Statement of Work (SOW) for Baseline of the Community Action on Zika (CAZ)

(Version 2 – February 17, 2017)

1. Description of Program

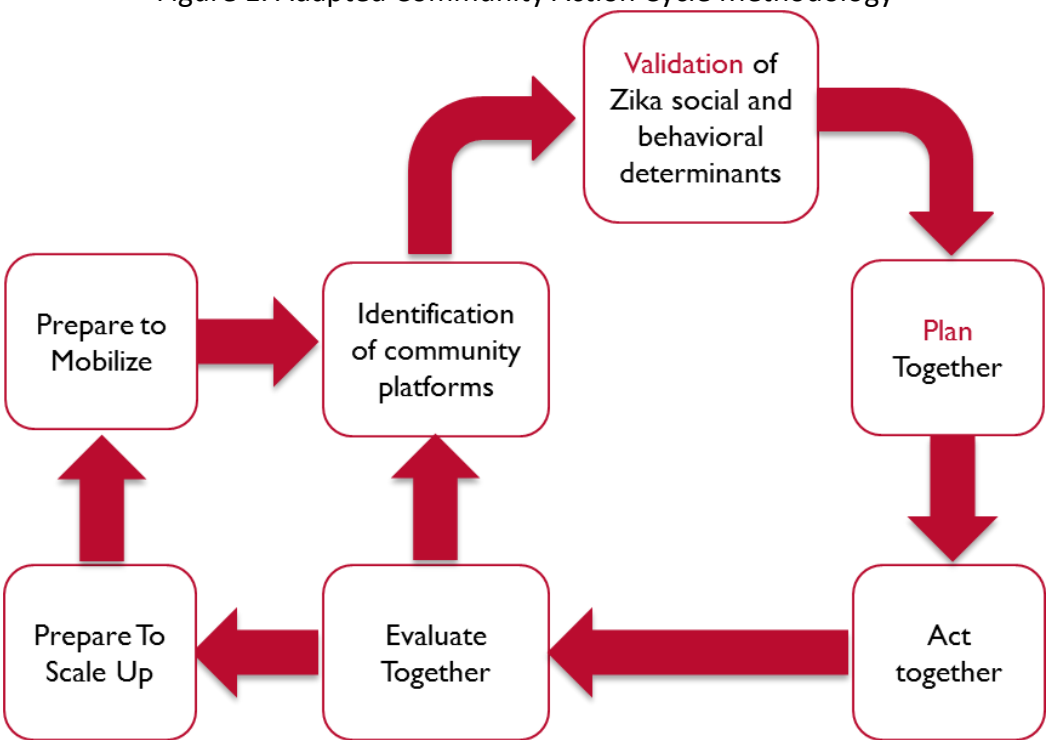
The goal of the Community Action on Zika (CAZ) project is to reduce Zika transmission and minimize the risk of Zika-related microcephaly and other neurological disorders among the most vulnerable through community-based prevention strategies in Colombia, the Dominican Republic, El Salvador, Honduras, and Nicaragua.

The CAZ will include a regional coordination component, and interventions in 42 departments and provinces of the five countries. Within each country the project will work in the highest risk areas: departments and municipalities with high population density, poverty, environmental suitability for Aedes, mosquito density, and/or recent outbreaks of Zika, Dengue, and/or Chikungunya, and will cover the majority of the high-risk departments or provinces in all CAZ countries other than Honduras, where others are covering much of the country with similar activities. The project will reach over 13 million people with vector control measures and communications interventions, while other interventions will reach more targeted populations.

CAZ will work with community-based organizations, central and local governments, and other stakeholders to reduce mosquito breeding sites and strengthen communities´ and individuals´ ability to protect themselves during the current outbreak and in the future.

CAZ will develop an integrated risk communication, community action and community-based surveillance model in order to prevent and manage Zika cases. This model will include a behavior change strategy grounded in the following pillars and implemented through Community Mobilization using the adapted Community Action Cycle (CAC) methodology. The CAC serves to organize and encourage community participation toward a common objective, summarized in Figure 1.

Figure 1. Adapted Community Action Cycle Methodology



At the school level, a School Mobilization Team (SMT) will be formed consisting of district/municipal level professors with some guidance from the respective community. They will be trained in the CAC and work with schools in their districts/municipalities to develop existing, or form new School Core Groups/Sanitation Teams/School committees. The School Core Groups will include professors, students, parents, and other relevant stakeholders. Training workshops and an action plan will be developed in each school. The SMT will implement the action plan. The majority of schools will be based in communities where the CAC is being implemented, therefore the activities in schools will be planned accordingly to complement and supplement community activities.

At the community level, Community Mobilization Teams (CMT) will be formed consisting of SC and IFRC staff and district/municipal level volunteers and stakeholders from various sectors.

The CMT and SMT will be trained in the CAC, and work with their communities to develop Core Group teams to include community individuals and community organization members. The School and Community Core Groups will develop community action plans to empower communities to lead vector control, sanitation and Zika prevention activities.

The CAC will also strengthen communities capacity through leadership and mentorship by the Core Group. They will be able to harness the power of group dynamics by creating collective action to advocate for change, receive guidance from the CMT on resource mobilization,

combining resources, enhancing individual skills by the combined sharing of skills. Through these activities, the Core Group will work with the communities to lead them to achieve the objectives laid out in the CAZ.

Social behavior change communication will be grounded in the Strategic Communication Guide for the Prevention of Zika developed by the Health Communication Capacity Collaborative (HC3, Johns Hopkins Center for Communication Programs, Nov 2016). Table 1 summarizes the audiences, approaches and messages that will be considered during Year 1 of implementation.

