firm/consultant(s), contact information of person responsible for the proposal including email address, postal address and phone number; web address (if available);
   b) Relevant Experience: Information on the history of the firm/consultant(s) and its work related to designing, implementing similar evaluations
   c) Evaluation plan outlining the overall understanding of the ToR, including:
      i. Proposed methodology including sampling design, data collection methods and procedures, data protection and data management, and proposed approach for enumerator/supervisor training, questionnaire piloting and revision. *NB: Please note this will be developed further and finalised with the selected bidder in collaboration with LIFT and DSW.*
      ii. Data entry and tabulation plan
      iii. Work plan with estimated timetable
   d) Team composition and qualifications (please indicate language skills):
      i. Proposed structure with justifications
      ii. CVs of the key technical team members. The CVs of the field survey managers must also be included.
      iii. Staff schedule[7]
   e) Samples of relevant past work

[6] note that only legally registered entities can be selected

[7] A Staff schedule that details how many days a team member will work, on which tasks, and at what time.

2. Financial proposal, with a budget that outlines the fees and associated costs in U.S. dollars. The firm/consultant(s) must budget for all relevant costs and provide explanatory notes.

The consultancy has been broken into four parts: A) Survey design B) the implementation of the study (data collection); and C) data entry and tabulation D) Final household report. Within the technical soundness criterion, firms will be scored for each part, as well as in total. Financial proposals must also divide the costs between each of these four parts. Please read carefully the requirements for the submission of the financial and the technical proposals in the information about submission.

Interested firms will need to illustrate the capacity to implement each part of the consultancy and as such may choose to associate with other organisations or consultants that possess complementary expertise. UNOPS's strong preference is to include all aspects of the study (parts A, B, and C) under a single contract with a single contractor.

Evaluation Criteria

The following criteria will be used to assess all proposals received:

Criteria for Evaluating Proposals	**Weight**
Proven experience and qualifications of the contracting firm to undertake the assignment ● Relevant experience of the firm in conducting similar service and experiences (10 points)	10%
Technical soundness of proposed approach ● Design and methodology, including the tool, the procedure for data sources and collection for conducting the activity (40 points) ● Work plan with estimated timetable, and deliverables (5 points)	45%
The consultancy teams must be as gender balanced as possible and have at least 35% women employed in the staffing working at the UNOPS project (5 points)	5%
Proven experience and qualifications of the proposed team to undertake the assignment, including longitudinal survey data collection, qualitative data collection, and mixed-data integrated analysis. ● Proposed team structure, composition and experience/qualifications (5 points) ● Procedures and list of pertinent similar services the organisation has successfully completed (for example. evidence in preparing reports for complex survey most relevant to this consultancy (4 points) ● Staff schedule is aligned with the implementation plan and the methodology proposed (1 points)	10%
Financial proposal	30%

Annex A: Indicators for Data Collection

These indicators are illustrative and are to be confirmed with key stakeholders during the Inception Phase.

Higher Level Outcome: Improved nutritional outcomes for all mothers and children in Kachin State during the first critical 1,000 days of life.

Improved nutritional outcomes for all children in Kachin State

i. Prevalence of low birth weight
ii. Prevalence of stunting among children <5 and <2
iii. Prevalence of wasting among children <5 and <2
iv. Prevalence of underweight among children <5 and <2
v. % of children who fall within the cut-off values in mid-upper arm circumference (MUAC)

Improved nutritional outcomes for all women and mothers in Kachin State

vi. Prevalence of underweight among non-pregnant mothers of children <2 years (BMI)
vii. Prevalence of low MUAC among pregnant women

Program Level Outcome: Pregnant women and mothers have improved practices on nutrition, IYCF, hygiene and health seeking behaviours during the first 1,000 days

1. Pregnant women and mothers have improved access to food and nutrition practices

1.1. % of women of reproductive age (15 - 49 years) who ate foods from ≥ 5 food groups the previous day or night (MDD-W)
1.2. % of children 6-59 months of age who consume minimum IDDS in the past 24 hours
1.3. % of pregnant and breastfeeding women who report eating more than they did before they were pregnant
1.4. Number of households that report to have 12 months of adequate household food provisioning
1.5. Number of households with an acceptable dietary diversity score (HDDS)

2. Pregnant women and mothers have improved IYCF practices

2.1. % of newborns who were put to the breast within one hour after birth (early initiation of breastfeeding)
2.2. % of infants < 6 months who were fed exclusively with breast-milk
2.3. % of infants (6-8 months) who receive timely introduction of complementary foods
2.4. % of infants still breastfeeding at 12-15 months
2.5. % infants still breastfeeding at 20–23 months
2.6. % of children 6-23 months of age who received foods from ≥ 4 food groups the previous day or night (Minimum Dietary Diversity-MDD)
2.7. Percent of children 6-23 months with Minimum Meal Frequency (MMF)
2.8. % of children 6-23 months of age who receive a minimum acceptable diet. (MAD)

