Personalised social support to the most vulnerable families living in India's slums.

Terms of reference for the final evaluation

April 2021

BRIEF DESCRIPTION OF ATIA

Created in 2008, **ATIA is a** non-profit organisation specialised in the implementation and follow-up of concrete development programmes. The programmes are defined on the basis of the needs of the families and are of several types:

- education: pre-schooling, prevention of drop-out in primary schools ,
- social: support for the poorest families (listening, guidance, advice), early childhood development,
- health: fight against tuberculosis, mutual health insurance,
- Access to employment: training and support for micro-entrepreneurs, encouraging savings, productive loans.

The countries of intervention are India, Madagascar, Bangladesh, Burkina Faso and Mozambique.

Methods and experiences are capitalised and shared through the *Pratiques* network (http://www.interaide.org/pratiques/) to improve development practices.

DESCRIPTION OF THE PROJECT

1. Summary sheet

Name of the association	ATIA (www.atia-ong.org)
Title of the project	**Personalised social support to the most vulnerable families living in India's slums**
Places of intervention	**Mumbai, Thane, Bhiwandi and Jaipur**
Thematic	**Social**
Main funders	AFD - Chanel Foundation
Total duration of the programme	3 years (July 2018 - June 2021)

Summary presentation of the project
By providing psychosocial support at home, the project aims to significantly reduce social problems in the vulnerable neighbourhoods of large Indian cities (non-vaccination of children, school drop-out, women without contraception, etc.). Rather than providing services to beneficiaries who remain more or less passive, the action increases the level of motivation and information of women, heads of households[1] in the most precarious neighbourhoods. The project does not create new services but maximises the use of existing services (public or private) by families in the slums.

Target groups	The project focuses on 7,000 disadvantaged families in vulnerable areas of Mumbai and Jaipur.

2. Geographical areas covered

India, an emerging country, still has more than 260 million poor people living on less than $1.90 a day (PPP)[2], or 28% of the world's poor[3]. 24% of its urban population lives in slums[4].

[1] ATIA defines the head of the family as the woman with whom the social worker has worked the most, analysing their situation and needs, as well as those of the other family members. In a nuclear family, this is the mother. In extended families (20% of cases among our beneficiaries), it is usually one of the daughters-in-law.

[2] According to the latest World Bank data (2011), there are 268,000,000 people below this poverty line (http://povertydata.worldbank.org/poverty/country/IND).

[3] According to the same sources, 946,300,000 people live below the $1.9 a day (PPP) poverty line worldwide.

[4] According to 2014 data from the World Bank (http://data.worldbank.org/indicator)

In the greater Mumbai area, the population is growing rapidly and has reached more than 21 million inhabitants[5], almost half of whom live in slums[6], fed by the permanent arrival of new migrants.

Faced with the continuing and massive influx of poor people from rural and disadvantaged areas of the country, social welfare systems are often powerless. They are lacking the human resources to promote their services or to liaise with isolated people. They are already overburdened by users who are able to contact them on their own; therefore, they fail to reach out to the most marginalised households, and no civil society organisations exist to facilitate this link (except in specialised thematic like legal advice or child protection. However, this does not cover all the needs of poor families. Moreover, the latter is resigned to living in the precarious conditions they have known for more than a generation and often reduced to live illegally and clandestinely, they are afraid to turn to the public authorities. In addition, their lack of education and low self-confidence makes them vulnerable to acts of corruption by administrative, hospital or other service agents, accentuating their difficulty in accessing citizenship, health, etc. Finally, many migrants are torn between the desire to eventually return to their farmland and the need to settle in the city: registering with the civil registry in Mumbai or Jaipur for rations card implies de-registering in their village of origin, sometimes reducing their chances of inheriting the parental property. These fears often paralyse the long-term process of receiving basic public benefits such as food rations or disability allowances.

The recent health crisis has had a major impact in India, the second most affected country in the world, with over 25 million cases. The peak was reached in September 2020, and to date, restrictions have been reinstated in India. The economic downturn has pushed many people into poverty. The millions of daily wage earners and migrant workers employed in the informal sector have been particularly affected by the containment measures and the recession.

In terms of cultural representations, women are systematically considered inferior to men[7]. This inferiority is expressed in everyday life and is present in most family interactions[8]. Women are often considered as minors for life: they are forced into arranged marriages, a constraint that applies *de facto* to both men and women. But women must leave their families to live with their parents-in-law. Once married, they must become mothers and if possible, mothers of a boy. They will be blamed for not having children. The woman 'belongs' to her husband's family and this becomes a reality when she is widowed and must marry a brother of her deceased husband[9]. They never eat first and are expected to carry out the orders of their husband or in-laws.

They also have limited mobility. The space outside the neighbourhood where they live is seen as dangerous and not suitable for a 'respectable' woman. They can only leave their homes for actions seen as necessary by their husbands and in-laws, such as taking the children to school. If they need to see a doctor, it is often compulsory for their husband or in-laws to accompany them.

