'Promoting mental health, well-being and resilient livelihoods in Chimanimani, Zimbabwe' Project

CONSULTANCY TO CONDUCT A BASELINE SURVEY
Commissioned by Find Your Feet

TERMS OF REFERENCE

1. Background

Founded in 1960, Find Your Feet (FYF) is a UK-based international development charity dedicated to working with poor, rural communities to create lasting solutions to poverty. We work with marginalised families living in South Asia and Southern Africa, building on their own skills and knowledge to develop sustainable solutions to poverty. We do this by supporting people to improve their harvests, set up small businesses, access services like clean water, healthcare and education, and participate in decision-making that affects them. FYF has a small, dedicated team of staff in the UK and programmes and partners in India, Nepal, Zimbabwe and Malawi. FYF is not an implementing agency but works through carefully identified local partner organisations who share our vision and values and who work directly with the rural poor. More information about FYF can be found at our website: www.fyf.org.uk.

After withdrawing from Zimbabwe in the 2000s due to the complex political and economic situation, FYF returned in 2011. Following a successful two-year pilot project, we secured a grant from UKaid in 2014 for a three-year project working with 2900 farming families in Chimanimani. Building on the learning from this project, in January 2015 we secured a grant for a new two-year pilot project entitled the 'Mutoko Livelihoods Project', which ran from from 1st April 2015 to 31st March 2018. From January 1, 2018, FYF secured £299,475 in funding from Comic Relief (total budget £332,750 including match funding) to implement a project that would address mental health within our livelihoods work in Zimbabwe in partnership with Zimbabwean NGO and livelihoods specialist Towards Sustainable Use of Resources Organisation (TSURO) and UK based organization and mental health specialist BasicNeeds.

2. The Project

Context. Once one of the breadbaskets of Africa, Zimbabwe has been ravaged by failed governance, HIV/AIDS and internecine violence, which have destroyed the social fabric of rural society. 72% of the total population live below the Total Consumption Poverty Line, and 58% live below the Food Poverty Line. The majority of the population depend on agriculture for their livelihood. However, a lack of access to good quality land, seeds and tools, coupled with economic and political unrest and failed government agricultural policies means that many families are struggling to survive. 1.3 million people are unable to feed their families adequately between January to March. Zimbabwe's hunger crisis is rated as "serious" by the Global Hunger Index.

Project details. The Promoting mental health, well-being and resilient livelihoods in Chimanimani, Zimbabwe Project, which is the focus of this baseline study is a 3 year project which runs from 1st January 2018 - 31st December 2020. The project will enable 2,039 people with mental health

conditions in Chimanimani district, Zimbabwe, to lead healthy and productive lives, by supporting them to access appropriate community mental health services, participate in support groups, improve their livelihoods, tackle stigma and discrimination, and advocate for improved policy implementation. The project will have the following outcomes:

1. People with mental health conditions are accessing appropriate and effective community-oriented mental health services
2. People with mental health conditions are participating in community-based groups and support networks
3. People with mental health conditions and their families have improved livelihoods, food security and nutrition
4. Stigma and discrimination against people with mental illness are reduced
5. National legislation and policies on mental health are influenced by the project's activities

The project will be overseen by FYF's office in London, implemented with Zimbabwean NGO and livelihoods specialist Towards Sustainable Use of Resources Organisation (TSURO), with technical support and training by UK based organization and mental health specialist BasicNeeds' offices in London and Nairobi.

Project outcomes, indicators, targets, learning objectives, beneficiaries and activities are below:

Outcome 1: People with mental health conditions are accessing appropriate and effective community-oriented mental health services							
Number-based (quantitative) indicators							
	Indicator (30 words max.)	Baseline	Target	*If indicator is about people:*			Data collection methods and frequency
				Total benefitting *(target-baseline)*	Males benefitting	Females benefitting	
1a	% increase of people with mental health conditions who access community-based mental health services (disaggregated by sex, adult/youth, HIV status, etc.)	Tbc	Tbc	Tbc	Tbc	Tbc	• Household surveys (Baseline survey [Y1], endline evaluation [Y3]) • Review of health facility records (Monthly data collection, compiled quarterly) • Partner reports (Biannual)
1b	# of general health practitioners who have improved skills on appropriate mental health screening, diagnosis and treatment	0	80	80	8	72	• Training records and pre and post training questionnaires (All training events) • Supportive supervision visits (Quarterly) • Partner reports (Biannual)
1c	# of community health workers and volunteers who have strengthened capacity to deliver services to people with minor conditions and provide counselling and adherence support	0	250	250	25	225	• Training records and pre and post training questionnaires (All training events) • Partner reports (Biannual) • Focus group discussions (Baseline survey [Y1], endline evaluation [Y3])
Narrative-based (qualitative) indicators							
	Indicator	Change you expect to observe over the life of the project					Data collection methods and frequency
1d	Emerging evidence and stories of improved coordination between health facilities, traditional healers, private pharmacies and clinics, and community care	There is currently very little coordination between the different actors involved in supporting people with mental health conditions. Several studies have highlighted in particular the need for improved cooperation between mental health professionals and traditional/faith healers, as the latter are often the first line of support and can plan an important role in referral and ongoing support. The project will improve coordination between all stakeholders involved in referring, diagnosing and treating people					• Key informant interviews and focus group discussions (Annual) • Partner reports (Biannual) • Supportive supervision visits (Quarterly)

		with mental health conditions.					
1e	Extent of the integration of mental health services into other health services such as HIV services	Studies have shown that poor communication and coordination between government departments have made it difficult to integrate mental health care into other health-care settings. By working closely with the line ministries at district level, particularly the Ministry of Health and Child Welfare, the project will ensure greater integration of mental health services into other health services in Chimanimani, such as HIV services.					• Key informant interviews (Baseline survey [Y1], endline evaluation [Y3]) • Partner reports (Biannual) • Supportive supervision visits (Quarterly)
Outcome 2: People with mental health conditions are participating in community-based groups and support networks							
Number-based (quantitative) indicators							
	Indicator (30 words max.)	Baseline	Target	*If indicator is about people:*			Data collection methods and frequency
				Total number benefitting *(target-baseline)*	Males benefitting	Females benefitting	
2a	# of people with mental health conditions receiving social and economic support through community-based self-help groups (disaggregated by sex, adult/youth, HIV status, etc.)	0	2039	2039	204	1835	• Partner reports (Biannual) • Self-help group records (CHCs, FALGs) (Monthly, compiled biannually) • Case studies (Biannual) • Focus group discussions (Baseline survey [Y1], endline evaluation [Y3])
2b	# of people with mental health conditions receiving psychosocial and adherence support from community volunteers (disaggregated by sex, adult/youth, HIV status, etc.)	0	286	550	55	495	• Partner reports (Biannual) • Case studies (Biannual) • Focus group discussions (Baseline survey [Y1], endline evaluation [Y3])
Narrative-based (qualitative) indicators							
	Indicator	Change you expect to observe over the life of the project					Data collection methods and frequency
2c	Extent to which people living with mental health conditions feel a sense of belonging (disaggregated by sex, HIV status, etc.)	As a result of social, cultural and economic factors, people with mental health conditions are often excluded from many aspects of life, which can lead to a downward spiral of unemployment, poverty, family breakdown and deteriorating health. By supporting people with mental health conditions to join and contribute to existing community groups and improving their livelihood opportunities, the project will increase their sense of belonging and self-worth.					• Household surveys (Baseline survey [Y1], endline evaluation [Y3]) • In-depth interviews (Annual) • Case studies (Biannual)
2d	Emerging evidence and stories of improvements in support networks	As a result of their exclusion, people with mental health conditions often remain isolated within their communities, receiving limited support. The project will integrate people living with mental health conditions into existing community groups such as the Community Health Clubs and Farmer Action Learning Groups, enabling them to receive support from other group members, including others with mental health conditions.					• Household surveys (Baseline survey [Y1], endline evaluation [Y3]) • In-depth interviews (Annual) • Case studies (Biannual)
Outcome 3: People with mental health conditions and their families have improved livelihoods, food security and nutrition							
Number-based (quantitative) indicators							
	Indicator (30 words max.)	Baseline	Target	*If indicator is about people:*			Data collection methods and frequency
				Total number benefitting *(target-baseline)*	Males benefitting	Females benefitting	
3a	# of mentally ill people who have newly joined the FALGs and are engaged in productive activity (e.g. employment, income generation activities) with the FALGs during the life of the project (disaggregated by sex, adult/youth, HIV status, etc	0 or N/a	300	300	150 (estimated)	150 (estimated)	• Partner reports (Biannual) compiled from FALG registrations

