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Health, Education, Equality, Protection
ADVANCE HUMANITY

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UNICEF IRAN Country Office

TERMS OF REFERENCE

EVALUATION OF THE "NEW-BORN INDIVIDUALIZED DEVELOPMENT CARE & ASSESSMENT (NIDCAP)" PROGRAMME

TYPE OF ASSIGNMENT: INDIVIDUAL CONSULTANCIES (TEAM LEADER & TEAM MEMBER)

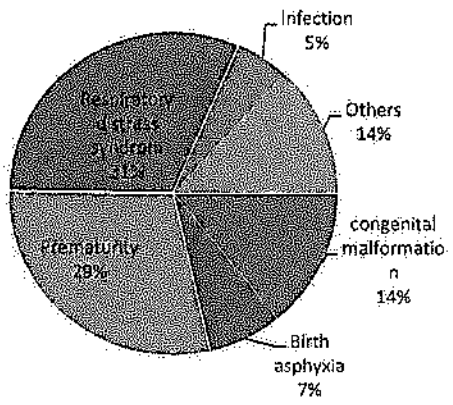
1. Background, Context & Programme Objective

UNICEF is the United Nations agency for children established by the General Assembly in 1949. UNICEF is the largest international organization that works in more than 190 countries in the field of health and nutrition, education, protection, and access to equal opportunities for all the children. In the Islamic Republic of Iran, UNICEF has been supporting the Government in its work for children living in Iran since the early 1950s.

UNICEF Iran has been supporting the Ministry of Health and Medical Education in line with the national priorities including helping prevent premature labour and build health service capacity to promote health care at the time of birth. Furthermore; UNICEF has been facilitating enhancing national capacity for availability of effective team-based care for health professionals who look after newborns at the time of delivery.

In Iran under-five mortality rate has dropped from 60 per 1,000 live births (1989) to 16 per 1,000 live births (2015), but the average under-five mortality rate in low-income regions is still three times worse than in higher-income regions. Most under-five deaths (81 per cent) occur before children reach their first birthday and 62.5 per cent during the first month of life. However, the average U5MR in Iranian regions with economic disparities and poverty (e.g. Sistan and Baluchistan and Hormozgan). In addition, out of 18/1,000 U5MR in 2014, 83 per cent are happening before the first birthday and 61 % during the first month of life (equivalent to a Neonatal Mortality Rate (NMR) of 11/1,000 live births).

Causes of Neonatal Mortality 2015



Prematurity and the related Respiratory Distress Syndrome (RDS) counts as the main cause of neonatal deaths. Based on the 2013 report on the assessment of Neonatal Intensive Care Units (NICUs) in Iran, the main contributors are the poor quality of developmental care and mismanagement of resuscitation and ventilation care. In addition, unnecessary hospitalization of neonates in NICUs for simple medical problems has occupied existing NICU beds. This has caused unreal shortage of NICU bed in the country. Often the NICU beds are taken by healthy neonates for basic and simple medical care instead of premature babies with complications. This is equivalent to a virtual lack of supply in NICU services, however the main issue is inappropriate use

and distribution of existing capacity[1]. Considering the relatively high prevalence of premature births and the relevant complications such as Respiratory Distress Syndrome (RDS) and weak management of the prematurity, UNICEF Iran country programmes (2012 – 2017) focused on both prevention and better management of the prematurity and its related complications. To achieve the prevention objective, the capacity of MOHME was enhanced to upgrade the quality of care for high risk pregnancies to secure healthier pregnancy outcomes. At the same time, UNICEF supported MOHME to enhance the timely utilization of high-risk pregnancy management services by mothers.

