

Terms of Reference

Endline survey for implementation research study on optimizing routine delivery of essential child health and nutrition package in Kisii County, Kenya

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1. Background

1.1 About Nutrition International

Founded in 1992, [Nutrition International](#) is a global organization dedicated to delivering proven nutrition interventions to those who need them most. Working in partnership with countries, donors and implementers, our experts conduct cutting-edge nutrition research, support critical policy formulation, and integrate nutrition into broader development programs. In more than 60 countries, primarily in Asia and Africa, Nutrition International works to deliver better nutrition for people and communities, helping people thrive throughout their lives.

1.2 Background on the research study

The advent of Maternal and Child Health (MCH) clinics aimed at providing services to women and children are under the same roof. However, many child survival interventions, despite targeting the same cohort of children, are separately financed, planned for, and monitored at the national and sub-national level. Kenya has put many guidelines in place, such as the Kenya Health Policy (2014-2030), Kenya Essential Health Package Policy, Kenya UHC Policy 2020-2030, Vitamin A Supplementation and Deworming Policy and Guideline (2022), Kenya National Immunization Policy Guideline (2023), MIYCH Guidelines, and the Kenya Primary Health Care Framework 2020-2024. Nevertheless, the services are not yet delivered in a way that creates synergy and ensures coverage of all services a child needs. The Ministry of Health in Kenya laid out a clear vision for delivery of the Essential Package of Health Services (EPHS) in Kenya through the Kenya Health Policy, in which health and related services will be available to all Kenyans through four tiers of care: Community, Primary Care, County Services, and National Services. This effort sought to bring together these services and integrate them as much as possible.

Despite the aforesaid, access and utilization of essential child health and nutrition services in Kenya remain a challenge with inequalities reported. According to KDHS 2022, only 55% of children 12-23 months were fully vaccinated according to the national schedule, 53% having received the vaccines at their appropriate age. The coverage of children 24-35 months fully vaccinated according to the national schedule was 38% with 34% having received the vaccines at the appropriate age. On growth monitoring and promotion, which monitors children's nutrition status through physical growth measurements, the coverage for key components was reported as 45% for weight, 37.5% for length/height and 16.3% for Mid-upper arm circumference (MUAC). Only 15.3% of the children had all three growth monitoring parameters measured. While 59% of the children 0-23 months had their height/length plus weight taken, only 22% had the same measured in the age cohort 24-59 months. For the same year (2022), the national two dose VAS coverage for children 6-59 months was reported at 84% (KHIS 2022). This is mirrored in Kisii county, where, other than immunization services, coverage of all other essential child health and nutrition services is well below 30% (KHIS, 2023). This situation points to the fact that children do not receive all the services due when they visit the service delivery points. Furthermore, care-seeking often declines after a child's first birthday, meaning that if a child has missed a vaccine and is now outside the target age, they are less likely to complete their full series of vaccines. This missed opportunity affects coverage of other core child survival interventions as well.

Nutrition International is conducting an effectiveness-implementation research study to test the effect of optimizing routine delivery of VAS on the coverage of all essential child health and nutrition services for children below the age of five years in Kisii County, Kenya. The fidelity, feasibility, and acceptability of the intervention model will also be assessed using mixed methods.



The implementation of optimization model for 12 months will end in December 2026. A baseline survey was conducted in February-March 2025. An endline survey will be conducted by mid-February 2027 as part of this research. The endline survey will be conducted in the same two Sub Counties in Kisii County, to collect data on coverage of essential health and nutrition services for children, as well as the determinants of coverage. The endline survey data will be used to assess any differences in coverage and uptake between the control and intervention Sub Counties, what changes have taken place in the two Sub counties since the baseline survey, and whether any changes in coverage and uptake can be attributed to the optimization.



2. Objective of consultancy

The objective of the consultancy is to conduct an endline survey for the implementation research study in Kisii County, Kenya. This will be achieved by completing the following:

1. Complete all necessary planning and preparation;
2. Coordinate, supervise and quality assure data collection for endline survey; and
3. Clean, analyze, and present the endline data and report.

