Consultancy Terms of Reference for External End-Term (final) Evaluation of the Afya Zaidi Project:

The Farmamundi/Foundation for Health and Social Economic Development Africa (HESED- Africa) in conjunction with her partner, Generalitat Valenciana, in the **Afya Zaidi** Project, wishes to announce Request for Proposals from qualified consultants on the above consultancy assignment as per the details below.

I. Background	
1.1 NATURE OF THE CONSULTANCY ASSIGNMENT	
The Foundation for Health and Social Economic Development of Africa is seeking the services of an external consultant to undertake Final Evaluation of its project **"AFYA ZAIDI": whose goal is to improve health among vulnerable and refugee population in the informal settlements of Kasarani, Nairobi.**	
1.2. PROJECT IMPLEMENTATION PERIOD	
IMPLEMENTING PERIOD	From 20 June 2022 to 30 July 2023
1.3. PROJECT BACKGROUND AND INFORMATION	

The desired change sought with the proposed intervention was to improve the capacity of Kasarani sub-county (Nairobi, Kenya) for the prevention and care of critical public health situations, including sexual and gender-based violence, and to realize reproductive rights among local and refugee populations in a COVID context.

Such a desired change seeks to contribute to improving (as a positive impact) the 'universal access to sexual and reproductive health and reproductive rights as agreed upon in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the final review documents' (target 5.6 of the SDGs).

The causal articulation underlying this logic is that, if access, availability, coverage and quality of sexual and reproductive health services (including SGBV) are improved, the acceptability of such services among the refugee and local population is improved, with a special focus on the youth and adolescent population, and if the health information systems of the sub-county are improved, the exercise of sexual and reproductive rights in the area will be improved.

In order to achieve this proposed change, three componenets have been addressed:

- Strengthening of the Kasarani health centre (accessibility, availability, acceptability and quality) - CARE
- Connecting health with educational and community programs in the area (liaison with schools and community organizations) – PREVENTION
- Data-derived analysis to make evidence-based improvements (information systems, epidemiological surveillance and learning information systems, epidemiological surveillance and health learning) - KNOWLEDGE MANAGEMENT

In relation to the first axis of intervention, it is understood that the health response of the Kasarani Health Centre and the annexed Maji Mazuri dispensary were aimed at improving the the human rights framework in order to provide quality care. This implies that the health structures have the necessary material and supplies to provide

an accurate response to situations of rights violations, with spaces that respect privacy and reliability of care and with qualified personnel (both in their professional field and in cross-cutting approaches: Gender, interculturality, age, rights...) informed of their functions and where to refer in case of not being able to achieve the required health standards among people accessing and using sexual and reproductive health (SRH) services (e.g., referral for legal care, nutritional support, etc.).

Regarding the second component (axis) of intervention, it is considered that a qualified SRH orientation among the group of people of childbearing age in the intervention area, led by health personnel, community promoters and trained educational agents (connecting health structures with community and schools), will improve the acceptability of services (cultural and relational change). In addition, to improve the acceptability of SRH services, they must be available to respond to the needs raised.

In relation to the last axis, health information systems (HIS) constitute a fundamental support for decision making in health institutions, since health indicators reflect progress in the health-disease process and allow us to know the coverage of health services, as well as the morbidity and mortality of the population we work with and to detect early possible outbreaks of infectious diseases (such as COVID or cholera, a recurrent disease in informal settlements and marginal neighbourhoods of the capital). This information is key for the planning of health actions, as well as for their monitoring and evaluation. Health information systems are also a tool for accountability and for encouraging community participation in health management**.**

The prevailing situation before Project intervention

Again, this situation has an **unequal impact on the living conditions of women, men and children**. In this sense, we observe that, in relation to women's access to health, the system of patriarchal organization of gender relations limits the power of decision on the destination of the scarce household income to the husband, father and/or brother head of the family, making the specific health needs of women in the group not considered a priority.