3b	% of HH affected by mental illness that are food secure – among the families of 300 involved in the FALGs	Tbc	Tbc	xx	xx	xx	• Household surveys (Baseline survey [Y1], endline evaluation [Y3])
3c	% of HH affected by mental ill-health that are eating a nutritionally balanced diet – among the families of 300 involved in the FALGs	Tbc	Tbc	xx	xx	xx	• Household surveys (Baseline survey [Y1], endline evaluation [Y3])
Narrative-based (qualitative) indicators							
	Indicator	Change you expect to observe over the life of the project					Data collection methods and frequency
3d	Extent to which people with mental health illness perceive: 1) self-worth 2) self-reliance, and 3) respect from others (disaggregated by sex, HIV status, etc.)	People living with mental illness (particularly PLWHIV) are often unemployed, and unable to, or discouraged from engaging in productive activities. As a result, their sense of self-worth and self-reliance (and their chances of recovery) are negatively affected. The project will facilitate opportunities for affected individuals to gain or regain the ability to engage in productive activities and contribute to family and community life, helping them to restore their sense of self-worth and feel respected within their communities.					• Household surveys (Baseline survey [Y1], endline evaluation [Y3]) • In-depth interviews (Annual) • Case studies (Biannual)
3e	Emerging evidence and stories of improved livelihoods, food security and nutrition among people with mental health conditions and their families	People with mental health conditions often experience severe poverty and hunger as a result of unemployment or barriers to engaging in productive agricultural activities that would enhance their livelihoods and food and nutrition security. The project will improve their livelihood opportunities, food security and nutrition by enabling them to seek support through the Farmer Action Learning Groups to grow more nutritious food and access marketing opportunities to increase their income.					• Household surveys (Baseline survey [Y1], endline evaluation [Y3]) • In-depth interviews (Annual) • Case studies (Biannual)
Outcome 4: Stigma and discrimination against people with mental illness are reduced							
Number-based (quantitative) indicators							
	Indicator (30 words max.)	Baseline	Target	*If indicator is about people:*			Data collection methods and frequency
				Total number benefitting *(target-baseline)*	Males benefitting	Females benefitting	
4a	Increase in % of people with mental illness who feel accepted within their community (disaggregated by sex, HIV status, etc.)	Tbc	Tbc	x	xx	xx	• Household surveys (Baseline survey [Y1], endline evaluation [Y3]) • In-depth interviews (Annual) • Case studies (Biannual)
4b	Reduction in % of people with mental illness who report having experienced discrimination at least once in the past 3 months (disaggregated by sex, HIV status, etc.)	Tbc	Tbc	xx	xx	xx	• Household surveys (Baseline survey [Y1], endline evaluation [Y3]) • In-depth interviews (Annual) • Case studies (Biannual)
4c	Reduction in % of people with mental illness who report having experienced verbal or physical abuse at least once in the past 3 months (disaggregated by sex, HIV status, etc.)	Tbc	Tbc	xx	xx	xx	• Household surveys (Baseline survey [Y1], endline evaluation [Y3]) • In-depth interviews (Annual) • Case studies (Biannual)
Narrative-based (qualitative) indicators							
	Indicator	Change you expect to observe over the life of the project					Data collection methods and frequency
4d	Emerging evidence and stories of reductions in stigma, discrimination, and beliefs on myths	The social stigma attached to mental ill health and the discrimination experienced by people with mental health conditions can make their difficulties worse and impede their recovery. The lack of understanding and cultural interpretations of mental health disorders have led to a range of myths surrounding mental ill health. By helping the broader community to understand mental health issues, and training mental health workers and volunteers to sensitively treat and support mental health patients, the project will reduce the stigma and discrimination faced by people with mental					• Household surveys (Baseline survey [Y1], endline evaluation [Y3]) • In-depth interviews (Annual) • Case studies (Biannual)

		health conditions and their families.	