EXPECTATIONS

Under this ToR, the consultancy team will take responsibility for the management of field work and analysis of the survey data-report, using NI survey tools and adhering to the quality assurance procedures set out in the survey tools. The consultancy team will work closely with the NI survey management team to achieve this. The division of responsibilities is as follows:

- The NI survey management team: will provide the design of the survey, sample sizes and methodology; obtain all permissions for the survey; prepare the indicator list, tabulation plan and the questionnaires; provide quality assurance guidelines for the consultancy team; monitor quality throughout the survey and review all processes and outputs provided by the consultancy team.
- The consultancy team: will create the survey implementation plan; review and field test/contextualize the tools; finalize and digitize the tools, create the sampling frame and protocol according to the survey design set out by NI; recruit, manage and train all human resources for data collection; manage all logistics for the data collection; operationalize and adhere to quality assurance guidelines, manage and clean all the data, run the analyses using the agreed upon syntax and set out the findings in results tables and reports.



3. Scope of work

The implementation of this study is in collaboration with the County Government of Kisii and is guided by the Principal Investigators and Co-Investigators with support from a Research Coordinator based in Kisii County. The consultant(s) will work under the supervision of the Principal Investigators with support from the Research Coordinator and NI project team.

The following section describes the activities the consultancy team will complete and the products and deliverables they will prepare. The field work/ data collection is expected to be conducted between mid-January to mid-February 2027.

Activity 1: Complete all necessary planning and preparation for endline survey

Sub activity 1.1: Prepare a study plan for endline survey in accordance with the study protocol, sample size and methodology designed by NI, setting out:

- Survey plan, including:
 - A detailed sampling methodology with a plan for random selection
 - Sampling plan for each method of data collection
 - Data collection tools
 - Outcomes of interest
 - A data collection plan that includes details of all necessary logistics and supplies (including devices for electronic data collection)
 - Data analysis plan for both quantitative and qualitative data.
 - A plan for recruiting and training interviewers, including the composition of data collection teams (number of interviewers, supervisors, team leaders, etc.)
 - A quality assurance and supervision plan for data collection
 - A timeline or Gantt chart
 - A detailed budget
 - A final report outline

Deliverable 1.1: Draft study plan for approval by Nutrition International including all the elements listed in Activity 1.1

Sub Activity 1.2: Nutrition International has applied for and obtained all required permissions and approvals for the endline survey to take place. The consultant will complete the necessary ethics training and guidance detailed below:

- Any and all consultancy team staff who will participate in data collection and have access to survey data will be required to complete an internationally recognized training on Protecting Human Subject Research Participants as well as sign data confidentiality agreement with the Principal Investigator.
- The survey training will cover ethics for all staff and require signed confirmations from each staff member confirming s/he is fully aware of and bound to abide by ethical conduct with all aspects of this survey, will not use or disclose any survey data for personal or agency use, and will not disclose any data that could in any way be connected back to any survey participants, thus ensuring full confidentiality of collected data. Should there be any desire to use the data for purposes other than the protocol associated with this survey, these additional uses must be approved by NI project team and the relevant ERB.

- Approvals and training must also include “child protection and safeguarding” standards, relevant to Kenya and NI – in consideration to the fact that the adolescents (under 18 years of age) interviewed will not always be accompanied by a guardian. Logistics will include preparations to inform and obtain consent from parents prior to the interview.
- If interviewing adolescent caregivers/mothers, “informed assent” will be sought for adolescent girls, and the consultants will ensure no adolescent girl is alone with any supervisor or enumerator in a closed or distant room with no ready line of sight to observers.

Deliverable 1.2.1: Certificates demonstrating completion of internationally recognized training on Protecting Human Subject Research Participants by all staff who are participating in the endline survey and who will have access to survey data.

Deliverable 1.2.2: Signed data confidentiality agreements

Sub Activity 1.3: Reviewing indicator list and the data collection tools, prepare digital versions before training begins. This activity includes:

- Reviewing the indicator list that details every indicator, its definition, and how it will be calculated;
- Developing electronic versions of the data collection tools provided by Nutrition International, preparing a server to store the data (using Google Cloud or equivalent), and testing the electronic version to ensure it accurately follows the paper data collection tools; including data fields, skip logic, validation rules, and workflows.
- Preparing all electronic devices to be used for data collection, including activating SIM cards and loading the questionnaires onto the devices; and
- Verifying that the data collection tools will report on all the indicators according to the tabulation set out in the indicator list.

Deliverable 1.3.1: Contextualized data collection tools in both paper and electronic format (e.g., ODK xls form file), using a recognized secure electronic data collection platform.

Sub Activity 1.4: Develop a training curriculum, to be reviewed and approved by Nutrition International. As per Sub Activity 1.2, training for all data collection team members must include ethics and “child protection and safeguarding” standards relevant to Kenya and NI.

