

**Terms of Reference**

**BHA/USAID Funded Grant**

**Agreement No. 720BHA23GR00027**

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| **External Evaluation****TOR** |
| **Zone/Country** | Afghanistan (Kabul, Ghazni, Paktia, Kandahar, Zabul, Nangarhar, Laghman, Kunar, Logar, Khost, and Wardak provinces) |
| **Title**  | Lifesaving assistance of integrated Health, Nutrition, WaSH and Protection services for crisis-affected populations in East, Southeast, South and Central regions of Afghanistan |
| **Duration of evaluation** | 45 days  |
| **Author(s)** | PUI Afghanistan, DACAAR, INTERSOS Afghanistan  |

1. **Introduction**
	1. **Context of Intervention**

Since 2021, the situation in Afghanistan has been deteriorating, with significant consequences for the most vulnerable members of the population. The economic decline after the political transition, coupled with the suspension of major development cooperation, has worsened existing vulnerabilities. This is especially true for civilian infrastructure, such as hospitals, water systems, and roads. The interim Islamic Emirates of Afghanistan's restrictive policies on women's education and work hinder the country's recovery prospects. Despite the end of conflict, half of Afghans still live in poverty. According to the Humanitarian Needs and Response Plan (HNRP) for 2024, over half of Afghanistan's population, or 23.7 million people, require humanitarian assistance. Additionally, Afghanistan is vulnerable to geopolitical and regional dynamics. For instance, in 2023, 1.9 million Afghans returned to their country, including over 471,000 from Pakistan since September 15, 2023, following a decree from the Pakistani administration to evict undocumented Afghan nationals.

In response to the continuously worsening crisis, Premiere Urgence Internationale (PUI), INTERSOS and the Danish Committee for Aid to Afghan Refugees (DACAAR) provide life-saving assistance through a strengthened, integrated and complementary approach, since January 1st, 2023 until November 31st, 2024 (with a potential top up until May 31st, 2025). This includes the provision of Health, Nutrition, Protection, Water, Sanitation and Hygiene (WasH), Economic Recovery and Market Systems (ERMS) and Shelter and Settlement services across 11 targeted provinces to the most affected population. Their action particularly focused on vulnerable population living in white and underserved areas, focusing on women’s and girls’ access to assistance, particularly healthcare services.

PUI Afghanistan and its partners have designed an intervention, implemented with the support of USAID's Bureau for Humanitarian Assistance, to help reduce mortality and morbidity by increasing access, coverage, use, and quality of basic primary health care services, integrated management of acute malnutrition, and water, sanitation, and hygiene services. Additionally, the intervention aims at enhancing the dignity of vulnerable households affected by violence, conflict and natural disasters by restoring livelihoods and responding to the urgent needs of vulnerable Internally Displaced Persons (IDPs) and affected populations facing harsh winter conditions. To implement these changes, PUI and its partners provide training to staff who carry out integrated activities in supported health facilities and at community level, in addition to rehabilitating water supply systems to ensure water supply to the catchment population.

* 1. **Partners’ History and Operational Strategy**

The Afghan mission is the historic mission of PUI, as it has been running since 1979. PUI teams provide emergency assistance to the most vulnerable communities through an integrated approach in sectors such as Health, Nutrition, Mental Health and Psychosocial Support (MHPSS), WaSH). The teams also develop community resilience activities in collaboration and coordination with other humanitarian partners. Through this integrated approach, PUI seeks to address all dimensions of the needs of people affected by crises and to propose a combination of solutions that will have a lasting impact on them.

INTERSOS has been present and operational in Afghanistan since October 2001, when it launched its first emergency operations in response to the conflict and resulting humanitarian crisis-in. INTERSOS' main areas of intervention in the country are: 1 ) Health - consultations, provision of medicines, referrals, support to health systems to contain public health crises, immunization, pre- and post-natal and maternal care services, and emergency/trauma services); 2) Nutrition - through a feeding program for children and pregnant and lactating women; 3) Protection - particularly with individual case management activities, mental health and psychosocial support services, and services for women/girl survivors of gender-based violence, including through their economic and entrepreneurial support, and safe spaces for children; 4) WaSH, particularly within the supported health centers (WaSH in Health); 5) Non-food Items (NFI) ; and 6) Multi-purpose Cash Assistance (MPCA), with a focus on children and youth, mothers, persons with disabilities and elderly at risk, and displaced or returning populations.