Domestic violence is more the rule than the exception and is perfectly tolerated: 56%[10] of women consider it acceptable for a man to beat his wife and 21% of women have been victims of domestic violence at least once in their life[11]. From puberty onwards, women are subjected to tight control over their sexuality and mobility (only 34.5% of women can go alone to the market or to the health centre[12]), as "female

[5] According to "United Nations - World Urbanization 2018 prospects" (https://www.un.org/en/events/citiesday/assets/pdf/the_worlds_cities_in_2018_data_booklet.pdf), the urban agglomeration of Mumbai has more than 19 million people in 2018 and will reach 24.5 million in 2030, i.e. , and is growing at an average rate of 375,000 people per year who continue to flock, mainly to informal areas...

[6] At the last census in 2011, this figure was 42.84% (http://www.census2011.co.in/census/city/365-mumbai.html)

[7] Gupta, "Women's Empowerment in India and Its States: Evidence from the NFHS",*Economic and Political Weekly*, 2004, 39, 7, pp. 694-712

[8] V. Chasles, 'Femmes en Inde',*L'Information géographique*, 2008, 72, 1, p. 57-69

[9] V. Chasles, 'Femmes en Inde', L'Information géographique, 2008, 72, 1, p. 57-69.

[10] National Health Survey 2015/2016 Table 15.14 - Lowest wealth index

[11] Ministry of Health and Family Welfare, National Family Health Survey (NFHS-4) 2015-2016, op. cit, 2017.

[12] National Health Survey 2015/2016 Table 15.13 - Lowest wealth index

morality" remains an essential criterion for the honour of the family, the clan and the lineage[13]. Sexual violence outside the marital domain is regularly reported and condemned in the media[14], but domestic violence is culturally accepted[15], particularly in its psychological and economic form of abuse of power, control and neglect[16]. Finally, this domestic violence affects mostly the poorest women and those with a low level of education[17].

3. Local partners

In Mumbai and adjacent cities, five Indian associations carry out activities in partnership with ATIA: ALERT India, Keshav Gore Smarak Trust (KGST), Lok Seva Sangam (LSS), Navnirman Samaj Vikas Kendra (NSVK), Sarvajani Mahila Utkarsha Sanstha (SMUS, whose partnership ended in late 2019). These are Indian associations that have been active in the Mumbai region for many years and with whom ATIA has worked for several years, chosen for their professionalism, their efficiency and their proximity to the communities they help. They all have the required administrative authorisations for foreign funding (FCRA).

As shown in the table below, the partner organisations operate in different areas of the Mumbai and Jaipur metropolitan areas.

Association	**Areas of intervention**	**Municipality**
ALERT India	Bhim Nagar (completed 2019), Bhaskar Nagar Charnipada (started in 2020)	Thane
KGST	Pathan Wadi	Mumbai (Goregaon)
NSVK	Damu Nagar, Dharkhadi	Mumbai (Malad)
LSS	Bainganwadi (completed in 2019) Maharashtra Nagar	Mumbai (Mankhurd)
SMUS (end of partnership in 2019), taken over by LSS	Indira Nagar	Bhiwandi
SB (end of partnership in 2019), taken over by IADI then LSS in Jaipur	Shastri Nagar (SB/IADI/LSS) Jawahar Nagar (IADI/LSS)	Jaipur

After a preliminary study in 2016 to assess the needs for psychosocial support, the activities started in Jaipur in 2018 with a local structure: Sewa Bharat (SB). Unfortunately, in 2019, SB expressed its desire not to renew the partnership with ATIA. Indeed, SB was in the process of restructuring its Jaipur office and feared that the high turnover of coordinators would not allow the implementation of a programme like the one proposed by ATIA. The teams and the programme manager have maintained very good relations with SB and continue to be informed of the evolution of their activities. As a result, IADI and then the partner

[13] I. Guérin and S. Kumar, 'L'ambiguïté des programmes d'empowerment : entre domination, résistance et instrumentalisation' in Femmes, économie et développement, ERES, 2011, p. 129-154.
[14] A. Raj and L. McDougal, 'Sexual violence and rape in India', The Lancet, 2014, 383, 9920, p. 865.
[15] J.G. Silverman et al, 'Family violence and maltreatment of women during the perinatal period: Associations with infant morbidity in Indian slum communities', Maternal and child health journal, 2016, 20, 1, pp. 149-157.
[16] A.S. Kalokhe et al, "How Well Does the World Health Organization Definition of Domestic Violence Work for India? ", PLoS ONE, 2015, 10, 3; A. Kalokhe et al, "Domestic violence against women in India: A systematic review of a decade of quantitative studies", Global public health, 2017, 12, 4, pp. 498-513.
[17] Ministry of Health and Family Welfare, National Family Health Survey (NFHS-4) 2015-2016, op. cit, 2017.