Deliverable 1.4: Training curriculum for data collection team members, including training materials, a schedule for training of enumerators, team leaders and supervisors, and pre-and end-of-training test.

Sub Activity 1.5: Prior to commencing data collection, pilot test the data collection tools. Pilot testing will be done to ensure respondent understanding and relevancy to local context, and the consultant will incorporate relevant feedback from the pilot test into the final data collection tools.

Deliverable 1.5: Finalized data collection tools in both paper, electronic format (e.g., ODK xls form file) with the electronic forms deployed and configured on a secure data-hosting server.



Activity 2: Complete enumerator recruitment and training

Sub Activity 2.1: Recruit enough data collectors according to the data collection plan set out in Sub Activity 1.1 and as per the human resource requirements set out in Section 4.

Deliverable 2.1: Data collection team member roster, including their individually assigned codes, results from their pre and end-of-training test and their proposed role during data collection

Sub Activity 2.2: Train the data collection teams according to the approved training curriculum. All data collection team members and supervisors must have participated in the training sessions. The training must include a pre and end-of-training test which the data collection team members must pass before collecting data in the field.

Deliverable 2.2: List of signatures from all data collection team members ensuring that they are aware of and will abide by ethical standards. Pre and post training test summary results per data collection team member (as detailed in Sub Activity 1.2).

Activity 3: Sampling frame preparation and fieldwork

Sub Activity 3.1: Prepare a cluster sampling frame (list of enumeration areas (EAs) and randomly assign clusters as per the sampling strategy agreed on between the consultants and NI. Clusters should be randomly selected using probability proportional to size (PPS).

Deliverable 3.1: Complete cluster sampling frames for all survey areas; finalized list of survey locations.

Sub Activity 3.2: Update the household sampling frame by conducting a household mapping and listing in all selected clusters. Then randomly select households as per the sampling strategy that will be shared by Nutrition International.

NB: If you are using census EAs as your cluster, you can start with the EA base maps provided by the National Institute of Statistics and update the maps

Deliverable 3.2: New or updated map of the sampled clusters that shows all of the dwellings, and the listing (enumerating) all the households in the cluster along with their dwelling number.

Activity 4: Coordinate, supervise and quality assure data collection for endline survey

Sub Activity 4.1: Organize and implement the end-line survey according to the plan described in Sub Activity 1.1. This will include:

- Arranging for all logistics and transport of data collection teams;
- Supervising the data collection teams to ensure they abide by the data collection plan and follow the rules of cluster and random sampling;
- Managing all data collection devices and ensuring upload of survey data at the end of each day of data collection or as soon as network is available;
- Preparing and implementing quality control and quality assurance
- Ensure daily and periodic checks for quality of data (e.g., number of respondents/children sampled and balance across age groups) and re-sampling for any replacements; and
- Documenting and communicating any findings and issues to NI.



Deliverable 4.1.1: Data quality control and assurance protocol: outlining steps to ensure random sampling is adhered to, clear protocol/rules on how replacements will be done, and data quality checks to ensure balance across sub-counties and age groups.

This should include a data quality assurance tracking tool or dashboard that reports:

- Response rate: overall, by sub-counties and by clusters
- Completeness
- Age ratios
- Household/respondent identification
- Excessive don't know/refusal

Deliverable 4.1.2: Complete endline survey data collected as per the survey plan (i.e., raw data sets).

Deliverable 4.1.3: Completed field work documentation report including challenges, changes to the sampling plan, deviations from the sampling plan and justification, and other notes about the field work.

Activity 5: Clean, analyze, and present the endline data as per analysis plan

Sub Activity 5.1.1: Clean and organize all final datasets using a recognized software package (Preferably on STATA). This includes:

- Data cleaning;
- Attaching all variable and value labels, or providing a data dictionary; and
- Ensuring the cluster variable is identified so that the analysis can be conducted using complex sampling analysis.

Deliverable 5.1.1: Data cleaning do-file/syntax.

Sub Activity 5.1.2: Clean and organize all FGD and KII transcripts and respondents' demographic data.

Deliverable 5.1.2: Final clean dataset from endline survey in recognized software with accompanying variable and value labels.

Deliverable 5.1.3: Final clean FGDs and KIIs transcripts and summary of demographic data of FGD respondents

Sub Activity 5.2: Run the endline survey data analysis and write a report.