Thus, in relation to **access to maternal health and sexual and reproductive** health (SRH), there is a widespread lack of access to family planning services, prenatal care and attendance at birth. This, together with the persistence of high fertility rates among refugee women (6.6 children per woman) and the high rate of teenage pregnancies (106 per 1,000 women), are factors that contribute to maintaining high infant and maternal mortality rates, with the latter almost double the national rate (706 per 100,000 births).

standards and many of them do not have the necessary Ministry license for their exercise, causing the consequent risks to the health of the users.

Sexual and reproductive health and rights (SRHR) encompasses efforts to eliminate preventable maternal and neonatal mortality and morbidity, ensure quality sexual and reproductive health services, including contraceptive services, and address sexually transmitted infections (STIs) and cervical cancer, violence against women and girls, and the sexual and reproductive health needs of adolescents. Unfortunately, **many vulnerable people have poor access to sexual and reproductive health (SRH) services** that address these issues. As a result, their rights are not met, resulting in poor SRHR outcomes such as unintended pregnancies, maternal mortality, neonatal mortality, and sexually transmitted infections (STIs). Women and girls are known to face numerous **challenges in accessing sexual and reproductive health services.** On the demand side, **barriers** include, among others, lack of SRH knowledge, sociocultural and religious beliefs and practices, poverty, stigmatization, and negative attitudes of health personnel. On the supply side, barriers include lack of availability and affordability of commodities and services, shortages, distance to health facilities, staff shortages and poor training of health workers.

Infant mortality in the settlements reaches 151 deaths per 1,000 live births, which is double the rate in Nairobi County (62 deaths per 1,000) and even exceeds the rural infant mortality rate (113 per 1,000). Among the underlying factors we find: higher incidence of malnutrition (17.2% of children under 5 suffer from acute

malnutrition), limited immunization coverage (less than 46% of children under 5 comply with the WHO recommended vaccination schedule and since 2012 there has been an increase to 15% in the percentage of children under 12 months who have not received any vaccination) and precarious sanitation and hygiene conditions. These factors contribute to weakening the immune system, positioning them in a situation of extreme vulnerability to the incidence of opportunistic and infectious diseases.

Likewise, **infant mortality affects boys and girls differently**. The probability of dying before the first month of life is 1.8% higher in the case of girls, while the probability of dying during the first year of life or the following five years is higher in the case of boys. On the one hand, babies born with deficiencies linked to weight and height are twice as likely to die in the first month of life, as well as **contracting infections** such as diarrhoea and pneumonia as a result of their weakened immune system. In many cases, the risk of low birth weight is a consequence of pre-term or premature births, as well as restricted growth of the foetus, situations that are determined by the mother's poor nutritional and health status.

The main causes of mortality are related to complications related to pregnancy and/or childbirth, as well as the contraction of infectious diseases, mainly diarrhoea and respiratory infections. Most of the diseases that cause infant mortality are preventable and are related to poor hygiene practices and living conditions in degraded environments.

Likewise, the **incidence of infant malnutrition** is an important determinant of morbidity and mortality levels and is a condition that limits the chances of survival of the population under 5 years of age. Thus, we found an acute malnutrition rate of 2.6%, to which we must add that 10% present weight deficits for their height and 23% are stunted.

Another factor that directly influences infant mortality rates is related to the **percentage of immunization coverage.** In this regard, 73% of children under 12 months comply with the recommended vaccination schedule, however, there has been a significant setback in relation to immunization coverage among children under 5 years of age of 34 percentage points (from 94.5% in 2012 to 60.4% currently), placing it below the national average.

The **maternal mortality rate** recorded in the county is slightly below the national average at 458 deaths per 100,000 births, compared to 510 per 100,000 for the country. However, there are significant disparities between sub-counties, especially those with a proliferation of informal settlements, with rates as high as 706 deaths per 100,000 births.

Access to maternal health care has a double impact on reducing both infant and maternal morbidity and mortality rates. It is agreed that an adequate follow-up of pregnancy, compliance with ANC (Antenatal Pre-Natal Care) visits, assistance at delivery and postpartum and access to family planning, contribute to reduce by almost half the number of deaths related to maternal health. In this sense, statistics show a percentage of 87% access to prenatal care services, a percentage that is reduced to 49% if we analyse the group of women who have access to the 4 consultations recommended by the WHO. Likewise, the percentage of births attended by qualified personnel in a health structure is 77% and the percentage of women who use some method of prenatal control is 49%.