To enhance the life expectancy and developmental status of premature new-borns, UNICEF supported MOHME to adopt and roll out an upgraded Neonatal Resuscitation Programme (NRP) and the Neonatal Individualized Developmental Care and Assessment Programme (NIDCAP) as well as service package for ventilation care for premature new-borns in NICU settings. UNICEF support to NIDCAP programme aimed at 80 per cent of the premature neonates to have a higher chance of survival and their ability to catch up with their developmental milestones. Exchanging the womb for the NICU environment at a time of rapid brain growth compromises preterm infants' early development, which results in long-term physical and mental health problems and developmental disabilities. The NIDCAP aims to prevent the iatrogenic sequelae of intensive care and to maintain the intimate connection between parent and infant.

UNICEF successfully advocated for the application of the NIDCAP and in 2013, capacity of 65 health professionals in Neonatal Intensive Care Units (NICUs) was built through an internationally supported training workshop. As a follow-up action to the training, UNICEF enhanced the system capacity of the health sector through the establishment of a NIDCAP committee, for coordination and leading the national scaling up of the programme in 2014.

Through UNICEF's support 2014, the NIDCAP national committee initiated a national assessment on the status of the development care at NICUs in 23 hospitals (9 Universities).. Furthermore; seven neonatologists and nurses were supported to benefit from Dutch experience on NIDCAP and advanced NICU care, with the objective of cascading the knowledge gained. In 2016, UNICEF also supported the first national seminar on NIDCAP, which was attended by more than 350 health experts and neonatologist to sensitize and raise awareness. In addition, a series of introductory workshops were conducted and 134 health experts from 19 medical universities were trained on NIDCAP concept and approach

Building on earlier efforts in the country programme (2014-2016), UNICEF facilitated NIDCAP on-job training in four hospitals (2 in Tehran, 1 in Tabriz and 1 in Shiraz) and16 NICU paediatricians, neonatologist and nurses were certified as NIDCAP providers by early2017. All the selected hospitals were government hospitals administered by the Ministry of Health based on the contextual challenges around neonatal health and due to their potential to pilot the programme. Moreover, UNICEF has been supporting development of the nutritional protocol for NICUs, which includes a situation analysis of the knowledge gaps and practises of NICU personnel on breast/formula feeding and parental nutrition's to complement the standard service package for NICUs.

It can be concluded that NIDCAP prevents the consequences and impacts of preterm infants' early development, which in many cases includes long-term physical and mental health problems and developmental disabilities. It is redundant to mention that right after birth, preterm infants become

[1] MOHME official Data on mortality, HMIS Report 2014 and 2015

exposed to various stressors in the delivery and operating rooms, the neonatal intensive care unit (NICU) and the neonatal ward. These include painful stimuli, sleep disruption, high levels of light and noise pollution, and separation from the mother, getting exposed to higher risk of hypoxia, apnea, and fluctuations in blood pressure. Such a highly stressful environment can adversely affect the infants' vision, hearing, sleep patterns, and neurobehavioral development and by avoiding these painful and stressful measures infant can be protected from infection and co-morbidities

2. Evaluation purpose, objectives and criteria

As foreseen in UNICEF's current country programme (2017 - 2021) evaluation plan, the first phase of the NIDCAP is to be evaluated for necessary programme revisions and validating the intervention for national scale up.

In accordance to the DAC[2] criteria, the objective of the evaluation is to determine, as systematically and objectively as possible, the relevance, efficiency, effectiveness, and sustainability of UNICEF's support. Impact will not be considered as one of the evaluation criteria; though unanticipated impact will be looked into and documented for future programming adjustments if required.

In accordance with UNEG norms and standards (2016), this evaluation has a dual purpose of accountability and learning. It will support (i) generation of knowledge on the successes and challenges of the Neonatal Individualized Developmental Care and Assessment Programme (NIDCAP) to inform future programming, (ii) accountability for UNICEF and national partners, as well as the beneficiaries of the programme.

The evaluation would consider the inclusiveness of services offered for the beneficiaries with the equity lens.

3. Scope

The scope of the evaluation is limited to UNICEF supported interventions and programme implementation in the four national hospitals in which the NIDCAP programme was launched and subsequently capacity of the paediatricians, neonatologist and nurses were built over the period of 2013 to 2018.