For quantitative data, create results tables according to the following guidance:

Create tables for results with all indicators, calculated according to the tabulation plan developed as part of Sub Activity 1.3. Results must be analysed using appropriate statistical procedures, and results tables must include 95% confidence intervals, coefficient of variation, and design effect. Results tables are to be presented in a format agreed by Nutrition International, and results (all indicators) must be provided for each stratum as well as a weighted average for the geographical area covered by the survey.

For qualitative data:

Create summary of key thematic areas (according to the indicator list), themes and sub-themes. The summary will be presented in a format agreed upon by NI, preferably following NVIVO output tables showing thematic content analysis and frequencies.



Deliverable 5.2.1: Quantitative data analysis plans

Deliverable 5.2.2: Verifiable quantitative data cleaning and analysis syntax for endline

Deliverable 5.2.3: Complete indicator as per the description in Sub Activity 5.2.

Deliverable 5.2.4: Complete summary tables of key thematic areas, themes and sub-themes as per description in Sub Activity 5.2.

Deliverable 5.2.5: Raw and cleaned versions of the data sets and data dictionary

Sub Activity 5.3: Write the endline survey report. The consultant will prepare a short adequately detailed report based on the quantitative results, which should include a brief background, objectives, design and methods, results including graphs to present the results, and a brief discussion including a summary of high-level findings. The report should include a discussion on strengths and weaknesses of the data, any relevant observations from the data collection process and any recommendations for further analysis of the data. All other information should be included as annexes.

The consultant will also prepare a short report based on the qualitative results outlining key thematic areas, major themes and sub-themes supported by relevant and insightful quotations from the respondents.

Deliverable 5.3: Endline survey report: summarizing high-level findings from the quantitative and qualitative results.

Schedule of Major Deliverables for the Endline Survey

Milestone	Description of Major Deliverables	Due Date	Submitted by
Inception report	Submit inception report, including survey plan, training curriculum, plans for recruitment and training of enumerators	November 27th, 2026	The firm
Pilot testing of data collection tools	Finalized data collection tools in both paper and electronic format	Finalized data collection tools by December 11th, 2026	The Firm
Sampling frame and detailed sampling plan for all survey areas; finalized list of all survey locations	Complete sampling frame and protocol for clusters and households.	Sampling frame and protocol by January 8th, 2027	The Firm
Complete data collected according to survey plan	Raw data (Quantitative and qualitative data)	Completion of data collection and raw data by February 16th, 2027	The Firm
Clean, analyze, and report on the endline data	Final clean quantitative dataset. Final clean FGDs and KIIs transcripts Endline survey report(s): summarizing high-level findings from the quantitative and qualitative results.	Final clean data by March 5th, 2027 and data dictionary Draft report(s) and Data Cleaning and Analysis Stata syntax for endline and log files by March 31st, 2027	The Firm

Please refer to section 3 for a full list and details of all expected deliverables.



4. Profile of the consultant or consulting firm

We are seeking a consultant or consulting firm with expertise in mixed methods research, data collection and data management including statistical analysis of health and nutrition research studies. The consultant or consulting firm selected for this survey must have the following mix of qualifications/expertise:

- Master's degree in nutrition, public health, statistics or social sciences. PhD is an asset.
- Demonstrated at least five years' experience in conducting health and nutrition studies including organizing large-scale household and community surveys.
- In-depth knowledge of quantitative and qualitative research methods. Strong demonstrated ability in the design of data collection tools and in the collection and management of data using ODK tools.
- Strong demonstrated ability in processing and analyzing large data sets, using appropriate statistical methods. Experience in Difference-in-Differences (DiD) analysis methods is preferred.
- Proficiency in the use of statistical software packages (e.g. Stata, R, NVIVO) for quantitative and qualitative analysis.
- Analytical skills and ability to produce clear, concise summaries.
- Strong writing skills. Proven experience in producing high-quality documents.
- Strong interpersonal, teamwork and organizational skills.
- Perfect command of English.



5. Technical and financial proposal

To be considered, the proposal must include:

1. A technical proposal including:
 - a. A methodological note demonstrating the principal consultant's understanding of the assignment.
 - b. A detailed schedule for carrying out the survey; and
 - c. A detailed curriculum vitae of the consultant(s) involved in the assignment, and a summary of how you meet the required profile according to the qualifications listed in section 4.
2. A financial proposal with a line-item budget clearly indicating the unit costs (in KES) and corresponding quantities associated with the consultancy: Endline survey (Activities 1-5)
3. Reports of at least 3 evaluations/research activities carried out in a similar field by the consultant(s) proposed for this project.