1.4. CHARACTERIZATION OF THE DIRECT AND INDIRECT PROJECT BENEFICIARIES

A table is shown with the people involved/affected by the intervention according to their roles:

ROLE	DEFINITION	AGENTS
RIGHT BEARERS	People who suffer the violation of their rights and who are protagonists of the transformation of this situation, with	- Refugee women and girls who suffer or have suffered SGBV and violation of the right to health (DAS).

	capacities to materialize their rights and those of their communities.	- Local women and girls who suffer or have suffered SGBV and DAS violations. - Women and girls at risk of SGBV. - Women and adolescents who are unaware of reproductive rights and DAS - Men and adolescents who are unaware of reproductive rights and DAS
OBLIGATION'S BEARERS	Institutions that have the legal and moral obligations to ensure the guarantees, fulfilment and development of rights.	-States, especially the public health, education and justice systems as well as all the authorities that represent the State at any given time. -International organizations present in the area.
RESPONSIBILITY BEARERS	Subjects that have to apply the rules and protocols, taking into account the consequences, seeking prudent actions that damage as little as possible the values in conflict in each case.	- Families - Authorities and traditional leaders (civil, religious) - Health professionals - Civil society and associations - Educational agents - Media

II. SUBJECT MATTER AND SCOPE OF THE EVALUATION

II. 1. OBJECTIVE AND PURPOSE OF THE EVALUATION

a. Evaluation objective

Evaluation, in addition to being mandatory according to the regulations of the Generalitat, allows the organizations executing the project to improve the quality of their interventions, and the evaluation process is a strategic instrument for this purpose.

Consequently, from the formulation stage, a final external evaluation exercise was incorporated to assess its performance and provide conclusions and recommendations with which to provide feedback on its support to local development processes. **Thus, the evaluation will refer to verifying the achievement of the expected result**s - effectiveness - according to the deadlines established by the project, the efficiency in relation to the administrative management and organization of activities in an appropriate manner, the lowest cost in obtaining the expected outputs per component and the relevance or not of the defined strategies, according to the evolution of the crisis, the felt and expressed needs of the different groups of stakeholders, the counterpart's plans, institutional and Generalitat Valenciana priorities, etc. Evaluation will involve project staff at headquarters and in the field, as well as the different stakeholders in the field.

In this perspective, the contracted consultancy should mainly respond to the following **functions** of this type of evaluative actions:

- **Formative function**, satisfying the informative and knowledge needs of the population and the rest of the participating stakeholders. In this sense, it is expected that the consultancy:
    - provide reasoned judgments and substantial learning based on evidence that will enable the organizations promoting the project to improve their intervention strategies in a priority area and sector and be relevant for the Generalitat Valenciana institutions, useful for other organizations

interested in the subject and understandable for the citizens.

- ensure that participating men and women, boys and girls access, understand and appropriate its main contents.

- **Summative function**, analysing the degree of fulfilment of the foreseen planning, the scope of the expected results and their impact on the pursued goals.

b. Scope of the evaluation

From the **temporal point of view**, the basis of analysis of the evaluation corresponds to the period of execution of the project, from June 20, 2022 to July 30, 2023. However, where appropriate, it is considered important to also assess the degree of continuity of the processes involved in the project at the date of the evaluation exercise itself. In addition, the evaluation team is requested to develop a Results Socialization Plan in the terms discussed in this point in order to strengthen the sustainability of the project once the intervention is concluded.
Geographically, the evaluation will cover the entire project area, Kasarani Sub-county, Kasarani Settlement, Nairobi, Kenya.
In terms of **thematic scope**, the evaluation will consider all components of the intervention and should also address the following levels:

- Analysis of results and their degree of contribution to the achievement of the expected objectives.
- Analysis of the design, assessing its internal and external coherence.
- Analysis of the implementation process, with special attention to communication and decision-making procedures among actors.
- Analysis of the impact of the intervention carried out.

