A stethoscope and a logo

AI-generated content may be incorrect.A group of people sitting in a circle

AI-generated content may be incorrect.Terms of Reference

**Baseline Study**

UMN Monitoring, Evaluation & Learning Team

**Project Name: Achieving Community-Based Inclusive Development in Okhaldhunga**

**Project Duration: January 2025 to December 2029**

**Funded by: People of Norway**

# Background

## Brief introduction about UMN and its work

United Mission to Nepal Medical and Development Trust (UMN MDT), and Okhaldhunga Community Hospital (OCH) have been dedicated to serving the people of Nepal. OCH is a primary care hospital with 50 inpatient beds and plans to expand to a 100-bed hospital in the future. It also hosts a Community-Based Inclusive Development (CBID) project with the financial support of the Norwegian Government. The duration of the project is from January 2025 to December 2029. The project will take place in two municipalities: Siddhicharan Municipality, which covers 168 square kilometres, with a population of 27,351 and 12 wards, and Chisankhugadhi Rural Municipality (RM), which covers 127 square kilometres, with a population of 13,844 and eight wards. These two municipalities lie to the south and east of Khijidemba and Molung, the municipalities from the previous project phase (January 2020 to December 2024).

**Achieving Community-Based Inclusive Development through Community-Based Rehabilitation in Okhaldhunga District, Nepal** has a big vision to see the whole of Okhaldhunga District become a place where Persons with Disabilities (PwDs) are respected and valued as equal members of society and are included, participate in, and contribute to their communities in meaningful ways, thereby achieving not only the fullness of life for those with disabilities but also improving social harmony and economic prosperity within their communities. It will do this by using a rights-based approach to disability, with a focus on rehabilitative activities that will bring PwDs, the rights holders, to a place where they can independently gain access to and enjoy their rights as fully empowered members of their communities.

The project is far-reaching in scope: it will work in health, education, economic empowerment, and social empowerment of both the community and rights holders and will ensure rights holders' equal and safe participation in society. It will work closely with both local government and civil society to create awareness that will change the way PwDs are perceived (reducing stigma) and treated (reducing discrimination) so that their inclusion and meaningful participation becomes a reality. The twin-track development approach will be used. This will ensure that both the community and rights holders experience empowerment. Disability issues will be mainstreamed into all areas of society, empowering communities and creating positive changes in knowledge, attitudes, and practices. At the same time, PwDs will be empowered by project activities that meet their specific needs. Both empowerment interventions are required simultaneously to ensure the greatest possible long-term impact. Empowerment is understood as a process where necessary; it begins with welfare activities and moves to access, awareness, participation, and control.

## Project Profile

|  |  |
| --- | --- |
| Project name | Achieving Community-Based Inclusive Development in Okhaldhunga |
| Project Goal | Okhaldhunga District is transformed into a disability-inclusive society, where PwDs and their families experience fullness of life through their full inclusion, participation, and contribution. |
| Project period | January 2025 to December 2029 |
| Project Locations | District(s): Okhaldhunga  Municipality(ies) & Ward(s): Siddhicharan Municipality (12 Wards)  Chisankhugadhi RM (Eight Wards) |
| Supporting partner | Normisjon |
| Community partners (project participants) | Rights holders (direct participants): PwDs and their families  Duty bearers (direct participants): Local government, Outpatient Department, Community groups |
| Implementing partners | UMN MDT, OCH |
| Other stakeholders | NGOs/INGOs working in respective RM |

# Purpose and scope of the baseline study

This baseline study aims to provide project staff with detailed baseline data on the key indicators so that expected changes can be measured throughout the project.

The baseline study of projects should generally include the collection of data that is both quantitative and qualitative in nature. However, it should be guided by the nature of the indicators and information required to measure the changes as closely as possible. As such, only quantitative or qualitative data may be collected if that sufficiently serves the purpose of the baseline study. The data collected will generally include information on outputs and outcomes indicators and on facts, knowledge, attitudes, and practices of the (intended) project participants. The data will be used to measure change over time, monitor and evaluate, and in capacity-building activities such as training. Tools should be developed to collect data that can be used again during future monitoring. Therefore, both guidelines for the tools used and the data collected from them should be included in the baseline report.