5.1 Criteria for analyzing the proposals

The proposals will be analyzed in 3 critical areas:

1. Technical content:
 - a. Understanding of the Terms of Reference
 - b. Quality of the proposed technical approach and methodology
2. Breadth and depth of institutional expertise in recent similar surveys
3. Personal experience and technical capabilities of consultant and team members
4. Quality of previous work with Nutrition International (if applicable)
5. Financial proposal – clear to follow, addresses all critical budget drivers, reasonable

5.2 Deadline for receipt of technical and financial proposal

All proposals must be received by 23rd October 2026, 11:59pm EAT. Technical and financial proposals should be sent by e-mail to bidsAfrica@NUTRITIONINTL.ORG with the subject line: Kisii IR Study.

Annex 1: Study Methodology

STUDY DESIGN

The study will use an effectiveness implementation hybrid design that combines effectiveness and implementation research. The effectiveness of the optimized delivery system using PHC contacts (the intervention) to deliver the essential child health and nutrition package (including VAS, EPI, MUAC, and GMP), will be determined using a non-randomized experimental design with two arms – the control (Bomachoge Borabu) and the intervention (Kitutu Chache North). Qualitative and quantitative data will be collected at baseline and endline. A detailed protocol for this study will be shared with the successful consultant(s).

STUDY POPULATION

The study will be implemented in Kisii County, Kenya. The primary target population are caregivers of children aged 12-59 months. In addition, the following will be targeted to provide data on health provision: Sub-County health management team members, health facility staff, health workers including Community Health Assistants (CHAs) and their community health promoters (CHPs).

SURVEY DESIGN AND SAMPLING STRATEGY

Systematic cluster random sampling will be used to select research participants. The sample sizes for each round of the baseline and endline assessment were estimated using Stata 17.0. Sample sizes were calculated for (a) the coverage of measles one among children 12-23 months of age, using an effect size of 12 percentage points and prevalence of measles one coverage of 74%, and (b) the coverage of VAS among children 24-59 months of age, using an effect size of 30 percentage points and prevalence of VAS coverage of 14%. Both calculations were computed using a two-tailed alpha of 5%, and a power of 90 % ($1-\beta$). A cluster size of 30 and an intraclass correlation coefficient (ICC) of 0.07 were applied to the sample size calculations. In the absence of any reliable ICC value from previous similar studies, this ICC value of 0.07 has been assumed, as it yields a DEFF of 3.03 for a cluster size of 30 as usual design effects are considered between 1.5 and 3. The estimates were then adjusted for response rate (assumed at 90%) and adjusted for finite population correction factor (fpc). The sample sizes have been computed based on a two-sample proportions test using a Pearson's chi-squared test for an expected percent point change between baseline and endline in the intervention areas assuming exchangeability between the intervention and control areas.

Subcounty			
Population group	Kitutu Chache North (Intervention)	Bomachoge Borabu (Control)	Total sample across sub-counties
Children 12-23 months of age	578	578	1156
Children 24-59 months of age	153	153	306
Total	731	731	1462

INDICATORS

An indicator list and tabulation plan must be generated prior to data collection to ensure consistency. Nutrition International will provide the consultant with a draft indicator list for the baseline and endline. Before proceeding to data collection, the indicator list will be finalized and the tabulation plan for all indicators agreed on by Nutrition International and the consultancy team.

TOOL DESIGN

Nutrition International will provide the consultant with draft tools for quantitative and qualitative data collection. The consultant will be responsible for pre-testing and finalizing the quantitative and qualitative tools. Specifically, Nutrition International will provide the following tools:

Tool	Subject
Caregiver questionnaire	The main caregivers of children aged 12-59 months
Health worker questionnaire	Health workers
Community health promoter (CHP) questionnaire	CHPs
Key informant interview guide	Health workers and health management teams

After the indicators have been agreed upon, the consultant will revise the draft data collection tools to ensure that all data questions required in the tabulation plan are present, and that the data collection tools are adjusted for the local context. When the draft data collection tools have been completed, the consultancy team will pilot test the tools and make any necessary changes to ensure that the tools are well understood in the local context. The consultancy team will provide Nutrition International with documentation of this process and corrections made.

Data collection will take place electronically where possible. To facilitate this, the consultancy team will set up a server using a recognized mobile data collection platform. Data will be uploaded daily to facilitate quality checks.

Prior to live data collection, Nutrition International must sign off on both the paper and electronic versions of the tools.

DATA PROCESSING AND MANAGEMENT

The research plan drawn up by the consultant must include a data processing and management plan. The consultant is responsible for the translation and back-translation of all qualitative and quantitative data collection documents.