Table 1. CAZ Audiences, Approaches and Messaging

Audiences	Communication Approaches
Pregnant & Women of Reproductive Age Adolescents Couples Health workers Community organizations Community volunteers National and departmental authorities Municipal governments Universities	Advocacy Counseling Peer communication Mass media Community-based participatory approach Printed media E-learning Digital media (including U-report)
Key Messages	
Zika risk communication, including microcephaly and other neurological disorders	
Zika Prevention, vector control and protection measures	
Messaging on family planning access and methods: Pregnant women and those planning to get pregnant should protect themselves from unprotected sexual contact with partners who may be infected with Zika virus Women who voluntarily want to avoid or delay pregnancy should be informed about use of effective contraception. If contraception fails, immediately seek emergency contraception as soon as possible from a healthcare provider or pharmacy. All men living in Zika outbreak areas should consider using condoms for sexual intercourse to avoid the risk of sexual transmission of the virus	
Adolescent sexual and reproductive health messaging: Zika prevention, personal protection measures by avoiding mosquito bites and preventing sexual transmission, promotion of the use of sexual and reproductive health services, use of condoms to avoid unintended pregnancy, prevent sexual transmission of Zika.	
Care and support for affected children: reinforce messages seeking care in health service providers.	
Psychosocial support to families with children affected by Zika, Stigma management	

Community intervention with the CAC methodology will train community volunteers from Save the Children and the Red Cross to participate in social mobilization for breeding mapping, breeding monitoring, ovitrap surveillance, protection of water storage tanks, home visits, IEC to

prevent Zika, community cleaning campaigns, protection of vector bites, use of condoms during pregnancy, among others. There is evidence to show the impact of this intervention model on dengue control.[1] [2]. Community vector control will be mandatorily linked to the efforts of national and local health authorities.

In each community, the community committees will be strengthened, which will develop the community plan that will include actions to monitor breeding and vector control.

Community surveillance will focus on: a) vector surveillance; b) case surveillance; and c) the mapping of sexual and reproductive health services for pregnant women and adolescents.

The surveillance component of the project will implement small-scale pilot projects to test strategies and techniques for community participation in vector surveillance and control, including the use of ovitraps for community surveillance of the vector. These pilots will be coordinated with the Ministry of Health, PAHO and ZAP to ensure that community surveillance will be complementary to the efforts of the Ministry of Health and PAHO and ZAP actions in selected locations.

CAZ will also broaden a community monitoring protocol developed by IFRC used to respond to diseases transmitted by Aedes Aegypti, which includes an online tool that captures data through mobile devices (ODK). CAZ will strengthen community volunteer networks, improving their ability to detect possible Zika cases and support health service referrals. To complement referrals, CAZ will also monitor the provision of health services, mapping the availability of and access to contraceptive methods.

Geographic Focus Areas

Department, province, and municipality selection will be reviewed at CAZ start-up with key stakeholders, including the MOH, local government, USAID, UNICEF, PAHO, and other stakeholders working on Zika response, to maximize geographic coverage of high risk populations and to minimize duplication of activities. Table 2 outlines the breakdown proposed by country.

[1] Andersson et al. (2015). Evidence based community mobilization for dengue prevention in Nicaragua and Mexico (Camino Verde, the Green Way): cluster randomized controlled trial. *BMJ* 2015;351:h3267 doi: 10.1136/bmj.h3267

[2] Al-Muhandis N, Hunter PR. The value of educational messages embedded in a community-based approach to combat dengue fever: a systematic review and meta-regression analysis. *PLoS Negl Trop Dis* 2011;5:e1278.

Table 2. CAZ Departments and Municipalities

Country	Departments/ Provinces	Municipalities
Colombia	Valle del Cauca	Cali, Cartago, Palmira
	Santander	Bucaramanga, Barrancabermeja, Floridablanca
	Tolima	Ibague, Espinal, Flandes
	Atlántico	Barranquilla, Soledad, Puerto Colombia
	Meta	Villavicencio, Acacias, Granada
	Antioquia	Medellín, Turbo, Apartado, Carepa, Caucasia, Chigorodó
	Magdalena	Sta Marta, Cienaga, Fundacion
	Cesar	Valledupar, Aguachica, Curumani
	Risaralda	Pereira, La Virginia, Dos Quebradas
	Cordoba	Monteria, Momil, Lorica, Montelibano
Dominican Republic	Distrito Nacional	Man Guayabo, Gualey, Guaricano
	Santa Domingo	S. Domingo Este, S. Domingo Oeste, S.
	Santiago	Santiago de C, Puñal, V. Gonzalez,
	Puerto Plata	Puerto Plata, Alta Mira, Imbert, Los Hidalgos, Luperon, Sosua, Villa Hermosa
	La Vega	La Vega, Constanza, Jarabaco, Jima Abajo
	La Altragracia	Higuey, San Rafael del Yuma
	Azua	Sabana Yegua, Pueblo Viejo, Azua de Compostela
	San Cristobal	Bajos de H, Cambita G, S.Gregorio N
	La Romana	La Romano, Guaimate, Villa Hermosa
El Salvador	San Salvador	San Marcos, Ciudad Delgado
	San Miguel	San Miguel, San Rafael Oriente, San Jorge, Chinameca, El Tránsito, Lolotique, Ciudad Barrios, Moncagua
	Usulután	Jiquilisco, Puerto El Triunfo, San Dionisio
	Cabañas	Ilobasco, Guacotecti, Tejutepeque
	La Paz	San Pedro Masahuat, San Luis La Herradura, San Luis Talpa, Olocuilta, Santiago Nonualco
	Ahuachapán	San Francisco Menendez, Jujutla, Guaymango, Tacuba
	Sonsonate	Nahuizalco, Izalco, Sta. Isabel Ishuatán, Cuisnahuat, Sonzacate
	La Libertad	Quezaltepeque, Nueva Sal Salvador
	San Vicente	San Vicente
Honduras	Paraíso	Danlí, El Paraíso, Jacaelapa
	Valle	San Lorenzo, Nacaome, Langue
	Olancho	Juticalpa, Catacamas
	Choluteca	Choluteca, Pespire
	Francisco Morazán	Distrito Central
	Cortés	Omoa, Pimienta, Potrerillos, Puerto Cortes, ~~San Francisco~~, San Manuel, Villanueva
Nicaragua	Matagalpa	San Isidro, Sébaco, Ciudad Darío, Matagalpa, Tuma La Dalia, Matiguas, Rio Blanco
	Jinotega	Wiwili, El Cua, Santa Maria de Pantasma, Jinotega
	Leon	Leon, Telica, Larreynaga, El Sauce, Achuapa, Santa Rosa del Peñon, El Jicaral, La Paz Centro
	Rivas	Rivas, Altagracia, Moyogalpa
	Masaya	Masaya
	Granada	Granada