The design of the baseline study ensures that the Poorest People Living in Poverty (PPLP), in this case, PwDs, are at the centre of the baseline study; duty bearers and rights holders are identified and involved appropriately; and the principles of inclusion, gender equality, non-discrimination, participation, Do No Harm and sensitivity to the environment and climate change are considered throughout the study. The study abides by relevant UMN MDT policies, particularly the Safeguarding Children and Vulnerable Adults Policy. The study also follows high ethical standards, including, for example, obtaining informed consent from the respondents, ensuring confidentiality, allowing voluntary participation, etc.

# Use of the Study findings

While designing and conducting the baseline study, the study team will keep in mind the following uses of the findings:

* Provide baseline data on the project indicators, cross-cutting indicators (if not otherwise incorporated into the log frame), and basic project statistical data. This should include a basis for measuring change throughout the project.
* Develop and strengthen project-specific tools and instruments that can be used throughout the project period for monitoring or evaluation purposes as they are relevant to the specific indicators.
* Provide guidance on key concepts that may require close monitoring to capture learning and improve the design and implementation of interventions during the life of the project.
* Provide UMN MDT with accurate and reliable information on relevant issues. This may serve as evidence for advocacy at different levels.
* The findings of the study will be disseminated to relevant stakeholders, including the supporting partner, project team (UMN MDT), wider UMN MDT teams, local governments, and the respondents.

# Methodology

## Use of mixed-methods

It is recommended that the study include a mix of methods that are appropriate for capturing information specific to the specific project indicators. The consultant will develop an Inception Report. Possible methods include, but are not limited to:

* A household survey (using KoBo) of PwDs in the project area
* Key Informant Interviews with semi-structured questions
* Focal Group Discussions with
  + Semi-structured questions

## Training enumerators

Project staff will be mobilised as enumerators. The training will include skills relevant to the data collection method. The training will include skills to use mobile phones with the KoBo data collection app for the survey, detail discussion on the baseline questions, ethical procedures, and rapport building. The enumerators will have supervisory support while collecting data in the field.

## Collection of data

Quantitative data will be collected generally through a digital survey system. UMN uses KoBo, a mobile-based android application, for the survey. Generally, a 3-day training course, including field testing, is recommended. Data is automatically entered into the dashboard once it is submitted and sent from the mobile phone. Qualitative data will be collected using focus group discussion, key informant interviews and other participatory exercises.

## Analysis of data

When the data is sent from the mobile phone, it is readily available on the dashboard. The dashboard includes features such as visualisation of data points, cleaning raw data, and generating summary statistics. Therefore, preliminary analysis can be done using the dashboard features. However, the data can also be exported from the dashboard in Excel format to carry out more complex analyses using Excel or SPSS. In the case of qualitative data, the research team will use qualitative data analysis techniques such as coding, identifying themes, and interpreting perspectives.

## Incorporation of needs assessment data

Where possible and relevant, data from the needs assessment will be incorporated into the baseline study for the preservation of learning.

# Key deliverables

* Survey design and the development of relevant tools and questions for the baseline study. The external consultant and project team will be involved. Together, they will be responsible for designing and using relevant tools and study questions. The study design, tools, and questions must be agreed upon and approved by the UMN MDT project team before being implemented in the field. Please refer to the indicators and means of verification in the attachment for developing study questions.
* Training the enumerators and field testing
* Conducting field study in study sites
* Preparing draft and final reports
* Presentation of the findings from the final report

# Duration and timeline

The study is expected to be completed in 60 days and will take place from *1 April 2025* to 15 June 2025

Preparation: Seven days

Training: Three days

Fieldwork: Approximately 16 days

Data analysis: 15 days

Synthesising and reporting: 19 days

The draft report will be circulated among the key stakeholders UMN MDT, and their feedback will be used to correct factual errors and address requests for clarification. The study team will then make the second draft report. Further work may be needed if errors or clarification requests have not been addressed.