Lok Seva Sangam (LSS), an Indian structure with which ATIA works in Mumbai, agreed to take over the administrative management of the activities in Jaipur from 2019.

4. Objectives and focus of the project

Overall objective: *To promote the social inclusion of vulnerable families in slums in India.*
Project impact indicator(s):
The prevalence of social problems (vaccination, schooling, women without contraception) will be halved among all the followed-up families by the programme

Specific objective(s):
SO1: Empower the most vulnerable families to improve their living conditions
SO2: Promote the sustainability and replicability of activities.

Expected results by specific objective:

SPECIFIC OBJECTIVE 1: *Empower the most vulnerable families to improve their living conditions.*
Indicator(s) of achievement of the specific objective*: The standard of living of the target households, as measured by the Poverty Assessment Tool [18], increases between the beginning and the end of the intervention.*

Result 1.1: *Supported families define and achieve objectives.*
Indicator(s) of results of the specific objective and targets: *At the end of the support, 75% of the followed-up families will have achieved at least 3 of the objectives identified with their social worker.*

Main activities planned:

- *Provide home-based psychosocial support for 7,000 highly vulnerable families.*
- *Helping families to identify their problems and guiding them in solving them.*

Quantified activity monitoring indicators and targets: *7,000 highly vulnerable families will receive psychosocial support.*

Result 1.2: *Women who are heads of household, through the follow-up regain confidence in their ability to solve their problems independently.*
On *average, at the end of their support and 6 months later, the women will have reached a level of 25 on the Connor-Davidson resilience scale[19], with 40 points.*

Main activities planned:

- *Apply active listening methods to encourage families' progress.*
- *To evaluate and value the progress made by families at the end of the support and 6 months later.*

Quantified activity monitoring indicators and targets: *on average, each supported family will receive 18 home visits over a 6-month period.*

Result 1.3: *Gender equality is strengthened within the followed-up families.*
Performance indicator(s) for the specific objective quantified and targets set: *70% of pregnant followed-up women receive pregnancy monitoring, 70% of households adopt the family planning method they want, 50% of birth certificates obtained concern girls.*

[18] The Poverty Assessment Tool is shown in Annex 10.2
[19] The Connor-Davidson scale is presented in Annex 10.3

Main activities planned:

- *Identify and strengthen factors that increase women's participation in family decisions*

Quantified activity monitoring indicators and targets: *on average, each supported family will receive 18 home visits over a 6-month period.*

SPECIFIC OBJECTIVE 2: To promote the sustainability and replicability of activities.
Indicator(s) of achievement of the specific objective: *Local associations co-deliver the programme and are supported by other local actors.*

Result 2.1: *Partner associations take ownership of the methods and help to adapt them to the context of their areas of intervention.*
Performance indicator(s) for the specific objective and targets: *The score of the partner associations progresses on the autonomy measurement grid developed by ATIA*[20].

Main activities planned:

- *Ongoing support, training and technical monitoring of 7 local partner associations and their field teams.*
- *Regular evaluation of the activities and concerted adaptation of the method to the context of the intervention areas during monthly technical exchange workshops.*
- *To support associations in planning their actions (human resources sizing, budget), steering and reporting (data management, narrative and financial reports), their institutional anchoring (visibility, link with public authorities and other associations) and the search for local funding.*
- *Bringing together partner associations at a national seminar.*

Indicators for monitoring activities with figures and targets:

- *7 local associations are involved in the project.*
- *30 coordination meetings.*
- *3 capacity building courses.*
- *1 national seminar organised.*

Result 2.2: *Public and private actors are involved in supporting the most vulnerable families.*
Performance indicator(s) for the specific objective quantified and targeted: *60% of families contact the structures to which they have been referred and 70% of them are satisfied with the service obtained.*

Main activities planned:

- *Identify and promote effective services that can be used by vulnerable families, in particular through the social services open in the neighbourhoods where the project is being implemented.*
- *Carry out awareness-raising operations in the neighbourhoods with the agents of the services that can meet the needs of families.*
- *Organise technical exchanges with other public and private actors involved in the social and economic development of families.*
- *To offer internships to 30 university social work students to raise awareness of future professionals in the sector.*
- *Organise 2 training courses for the staff of public and private partner structures.*

Indicators for monitoring activities with figures and targets:

- *3,000 families will be welcomed in guidance centres.*

[20] The grid for measuring autonomy is presented in Annex 10.4

- *5 technical exchanges will be conducted with public and private actors.* - *30 students will do an internship with the project team.* - *2 training courses will be offered to the staff of public and private partner structures.*	
Target group(s)	The beneficiaries of the project are the 7,000 very vulnerable families selected in the project's slums whose poverty level and social problems hinder the improvement of their living conditions. A socio-economic categorisation tool developed by ATIA contributes to this selection. 7 partner associations are co-implementing the project and benefiting from capacity building conducted by ATIA.

- **Methodology of psychosocial support**

ATIA has developed a specific methodology for the selection and monitoring of women, heads of household[21].