Country	Departments/ Provinces	Municipalities
	Madriz	Somoto
	Chinandega	Chinandega

The selection of areas of intervention has followed the criteria of Zika incidence, other diseases transmitted by the same vector, and populated areas of high susceptibility to the vector. The selection of municipalities and communities was carried out in coordination with the health authorities.

CAZ in phase I

CAZ started in October 2016 and has an extension of 3 years.

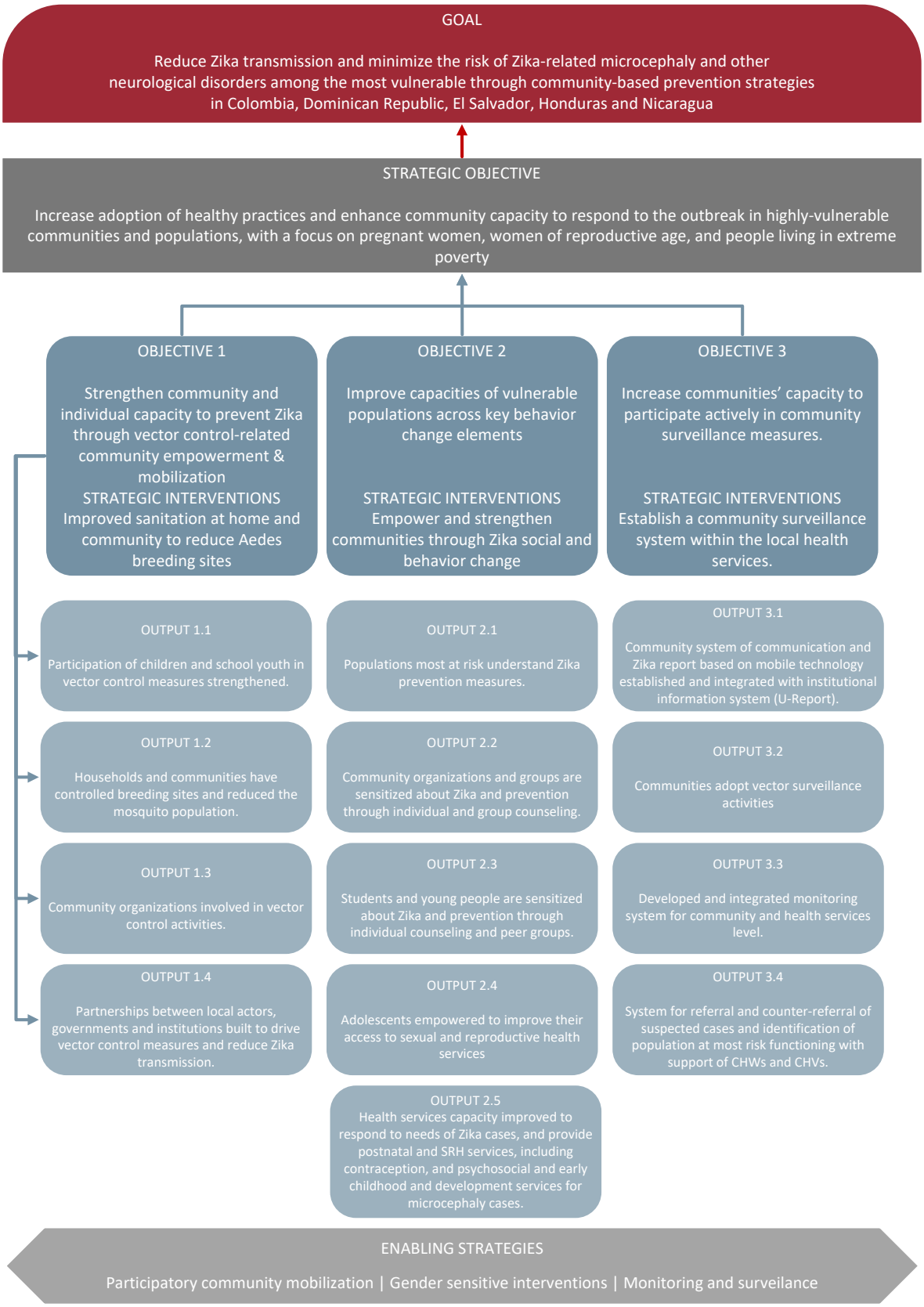
During Phase I of the project over the coming year, CAZ will work closely with MOH and local governments to expand community-based Zika prevention. The project activities will be integrated into existing sanitation, vector control, health, and education efforts. Leveraging extensive relationships with key national and local stakeholders will allow for rapid mobilization of activities. Existing networks of community organizations, including women´s organizations, water and development committees, municipal sanitation departments, schools, and Red Cross volunteer networks will be mobilized to scale up Zika prevention efforts. During project start up, sensitization sessions with stakeholders are taking place, starting with sensitization workshops at the national level, to be followed by department and municipal levels. Scale up in Phase I will be through the gradual inclusion of municipalities of each department.