The result of the evaluation process will respond to the following **objectives:**

- Assess the adequacy and relevance of the intervention design in relation to the context.
- To assess the levels of achievement of the planned results of the intervention. It is of interest to know to what extent the activities carried out have made it possible to achieve the expected results.
- To assess the implementation practices of the actors involved, especially with regard to the collaboration between FARMACEUTICOS MUNDI and HESED, paying attention to communication, coordination and decision-making procedures to facilitate the transfer of good practices.
- To assess the participation of rights holders in the management of the project and to what extent the experience has contributed to strengthen their role and leadership in local development.

Thus, the evaluation will contemplate the analysis of the information (records of the execution of the project tasks) in quantitative and qualitative terms. The **main instruments for evaluation** are: the project and its operational plans; baseline; indicators and sources of verification of the project; reports prepared by those responsible for the activities; records of the execution of the tasks of the activities by those responsible; follow-up and evaluation reports with the rights-holding population. In this sense, the quantitative and qualitative indicators defined establish with certainty the basic information on variables such as the initial situation of resource management, etc., which serve as a comparative instrument with the results at the end of the project.

Through the evaluation process, it is hoped to obtain clear judgments on the degree to which the humanitarian activities were adequate to the local needs, the achievements in the context of the protracted crisis, the broader effects of the project, the interrelationships generated, as well as the sectors of the population that were reached. For this purpose, the **qualitative in-depth or semi-structured interviews** follow a peer-to-peer conversation model, where the evaluator him/herself is an instrument. In this way, a script of information focuses is available beforehand, towards which the interviewee is guided throughout the interview. This type of in-depth interview is particularly suitable for the present evaluation since the interests of the evaluation are clear and well defined, the evaluation questions are not otherwise accessible, there are time constraints and the evaluation depends on

several scenarios or persons.

- **Focus groups**: health officials of Kasarani sub-county and units of the network of health centres and health posts. Grassroots community groups involved, public sector professionals and population using basic health and SRH services reinforced by the intervention. The focus group is a collective conversation with a group of informants with homogeneous conditions in the following factors: social class, gender, age and some other condition. As in the previous point on the in-depth interview, the focus group is a direct, open and informal conversation with the members of the group or groups of actors being evaluated. The difference lies in the fact that the opinions and topics are dealt with in a group or collective manner, which greatly enriches the information obtained as a result of the exchange of opinions and discussion of the topics. Again, the sessions will be conducted by means of guidelines or an agenda that will allow the person conducting the session to organize the participants' conversation.
- **Participant observation:** Visit to project sites, health centres, distribution and care networks. Participant observation is an observation technique where the evaluator shares with the actors of the project (in this case the subject population) their context, experience and daily life, in order to learn directly about the daily life of the group from the inside.

In the assessment of all the above dimensions, the priority given in its design and execution to the gender and age perspective, the human rights-based approach, the perspective of conflict sensitivity and culture of peace, the promotion of the participation of the subject population and a multicultural and environmental approach should be considered. The evaluation, understood as a process that seeks to obtain the most systematic and objective assessment possible of the project, through the review of ongoing or completed actions, paying special attention to their design, implementation and results, will be carried out continuously (formative evaluation), within the team, and externally and independently at the end of the project (summative evaluation).

c. Plan for dissemination of results

It is important to note that the evaluation process does not end with the presentation of the final evaluation report. The evaluation report cannot be understood as a final document in the management of the project. Its main interest lies in the development of knowledge and learning to be used in other contexts, and to strengthen the sustainability of the project once the intervention is concluded.

On this basis, we request a results socialization **strategy focused on the dissemination of information/communication of results based on the findings of the final evaluation process**, including **one or more innovative dissemination and participation tools and activities**, such as the design and development of an event, app, online site, video documentary, workshop, etc.

Thus, as part of the selection process of the evaluation team, it must also include a **proposal for a Dissemination Plan of the results** obtained in table format, identifying the audiences to be reached, the purpose of the socialisation of results, the design of activities and dissemination/communication tools and the participation in them, the key actors that will participate in their implementation and the scheduling of times and responsibilities.