Outcome 5: National legislation and policies on mental health are influenced by the project's activities

Number-based (quantitative) indicators

	Indicator (30 words max.)	Baseline	Target	*If indicator is about people:*			Data collection methods and frequency
				Total number benefitting *(target-baseline)*	Males benefitting	Females benefitting	
5a	At least 20 policy makers are briefed about project results and learning	0	20	20	15	5	• Meeting minutes (when meetings held with policy makers) • Distribution list (when best practice paper produced in Y3)
5b	At least 2 quotes from policy makers reflected that the project approaches have influenced their thinking	0	2	2	N/a	N/a	• Tracking tool for policy commitments, changes and implementation (ongoing, compiled biannually)
5c	At least 1 incidence where a change in policy or practice is attributed to the project	0	1	1	N/a	N/a	• Tracking tool for policy commitments, changes and implementation (ongoing, compiled biannually) • Key informant interviews (Endline evaluation [Y3])

Narrative-based (qualitative) indicators

	Indicator	Change you expect to observe over the life of the project	Data collection methods and frequency
5d	Perceptions of health workers and experts involved in mental health regarding the implementation of mental health legislation and policies	Zimbabwe has a relatively progressive policy and legislative framework on mental health – the problem is that due to lack of financial and human resources, policies are not being adequately implemented (Kushinga, 2016). By engaging in policy advocacy with government, engaging with the media, building the capacity of health workers and increasing demand for quality mental health services, the project will bring about more effective implementation of legislation and policies relating to mental health, particularly at the district level.	• Key informant interviews, focus group discussions (Baseline survey [Y1], endline evaluation [Y3])
5e	Extent to which learning and best practice from the project is used to inform policy advocacy	Given the high burden of mental illness and the lack of resources to address this problem in Zimbabwe, the project offers an excellent opportunity to generate a body of evidence in regard to mental health programming. The project will work closely with other stakeholders (e.g. other Comic Relief grantees, ZIMNAMH) to ensure that data and learning from the project are disseminated and used to inform policy-making and practice.	• Partner reports (Biannual) • Key informant interviews (Endline evaluation [Y3])

Activities:

Mental health care:

- Train general health practitioners in mental health to improve screening, diagnosis and treatment, and to integrate mental health services into other health services such as HIV services
- Offer supportive supervision to health practitioners to identify cases and ensure quality and differentiated case management considering age/gender
- Train community health workers for identification and referral of cases, community treatment of non-severe cases, and follow up of outpatient care patients and their home carers to ensure drug adherence
- Facilitate referrals and ongoing coordination between health facilities, traditional healers, private pharmacies and clinics, and community care by developing referral pathways, protocols, tools, and training to all actors, with follow up support
- Train traditional healers on mental health, supporting them to refer cases to health facilities or community care
- Create, train and support self-help groups for mutual support and saving money
- Link self-help groups to community health workers and health facilities, incl. to bring medication to club meetings

Improved livelihoods, food security and nutrition for the mentally ill:

- FALG exemplary lead farmer refresher training on: sustainable and climate-resilient agricultural technologies; organic farming and agribusiness;
- diversification (livestock, nutrient-dense foods); preservation (solar drying/juice extraction); and preparation and marketing of nutritious foods
- FALGs will be supported to train the mentally ill and their family members on the above, and provide ongoing support to these smallholder farmers
- Support interested smallholders to meet organic standards and participate in the participatory guarantee scheme, in cooperation with PELUM
- Zimbabwe and the Zimbabwe Organic Producers' Association
- Support the mentally ill and their family members to join collective marketing groups and market products through TSURO's Chimani Delights agro-processing and marketing initiative

Tackle stigma and discrimination about mental health:

- Sensitivity training for health workers and community health workers
- Mental health training (integrating HIV to establish links between the two issues) for TSURO village groups, FALG members, and the mentally ill and their family members through the self-help groups
- Information, education and communication materials
- Community radio shows on mental health, especially targeting taboos and misconceptions
- Support the village groups and self-help groups to conduct community dialogue meetings and joint campaigns to reduce stigma and discrimination and challenge stereotypes
- Interested people with lived experience of mental health issues will be trained and supported to offer testimonials at community events

Change in policy and practice:

- Documentation of project results and learning, including best practices paper
- 1 district and 1 national meetings to share project results, learning and best practice
- Advocacy meetings, document sharing, policy papers and press at district and national level to advocate for the replication of 1) the community based mental health care approach and 2) involvement of the mentally ill in other development interventions such as agriculture and livelihood support provided by government and other actors.

*a final version of the above will be shared during the literature review

3. Aim and objectives of the consultancy

FYF, TSURO and BasicNeeds would like to have an independent consultant conduct a baseline study for the Mental Health Project, using both quantitative and qualitative methods (e.g. household survey, focus group discussions, key informant interviews), in order to collect baseline data for all of the indicators above except for 1b, 1c, 5a, 5b, and 5c. The independent consultant/team will be responsible for designing the methodology, calculating an appropriate sample size, designing the data collection tools, collecting and analysing the data, and providing a report.