# Work plan

|  |  |  |  |
| --- | --- | --- | --- |
| Task | Responsible Person & Participants | Timeline | Remarks |
| Detailed guidelines (questionnaire) | MEAL, Project team, consultant | 1–6 April 2025 |  |
| Sampling frame | Project team |  |  |
| Skill development of staff in KoBo | Consultant, MEAL | 10–13 April 2025 |  |
| Questionnaire upload into KoBo | Consultant | 13 April 2025 |  |
| Questionnaire translation (final) | MEAL, Consultant | 1–6 April 2025 |  |
| Capacity building of enumerators (SM) for survey | Consultant, MEAL | 1–3 April 2025 |  |
| Survey data collection | Enumerators (with the supervision of MEL) | 10–13 April 2025 |  |
| Capacity building for FGD/KII |  |  |  |
| FGD/KII data collection | Consultant | 4–13 April 2025 |  |
| Data collection | Consultant | 14–20 April 2025 |  |
| Data analysis | Consultant | 21 April–10 May 2025 |  |
| Draft report | Consultant | 30 May 2025 |  |
| Feedback on report | Project team, Donor | 3 June 2025 |  |
| Final report | Consultant | 14 June 2025 |  |

# Study team skills and experience

* Substantial experience in conducting baseline/midline/endline studies
* Ability to design and implement qualitative and quantitative data collection tools
* Familiar with data collection and analysis using the KoBo application
* Strong research and analytical skills
* Familiar with project cycle management
* Project management and implementation experience
* Fluency in English and Nepali languages, both written and spoken

# Report

The final report should be a maximum of 30 pages, excluding appendices, and should be written in English. It should contain an executive summary of a maximum of two pages. The report should generally follow the following format:

* Title page
* Acknowledgment
* Acronym list
* Executive Summary
* Introduction
* Objectives/Purpose
* Methodology
* Constraints / Limitations
* Findings
* Conclusion and Recommendations
* Appendices

# Ethics of the study

The study will maintain the confidentiality and anonymity of information providers. Anybody, including direct or indirect beneficiaries, will not be forced to participate in the study process. The study team will not share or divulge the content of the final report to any person or persons. The study team will be sensitive to the local context and culture while carrying out the study and present themselves with modesty and humility while dealing with issues related to women, children, disability, and marginalised groups. The researchers (if external) will sign a safeguarding policy code of conduct, which will form part of the consultancy contract.

All data will belong to UMN MDT and the external consultant cannot use part or all of it for publication without written permission from UMN. (Also refer to the consultancy contract).

Acceptance of Terms of Reference

I declare that I have received and read the Terms of Reference and commit to conduct the data collection as per its guidelines and agree to meet the requirements stated.

|  |  |
| --- | --- |
| Consultant | |
| Signature |  |
| Name |  |
| Date |  |

|  |  |
| --- | --- |
| UMN MDT | |
| Signature |  |
| Name |  |
| Designation |  |
| Date |  |

PMF Template 11.2.7.2 VERSION: May 2024

UMN Code of Conduct for Safeguarding Children & Vulnerable Adults

This form needs to be signed by all UMN staff when joining UMN, and handed in at HR.

Code of Conduct

UMN staff, representatives and agents must:

1. Familiarise themselves with the UMN MDT Safeguarding Policy and indicate their acceptance of it by signing a copy of the Code of Conduct.
2. Ensure they always work with children and vulnerable adults, where possible, with the knowledge and informed consent of those responsible for them.
3. Report any allegations related to potential breaches of this policy to the relevant Safeguarding Focal Person.
4. Co-operate with any investigation process formed under the relevant procedure within this policy.
5. Not disclose the nature or details of an investigation to any unauthorised person.
6. Abide by the Safeguarding Policy on Communicating Electronically.