The consultant is required to describe the following elements in the data entry plan for the current project:

- How will the data be stored?
- Who will enter the data into the data storage system?
- Who will have access to identifiable data while it is being stored?

ETHICAL PROCEDURES AND SURVEY PERMISSIONS

NI will obtain all necessary permissions for the survey, including ethical approval from Amref Ethics and Scientific Review Committee, NACOSTI and local authorities at the County.

All interviews will be conducted using internationally recognized procedures for informed consent. Enumerators will be trained, and supervisors will ensure these protocols are followed by all survey personnel to ensure justice, equity and beneficence as well as maintaining confidentiality of all data. Interviews will only continue once the respondent is aware of the survey, provides willing consent and continues to be a willing participant of the survey. All data collection team members must sign a document confirming their understanding of these requirements and willingness to follow these protocols, including that they:

- Will not use or disclose any survey data for personal or agency use;
- Will not disclose any data that could in any way be connected back to any survey participants; and

- Will never be alone with an adolescent girl outside of sight by school officials or parents.

All consultancy team staff who will be involved in data collection and have access to survey data must provide evidence of completion of an internationally accepted human subjects research training course (4-hour course such as NIH online course).

HUMAN RESOURCES AND TRAINING

The consultancy team will take full responsibility for hiring, training, and supervising enough enumerators, supervisors and team leaders to complete the survey in the agreed upon survey period. There should be no more than 10 enumerators per supervisor. Prior to data collection, training will be conducted to supervisors, team leaders and enumerators. They will be trained on the objectives of the survey, a detailed review of the survey methodology, and data collection tools, the ethical standards for data collection from human subjects, and all logistics for the field including the safety of the team, daily schedules for data collection, and how to engage with communities/households, etc.

The training schedule should include role play exercises to practice the administration of the tools, including adequate time to practice using electronic data collection tools (e.g., tablets) and testing the digital data collection process. Trainers should plan to observe at least two interviews per enumerator to assess and provide feedback on her/his interview practices.

The training must include an end-of-training test, and one day to field test the data collection tools. Only those enumerators who pass the final test and are observed to be capable interviewers will proceed to collect data.

FIELD TESTING

As part of training, supervisors, team leaders and enumerators will practice the entire survey process—including mapping out clusters, randomly selecting households, conducting interviews, etc.—in an area that resembles possible survey areas but was not selected for the survey.

Supervisors will observe accuracy and precision of the filled information and team leaders will observe the quality of the interviews conducted by enumerators (e.g., how questions are asked, building rapport/trust with the interviewees, completing all questions as set out in the data collection tools).

AUTHORSHIP AND DATA OWNERSHIP

The research consultant(s) will have access to the research protocol and all datasets. NI retains ownership of the data and authorship of any publications. Authors will be considered in alignment with guidelines from the International Committee of Medical Journal Editors (ICMJE).



Annex 2. Declaration form

“We have examined the information provided in your Request for Proposals (RFP) and offer to undertake the work described in accordance with requirements as set out in the RFP. This proposal is valid for acceptance for 6 months and we confirm that this proposal will remain binding upon us and may be accepted by you at any time before this expiry date.”

“We accept that any contract that may result will comprise the contract documents issued with the RFP and be based upon the documents submitted as part of our proposal.

“Our proposal (Technical and Financial) has been arrived at independently and without consultation, communication, agreement or understanding (for the purpose of restricting competition) with any other Respondent to or recipient of this RFP from the Nutrition International.

“All statements and responses to this RFP are true and accurate.”

“We understand the obligations regarding Disclosure as described in the RFP Guidelines and have included any necessary declarations.”

“We confirm that all personnel named in the proposal will be available to undertake the services.”

“We agree to bear all costs incurred by us in connection with the preparation and submission of this proposal and to bear any further pre-contract costs.

“I confirm that I have the authority of **[insert name of organization]** to submit this proposal and to clarify any details on its behalf.”

Name: _____

Title: _____

Date: _____

Signature: _____



Annex 3. Nutrition International Global Child Safeguarding Policy

Policy

INTRODUCTION

Nutrition International (Nutrition International) is Canada's global nutrition organization. Founded in 1992, Nutrition International (formerly the Micronutrient Initiative) is dedicated to delivering proven nutrition interventions to those who need them most.

Nutrition International has grown significantly in the past 5 years and expects this to continue through at least to the end of the current strategic plan (2024). While we increase our investment in efforts to reach more children with health and nutrition interventions, we stand committed to preventing child abuse and to the safeguarding of children.