The specific baseline study objectives will be to:

a) Establish the situation of Mentally Ill persons in Chimanimani District.
b) Establish the status of Mental Health Services in Chimanimani District.
c) Establish baseline data for the "**Promoting mental health, well-being and resilient livelihoods in Chimanimani"** project's indicators.
d) Develop and provide tools for on-going project monitoring and train TSURO project staff on how to use the tools.

4. Process and methodology

Quantitative indicators above should be explored using an appropriate survey method that will capture the views of people with mental health conditions (including aspects related to stigma, community acceptance, integration into other existing groups etc.) and or, if more appropriate, a parent/guardian or household member who can represent the views of that person with mental health conditions or help communicate their views to the enumerators. Qualitative methods can also be used to elaborate, clarify, or triangulate the findings related to quantitative indicators. Consultant(s) will need to explain in detail their sensitive, harm-reduction method for locating families or individuals with mental health conditions without bringing negative consequences for confidentiality and stigma to those who may not wish to expose their mental health issue to neighbors or the community at large.

Qualitative / narrative indicators can be explored using a variety of methods which may include key informant interviews, focus group discussions, or other methods or participatory methods as proposed by the consultant with health facility staff, traditional healers, private pharmacists and clinics, NGOs or community care structures that exist already for people with mental health conditions, households and individuals affected by mental health conditions, and other key stakeholders identified by the consultant(s). Personal case studies / stories of health workers, people with mental health conditions or household members able to speak on their behalf are expected. Survey questions may also be included related to the qualitative indicators in order to determine wider trends and to triangulate findings.

In order to conduct the baseline research, the consultant(s) should:

a) Produce an Inception Report

- Meet with TSURO staff and other relevant stakeholders (face to face) to discuss the project and plan the baseline.
- Produce a draft inception report with research methodology including ethical considerations, sampling procedure, draft data collection tools, and an updated detailed schedule for the baseline. Survey tools must measure the baseline status against indicators in a way that they can be later used at midline and endline of the project to gauge changes and impact.

b) Collect Primary and Secondary Data

- Conduct a 'literature review' of all documents relevant to the project (project proposal, project start up form, M&E framework), to the context (Zimbabwe policies, other mental health studies and surveys) and other relevant reports as indicated by FYF, TSURO, and BasicNeeds.
- Develop baseline data collection tool sets (KII, KAPB, FGDG,) and field test them.
- Identify and train enumerators and other people to be involved in data collection.
- Collect data from primary and secondary sources as required.

c) Computer Analyse Data

- Share raw data with FYF, TSURO, and BasicNeeds.
- Analyse baseline data using both quantitative and qualitative computer programmes (like SPSS, EpiInfo, NVivo).

d) Prepare Baseline draft and final Reports
The consultant will prepare 3 reports as follows: 1) Draft Baseline report 2) Final Baseline Report.

- Prepare a draft report using the format outlined below and share it with FYF, TSURO, and BasicNeeds for review. A week after submitting the draft report, the consultant will conduct a validation meeting with TSURO staff and relevant stakeholders. The comments made at the validation meeting and those made by FYF and BasicNeeds will be incorporated into the Final baseline report.
- Prepare a Final Report incorporating any comments made on the draft. Please note all the tools, survey questionnaires, and scoring grids etc. both electronic or paper versions will be shared with and become the intellectual property of FYF. The full set of completed questionnaires should be made available to FYF.

e) Develop and provide tools for on-going project monitoring and train TSURO project staff on how to use the tools.

- Develop draft monitoring tools for the project and a draft training schedule / plan and share with FYF, TSURO and BasicNeeds for review.
- Prepare a finalised set of tools and plan for the training.
- Conduct the training for FYF/TSURO/BasicNeeds staff on the use of tools.

5. Expected outputs

The consultant will produce the following outputs:

- Inception report. This will include the research methodology including sampling procedure, draft data collection tools, and an updated detailed schedule for the evaluation.