For more information about the process, please consult the documentation attached to these TORs.

II. 2. RELEVANT ENTITIES OF THE EVALUATION

ENTITY	ROLE AND EXPECTED USE OF EVALUATION
Beneficiary entity of the GENERALITAT VALENCIANA funds: Partner based in Spain	Evaluation Committee. Supervision, coordination facilitator and logistical organization. Incorporation of recommendations. The use of evaluation by Farmamundi is related to two fundamental aspects linked to transparency and accountability and the incorporation of lessons learned for future interventions. Thus, on the one hand, Farmamundi will use the evaluation to disseminate the main achievements obtained with the project to funders and social base. On the other hand, the evaluation represents a learning process that will allow to incorporate aspects of improvement in the present and future interventions of FARMACEUTICOS MUNDI in Kenya in order to improve the scope and impact of the same.
Local partner:	Participants. Incorporation of recommendations. HESED, as a local partner of the project, acquires a fundamental role for the correct realization of the evaluation as the main responsible for the execution of the project and agents of civil society of reference. The evaluation will reinforce the performance of both organizations as a fundamental learning process that will allow them to incorporate lessons learned and aspects of improvement in their future interventions.
Duty Bearers: Institutions involved in the design and development of the intervention: Delegation of health facilities where the projects are being implemented.	Actors participating in the evaluation, key informants to measure the degree of achievement of the results and objectives of the project. The evaluation will also make it possible to be accountable to local institutional actors and report on the achievements and impact of the project, which we hope will ultimately result in the strengthening of relationships of mutual trust and commitment to future collaborations.

Rights holders: Target group of the intervention; women survivors of VSyBG, urban refugee population, children, civil society organizations (CSOs), community leaders.	Actors and actresses participating in the evaluation, key informants to measure the degree of achievement of the project's results and objectives. Their incorporation in the evaluation process is essential to strengthen the health resilience capacity of the refugee population under a prevention and protection approach considering the specific needs of gender and age, ultimately contributing to improve their degree of empowerment. Refugee women survivors of sexual violence, urban refugees using Kasarani's health services and health personnel receiving sensitizations are presented as key informants to be consulted in order to conduct a comprehensive evaluation that accounts for the impacts on the subject population and allows for accountability processes that feed into this evaluation. Likewise, CSOs and community leaders will be key actors in this evaluation process since their representatives will have been trained in HRDs and will have made field trips to collect information and testimonies related to the status of the exercise of SRHR and HRDs.
Responsibility holders: Partner CSOs, Women CHV, CHPs, Gender Defenders	Actors and actresses participating in the evaluation, key informants to measure the degree of achievement of the project's results and objectives. Their participation implies the strengthening of local involvement in the prevention of sexual and gender-based violence and the promotion of a culture of peace based on human rights and responsible sexuality. By making monthly reports and reports that feed a final document of recommendations on sexual and reproductive health (prioritizing SGBV with its causes and associated consequences) that are presented to local and regional authorities, thus ensuring the visibility and testimony of all forms of violence suffered by women and girls in their health areas of reference of action and urging the authorities to act accordingly to eradicate this flagrant violation of human rights, their participation is essential.

III. QUESTIONS TO WHICH THE EVALUATION AIMS TO RESPOND: EVALUATION CRITERIA AND QUESTIONS

CRITERIA	EVALUATION QUESTIONS
Adequacy and Relevance	• Does the intervention correspond to the priorities and needs of the participating population? • Is the intervention design (vertical and horizontal logic) coherent and relevant to the context of the intervention? • Have the operational principles of coordination and complementarity been taken into account? • Have existing health and gender policies at the state, local or stakeholder levels in the context been analysed and included in the project?