Nutrition International fully acknowledges the duty of care to protect and promote the welfare of children and young people it comes into contact with through our programs. In addition, Nutrition International is committed to ensuring child safeguarding practice reflects statutory/legal/legislative responsibilities and current guidance and advice and that it complies with best practice and any specific local requirements. Nutrition International recognizes that it is the shared responsibility of all adults to do what they can to prevent child abuse in all its forms.

This policy sets out our values, principles, and beliefs and describes the steps we will take to meet our commitment to safeguarding children.

DEFINITION OF A CHILD

The United Nations Convention on the Rights of the Child defines a child as “any human being under the age of eighteen, unless the age of majority is attained earlier under national legislation.” This means every human being under the age of 18 unless under the law applicable to the child, the threshold of adulthood is declared earlier.

Canada became a signatory to the Convention on May 28, 1990, and ratified in 1991.

For the purposes of this policy, Nutrition International considers a child to be a person under the age of 18 years.

The term “young person/people” is also used in this policy, in conjunction with the term “child”.

VALUES AND PRINCIPLES THAT INFORM THE POLICY

- **Children's welfare:** The best interests of the child are paramount.
- **Equity:** All children and young people have a right to be protected from abuse regardless of age, gender, disability, culture, economic status, language, racial origin, religious beliefs or sexual orientation.
- **Children's rights:** Children have the right to happy and healthy development without fear of harm or exploitation. Children also have the right to be heard and to be involved and consulted in matters that concern them.
- **Families and communities:** Measures that support parents, teachers, health workers and other members in the local community to provide children with care, love, and respect is the best way to contribute to their health, development, and safety.
- **Local and national authorities:** Local and national authorities have the primary responsibility to put in place structures to prevent, protect and take care of the recovery of abused children.



SCOPE OF THIS POLICY

This policy applies to all Nutrition International staff, including all implementing partners, Board members, contractors, visitors and volunteers involved in the work of Nutrition International.

WHAT WE WILL DO

Raise awareness amongst all staff and implementing partners

All Nutrition International staff and partners have a duty to safeguard children they come into contact with through the course of their work. This will be achieved by:

Training for staff: Nutrition International will provide staff with the appropriate level of training and/or learning opportunities to recognize, identify and respond to signs of abuse, neglect, and other child safeguarding concerns encountered in our programs. Nutrition International will also ensure that all staff understand their roles and responsibilities with respect to child safeguarding and what they should and shouldn't do when working with or around children.

Awareness raising for partners: Nutrition International will build the awareness of partner organizations so that they understand their responsibilities according to this policy and in order to minimize the risk Nutrition International's programs pose to children's safety.

Minimize the risk our programs pose to children

Nutrition International is committed to the promotion of a protective environment for children we work with and will seek to prevent violence, abuse, and exploitation of children. This will be done through:

Leadership: Nutrition International's Executive Management Committee will ensure appropriate child safeguarding skills, oversight, and accountability are built into the roles and responsibilities of nominated staff at different levels.

Open communication: Nutrition International will encourage open discussion of child safeguarding issues within teams and programs.

Situation analysis: Nutrition International will assess each program to identify situations that might put children at risk and develop mitigation strategies.

Children's participation: One of the best ways to safeguard children is to empower them to protect themselves. Age-appropriate mechanisms will be in place to ensure children's opinions are sought, their voice is heard and that they are treated with dignity and respect.

Safe recruitment: Nutrition International reserves the right not to employ any personnel that poses a risk to the safety of children and will take active measures to prevent this from happening.

Considered use of public communications: Nutrition International will put in place measures to ensure its public presence (electronic and in print) does not inadvertently put children at risk through the unintended use of digital images or of other communications material.

Put in place a reporting mechanism and ensure appropriate follow-up

Nutrition International will ensure that incidents or concerns of child abuse are reported internally and passed to the relevant agency or authority as appropriate. In addition, Nutrition International commits to:

Timely reporting and response: All suspicions and allegations of abuse will be taken seriously and responded to swiftly and appropriately, including formal reporting to official authorities when appropriate. Support will be provided to children who are the subject of reports.

Accurate and confidential records: Confidential, detailed and accurate records of all child safeguarding concerns will be maintained and securely stored.



Complaints mechanism: A complaints mechanism will be set up for staff or partners to make confidential reports.

Protection for whistleblowers: Provisions to support the welfare of the individual(s) who raise or disclose concern(s) will be put in place.