4. Evaluation questions

The evaluation will attempt to answer the proposed following set of questions, organized around the DAC/UNED evaluation criteria. It is redundant to mention that a set of sub-questions will be developed and framed in the evaluation matrices by the evaluator as a part of the deliverables of the inception report; however, the criteria will remain the same:

I. Relevance *The extent to which the objectives of a development intervention are consistent with target populations' requirements, country needs, global priorities and partners' and donors' policies.*	1- To what extend the intervention's design and its intended results were relevant to UNICEF's country programme health component and overall needs of the national health care objective including service providers and the beneficiaries?

[2] Development Assistance Criteria

II. **Efficiency** *Measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to results.*	2- Do the achieved results justify the resources invested and was reporting done sufficiently and appropriately?
III. Effectiveness *The extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance.*	3- Has the NIDCAP programme been successful in reducing neonatal morbidity in the four piloted hospitals 4- To what extent does the practice of the trained service providers differ from service providers who have not received the NIDCAP training? 5- What were the key factors influencing the achievement or non-achievement of the anticipated results?
IV Sustainability *(The probability of continued long-term benefits. The resilience to risk of the net benefit flows over time.)*	6- To what extend has the programme been incorporated into the national programmes and protocols? 7- To what extent the NIDCAP pilot initiative mature for replicability or scalability at national level without UNICEF's support.

The evaluation also has the potential to project the long-term change of the intervention by exploring the extent to which NIDCAP was planned and implemented in synergy with other health development actors.

5. Methodology and Technical Approach

The evaluation will adopt a mixed-method questions approach to answer the research questions outline above, including both qualitative and quantitively methodologies, Information collected will be triangulated to ensure soundness of analysis.

Data and information collection methods will include, but are not limited to: (1) structured document review and content analysis of key documents (such as programme documents, progress reports, and etc.); (2) primary and secondary analyses of data; (3) semi-structured interviews and focus group discussions with informed individuals including, trained personnel, pilot hospital service providers, UNICEF Iran relevant staff, relevant officials of MOH, and etc.

The analysis and the presentation of data and information will, to the extent possible, be gender-disaggregated and take into consideration the needs of vulnerable groups.

Data collection is expected to take place at the individual, service provider (i.e. Hospitals), as well as MOHME and UNICEF. The inception report must include an explanation of how the data collection instruments relate to the evaluation questions, and how the data is going to be triangulated.

Evaluation findings must be relevant, useful, and be presented in a clear and concise way. The final evaluation report must comply with UNICEF-Adapted UNEG Evaluation Report Standards.

Contextual restriction and the nature of intervention calls for some limitation to easily access hospital data. In addition, tracking earlier beneficiaries and/or service providers who have benefited from the intervention at early stages may not be possible.

6. Deliverables & Timing

Following timeframe describes the evaluation deliverable, key steps in the process and the formal meetings from contract award to post evaluation briefing:

Deliverables	Timeframe	No of working days	Payment
Start-up briefing	1 week	2	20% *(upon acceptance of the inception report)*
Desk review	2 weeks	5	
Inception phase & report	2 weeks	6	
Data collection & field work phase	3 weeks	10	30% *(Submission of the draft evaluation report)*
Data analysis & development of findings	2 weeks	8	
Presentation of preliminary findings & recommendations	1 week	2	
Report drafting *(UNICEF-Adapted UNEG Evaluation Report Standards.)*	2 weeks	8	
Sharing of report for comments	2 weeks	0	50% *(Acceptance of the finalized evaluation report by UNICEF)*
Consolidation of comments & revisions to report	2 weeks	5	
Management response	4 weeks	2	
UNICEF satisfaction questionnaire completion	1 week	1	
Additional debriefs/dissemination	2 weeks	1	
	24 weeks (6 months)	50 days	

N.B. All deliverables including an executive summary should be in English. It is expected that the evaluation findings be presented to UNICEF in a PowerPoint presentation.