2. Results framework

Strategic Objective (SO) of CAZ: to increase adoption of healthy practices and enhance community capacity to respond to the outbreak in highly-vulnerable communities and populations, with a focus on pregnant women, women of reproductive age, and people living in extreme poverty. CAZ will achieve this SO through the following three objectives:

- Objective 1: Strengthen communities' and individuals' capacity to prevent Zika through community empowerment and mobilization related to vector control. (By using the evidence-based Community Action Cycle, community individuals, groups, and organizations will plan, carry out, and evaluate activities on a participatory and sustained basis).
- Objective 2: Improve capacities of vulnerable populations across key behavior change elements: increased knowledge and community dialogue; essential attitude changes; demand for information and services; reduced stigma and discrimination; changes in key behaviors related to personal protection from Zika; and care and support of affected infants, children, and their families.
- Objective 3: Increase communities´ capacity to participate actively in community surveillance measures.

Results Framework



Performance Indicators and Targets

Indicator	Description	Type	Data Source	Frequency	End of Project Target	Baseline	Comment
Goal: Reduce Zika transmission and minimize the risk of Zika-related microcephaly and other neurological disorders among the most vulnerable through community-based prevention strategies in Colombia, Dominican Republic, El Salvador, Honduras, and Nicaragua.							
Strategic Objective: Increase adoption of healthy practices and enhance community capacity to respond to the outbreak in highly-vulnerable communities and populations, with a focus on pregnant women, women of reproductive age, and people living in extreme poverty.							
1. % of women of reproductive age who report applying key Zika protective practices	Numerator: number of reproductive age women from the project participant communities interviewed who accurately describe applying Zika protective practices according to the definition Denominator: number of reproductive age women interviewed	Impact	Household survey	Baseline and endline	70% at the end of the project	TBD	"Protective practices" include avoiding unplanned pregnancy and condom use during pregnancy
2. % of communities that show capacity for surveillance, prevention and control of Zika virus disease and care and support of affected infants	Numerator: number of communities reporting capacity for surveillance, prevention and control of Zika virus disease and care and support of affected infants according to the parameters defined by the project on "community capacity" Denominator: number of communities that were programmed in the work plan	Impact	Project registers and interviews with key stakeholders, and reports that demonstrate community capacity	Yearly	80%	TBD	
2a. % of communities that show capacity for surveillance of Zika virus disease and vector	Numerator: number of communities reporting capacity for surveillance of Zika virus disease and vector according to the parameters defined by the project on "community capacity" Denominator: number of communities that were programmed in the work plan	output	Project registers and interviews with key stakeholders, and reports that demonstrate community capacity	Quarterly	At least 20% more each quarterly	TBD	

Indicator	Description	Type	Data Source	Frequency	End of Project Target	Baseline	Comment
2b. % of communities that show capacity for prevention and control of Zika virus disease	Numerator: number of communities reporting capacity for prevention and control of Zika virus disease according to the parameters defined by the project on "community capacity" Denominator: number of communities that were programmed in the work plan	Output	Project registers and interviews with key stakeholders, and reports that demonstrate community capacity	Quarterly	At least 20% more each quarterly	TBD	
2c. % of communities that show capacity for care and support of affected infants	Numerator: number of communities reporting capacity for care and support of affected infants according to the parameters defined by the project on "community capacity" Denominator: number of communities that were programmed in the work plan	Output	Project registers and interviews with key stakeholders, and reports that demonstrate community capacity	Quarterly	At least 20% more each quarterly	TBD	
Objective 1: Strengthen communities' and individuals' capacity to prevent Zika through community empowerment and mobilization related to vector control.							
3. % and number of communities engaged in vector control activities	Numerator: number of communities that show engagement on vector control, according to the project definition for community engagement Denominator: number of communities that were programmed in the work plan	Outcome	Regular monitoring system	Quarterly	80% at the end of year 1	TBD	
4. % and number of schools which have implemented breeding site elimination campaigns with participation from school children	Numerator: number of schools which have implemented breeding site elimination campaigns with participation from school children Denominator: number of communities that were programmed in the work plan	Output	Regular monitoring system	Quarterly	80% at the end of year 1	TBD	UNICEF indicator
5. % and number of communities which have implemented breeding	Numerator: number of communities with breeding site elimination campaigns implemented Denominator: number of communities that were programmed in the work plan	Output	Regular monitoring system	Quarterly	80% at the end of year 1	TBD	

Indicator	Description	Type	Data Source	Frequency	End of Project Target	Baseline	Comment
site elimination campaigns							
6. Number of volunteers trained in community-based vector control	Number of target community volunteers who have completed vector control training	Process	Regular monitoring system	Monthly	1000 at the end of year 1	TBD	
7. Number of students informed about Zika prevention and control	Number of students recorded in the system who have been informed about Zika prevention and control	Process	Regular monitoring system	Monthly	2,000 at the end of year 1	TBD	
8. Number of communities with community plans for the prevention and control of Zika	Number of communities that are able to show their plans for Zika prevention and control	Output	Regular monitoring system	Monthly	700 at the end of year 1	TBD	
9. Number of community members participating in clean-up campaigns	Number of community members recorded in the system who have participated in cleanup campaigns, from all project participant communities	Process	Regular monitoring system	Monthly	Active participati-on of community members in each campaign	TBD	
Objective 2: Improve capacities of vulnerable populations across key behavior change elements: increased knowledge and community dialogue; essential attitude changes; demand for information and services; reduced stigma and discrimination; changes in key behaviors related to personal protection from Zika; and care and support of affected infants, children, and their families.							
10. % of women of reproductive age who report implementing personal preventive measures to avoid Zika virus infection	Numerator: number of reproductive age women from project participant communities interviewed who report personal preventive measures to avoid Zika virus infection Denominator: number all reproductive age women interviewed	Outcome	Household survey	Baseline, and endline	70% at the end of the project	TBD	
11. Number of target population provided with ZIKV key risk	Number of target population including: women of reproductive age, community members, community volunteers, children, youth, school	Process	Regular monitoring system	Monthly	TBD after the communic-	TBD	Adapted from