POOR PRACTICE

Nutrition International takes poor practice seriously and deems it unacceptable.

Examples of poor practice include – but are not limited to:

- When insufficient care is taken to prevent harm;
- Allowing abusive or concerning practices to go unreported;
- Placing children or young people in potentially compromising and uncomfortable situations with adults, including the inappropriate use of technology/social media;
- Ignoring health and safety guidelines;
- Failing to adhere to Nutrition International policies for staff conduct at work;
- Knowingly make false claims related to this policy against another staff member.

The judgment about whether an incident is one of child abuse or poor practice may not be able to be made at the point of reporting but will be made after an investigation and the collection of relevant information. All poor practice concerns will be dealt with initially by the Country Director, Regional Director, and the regional and global child safeguarding focal points.

All reported cases of poor practice in relation to this policy will be dealt with according to Nutrition International's disciplinary processes.

COMPLIANCE

Non-compliance with the child safeguarding policy will lead to disciplinary proceedings, with sanctions including suspension or termination of arrangements.

The Executive Committee will be notified of all reported incidents.



Nutrition International Global Child Safeguarding Policy Attachment 1: Relevant laws and endorsements

Canadian federal, provincial and territorial laws protecting children from abuse, violence and harm and those outlining measures for reporting known or alleged cases of abuse.

Applicable laws in the countries where Nutrition International operates programs, services and/or delegations.

The United Nations Convention on the Rights of the Child (UNCRC) and other applicable international treaties, laws and conventions.

Nutrition International is committed to ensuring children's right to protection, in line with UNCRC.

The following articles are particularly significant:

Article 19 – Protection from all forms of violence

Article 32 – Child labour

Article 33 – Drug abuse

Article 34 – Sexual exploitation

Article 35 – Abduction, sale and trafficking

Article 36 – Other forms of exploitation

Article 39 – Rehabilitation of child victims

Further information at https://www.unicef.org/crc/files/Rights_overview.pdf

Additionally, the Government of Canada endorses a number of international efforts to protect children from sexual exploitation, including:

- Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography that requires countries to undertake measures to prevent all forms of sexual exploitation of children;
- G8 Strategy to Protect Children from Sexual Exploitation on the Internet;
- International Labour Organization's Convention concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour; and
- Council of Europe Convention on Cybercrime.

Nutrition International Global Child Safeguarding Policy Attachment 2: Definitions of abuse

Child abuse includes physical, emotional and sexual abuse, child labor and/or neglect. It also addresses a pattern of abuse and risks of harm.

Physical abuse is any deliberate physical force or action, by a parent or caregiver, which results, or could result, in injury to a child. It can include bruising, cutting, punching, slapping, beating, shaking, burning, biting or throwing a child. Using belts, sticks or other objects to punish a child can cause serious harm, and is also considered abuse.

Neglect occurs when a caregiver fails to provide basic needs such as adequate food, sleep, safety, education, clothing or medical treatment. It also includes leaving a child alone or failing to provide adequate supervision. If the caregiver is unable to provide the child with basic needs due to financial inability, it is not considered neglect, unless relief has been offered and refused.



Emotional abuse is a pattern of behavior that attacks a child's emotional development and sense of self-worth. It includes excessive, aggressive or unreasonable demands that place expectations on a child beyond his or her capacity. Emotional abuse includes constantly criticizing, teasing, belittling, insulting, rejecting, ignoring or isolating the child. It may also include exposure to domestic violence.

Sexual abuse occurs when a child is used for the sexual gratification of an adult or an older child. The child may cooperate because he or she wants to please the adult, or out of fear. It includes sexual intercourse, exposing a child's private areas, indecent telephone calls, fondling for sexual purposes, watching a child undress for sexual pleasure, and allowing/forcing a child to look at or perform in pornographic pictures (child pornography) or videos, or engage in prostitution.

Child labor is often defined as work that deprives children of their childhood, their potential, and their dignity, and that is harmful to physical and mental development.

It refers to work that:

- Is mentally, physically, socially or morally dangerous and harmful to children; and
- Interferes with their schooling by:
 - Depriving them of the opportunity to attend school;
 - Obliging them to leave school prematurely; or
 - Requiring them to attempt to combine school attendance with excessively long and strenuous work.

Definitions used are taken from the Ontario Association of Children's Aid Societies (OACAS) www.oacas.org and from the International Labour Organization (ILO) <http://www.ilo.org/>.



www.NutritionIntl.org