	Efficiency	• Have the budgets initially established in the document been respected? • Have the planned schedules and times been respected? • Has the transformation of resources into results been efficient? • Have local resources been harnessed and enhanced? • To what extent have institutional collaboration and articulated management mechanisms contributed to achieving the results of the intervention? • How has the impact that can be generated on the environment with the implementation of the project been considered?
	Effectiveness	• Have the planned results been achieved? • Has the specific planned objective been achieved?
	Impact	• Have the planned impacts been achieved with the intervention? • Have there been unforeseen positive impacts on the rights-holding population? • Have there been any unforeseen negative impacts on the rights-holding population?
	Connectivity	• Have local regulations been respected in the implementation of activities? • Are the equipment and supplies made available to the population appropriate to the context of intervention? • Once external assistance has been withdrawn, is the functionality of the implemented health structures maintained? • Has public and community institutional capacity been positively influenced? • Has the gender and age perspective, the human rights-based approach, the conflict sensitivity and peace culture perspective, the promotion of the participation of the subject population, as well as a multicultural and environmental approach been incorporated in the intervention? • Did the assistance provided by Farmamundi take into account the link between emergency, rehabilitation and development?
	Coordination	• Have the development strategies and programmes of the country in which the intervention is implemented been taken into account? • Does the intervention include specific measures to strengthen the capacities of local institutions? Has it been achieved? • To what extent have adequate partnerships been established with national, international and local actors to assist people affected by the crisis? • Does the intervention complement the actions of local and national authorities, as well as those of other humanitarian organizations? • What internal (Farmamundi and HESED) and external (other actors) coordination mechanisms have been used?

	Coverage	To what extent did the rights-bearing population benefit from the humanitarian action of the project?
	Ownership and participation	• To what extent have local institutions been involved in the design of the intervention? • To what extent are local institutions involved in the implementation and management of the intervention? • To what extent and through what means and procedures has the rights-holding population participated in the whole process? • What mechanisms have been put in place by Farmamundi and local partners for communities and people affected by humanitarian crises to express their level of satisfaction regarding the quality and effectiveness of the aid they have received, paying special attention to gender, age and diversity of people expressing their opinion? • What grievance management systems have been implemented to receive and accept complaints and recommendations from communities and people with rights, responsibilities and obligations?

IV. METHODOLOGY AND PHASES

In order to coordinate and successfully complete the evaluation process, a **Follow-up Committee** will be formed, composed of at least:

- The headquarters staff in charge of the project.
- The management of the HEA Department of FARMACEUTICOS MUNDI.
- The principal investigator in charge of the evaluation.
- 1 representative of HESED

The responsibility and coordination of this committee will correspond to the staff in charge of the project.

The **functions of this committee** are the following:

- Facilitate the evaluation team's access to all relevant information and documentation of the intervention, as well as to key agents and informants who should participate in interviews, focus groups or any other information gathering technique.
- Supervise the quality of the process and the documents and reports that are generated, in order to enrich them with their contributions and ensure that their interests and demands for information and knowledge about the intervention are met.
- Disseminate the results of the evaluation, especially among the organizations and entities of its interest group.

The **methodologies and techniques for the collection and analysis of information** will be defined and detailed by the evaluation team in charge of this Final Evaluation in its technical proposal and will be reviewed and validated by Farmamundi, who reserves the right to make recommendations, suggestions and contributions, with the aim of ensuring the relevance of the techniques used in relation to the context of intervention and the social and cultural specificities of the selected informants. In this way, the methodology and techniques finally applied will be those resulting from the consensus of all the parties involved as proposed by the evaluation team, thus ensuring participation and methodological relevance.

In this sense, the following **fundamental lines of action** should be considered by the evaluation team for the fulfilment of the objectives of the process, without prejudice to those that the team considers necessary for a fully satisfactory execution of its work:

- Preparation of a definitive work plan describing objectives, proposed methodology, design of techniques, schedule of activities, information requirements, evaluation instruments and sources of data collection.
- Design of the research techniques considered most appropriate to answer the evaluation's starting questions (interviews with key informants identified for their direct interaction with the project, their institutional profile or their experience in the essential issues addressed in the project, participant observation, focus groups, surveys, etc.).
- Design, if warranted, of specific health indicators in addition to those formulated in the project proposal, for the assessment of project results.
- Analysis of all the information obtained in order to prepare the initial product that constitutes the draft or preliminary document of the evaluation.
- Periodic dialogue with the Follow-up Commission, so that it can be informed at all times of the progress of the evaluation process.