ATIA defines the head of household as the woman with whom the social worker has worked the most, analysing their situation and needs, as well as those of the other family members. In a nuclear family, this is the mother. In extended families (20% of cases among our beneficiaries), it is usually one of the daughters-in-law.

At the start of the project in an area, the teams of social workers carry out an exhaustive survey of the social services offered in the vicinity with useful information, such as opening hours or conditions for receiving the service... The project's social workers go door-to-door and survey each household. This initial survey is used to identify and select the families that will benefit from the programme (analysed via the Poverty Assessment Tool, each case is discussed in a selection committee). This method makes it possible to target the families that really need support. Women, heads of households are the project's main interlocutors and constitute almost all of our direct beneficiaries. Indeed, women often emigrate after their husbands and have a smaller social network and are responsible for the daily management of the household with young children. They are therefore the first to request psychosocial support and are the project's relays for disseminating its benefits to other members. The social workers, during their home visits, try to communicate with all the members of the household, especially with the girls and women present.

If the head of household agrees to the proposed follow-up, the social worker comes **for weekly home-visits for about 30 minutes, during 6 months**. An initial observation period of about two months is planned to ensure that a relationship of trust has been established between the social worker and the family members, encouraging the sharing of information, difficulties encountered and future plans. It is also an opportunity for family members to take stock of their situation and to tell a life story that is often painful and has not been heard by anyone before. Expressing these difficulties strengthens their sense of control over their lives and increases their motivation.

At the same time, depending on the needs expressed by the various family members (which will constitute the "*objectives*" of the support), the social worker provides initial information or referrals for problems that are "simpler" to follow (health, administrative documents for example).

If the mother is looking for a job, the social worker informs her about the opportunities in her neighbourhood. Often mothers look for work at home, which is fairly easy to find in Mumbai (before the 2020 pandemic). However, these jobs are low-skilled, such as inserting the spring in a hair clip, gluing glitter on saris etc.

[21] The evolution of this psychosocial support methodology has been described in the following document: http://www.interaide.org/pratiques/content/capitalisation-sur-la-methode-daccompagnement-des-familles-2010?language=fr

Throughout the support, the social worker gives the woman a sense of self-worth in order to help her gain self-confidence. In the majority of cases, after a few visits, a renewed motivation and self-confidence can be observed in the cleanliness and organisation of the house and the care of the children.
At the end of the 6 months-support, the families have generally identified 12 "objectives" and "achieved" 7 of them. Our teams note that the heads of household have regained their self-confidence, have gained autonomy and are able to call on the services available in their area when necessary.
The project analyses its results through: i) the rate of achievement of the objectives (at the end of the follow-up and 6 months later); ii) the evolution of the scores on the Poverty Assessment Tool[22] (at the beginning and end of the follow-up, and 6 months later).

From the analysis of the results of the families monitored in 2019, ATIA finds that the project has reduced the gender gap.

	of individuals with a need for				
	Before the intervention		After the operation		
	Woman	Male	Woman	Male	Comments
Birth certificate	18%	19%	11%	11%	On children (under 18)
Adhaar card	13%	6%	7%	4%	On adults (over 18)
Ration card	39%	31%	31%	25%	Of the total sample
Employment	29%	9%	10%	4%	On adults (over 18)
Savings	52%	6%	15%	3%	On adults (over 18)
Education (school)	39%	30%	19%	15%	On young people aged 13 to 17
Pre-school education	27%	24%	6%	6%	On children aged 0-5 years
Professional training	21%	6%	12%	4%	On youth and adults (13 years and older)
Vaccination	29%	29%	7%	8%	On children aged 0-5 years
Nutrition	24%	3%	4%	1%	On adults (over 18)
Disease	32%	8%	5%	2%	On adults (over 18)

It can be seen, for example, that at the beginning of the intervention 39% of girls between 13 and 17 years of age were not in school (31% for boys in the age group), but only 19% at the end of the period (15% for young men).
In the case of nutrition and illness, it was chosen to show the narrowing of the gap between adults (and not between girls and boys) because the social workers observed that heads of household do not allow themselves to think and act for themselves, neglecting to go to the doctor to treat their various illnesses, or depriving themselves of food for the benefit of their husbands and their children. During the visits, the social workers emphasised the importance of the head of household also taking care of herself.

We also wanted to analyse the level of women's empowerment by creating an empowerment scale and to see the impact of our intervention on this aspect via this scale which was administered to 152 women at the beginning of the support and to 152 women at the end of the support.