UMN staff, representatives and agents must not:

1. Threaten or use any form of physical punishment or hitting against a child or vulnerable adult.
2. Use language or behaviour towards child or vulnerable adult that is inappropriate, harassing, abusive, sexually provocative, demeaning or culturally inappropriate.
3. Spend excessive amounts of time alone with children or vulnerable adults. Meetings with individual children should take place within the sight of others and such meetings must occur with the knowledge of UMN MDT supervisors and those responsible for the child or vulnerable adult.
4. Fondle, hold, kiss, cuddle, tickle or touch children in an inappropriate or culturally insensitive way. Physical touch between adults and children can be healthy but should occur in public places. A general guideline is not to touch children in areas that are normally covered by shorts and t- shirt.
5. Take or use images of children or vulnerable adults which are detrimental to their dignity (see UMN MDT Visual Images Policy & Guidelines).
6. Use resources like telephones, mobiles or other IT/electronic/digital resources to develop inappropriate relationships with children or vulnerable adults or to store/view explicit or degrading images.
7. Fail to report when they have concerns about harm to a child or vulnerable adult.
8. Hire children or vulnerable adults for domestic or other labour which is inappropriate given their age or development stage, which interferes with their time available for education and recreational activities, or which places them at a significant risk of injury.

Signatures

I have read and understood this information. I understand that behaviour contravening these guidelines may be investigated by UMN and, if warranted, be reported to the appropriate legal authorities.

|  |  |  |
| --- | --- | --- |
|  | Employee | Witnessed by UMN MDT Staff Member |
| Name |  |  |
| Job title |  |  |
| Date |  |  |
| Signature |  |  |