Since its establishment in 1984, DACAAR has been a permanent name in the humanitarian and

development sectors in Afghanistan. As a nonpolitical, non-governmental, non-profit organization, it works to improve the lives of the Afghan people by addressing the acute needs of the most vulnerable and supporting early recovery and sustainable development for all. DACAAR’s early recovery and developmental interventions are aimed at building resilience, enhancing capacity and improving livelihoods for protracted internally displaced people and returning refugees and their vulnerable host communities. We currently work in the thematic areas including WaSH, Natural Resource Management (NRM), Small Scale Enterprise Development (SSED) and Women’s Empowerment (WE).

* 1. **Intervention areas**
* PUI (Health, Nutrition) works in Ghazni, Kabul, Kunar, Nangarhar, Laghman, Nuristan and Paktia provinces.
* INTERSOS (Health, Nutrition, Protection, Livelihoods, shelter/settlements) works in Kabul, Kandahar and Zabul provinces.
* DACAAR (WASH) works in Kabul, Zabul, Kandahar, Khost, Paktyia, Logar, Wardak, and Ghazni provinces.
	1. **Basis for the External Evaluation**

Since the project has been running for more than 12 months and will continue for another year, this evaluation will extract best practices, lessons learned, what worked and what didn’t, and make recommendations to enhance ongoing quality and what could be added or/and can be done differently in future programming.

The evaluation purpose is to understand to which level the project achieved its proposed objective: ***To contribute to a reduction in mortality and morbidity in the 11 targeted provinces of Afghanistan.***

1. **Evaluation Methodology**
	1. **Evaluation Type**

The type of evaluation proposed for this program is summative performance evaluation to establish a causal link between; increasing access, coverage, and use of health, nutrition, WASH, and protection services, responding to the needs of vulnerable households through livelihoods and winterization support, and achieving reduced mortality and morbidity, and enhanced dignity, of affected populations.

The evaluation approach should be based on the International Organization for Economic Co-operation and Development evaluation standards and guidelines (DAC criteria), namely; relevance, coherence, effectiveness, efficiency, and impact. As part of the evaluation process, a comparison of the initial (baseline) conditions of the affected groups should be reviewed compared to the mid-term conditions. Also, the evaluation approach will carefully review process-level and context data.

* 1. **Evaluation Questions**

The evaluation should be guided by a series of questions as follows[[1]](#footnote-1):

1. **Relevance:**
	1. Was the action adequately designed to respond to the needs of the affected persons?
	2. How involved were the affected communities in the design and implementation of the project, in terms of participation?
	3. To what extent did the project consider the needs of different groups (girls, boys, women, men, people with disabilities, etc.)?
	4. To whatextent are the activities conflict and gender-sensitive, and culturally appropriate?
2. **Coherence**:
	1. Is there complementarity/coordination with other actors in the target areas?
	2. To what extent is intervention adding value while avoiding duplication of effort?
	3. How has the coordination and collaboration in the consortium met the expected standards, and what factors have contributed to the achievement/non-achievement of those standards?
3. **Effectiveness**:
	1. How well did the project achieve its intended outputs and outcomes with respect to indicators?
	2. What are the critical enabling factors and inhibiting factors that have affected the project? (Including those beyond the control of the programs management structures)
	3. Are the quality and internal controls measures in place and consistency applied? How effective are partners at identifying risks and mitigating them?
	4. How was the activity implementation adapted based on monitoring information and feedback from the target population?
	5. What are the possibilities for replication and extension of the project? What adaptations should be made?
4. **Efficiency**:
	1. Was the project managed in a cost-efficient manner (in terms of human, financial and other resources), versus the results?
	2. Were synergies capitalized between the partners within the project?
5. **Impact**
	1. What intended or unintended changes have the program made in the lives of people?
	2. To what extent has safe and dignified programming been mainstreamed in the program?
	3. **Specific methodology**

The evaluation should have a mixed research design. Quantitative data will be provided by the partners (collected throughout the course of the project, including in the 3 months prior to the evaluation). The consultant must collect primary qualitative data, through Focus Group Discussions and Key Informant Interviews with beneficiaries, community stakeholders, and project staff. The consultant will be responsible for getting approval to the field locations to collect data, and have their own data collection team. Project data, such as monitoring records, indicator tracking tables, and such can be requested by the consultant from the partners.