The scale was created by taking the "classic" questions of empowerment measures as presented by the J-Pal and the National Family Health Survey in India.
In this scale, empowerment is measured on several axes: i) Mobility as freedom of movement (market, health facility, outside the community) and participation in meetings; ii) Decision-making power on major purchases, use of savings, number of children in the couple and use of contraceptives; iii) Financial

[22] Socio-economic categorisation tool ("family photo") developed by ATIA of 17 criteria, incorporating the Oxford University Multidimensional Poverty Criteria, grouped into five themes: economic, health, education, social (hygiene and paperwork) and comfort of living. A detailed description of this tool is available via the Practice Network: http://www.interaide.org/pratiques/content/photo-de-famille-outil-de-categorisation-socio-economique

autonomy (possibility of working outside the home and capacity to save and decide how to use it); iv) Acceptance of domestic violence and knowledge of women's rights (alimony, child custody rights); v) Nutrition and division of domestic tasks.

We found that there was a 2-point increase between the beginning of the intervention and at the end of it. The progress is on possession and decision related to women's savings (+0.4), and family savings (+0.25), on the decision to make major purchases (+0.2) and on mobility (+0.5 points on the 4 questions).

See details in Annex 2

5. History of the project in terms of evaluation and monitoring-evaluation

Activities are monitored by ATIA and its partners through a database allowing regular operational reporting on activities and results.

There have been no external evaluations of this project.

EVALUATION

1- Justification of the assessment

This evaluation comes at the end of 3-year funding cycle by the French Development Agency (FDA), under the ATIA-FDA CIN 1102 01 J agreement, which provides for a final evaluation in the last year of the project. The evaluation was delayed as much as possible due to travel restrictions related to the Covid pandemic. It will feed into the actions that will be implemented during the India-Madagascar multi-country project. Although the application has already been submitted, it will be enriched by the results of this evaluation.

2- Objectives of the evaluation

The evaluation focuses on the actions implemented within the project since July 2018 in Mumbai and Jaipur with our 4 Indian partners.

The general objectives of the evaluation are:

1. To **qualitatively evaluate the actions** implemented during the psychosocial support of the followed-up families.
   ATIA and the partners collect many indicators to analyse the results quantitatively. The aim would be to qualitatively evaluate the psychosocial support process, particularly regarding the effect on the empowerment of the heads of the followed-up families.

2. **To qualitatively evaluate ATIA's intervention strategy** with these families
   In view of the situation and the social isolation of the families, and especially of the women heads of household, it is a question of evaluating the home-based intervention strategy and the relevance or otherwise of supplementing these individual home-based interventions with collective/community activities. In particular, it is a question of assessing whether the followed-up women are likely to participate in community groups (which the vast majority of them do not do) and if so, under what conditions could they actively participate in these groups?

3. **Evaluate the referencing system.**
   The aim here is to assess the informal networks of public or private organisations to which partners refer family's members when needed.

3- Evaluation questions in relation to the objectives of the evaluation

This evaluation will not follow the classic model proposed by the OECD (6 main evaluation criteria), but will be based on an operational reading grid recommended by the F3E, comprising 3 categories of questions on:

- The action,
- The intervention strategy,
- The implementation mechanism.

The evaluation questions aim to clarify objectives 1 and 2 of the evaluation. They are listed hereinafter in full. During the preparatory meeting, ATIA will be able to guide the selected evaluation team as to the relative importance of each question. This prioritisation will enable the evaluation team to manage its time as efficiently as possible.

Evaluative questions concerning Objective 1 (qualitative evaluation of the actions implemented)

Although the project was not structured around gender issues, the actions carried out within the framework of the project have an impact on the position of women in their families, their level of training, information, health, etc. The women, heads of the families are, in fact, the privileged interlocutors of the project and constitute almost all of our beneficiaries. Culturally, women are in charge of the daily management of the household, so they are the project's relays for disseminating its benefits to other members.
In the next phase, we wanted to work more specifically with our local partners on the empowerment of these women. Therefore, we want to measure the effects of the intervention in terms of empowerment for the followed-up women.
ATIA mainly uses Naila Kabeer's definition, which defines empowerment as "the process by which those who have been denied the ability to make strategic choices acquire such ability"[23]. Naila Kabeer introduces a basic framework with three interrelated dimensions:

- Agency: increasing participation, voice, negotiation and influence in decision-making on strategic life choices.
- Resources: access to material, human and social resources that enhance people's ability to exercise choice, including knowledge, attitudes and preferences.
- Achievements: significant improvements in well-being and living conditions that result from increased free choice, including health, education, livelihood opportunities, rights and political participation, among others.

The quantitative data suggest that psychosocial support has a positive effect on the capacity to act, on access to resources and on the achievements of the families, and more specifically of the followed-up women.
However, we do not know precisely what in the psychosocial support process is particularly effective and useful in promoting this development. A qualitative analysis would allow us to better identify the key elements of this support.

EQ 1.1: Analyse to which extent psychosocial support has changed the agency of women heads of household.
To analyse to which extent psychosocial support has or has not influenced the head of household's perception of herself, her husband and her in-laws.
To what extent has psychosocial support enabled the head of household to increase her capacity to influence decisions concerning her or her children? What are the changes in practices that specifically concern women within families: speaking out, negotiating power, etc.?