# Annex A (Log frame)

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| --- | --- | --- | --- | --- |
| **ORGANISATION NAME: United Mission to Nepal, Medical and Development Trust, Okhaldhunga Community Hospital** | | | | |
| **PROJECT NAME: Achieving Community-Based Inclusive Development in Okhaldhunga** | | | | |
| Impact GOAL: Okhaldhunga District is transformed into a disability-inclusive society where PwDs and their families experience fullness of life through their full inclusion, participation, and contribution. | | | | |
| **Hierarchy of results** | **Results** | **Indicators** | **Means of verifications** | **Remarks/Assumptions** |
| **Access to Health (AH)** | |  |  |  |
| **Outcome 1** | **PWD and their families access and receive good quality physical and mental health services** | # of persons benefitting from health services due to project intervention (m/f) | Record of health institutions (hospital and clinics), project records |  |
| # of PWD referred to specialised health services (m/f) | Record of health institutions, project records |  |
| # PWD and their families report increased access to good quality health services | KII with PWD and their families through home visit, and FGD to PWDs committee in each ward from M&E officer one time in a year |  |
| Output 1.1 | Community has knowledge about health promotion, disability prevention and sanitation | # of community groups oriented in health promotion, disability prevention | Training/orientation minutes, | Community actively participate in the training programmes; PWD can afford the health care |
| # of people who received PRT to prevent disability | Home visit, record/PRT form of physiotherapist | Community actively participate in the training programmes; PWD can afford the health care |
| # of community groups trained in WASH | Training/orientation minutes, project record | Community actively participate in the training programmes; PWD can afford the health care |
| # of households improved in hygiene and sanitation | Home visit, record/PRT form | Community actively participate in the training programmes; PWD can afford the health care |
| # of health personnel who have new knowledge about health promotion, disability prevention and sanitation | Training/orientation minutes, project record, KII | Community actively participate in the training programmes; PWD can afford the health care |
| Output 1.2 | Project staff provide rehabilitation to improve PWD's mobility, ADL's and participation in social and vocational activities | # of PWD receiving assistive devices | Minute, record, physiotherapist PRT form record | PWD understand the benefits of ADs and PRT |
| # of PWD with improved ADLs | Physiotherapist PRT form record, observation | PWD understand the benefits of ADs and PRT |
| # of PWD with improved mobility | Physiotherapist PRT form record, observation | PWD understand the benefits of ADs and PRT |
| # of home modifications (kitchen, toilet, ramp etc) | Project records | PWD understand the benefits of ADs and PRT |
| # of PWD receiving rehabilitation services (m/f) | Physiotherapist PRT form record, | PWD understand the benefits of ADs and PRT |
| Output 1.3 | PWD receive their needed medical treatment | # of health personnel from local health unit with increased knowledge of health services | Record of health institutions, minutes, Project records | Transport costs are found; government HI facilities continue and are accessible |
| # of PWD receiving financial support for treatment | Project records | Transport costs are found; government HI facilities continue and are accessible |
| # of persons benefitting from health camps | Minute, project records | Transport costs are found; government HI facilities continue and are accessible |
| Output 1.4 | PWD and their families receive mental health support from Project staff, community, OCH, secondary and tertiary health centres | # of persons receiving mental health counselling services | Home visit record | Community understands the organic nature of mental health problems; stigma is reduced, so access to services and social events is increased |
| # of persons receiving medical treatment for mental health issues | Project support records | Community understands the organic nature of mental health problems; stigma is reduced, so access to services and social events is increased |
| **Access to Education (AE)** | |  |  |  |
| **Outcome 2** | **PWD, Children With Disabilities (CWD) and Children of PWD experience quality and inclusive education** | # of school with improved disabled friendly environment | Record, Observation |  |
| # out of school children of PWD and CWD regularly attending school because of project's intervention | Project and school record |  |
| Schools' and childrens' change of attitude to inclusive education | FGD, KII, case story |  |
| Output 2.1 | Project supports CWD, children of PWD and PWD to receive formal and non-formal education | # of CWD receive non-formal education | Distribution list, record, minute | Families of CWD understand the importance of education for their CWD; project data is accurate |
| # of PWD receiving support for higher education | Project Rcord | Families of CWD understand the importance of education for their CWD; project data is accurate |
| # of school teachers trained in ICDP | Training minute | Families of CWD understand the importance of education for their CWD; project data is accurate |
| # of CWD enrolled in school | School Record | Families of CWD understand the importance of education for their CWD; project data is accurate |
| Output 2.2 | Children of PWD receive support to attend primary and secondary school | # of children of PWD receive support to enrol in school | List of distribution, project record | Advocacy efforts are successful to persuade educational unit to provide the funds; schools are open; teachers are available; |
| # of children of PWD receive scholarship | Project and school records | Advocacy efforts are successful to persuade educational unit to provide the funds; schools are open; teachers are available; |
| Output 2.3 | Public and private schools receive information in disability inclusive education and accessibility | # of teachers, School Management Committee & Parent Teachers Association members trained in disability inclusive education and accessibility | Training minutes, Project record | Teachers use the new skills and knowledge; good quality monitoring by Education Unit |
| # of school received materials for inclusive education | Project records | Teachers use the new skills and knowledge; good quality monitoring by Education Unit |
| # of schools made physically accessible for CWD | Project records, RM education unit records | Teachers use the new skills and knowledge; good quality monitoring by Education Unit |