Indicator	Description	Type	Data Source	Frequency	End of Project Target	Baseline	Comment
communication messages.	teachers, recorded in the system who have been provided with ZIKV communication messages				ations plan has been developed		UNICEF indicator
12. % women of reproductive age who recognize Zika risk, prevention, and transmission	Numerator: number of reproductive age women from project participant communities interviewed who recognize Zika risk, prevention and transmission Denominator: number all reproductive age women interviewed	Output	Household survey	Baseline and endline	70% at the end of the project	TBD	
13. Number of pregnant women informed on Zika	Number of pregnant women recorded in the system informed on Zika	Process	Regular monitoring system	Monthly	All pregnant women detected by the CAZ project	TBD	
14. % and number of communities with a Zika risk communication strategy &/or implementation plan	Numerator: number of communities with ZKV risk communication strategy or implementation plan in place Denominator: number of communities that were programmed in the work plan	Output & process	Regular monitoring system	Quarterly	80%	TBD	Adapted from WHO/ UNICEF indicator
15. Number of children and adolescents participating as agents of social mobilization at community level	Number of children and adolescents who participate as social mobilization agents, and their participation is recorded	Process	Regular monitoring system	Monthly	Students actively involved in selected schools	TBD	

3. Baseline of CAZ: Purpose and objectives

Caz will have a performance evaluation that will take into account its relevance, effectiveness, efficiency and sustainability. Changes in the families, schools and communities will be evaluated by comparing indicators from before (year 2017) and after (year 2019) the project to assess the progress made in order to achieve the specific objectives of the result framework in El Salvador, Honduras, Nicaragua, Dominican Republic and Colombia. Baseline data will be collected during the first six months of the project and the endline will occur during the last six months before the project comes to end.

The baseline objectives are:

1. Measure:
    a. The basal situation of the indicators in the result framework both in families and communities from Colombia, El Salvador, Honduras, Nicaragua and Dominican Republic.
    b. The knowledge, attitudes and family practices at the beginning of the project abot the prevention, protection, control, attention and care of the Zika virus in the participating countries
    c. The basal level of participation and the communities' capacity

2. Analyze factors in context that could favor or limit the accomplishments of the project results.

The primary audiences for the evaluation are USAID and each of its offices in every country, Save the Children, IFRC and the authorities of the ministries of health and education. The most important results will be shared with partners including UNICEF, PAHO and USAID's partners.

Evaluation reports will be used for the development of success stories, lessons learned and best practices and will be reported to USAID, government authorities, other partners and communities.

4. Evaluation Questions

The following are key evaluation questions for the baseline:

KAP survey

1. Do families have the expected knowledge for prevention and care for Zika cases?
Specific questions:

- What is Zika?
- How is it transmitted?
- What are its symptoms?
- What is the difference between Dengue and Chikungunya?
- What are you supposed to do to prevent it and protect yourself? (individual, home and community level)
- What to do and where do you go if you present the symptoms?
- What are the consequences in the development of boys and girls (possible microcephaly and congenital anomalies)?
- What are the rights of very boy and girl in development?
- What risks and consequences bring Zika during pregnancy?
- What are ways of prevention? (emphasis on personal protection as in the use of a condom to avoid transmission and unwanted pregnancies)
- Which mosquito transmits the Zika virus?
- Are you aware of where are located the breeding grounds of this mosquito and how to avoid it from reproducing?

2. Do families have the expected attitudes for prevention and care for Zika cases?
Specific questions:

- Are you motivated to adopt the necessary measures for personal protection and avoid getting Zika?
- Are you willing to comply the recommendations for protection and even when you are sick in order to avoid spreading it?
- Are you willing to share this information with your peers and other family members and community since it is relevant?
- Do you value the right of boys and girls to enjoy a full development?
- Are you willing to engage in cleaning activities at home and in the community to eliminate breeding grounds?
- Are you willing to participate as a volunteer to aid the community to prevent, care and support for Zika cases?
- Are you willing to help organize community meetings to plan educational activities to promote prevention and care for Zika cases?
- Are you willing to lend your house in order to witness the vector?
- Are you willing to report suspicious cases of Zika or of newborn babies with congenital anomalies?
- Are you willing to let the health services account about the availability of contraceptive methods?
- Are you willing to use contraceptive methods to prevent pregnancies during Zika outbreaks?
- Do you agree with the use of condoms during Zika outbreaks?
- Are you willing to clean and correctly protect water reservoirs in your home?

- Are you willing to let in your house the Ministry of Health every time it performs an evaluation of breeding grounds?
- Are you willing to allow the use of larvicides in your home that the Ministry of Health uses for water reservoirs?
- What is your perception about the risk of falling ill of Zika?
- Do you sense that Zika is dangerous during pregnancy?
- Do you believe it is dangerous to get pregnant during Zika outbreaks?
- Do you think it is necessary the use of a condom to avoid unwanted pregnancies and avoid the contagion of Zika?
- If you had Zika, would you protect yourself from vector sting in order to protect others?
- Are you willing to eliminate mosquito breeding grounds permanently?
- Would you allow a glass of water in your house for the surveillance of the vector?

3. Do families have the necessary practice for the prevention and care of Zika cases?
Specific questions:

- Are you taking measures to protect yourself from mosquito bites to prevent Zika; the use of repellent, clothing that cover arms and legs and metallic nets in doors and windows?
- Are you taking measures to prevent unwanted pregnancies; the use of condoms and abstaining from having sexual relations?
- Are pregnant women taking measures for personal protection against mosquito bites?
- Have you taken the measures to prevent and eliminate breeding grounds inside and outside your home?
- Have you looked for information about Zika, the ways to prevent and avoid consequences?
- Do you share information with your family and peers?
- Do you go to health establishments for information or attention?
- Do you participate in cleaning activities and elimination of breeding grounds?
- Do you participate in the elaboration of the community health plan to fight Zika?
- Do you participate in the trainings of family planning?
- Do you use contraceptive methods?
- Do you allow health personnel to enter your house to evaluate the presence of breeding grounds?
- Do you allow the use of larvicides in your home?
- Has someone on your family has shown signs of Zika and has that person received attention?
- Are there pregnant women who receive home visits from community volunteers or health personnel?
- Do these pregnant women receive prenatal control?
- Will these pregnant women give birth in the health services?
- Does the newborn baby receive its controls in the health services?
- Are you seeking for information on how to protect or postpone a pregnancy?
- Do you follow the recommendations of protection against the vector´s sting?
- Do you implement actions to avoid pregnancy and prevent the contagion of Zika?