[23] N. Kabeer, 'Resources, Agency, Achievements: Reflections on the Measurement of Women's Empowerment', *Development and Change*, 1999, 30, 3, p. 435.

What were the key elements of the psychosocial support that enabled this change (in their own perception of themselves, in their relationships with family members,...): was it the encouragement of the social worker, her empathetic listening, her advice, the fact that she was able to discuss with other family members...
Did the psychosocial support have unexpected effects on the beneficiaries?

EQ 1.2: Analyse to which extent psychosocial support has changed the access to resources of women heads of household.
Has access to women's health care been improved: are women more aware of the services available to them? Do they use them for themselves? And/or for their children? Under what circumstances?
To what extent has women's relationship to money changed? Has there been an increase in women's income? An increase in their savings? In terms of amount, regularity?
Has this changed the decision-making process on family money...?
What were the key elements of the psychosocial support that enabled this change (in their own perception of themselves, in their relationships with family members, ...): was it the encouragement of the social worker, her empathetic listening, her advice, the fact that she was able to discuss with other family members...?

Evaluation questions concerning Objective 2 (qualitative assessment of the intervention strategy)

EQ 2.1: Analyse to which extent the followed-up women would be likely to participate in community groups.
Do the followed-up women already actively participate in community groups? If yes, which ones, if not, why?
If not, under what conditions could they actively participate in such groups? What types of community groups would be of interest to them? Discussion groups? If so, on what topics? Activity groups? If yes, what kind? How often? How would they get to a group meeting at a fixed time and day outside? What is the maximum distance?
Do they feel that they could more easily participate in group activities now than before the psychosocial support?

Evaluation questions for Objective 3 (evaluation of the referencing system)

Our partner organisations are continuously working to identify existing social services to which our beneficiaries can be referred, depending on the situations they face. Our partners take several factors into account before referencing these services, ensuring firstly that they are of high quality, geographically accessible for our beneficiaries and affordable. At the same time, they also carry out networking activities to maintain good relations with these services and the people employed in them.

EQ3.1: Have partner organisations identified effective services that can be accessed by women heads of household? Are these services easily accessible in geographical terms, financially and offer quality care?

EQ3.2: Do the identified services cover the most frequent needs of beneficiaries?
Is the service network complete? Sustainable? Can this arrangement be improved?

4- Indicative methodological approach

To avoid "staying on the surface", it will be necessary to avoid revalidating a well-established reporting system and to focus on analysing the available quantitative data, conducting qualitative interviews with beneficiary families and project partners.

The evaluation will be based on:

- Single individual non-directive or semi-directive interviews with women heads of household. A methodology based on the recording of these interviews may be proposed.
- Interviews with spouses and other family members (mother-in-law, etc.) separately.

- The interview grid will be the subject of discussions between the ATIA team dedicated to the study and the selected evaluators. The interview grid should contain mostly open questions.
- Interviews with the different actors of the project during field visits: the animation teams, the services to which the beneficiaries are referred;
- Discussions with ATIA's area managers in France, ATIA's programme managers based in India and the coordinators of the Indian partner associations.
- This qualitative assessment may be supplemented at the margin by a quantitative analysis of the data from the management systems in place.

The evaluators will outline recommendations. Based on the elements in the psychosocial support process identified as promoting women's empowerment (objective 1 of the evaluation), ATIA and its partners in India will adjust the support process to emphasise and systematise these elements.

As to the intervention strategy (objective 2 of the evaluation), ATIA plans in the next phase to combine individual psychosocial support with collective actions. The recommendations will help guide the implementation of these activities.

For the question on the referral system (objective 3 of the evaluation), the recommendations of the evaluators will help to improve the system.

Nature and duration of the main steps of the evaluation: (suggestions)

- Consultation of the document base: 3 days
- Preparatory meeting (including drafting of the interview grid with the ATIA team and selection of families to be interviewed): 1 day
- Framework paper (or scoping note): 1 day of drafting
- Field mission: interviews with field teams and beneficiary families: 9 days (6 days in Mumbai and 3 days in Jaipur)
- Field feedback based on interviews and discussion with teams: 1 day (½ day in Mumbai and ½ day in Jaipur)
- Draft report: estimated writing time: 5 days
- Feedback meeting in Versailles based on the draft report: ½ day (can be done remotely if the evaluator is not in Europe)
- Final report: 2.5 days

A total of 23 days.

EXPECTED DELIVERABLES

The deliverables for this evaluation **will be written in English or French and in Word (or compatible) format** and are as follows

- A f**ramework paper (or scoping note)**, sent to ATIA several days before the field visits, will report on the Evaluator's initial investigations based on the reading of the documents and the interviews conducted with France during the scoping meeting.
- It will present the questions and hypotheses supporting the fieldwork, as well as the proposed evaluation methodology for the subsequent phases of the evaluation.
- A **provisional report** will be given to ATIA and will be the basis for a **dissemination meeting** in the field and in Versailles
- A **final report** (**maximum 30 pages, including annexes**) will be produced following the discussions on the draft report. The moral and economic rights of the consultants will belong to ATIA.