Qualitative data will be collected from targeted communities by the consultant, the sample size will be based on theoretical saturation principles. Data collection will take place in some of the areas of intervention. The area selection will be decided by the external evaluator, however should cover a range of distinct sites (e.g. At least two sites per province, rural and urban, remote sites).

The following is a list of suggested sites within each province prepared by the partners. The consultant may use this as a basis for planning their methodology:

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| **Province** | **Suggested districts** |
| Kandahar | Arghistan, Zhari, Maiwand, Spinbuldak, Zheray |
| Zabul | Qalat, Seorai, Shinkai, Zuzgara, Bawary  |
| Ghazni | Waghaz, Qarabagh, Giro, Khogyani |
| Wardak | Sayed Abad, Narkh, Maidan Shar |
| Kabul | Bagrami, Deh Sabz, Qara Bagh |
| Logar | Mohammad Agha, Baraki Barak, Charkh |
| Paktia | Ahmad Abad, Said Karam, Zurmat, Jani khel, Garda serai |
| Khost | Matoon, Gurbaz, Mandozi, |
| Nangarhar | Batikot, Momandara, Khogyani |
| Kunar | Sarkani, Khas Kunar, Dangam, Narang |
| Laghman | Qarghayi, Alingar, Alishang, Mehterlam  |

PUI, DACAAR, and INTERSOS will collect the primary quantitative data through a household survey. This data is available for the start of the project (baseline in mid-2023) and a midterm conducted between June and August 2024. Besides this, internal project records and monitoring reports will also serve as data sources. In addition, the consultant should consult secondary data published by the UN and other stakeholders, and their own qualitative primary data. Consultant will use both paper and digital devices (based on the differences in permissions between provinces) to collect the qualitative data. Data should be analyzed using proffesional software of the consultant’s choice, for data analysis and tabulation/graphs. In addition, data must be analyzed by at least Province, Gender, and Status.

The project has 66 indicators, which will be shared with the consultant upon the start of the evaluation planning. There are 19 outcome indicators and 47 output indicators, spread across Health, Nutrition, WASH, Protection, ERMS/livelihoods, and shelter/settlements sectors.

**2.4 Evaluation Timeline**

A total of 45 days’ assignment[[2]](#footnote-2), the evaluation is expected to be started tentatively in **September-October 2024**. The exact schedule/plan of the consultancy will be agreed upon with the consultant during the signing of the contract. Prior to the data collection, the external evaluator will share the tools with PUI coordination team for review and validation.

**2.5 Profile of the external evaluation team**

* Post-graduate degree in Humanitarian Studies, Disaster Management, Development Studies, and/or relevant Social Sciences discipline;
* At-least 3 years’ proven experience conducting evaluations of humanitarian programs. Consultants should have previous experience in evaluating Health and WASH projects (additional experience in evaluating protection and mental health related projects desired);
* Familiarity with international quality and accountability standards;
* Strong analytical and conceptual skills;
* Experience in the use of participatory methodologies;
* Knowledge of the Afghanistan context and languages (Dari and Pashto) is essential;
* Excellent written and spoken communication skills in English;
* Proof of having access and approvals to conduct the data collection; PUI will not be responsible;
* Experience with BHA/USAID-funded projects is an advantage.
1. **expected outputs**
2. **Inception Report:** The consultant will prepare and submit an inception report/technical proposal describing a detailed evaluation methodology, budget, and timeline;
3. A **presentation to disseminate draft findings** to partners before validation of report;
4. **Draft Report:** A draft evaluation report will be submitted to PUI Coordination for feedback with 35 days of signing the contract;
5. **Final Report:** A final report detailing the findings, conclusions, targeted recommendations, experiences, and lessons learned (this should also consider the feedback provided on the draft report and feedback during the presentation of findings meeting). The final report should be no longer than 25 pages, including a 2–3-page executive summary. PUI will require a digital copy of the raw data, analyzed data, and report at the end.

**Note: The findings of the evaluation will be the property of PUI, DACAAR, and INTERSOS**

1. **Selection process**

Information about the selection process, including what documents are required in the submission, the contact information, etc, can be found in the annexes

1. These are guiding questions to be more adapted to the activities after discussion and revision with the external evaluator. [↑](#footnote-ref-1)
2. Activity Days: Preparation & Inception Report (4 days), Meetings, data collection, field work (20 days) de-brief & Report (21 days) Total Days 45 [↑](#footnote-ref-2)