4. Qualitative study

General Questions:

- What are the main issues on health in your community?
- Is the community organized? Does it have representatives rightfully recognized by the community?
- Do you sense solidarity in the community?
- Do you believe social organization will solve your own problems?
- Does unity and harmony exist in your community?
- Does violence or danger exist in your community?
- What is needed for an external agent who offers aid be received in your community?
- Is the Red Cross known in your community?
- Is Save the Children known in your community?
- Who are the leaders in your community?

Knowledge:

- Where or from who you first heard about Zika?
- When did you hear for the first time about Zika?
- In your opinion, how can a person contract Zika?
- Do you think that Zika can be sexually transmitted?
- What group of people is more likely to contract Zika?
- What are the signs and symptoms Zika produce?
- Have you heard about the risks associated with Zika?
- In your opinion, does everybody with Zika present symptoms?

Risks:

- If a pregnant woman contracts Zika, what are the risks for her and the baby?

Behavioral Change:

- What are the factors that favor a change in behavior to prevent Zika?
- What are the factors that limit a change in behavior to prevent Zika?
- Are there any examples of change in behavior in your community? What promoted it?

Seeking medical attention: barriers

- What type of difficulties do pregnant women suffer when they try seeking for medical attention or family planning? What suggestions do you give?

Behavior for medical attention

- If somebody contacts Zika in your community, what do you do for treatment?

Prevention:

- What do you do in your community to protect you and your family form Zika?
- Why is it important to protect you and your baby form the Zika virus?

Psychosocial help

- If a woman in your community has a baby with microcephaly or other disability, are they discriminated because of it? Why do you think this happens?
- What type of psychosocial support are you receiving or received recently? What kind of activities did it include?

Communication

- What are the main sources of information/communication regarding prevention of Zika for pregnant women in your community?
- What ways of communication you find more effective? Why?
- What are the main questions, doubts or fears surround Zika that you and your family members have?

Rumors, doubts

- What are the main questions, doubts or fears that you, as a pregnant woman, have?

Community engagement

- Why do you think your role in the community to prevent Zika is so important?
- What are the factors that favor the participation as a community to face a Zika epidemic?
- What are the factors that limit the participation as a community to face a Zika epidemic?
- Is participation in rural areas the same as in urban ones?
- What characteristics and incentives have the participation in urban areas?
- What characteristics and incentives have the participation in rural areas?
- What motivates to become a volunteer in the community?
- What are the most important incentives for the health volunteers?
- Since when are they volunteers?
- What actions are important in the community to prevent and control Zika?
- Is Zika an issue that need community participation?

EVALUATION DESIGN AND METHODOLOGY

The CAZ project will conduct a baseline measurement at the beginning of the project and another survey at the end of the project to report on achievements against project objectives (Table 3). The population baseline survey will measure knowledge, attitudes, and practices (KAP) in families. Interviews of key actors and review of documents will also be conducted to measure other community indicators.

The results from the baseline will provide information to revise indicator targets, and confirm or indicate needs for adapting the project strategies and approaches. Baseline data will be collected during the first 6 months of the project and the endline will occur during the last 6 months before the project ends.

The objective of the evaluation´s first moment is to have a baseline, while the intervention is just starting. The objective of this baseline is to measure specific indicators of process, products and outcomes in the selected areas of Colombia, Honduras, Dominican Republic, Nicaragua and El Salvador. CAZ and USAID shall use the baseline reporting to adjust the Project's approach, methodologies and activities to achieve its objectives.

The objective of the second moment of the evaluation is to compare the indicators measured at the baseline and those that will be measured at the end of the project, three years after the start of the CAZ project. This comparison will measure changes in indicators (process, outputs and outcomes) and determine the achievements of the CAZ.

For the baseline measurement stated above, it will take into consideration the knowledge, attitudes and practices (KAP) in each family about prevention, protection, control, attention and care for people during a Zika outbreak; also bearing in mind the capacity and level of participation of communities to face the Zika epidemic.

Quantitative and qualitative methods will be used. The KAP will be evaluated by home surveys; the capacity and participation by Interviews of key actors and the review of documents from the five participating countries.

The regional team will design the assessment and data collection instruments for the five countries and will hire experts for the design, conduct of the field work of data collection and reporting. Data collection will be carried out by the national project team and the volunteer network of the chosen communities.

Table 3: Evaluation moments and approaches

	Pre-enumeration	Enumeration	Post-enumeration	Data Use
Basal (Year 2017)	Complete the design; collect background documents; design sample, develop data collection instruments, pilot-test tools. Techniques: KAP household survey and in-depth interviews with key informants	Collect data; review data for quality control	Data entry; descriptive data analysis; draft report; review final report	USAID reporting; project design; target setting; inform governments authorities and communities
Final (Year 2019)	Update background documents; add questions related to the intervention and factors that favored or limited the implementation of activities or the achievement of results; Techniques: KAP household survey and in-depth interviews with key informants	Collect data; review data for quality control	Data entry: data analysis; evaluation of changes and attribution; draft report; review final report	USAID reporting; subject-based briefs for decision makers: international and national; lessons learned, best practices and success stories

KAP survey

The surveys that will measure KAP for Zika will be based on questionnaires developed by UNICEF and WHO. UNICEF and WHO have established proposed knowledge, attitudes and practices for the prevention and care of people affected by Zika. UNICEF has also developed indicators to measure them.

The questionnaire will measure the baseline study questions that are set out in this SOW. The questionnaire will then be reviewed and validated in each country and adjusted to the cultural context if necessary.