- Complete dataset. This should be provided to FYF in an appropriate format (e.g. SPSS, Microsoft Excel).
- Draft report. The draft report should be shared with FYF, TSURO and BasicNeeds for review and comment. Once the draft report has been reviewed, the consultant(s) should incorporate any comments/suggestions.
- Final report. The consultant(s) should submit the final report (incorporating proposed changes) to FYF, TSURO and BasicNeeds. It should include the following sections:

    1. Cover page (including date and name/organisation of consultant)
    2. Table of contents + list of tables/graphs (if app.)
    3. Acronyms (alphabetical) – *if relevant*
    4. Executive summary
    5. Background/Introduction
        - Purpose
        - Survey location (including map of project area)
        - Limitations
    6. Methodology
        - Detailed description of methodology and tools.
        - Sampling design
        - Description of data collection process
        - Ethical Considerations
        - Method of data analysis (e.g. SPSS)
    7. Findings
        - Presentation of findings in relation to each of the indicators in the logframe above, including narrative analysis, relevant tables/graphs and explanations of analysis as appropriate. At least 3 case studies should be included. This section should also include a summary table of the baseline status against all the project indicators except for 1b, 1c, 5a, 5b and 5c.
    8. Appendices
        - Tools
        - Complete dataset
        - List of interviewees by category, numbers and locations of participants (GPS positions for health centres and households visited) and stakeholders consulted during baseline, except for survey respondents.
        - Schedule of activities
        - Terms of Reference

- Draft monitoring tools. Develop draft monitoring tools for the project and a draft training schedule / plan and share with FYF, TSURO and BasicNeeds for review.
- Final monitoring tools. Prepare a finalised set of tools and plan for the training.
- Project staff training on monitoring tools. Conduct the training for FYF/TSURO/BasicNeeds staff on the use of tools.

6. Timeframe

The final report should be submitted and approved no later than 7 June, 2018.

7. Resource implications

The budget for the consultancy will be agreed with the selected consultant(s), based on quotations submitted to FYF. Value for money will be an important scoring criteria in the review for bids. Please note that bids over £10,000 (including consultancy fees, flights if needed,

accommodation/meals, and enumerators) will not be reviewed or considered at all due to budget limitations.

Payment of consultancy fees will be made in two installments, as follows: 25% immediately after submission of the inception report and 75% upon receipt of the final report to a satisfactory standard in the specified format within the agreed timeframe.

8. Baseline team composition and competencies

- Lead consultant to hold a graduate degree in Social Sciences, mental health or related discipline, with 5 years' experience in mental health or related work. A post-graduate qualification would be an advantage.
- Proven experience of designing and conducting complex household surveys for development projects (including the design of survey questionnaires).
- Proven experience with participatory methods and gathering and analysing qualitative findings.
- Strong analytical and writing skills and proven experience of writing analytical reports.
- Proven skills and experience in statistical analysis and use of statistical software such as SPSS.
- Experience leading surveys/research of this nature.
- Experience working in Zimbabwe essential.
- Fluent written and spoken English is essential and Shona would be an asset. Knowledge of local languages relevant to the project area Chimanimani would be an advantage.
- Experience facilitating surveys or other research with people with mental health challenges would be an asset.
- Experience animating or training enumerators to animate vulnerable groups to participate effectively would be an asset.

9. Evaluation Management

Contracts with consultants and financial transfers to consultants will be arranged by Find Your Feet. The contact will be: Nicole Tobin nicole@fyf.org.uk

Costs for logistics and other baseline related costs will be managed by TSURO according to a specific budget approved by Find Your Feet. TSURO will assist in field work arrangements as necessary.

10. How to apply

All interested organisations or persons should send in the following documents to nicole@fyf.org.uk **by midnight Zimbabwe time on April 18, 2018**:

Technical proposal (maximum 4 pages)
a) Understanding and interpretation of the TOR
b) Methodology to be used in undertaking the assignment
c) Time and activity schedule

Organisational and personnel capacity statement (maximum of 4 pages excluding point d)
a) Relevant experience related to the assignment
b) Testimonial or reference contact details from two organisations previously worked for
c) Curriculum Vitae of key personnel
d) Example(s) of similar work undertaken, particularly examples of previous evaluation reports written (will be kept confidential)

Financial proposal (maximum 1 page)
a) Indication of fees for carrying out the assignment and any other costs involved. Please include any flight costs, perdiem/accommodation/ food costs (for the consultant/consultant team) and

enumerator cost estimates in your budget. We understand that some of the exact costs may not be known to you at this point (ex. ground transportation, driver, training venue etc.) and even for enumerators and accommodations you might need to put estimates for now, but before signing the contract we will organize a more detailed discussion on the budget in detail and consultant(s) will be permitted to submit a revised budget based on clarifications and corrections from FYF/TSURO/BasicNeeds.