3. Pregnant women and mothers have improved hygiene and health seeking behaviours

3.1. % of mothers of children of 0-59 months who had four or more antenatal visits for their most recent pregnancy
3.2. % of mothers of children of 0-59 months whose last delivery was attended by a skilled birth attendant.
3.3. % of mothers of children 0-59 months of age who received at least 1 visit post-delivery of their youngest child within 48 hours
3.4. % of immunization coverage for children 12-23 months of age
3.5. % of children 6 – 59 months receiving Vitamin A supplementation twice a year in the last 12 months
3.6. % of children 6-59 months receiving deworming twice a year in the last 12 months
3.7. % of children < 5 years with diarrhoea, ARI, or fever in the previous 2 weeks
3.8. % of children < 5 with diarrhoea, ARI or fever who were taken for appropriate health care from health facility

3.9. % of mothers of children 0-59 months who took iron/folate during their last pregnancy
3.10. % of households with basic hand washing facilities (water and soap)
3.11. % of households using basic drinking-water services (main source of water is from an improved source)
3.12. % of households using basic sanitation services (households with improved toilets or latrines for household members, that are functional at the time of visit)
3.13. % of children 0-23 months whose faeces were disposed of safely

Program Level SBCC Outcome: Pregnant women and mothers have improved knowledge on nutrition, health and hygiene behaviours during the first 1000 days

4. Pregnant women and mothers have improved knowledge on nutrition

4.1. % of pregnant women who know they should consume 5 out of 10 defined food groups and who can list them
4.2. % of mothers who know the recommended minimum dietary diversity for their child
4.3. % of women who know they should eat more during pregnancy and while breastfeeding than before they were pregnant
4.4. % of mothers who know the recommended minimum meal frequency for their child according to their child's age
4.5. % of pregnant women who could correctly identify that they should start breastfeeding within one hour after birth
4.6. % of pregnant women who know they should breastfeed exclusively until their child is 6 months of age
4.7. % of mothers who know that they should introduce solid, semi-solid or soft foods at 6 months of age
4.8. % of mothers who know that they should continue breastfeeding up to 2 years old or beyond

5. Pregnant women and mothers have improved knowledge on health and hygiene behaviours

5.1. % of pregnant women who know the recommended number of ANC visits.
5.2. % of pregnant women who know that a child delivered by a skilled birth attendant is safer for mothers and children
5.3. % of pregnant women who know the recommended timeframe for postnatal contact with a health provider
5.4. % of mothers who know they should seek health care service from a health facility or health staff when the child shows symptoms of ARI or fever.
5.5. % of mothers and caregivers who know they should wash their hands at 5 critical times
5.6. % of mothers who know how to dispose of child faeces safely
5.7. % of women with knowledge on pregnancy spacing and contraception

Social Protection-Related Indicators:

1. % of children without birth registration
2. Reasons for not having birth certificate
3. % of household members (including children) who were ill/sick in the last two weeks
4. % of household members (including children) who sought formal health care when sick/ill
5. Reasons for not seeking formal health care
6. % of mothers who stop field work / heavy work 1 months before and up to 3 months after delivery.
7. % of individuals (including children) employed within the household
8. % of households who receive non-labour income, by source
9. Mean monthly household income from employment
10. % of households receiving remittances
11. Annual amount of remittances
12. Mean monthly expenditure categorized by appropriate food groups and non-food groups
13. % of food types consumed that are produced by households

14. Mean monthly consumption of households from own produce
15. % of households with experiences on shocks in the past 10 years including events that occurred this year
16. % of households using various coping mechanisms in the event of food insecurity
17. % of households perceived themselves as non-poor, moderately poor or very poor
18. % of households who perceive the need for improved supply of facilities, such as schools, health care, transport, communication, electricity
19. % of women who have decision making power in use of money, purchases of durable goods, assets, migration and marriage
20. Mobile phone usage
21. % of households accessing other government development programs
22. Indicator(s) of participation/support of other household members in child care and child nutrition-related activities (*to be decided)*
23. Access to finance indicator (credit and savings; including use of mobile money) *(to be decided)*
24. Knowledge of MCCT program
25. Participation in COSS sessions
26. Frequency of contact with VCSWs

Demographic Factors, to be captured in the household questionnaire:

1. Age distribution of household members (including children)
   Age distribution of head of household
2. Age distribution of mothers with children < 5 years
3. % of female headed households
4. % of children living in female headed households
5. % of children living without mother or father (or) living with relatives because of migration
6. Household size and composition
7. Education status/highest grade achieved of all household members (5 and above) including head of household
8. Distance (in meters) to water/toilet facilities

Village-level Indicators, to be captured in the Village Profiles:

1. Number of villages that have the following services such as:
   - Health centre
   - Presence of MW and/or PHS
   - Presence of an AMW and/or CHW
   - Presence of a VCSW
   - Presence of a village health committee or maternal and child health health committee
   - Regular visits from a MW (at least every 2 months)
   - Regular visits from NGO worker
2. Number of and distance to nearest health facilities
3. Number of and distance to education facilities
4. Number of and distance to markets (in km)
5. Number of and distance to a bank branch
6. Number of and distance to a mobile money agent
7. Number of villages with access to markets in less than 3 hours in the rainy season.
8. Number of villages with access to health centre in less than 3 hours in the rainy season.
9. Number of villages with year-round vegetable production
10. Number of villages with at least 9 months vegetable production
11. Number of villages with less than 6 months vegetable production
12. Number of villages with access to road (wet and dry season)
13. Number of villages with reliable access to mobile network