The evaluation will apply the technique Lot quality Assurance Sampling (LQAs). For this purpose a sample design will be applied using the community maps of each selected area. The selection of households will be done by random sampling.

LQAS[3] [4] [5] is a rigorous statistical model that allows to monitor and measure the quality of the interventions developed in target communities by a random selection of cases/observations to interview/assess. This statistical method is very useful for decision making process evidence based, allowing to continuously improve the interventions in the target areas of a project. LQAS allows the decentralization of the data collection, working directly with the supervisors of the selected areas, which means lower cost of implementation compared to cluster sampling method.

For the CAZ project the LQAS method will be applied to measure the quality of interventions and the behavioral changes achieved in the target communities of the 5 countries, and will give reliable data about the project performance to develop working plans to address the challenges in order to identify the actions to reach the quality standards defined.

The LQAS technique is based on a binomial model, and is useful for indicators that measure the fulfillment of a condition or target in each area of supervision.

LQAS is applicable to the systematic, repeated and planned monitoring of quality indicators to control if the program's performance reaches pre-established levels. This continuous measurement makes it possible to identify the existence or not of problematic situations that require further evaluation or immediate action.

The LQAS requires establishing the maximum number of non-compliance with the indicator's targets and what is acceptable in a given sample. When the variable measuring the indicator is dichotomous (presence / absence of a given quality), the use of the probabilities of the binomial distribution gives us a quick and efficient way of deciding whether or not the project is facing a problematic situation with a relatively small sample size.

For example, the target of the percentage of houses that do not have mosquito breeding sites is 80% in all areas of supervision, then a sample is performed using the LQAS technique to assess compliance with this target. If a measurement found that 12 households did not have mosquito breeding sites in a sample of 19 households interviewed, we will conclude that they did not meet the target of 80% (because there should be 15 or more households that do not have mosquito breeding sites).

To find the probability of compliance with the standard, it is based on the probability formula of the binomial distribution:

$$P_{(x)} = \binom{n}{x} \pi^{x} (1-\pi)^{n-x}$$

[3] Methodology and Sampling Issues For KPC Survey: http://pdf.usaid.gov/pdf_docs/Pnach754.pdf

[4] NGO networks for health detailed monitoring and evaluation plan http://pdf.usaid.gov/pdf_docs/Pdabs202.pdf

[5] WHO. Monitoring immunization services using the Lot Quality Technique. WHO/VRD/TRAM/96.01.

Where: P (x) is the probability of finding x compliance (or non-compliance) cases, as defined by the standard in the sample.

n is the size of the sample,
x are the compliance (or non-compliance) cases found in the sample,
π is the probability of: compliance (or non-fulfillment) of the predetermined target (standard), which is assumed to exist in the population from which the sample is drawn

$\binom{n}{x}$ is a combinatorial expression that is equivalent to:

$$\frac{n!}{x!(n-x)!},$$

It is important to note that the values of π and *x* must go in the same direction; That is, if the standard is compliance *x* must be number of compliances, but if the standard is negative or non-compliance, *x* must be non-compliance.

The use of LQAS in the areas of supervision requires the following:

- Identify indicators of practices that require monitoring of compliance with a target.
- Establish targets or standards for each indicator.

Each country will select one sample from each monitoring area. The areas of supervision are established with the following criteria:

A) Accessibility to the communities independent of their structure of geopolitical influence of the districts.
(B) Proportionate population size by area of supervision.
(C) Urban or rural areas
(D Supervision areas have staff responsible for accompaniment during the intervention process.

The sampling frame of communities and households will be based on census data, in the absence of this information, a sample design will be applied using the communal records and sketches of the households in each zone. The selection of households will be done by systematic random sampling until the quota for each area of supervision is reached. In case of not finding an informant in the randomly selected household will proceed to survey the neighbor household.

Evaluation of indicators in the community

Measurement of community participation indicators in vector control, risk communication and community surveillance will be conducted through household survey questions, in-depth stakeholder interviews, case studies and document review.

In-depth interviews

The evaluator will interview key informants from the community, local health and education authorities, local health services staff, schools and municipalities. Informants will be interviewed with a view to gaining more detailed and deeper understanding of participation in preventive health activities and in the prevention and care of the Zika.

Interviews should take place in a mutually agreed upon locale, typically the interviewee´s office. Issues such as interviewer and participant safety, comfort and convenience, participant confidentiality, and background noise should be considered in selecting the interview site.

Interviews are based upon the standard interview templates with optional prompts of follow-up questions. The consultant in each country should develop an interview guide and intended to provide consistency and coherence in interviews, given that there are country-specific elements that interviewers may want to add or adapt.

Key informant sampling

CAZ will use two sampling techniques:

Purposive sampling: this involves selecting participants on the basis of their characteristics, roles or experiences in order to shed light on a range of issues relevant to research questions. The aim is to interview as diverse a range of individuals as possible.

Snowball sampling: This involves asking interviewees to nominate other people they know who may be willing to participate in the research. This allows researchers to identify and interview key informants who are not known at the start of the research project.

The study´s sample size should reflect the number of key individuals who had particular characteristics, roles or experiences that are relevant to the baseline. The precise number of interviewees is not able to be determined before fieldwork commences since evaluator should use snowball sampling to identify key informants during data collection.

Since the sample will have a diversity of opinion, the evaluators should use a strategy of maximum variation throughout the study to appropriately collect, analyze and present the various viewpoints.

The evaluator, together with CAZ, should build a matrix of the key informants interviewed to ensure an adequate sample of key informants.

The instruments will have a predefined set of key questions to enable the user to capture necessary information.

In-depth interviews will be face to face. In all cases, a question guide will be used. The question guides will be developed according to each group of informants.

Interview Summary Sheet

The interviewers should complete an interview summary sheet after each interview, preferably on the day of the interview. This summary includes key informant information and interview details. This form also serves as a checklist of items addressed in the interview and provides an opportunity to reflect on the items included and excluded as well as any outstanding comments and issues in the interview. The information in the summary sheet will be used to frame the analysis of the interview data.