This report will include:

- A **main part** that will deal with :
  - The analysis of the results that have been achieved by the project, detailed and compared with the objectives of the project,

- Perspectives and recommendations, with concrete proposals and strategic proposals.
- A **set of appendices** containing the results, factual data and, above all, a set of extracts from the interviews carried out, necessary for a better understanding of the information developed in the main report.
- A **summary (8 to 10 pages maximum)** which will include
  - A situational analysis,
  - A summary of the analysis of the achieved results, the main findings or major conclusions based on the expectations expressed in these terms of reference,
  - The main recommendations of the evaluators.

This summary will also be written in English. An electronic version (Word and PDF versions) of the documents will be systematically attached to the paper versions.

HUMAN AND FINANCIAL RESOURCES

1- Evaluation team

This evaluation will be conducted by an Indian resident expert (due to travel restrictions) who will be responsible for the evaluation and available for meetings (by video) with whom the contract will be signed. This expert may be accompanied by collaborators.
Given the difficulties in travelling in 2021 due to the coronavirus pandemic, the ability of the consultant team to physically visit the project within the planned dates will be an important criterion in the selection process.

Consultants with proven experience and expertise in:

- Surveys of poor households and comfort in talking to similar audiences
- Qualitative survey methodology
- Evaluation of development projects in urban areas
- With good listening and interpersonal skills and a command of English and Hindi (and if possible Marathi).
- Good previous knowledge of slums in large Indian cities

The team should also have a good knowledge and some operational experience in the following areas

- Social work
- Psychosocial approach
- Gender inequalities

Finally, it is imperative that the team has an **excellent level of English**.
The choice will be made on the basis of a call for tenders.

Proposals from consultants interested in this evaluation should include:

- A technical proposal presenting the **understanding of the stakes in** this evaluation and the terms of reference, as well as the **proposed evaluation methodology;**
- A financial proposal (including VAT, payable where the service provider is established) ;
- The CV of the consultants: training, expertise and experience in the fields covered by the project and in this type of action, as well as any references.

2- Planned budget and duration of the evaluation

ATIA foresees 23 days of mission *(see Methodology section above).*
The financial offers will amount to a maximum total of €12,000 *(excluding the amounts paid by ATIA)***.** Travel costs to Mumbai and Jaipur will be included in the proposal.

ATIA will reimburse the Mumbai-Jaipur airfare and local accommodation costs upon presentation of receipts. The consultant is responsible for the local logistical organisation related to the smooth running of the evaluation (accommodation bookings, local transport if necessary...).
VAT is payable in the country where the service provider is established; if the service provider is subject to VAT, he must invoice ATIA with VAT, indicating the amount before and after tax (in accordance with Directive 2008/9/EC of 12 February 2008 on the place of supply of services: new taxation rules).

The service provider's quotation will therefore consist of two parts in accordance with Annex 3:

1. **Fees,** including VAT where applicable;
2. **Other expenses,** reimbursable upon presentation of receipts.

Travel costs to Mumbai and Jaipur will be included in the proposal.

ATIA will reimburse the Mumbai-Jaipur airfare and local accommodation costs upon presentation of receipts.

The consultant is responsible for the local logistical organisation related to the smooth running of the evaluation (accommodation bookings, local transport if necessary...).
The ATIA teams will, if necessary, make appointments with beneficiaries and members of the teams of partner organisations and public or private services.

PROVISIONAL TIMETABLE

The provisional timetable for the evaluation is as follows (dates at the latest):

31 May 2021	Publication of the offer
Sunday 20 June 2021	Deadline for receipt of tenders
Friday 25 June 2021	Analysis of bids and selection of evaluators
Until the scoping meeting	Analysis of the documentation by the selected team of evaluators
5 July 2021	Scoping meeting
9 July 2021	Delivery of the framework note
July 2021	Field mission
mid-August 2021	Submission of the interim report
Week of 23 August 2021	Dissemination meeting of the draft report in Versailles (by teleconference)
End of August 2021	Local return and possibly further return for headquarters staff
End of August 2021	Delivery of the final report

The Field mission could only be carried if field activities resumed in the field, which is not the case at the time of writing this Terms of Reference.

HOW TO APPLY

Please send your bids **by 20 June 2021** to laurence.jannet@atia-ong.org with the subject "EVAL/INDIA".

The project document sent to the main donor (AFD) can be provided to applicants on request.
In addition, a document database will be made available to successful applicants (see Annex 1).