7. Arrangements for Managing the Evaluation

- Evaluation ToRs and inception report are approved by the Steering Committee co -chaired by the MOH and UNICEF's management . Provision of office space will be clarified with the Evaluator.
- The Evaluator will report to UNICEF Planning, Monitoring and Evaluation Officer (the Evaluation Manager) in close consultation with the Deputy Representative.
- The Evaluation Manager will facilitate access of all documents and information required, coordinate visits to UNICEF office and the MOH, organize meetings/interviews with relevant UNICEF and MOH staff, provide backstopping and liaise regular on the progress of the evaluation with internal UNICEF management.
- The evaluation deliverables will be quality-assured by the Evaluation Manager and UNICEF regional evaluation advisor.
- The MOH is responsible for the coordination of the required travels and visits for the purpose of this evaluation research.
- UNICEF Iran Country office will pay for the travel cost and DSA incurred.
- The consultant shall use their own facilities to manage the work.
- The Evaluator is expected to undertake the evaluation in consultation with UNICEF, in full accordance with the terms of references outlined herewith and in full compliance with the UNEG's norms and standards for evaluation

8. Evalution team composition and required competencies

I. Main Evaluator (Team Leader)

- The Evaluator should hold an advanced university degree (Masters or equivalent)
- Completed training on evaluation, research and analysis.
- The Evaluator should have led at least five independent international evaluations, comprising field work for primary data collection. Previous experience evaluating UN Agencies programmes/projects would be a distinct advantage.
- Working experience in the Middle East and being based in the region is considered.
- High level analytical and report writing skills and experience writing clear and concise reports for a range of audiences are required.
- Excellent oral and written communications skills in English.
- Should not have any conflict of interest through paid involvement or any other aspect with the intervention under evaluation

II. Technical Evaluator (Team Member)

- The Evaluator should hold an advanced university degree (Masters or equivalent) in public health or related fields.
- Well knowledge on Iran's health system and interventions related to neonatal health.
- Experience in health and/or social research and in applying qualitative and quantitative research methods.
- Flexible team member to work with the team leader (main evaluator).
- Excellent oral and written communications skills in English and Persian.
- Should not have any conflict of interest through paid involvement or any other aspect with the intervention under evaluation

9. Application Submission

- Interested applicants are requested to submit i) CV and ii) Cover letter and iii) 3 professional reference
- In the cover letter applicants should highlight his/her interested position for the evaluation i.e. Main Evaluator (Team Leader) or Technical Evaluator (Team Member)
- Applicants for the Main Evaluator (Team Leader) should submit samples/hyperlinks of the international independent evaluations led.
- Interested applicants i.e. the Evaluator (Team Leader) and the Technical Evaluator (Team Member) is requested to provide his/her financial proposal with the break breakdown of professional daily fee and if any international travel expenses (round trip ticket from origin to Tehran, accommodation, and 3 meals, and transportation)
- Domestic travel arrangements (ticket, accommodation, and transport) will be reimbursed by UNICEF based on actual travel
- Only shortlisted applicants will be contacted for the interview.

10.Ethical Note

All the products, including data and analyses, developed in the course of this consultancy are the intellectual property of UNICEF and MOHME. The consultant may not share these products without the expressed permission and acknowledgement of UNICEF Iran and MOHME. All the products developed during the course of this consultancy must comply with the UNEG norms and standards and UNICEF-Adapted UNEG Evaluation Report Standards.

Terms of Reference reviewed and endorsed by the evaluation steering committee adjourned on 13th November 2019, Co-Chaired by the MOHME & UNICEF.

Prepared by: Nazanin Akhgar, PME Officer

Reviewed by: Gilles Chevalier, Deputy Representative

Approved by: Mandeep O'Brien, Representative