Information processing

The interviews will be recorded in magnetic form, with the consent of the interviewees, then these interviews will be transcribed verbatim. The texts will be systematized according to the study subjects and study group. The analysis will be based on the recognition and description of the perceptions of the respondents, according to the study group, and then move to a comparative and interpretive analysis of the differences in the speeches of the key informants.

After completing the data collection phase, extensive case reports will be created with an emphasis on developing descriptive, narrative accounts, which are central to the generation of insight.

With fieldwork complete, the next step is single case analysis, which involves examining the case and themes in order to code and index the data accordingly.

Ethical issues

The CAZ evaluation will include the following considerations during the data collection phases:

Informed consent. Individuals that participated in this research do so voluntarily. Prior to each interview, interviewers inform participants of the nature of the research, the level of confidentiality being maintained, information regarding how interview material will be used, and their rights as participants to end the interview at any time without consequences. Interviewers obtain written consent from each participant.

Confidentiality. Participants are advised about the confidentiality of their interviews. Case study data is stored in secure locations that are protected from unauthorized access.

Permission to Quote. The evaluation will not attribute quotes to specific individuals; when quotes are used, they should be attributed in such manner that readers can not identify the speaker.

Permission for recording. Permission for the electronic recording of case interviews is obtained verbally from the participants at the start of the interview, before turning on recording devices. Participants are advised that, if at any time the participant does not feel comfortable, the recording device could be switched off. Participants are advised that recordings are for CAZ program evaluation reports only.

5. Baseline Deliverables

5.1. KAP survey

The consultant in each country will be responsible for the following deliverables:

Deliverable	Estimated of level of effort (LOE)
1. KAP survey proposal, including a full description of the methodology, with drafts of questionnaire, sampling plan, interviewer training plan, and analysis plan	3 días
2. KAP questionnaire validation report	2 días
3. Reporting of training to interviewers	5 días
4. Supervision of fieldwork report	5 días
5. Draft Evaluation Report	5 días
6. Final Evaluation (evaluation data: data sets, codebooks, transcripts)	2 días

5.2. Qualitative evaluation of the baseline

The consultant in each country will be responsible for the following deliverables:

Deliverable	Estimated of level of effort (LOE)
7. Qualitative evaluation proposal, including a full description of the methodology, with drafts of collect data instruments, sampling plan, list of key informants and analysis plan	2 days
8. Report of collect data	10 days
9. Draft Evaluation Report	5 days
10. Final Evaluation (evaluation data: data sets, codebooks, transcripts)	2 days

All documents and reports will be provided electronically to CAZ. All qualitative and quantitative data will be provided in electronic format to CAZ either by email or by thumb drive, depending on the size of the files being provided.

6. Team Composition

Evaluation expert. This consultant should have at least 5 years experience designing, implementing and evaluating public health programs, with expertise in household surveys, it is desirable that he/she has conducted KAP surveys. He / she should also have a post-graduate degree in public health or an applicable social sciences field. Excellent oral and written skills and fluency in Spanish are required.

He/she will provide leadership for the interviewers team, finalize the evaluation methodology design, select households using the LQAS technique (see Annex 1), plan and coordinate data collection with the household survey, train surveyors, supervise fieldwork, and write reports of deliverables.

Qualitative Evaluation Expert, the qualifications are at least 5 years of experience in performance evaluations, qualitative evaluations or qualitative research. Familiarity with community engagement, behavioral change communication is desirable. He / she should have a post-graduate degree in social sciences. Excellent oral and written skills are required and fluency in Spanish.

The specific responsibilities are: elaborate the fieldwork plan of the qualitative evaluation, data collection protocol and tools, and analysis plan. Defines the scope, techniques and instruments of the qualitative evaluation. Prepare qualitative interviews and the list of key informants to be

interviewed by the evaluation team. Write the analysis plan of the qualitative evaluation. Interviews to stakeholders. Write the report of qualitative analysis of baseline.

7. Scheduling and Logistics

The following GANTT chart provides a general overview of the anticipated timeframe for baseline activities and deliverables. This schedule is assuming the consultant's contract is in March. The evaluation implementation is anticipated to run in March and April.

Estimated Baseline of CAZ Timeframe (2017)

Task/Activity	Mar	Apr	May
Evaluation Design			
Evaluation Preparation			
Field Work			
Report Writing			
Draft Report			
Final Report			

Save the Children and Red Cross in each country, as appropriate, will provide information for design and sampling. They will logistically support the consultant to conduct survey validation, recruit interviewers and cover their expenses during training and fieldwork. Each organization will also provide logistical support to the consultant for the interviewer training workshop, appointments with stakeholders for interviews, supervision of fieldwork by the consultant, and assignment of supervisors for the survey.

8. Reporting Requirements

The format of the baseline report should follow USAID guidelines set forth in the USAID Evaluation Report Template (http://usaidlearninglab.org/library/evaluation-report-template) and the How-To Note on Preparing Evaluation Reports (http://usaidlearninglab.org/library/how-note-preparing-evaluation-reports).

The final version of the evaluation report will be submitted to USAID and should not exceed 30 pages, excluding references and annexes.

USAID Evaluation Policy, Appendix 2

CRITERIA TO ENSURE THE QUALITY OF THE EVALUATION REPORT

- The evaluation report should represent a thoughtful, well-researched and well organized effort to objectively evaluate what worked in the project, what did not and why.
- Evaluation reports shall address all evaluation questions included in the scope of work.
- The evaluation report should include the scope of work as an annex. All modifications to the scope of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology or timeline need to be agreed upon in writing by the technical officer.
- Evaluation methodology shall be explained in detail and all tools used in conducting the evaluation such as questionnaires, checklists, and discussion guides will be included in an Annex in the final report.
- Evaluation findings will assess outcomes and impact on males and females.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence and data and not based on anecdotes, hearsay or the compilation of people's opinions. Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an annex.
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical, and specific, with defined responsibility for the action.