LIST OF ANNEXES

Annex 1: Documentation
Annex 2: Logical framework
Annex 3: Sample quotation (can be provided in Excel)

ANNEX 1: Documentation available to the selected expert

Project documentation

- Logical framework (in French)
- Project document sent to the principal funder (may be sent to applicants on request) (in French)
- Interim technical report to AFD (covering the period from July 2018 to December 2019) (in French and English version)
- Half-yearly interim reports to the Chanel Foundation (January-June 2020 half-year and July-December 2020 half-year) (in French)
- History of the methodology for supporting families (in French and English).
- Family file

Resource persons

- ATIA Area Managers (*they carry out regular missions in the countries of intervention*)
- Programme managers (*expatriate, they are in charge of the follow-up of each programme*)
- Local ATIA team
- Local partner managers: local NGOs

APPENDIX 2: Table of indicator achievements during first instalment

Specific objectives	Expected results	Planned activities	Indicators over the 3 years	Monitoring indicators for phase 1 (18 months)	Achievements tranche 1
SPECIFIC OBJECTIVE 1 SO1: Empower the most vulnerable families to improve their living conditions.	R 1.1 - Supported families define and achieve objectives	**R1.1A1: Provide** psychosocial support at home for 7,000 very vulnerable families. R1.1A2: Help families to identify their problems and guide them in resolving them.	For SO1: The standard of living of the targeted households, as measured by the internal tool "Family Photo", increases between the beginning and the end of the intervention. For Result 1.1: At the end of the support, 75% of the followed-up families will have achieved at least 3 of the objectives identified with their social worker.	3500 very vulnerable families will receive psychosocial support.	The standard of living o families, as measured b the "Family Photo" tool increased by 5.2 points 93% of the families benefiting from the intervention achieved a least 3 objectives that t themselves had identifi 4,344 families were supported in this way
	Result 2: R 1.2 - Women heads of family, through the follow-up regain confidence in their ability to solve their problems independently.	**R1.2A1**: Apply active listening methods to encourage families' progress. **R1.2A2**: Evaluate and value the progress made by families at the end of the support and 6 months later.	For Result 1.2: On average, by the end of their support and 6 months later, women will have achieved a level of 25 on the Connor-Davidson Resilience Scale, with 40 points (Band 2)	On average, each supported family will receive 18 home visits over a 6-month period.	The families received 2 home visits over a perio of 6-7 months.
	Result 3: R1.3 - Gender equality is strengthened within the followed-up families	**R1.3A1**: Identify and strengthen factors that increase women's participation in family decisions	For Result 1.3: 70% of the pregnant women accompanied, benefit from a pregnancy follow-up, 70% of the households adopt the family planning method they want, 50% of the birth certificates obtained concern girls.		71% of pregnant wome received prenatal care. 74% of the couples who wanted to use a family planning method did so 47% of birth certificates for minors were for girl
SPECIFIC OBJECTIVE 2 SO2 - Promote the sustainability and replicability of activities	**Result 1:** R 2.1 - The partner associations take ownership of the methods and help to	**R1A1**: Ongoing support, training and technical monitoring of 7 local partner associations and their field staff.	For SO2: Local associations co-deliver the programme and are supported by other local actors.	7 local associations are involved in the project. 15 coordination meetings	7 associations carried o the project: ALERT, KGS LSS, NSVK, SMUS, SB ar IADI.

	adapt them to the context of their areas of intervention.	**R1A2**: Regular evaluation of activities and concerted adaptation of the method to the context of the intervention zones during monthly technical exchange workshops. **R1A3**: Support the associations in planning the action (dimensioning of human resources, budget), steering and reporting (data management, narrative and financial reports), their institutional anchoring (visibility, link with public authorities and other associations) and the search for local funding. **R1A4**: Bring together partner associations for a national seminar (Phase 2).	For Result 2.1: Partner associations' scores improve on the autonomy measurement grid developed by ATIA (bracket 2).	1 capacity building course in Mumbai	15 coordination meetin were held between the partner organisations ir Mumbai. A training session was organised in January 20 for all administrative ar financial managers.
	Result 2: R 2.2 - Public and private actors are involved in helping the most vulnerable families.	**R2A1**: Identify and promote effective services that can be called upon by vulnerable families, in particular via the social services open in the intervention areas. **R2A2**: Carry out awareness-raising operations in the neighbourhoods with the agents of services that can respond to the needs of families. **R2A3**: Organise technical exchanges with other public and private actors involved in the social and economic development of families. **R2A4**: Offer internships to 30 university social work students to raise awareness among future professionals in the sector (phase 2). **R2A5**: Organise 2 training courses for the staff of public and private partner structures (phase 2).	For Result 2.2: 60% of families contact the structures to which they have been referred and 70% of them are satisfied with the service obtained.	1,500 families will be welcomed in guidance centres. 2 technical exchanges with public and private actors in Mumbai. 30 students will do an internship with the project team.	84% of families contact the structures to which they were referred. 88% of them are satisfi with the service they received. 3,898 people came to t social services. 1 meeting with the coordinator of the protection officers responsible for the protection of women victims of domestic violence. 20 student trainees we hosted in the partner organisations.

APPENDIX 3: SAMPLE QUOTATION

Can be provided in Excel version