| # of children oriented in inclusive education | Training minutes | Teachers/children use the new skills and knowledge; good quality monitoring by Education Unit |
| **Economically Empowered (EE)** | |  |  |  |
| **Outcome 3** | **PWD and their families are economically empowered** | # of PWDs and their families reporting increase in income due to project intervention (m/f) | Home visit record |  |
| # of PWD employed or self-employed after completing vocational training (m/f) | Project records, list of support received |  |
| # of new businesses/enterprises started annually due to project intervention | Project records, training participants list, list of support received |  |
| # of active savings and loans groups | Project Records |  |
| Output 3.1 | Small businesses and enterprises are developed and new jobs created for PWD through the project intervention | # of PWD and their family receive support for small businesses and enterprises | Training minutes, support received list | demand for products is sufficient; access to markets is possible and financially viable; training is relevant |
| # of PWD employed in small businesses and enterprises due to the project intervention | Project Records | demand for products is sufficient; access to markets is possible and financially viable; training is relevant |
| # of new and existing savings and loans groups strengthened due to the project intervention | Project Records | demand for products is sufficient; access to markets is possible and financially viable; training is relevant |
| Output 3.2 | PWD and their family receive training and support in agriculture farming through the project's intervention | # of PWD have increased income from agriculture farming | Training minutes, support received list | demand for products is sufficient; access to markets is possible and financially viable; training is relevant |
| Output 3.3 | PWD and their family receive training and support in livestock farming through the project's intervention | # of PWD have increased income from livestock farming | Training minutes, support received list | demand for products is sufficient; access to markets is possible and financially viable; training is relevant |
| Output 3.4 | Private sector receive training related to disability law and polices to provide support to PWD and families related to income generation | # of private institutions and individuals providing support to PWD and families for income generation | Training minute | demand for products is sufficient; access to markets is possible and financially viable; training is relevant |
| **Social Empowerment (SE)** | |  |  |  |
| **Outcome 4** | **Community members are empowered to include PWD, and PWD and their families are empowered to demand their rights** | # of PwD and their families who received benefits and entitlements through advocacy | RM/Ward record, home visit record, community group minutes,GCA, |  |
| # of groups/networks organised | RM/Ward record, home visit record, community group minutes,GCA, |  |
| # of groups engaging with relevant duty-bearers and voicing their interests | RM/Ward record, home visit record, community group minutes,GCA, |  |
| Output 4.1 | Government Disability Coordination Committees (GDCC) and PWD committees get support to advocate for the rights of PWD and provide support to them | # of persons trained in organisational skills (m/f) | Training minutes, project minutes | If training in disability laws and policy receive by committee members |
| # of PWD committees strengthened | Project records | If training in disability laws and policy receive by committee members |
| Output 4.2 | Community groups become aware of disability rights and are able to be active in disability inclusion activities | # of local churches/congregations/other religious groups participating in project activities | Minute | If community group members are actively participating in the project intervention activities |
| # of community groups starting their own disability inclusion activities | Record of community group and project | If community group members are actively participating in the project intervention activities |
| Output 4.3 | Using advocacy, project supports duty bearers to implement government law and policy and provide services to PWD | # of organisations implementing PWD law and policy and providing services to PWD accordingly | Project records, Records, KII | If fund is available from province and central level government |
| # of PWD accessing private and public services | KII with PWD, Home visit record | If fund is available from province and central level government |
| Output 4.4 | Project supports duty bearers and rights holders to help PWD receive relevant ID cards and gain their legal entitlements | # of PWD received disability ID card/citizenship | RM/ward records, project record | If PWD are aware about the benefit of ID cards |
| # of PWD and their families received support to register for health insurance | RM/ward records, project record | If PWD are aware about the benefit of health insurances |
| **Equal Participation (EP)** | |  |  |  |
| **Outcome 5** | **PWD and their families have more equal and safe participation in society** | # of persons with physical or mental illnesses reporting reduced stigma in local communities (m/f) | Home visit record, KII, FGD |  |
| # of PWD participating in social and cultural events | Home visit record, KII |  |
| Output 5.1 | Project empowers community regarding non-discriminatory attitudes and behaviour towards PWD and their families | # of PWD and carers who are members of community groups | Minute, FGD, KII | If the government strictly implements law and policy related to rights. |
| # of PWD participating in recreational activities | Minute, project records | If the government strictly implements law and policy related to rights. |
| Output 5.2 | Project advocates for PWD to participate in social, cultural, political events and daily life | # of PWD counselled on stigma related issues | Home visit records, | If PWD family members get knowledge and provide supportive roles towards PWD |
| # of PWD oriented/counselled/trained on GBV related issues | GBV training minutes | If PWD family members get knowledge and provide supportive roles towards PWD |
| Output 5.3 | Communities have knowledge about disability-inclusive ways to reduce the impact of disasters and protect the environment | # people taking part in orientations on DRR and environmental awareness raising | DRR orientation participation minutes Environmental orientation participation minutes | If training is available in local level for community groups |
| # people taking part in DRR and environmental protection events | Attendance sheet | If training is available in local level for community groups |