The work plan proposal shall be presented **organized in phases** and shall include an **estimation of its deadlines and delivery of the agreed intermediate and final products**. The estimated work time is between 6 and 10 weeks.

Likewise, it will have to indicate if, in the opinion of the evaluation team, it is considered pertinent that a representation of the entities responsible for the project be incorporated in any of the foreseen phases and under what conditions and with what objectives.

The reports produced by the professional or evaluation team should also include a **proposal for a Dissemination Plan for the results obtained**, identifying the audiences to be reached, the purpose of the socialization of results, the design of activities and tools for dissemination/communication and participation in them, the key actors that will participate in their implementation and the scheduling of times and responsibilities.

VI. STRUCTURE AND PRESENTATION OF THE REPORT

The final external evaluation report shall present the following **structure:**

a) Executive summary (maximum 4 pages).
b) Introduction: Background, general data and objectives of the evaluation.
c) Brief description of the object of the evaluation and its context.
d) Methodological approach and techniques used in the evaluation: evaluation questions, methodology and techniques applied and conditioning factors of the evaluation carried out.
e) Analysis and interpretation of the information gathered and evaluation results. The analysis of the information should respond to the evaluation criteria and questions. Special emphasis should be placed on compliance with the planning matrix (objectives, results, activities and indicators).
f) Conclusions of the evaluation in relation to the evaluation criteria. The conclusions should be drawn from the analysis of the information gathered and should be presented in accordance with the evaluation criteria.
g) Evaluation recommendations. It should indicate to whom the recommendations are addressed (GENERALITAT VALENCIANA, applicant entity, local partner entity, others).
h) Annexes.

In addition, the evaluation report must contain, at least, **a clear judgment on**:

- The implementation of the intervention, in technical and financial terms.
- The degree of fulfilment of the formulated objectives and expected results.
- The adequacy of the resources used to achieve the objectives and results.
- The impact of the intervention.
- The sustainability of the benefits generated by the intervention.
- The transfer of goods and equipment acquired by the intervention.
- The connectivity of the intervention.
- The consideration of humanitarian principles in its execution: humanity, universality, impartiality,

neutrality, independence, consent, participation and testimony when appropriate.
- Respect for the specific quality standards of a humanitarian action intervention and compliance with international reference protocols.

In its final version, the discrepancies or clarifications that, if any, are revealed in the joint review phase of the draft report shall be recorded, clearly expressing the content of the same and the final assessment by the person or entity responsible for the evaluation process.

In general, the Final Evaluation Report **shall not exceed 50 pages**. A paper copy and an electronic copy will be provided. The report **must be written in English.**

In addition, **a dissemination/socialization plan will be developed** identifying the objective, the audience to be reached, the participation of other key actors, the definition of time and responsibilities and the details of the activities **and innovative socialization tools**; based on the findings of the final evaluation report. Innovation in the design of dissemination tools and activities will be highly valued in the initial proposal.

a. Payment

The consulting team, natural or legal person, will receive a payment appropriate to the offer submitted.

b. Terms of payment

- 50% Upon signature of the contract, against delivery of the final methodological design.
- 50% Upon delivery of the Final Report.

Deadline for Submission of Proposals

The deadline for the submission of applications by interested persons or evaluation entities is **October 2nd, 2023.**

Technical and Financial Proposals should be sent to the e-mail addresses **programs@hesedafricafoundation.org** and indicating in the subject line "***Technical evaluation bid-...***" followed by the name of the consultant or professional responsible for the bid.

The **deadline for the award will end on October 15th, 2023**, after which there will be interviews for the shortlisted consultants. Only those who make it to the shortlist will be contacted.

The total duration of the evaluation process, excluding the phase of dissemination of its results, shall not exceed **3 months from the date of signature of the corresponding contract**.

However, the provision of the service will not end until the Evaluation Report is accepted by the Generalitat Valenciana.