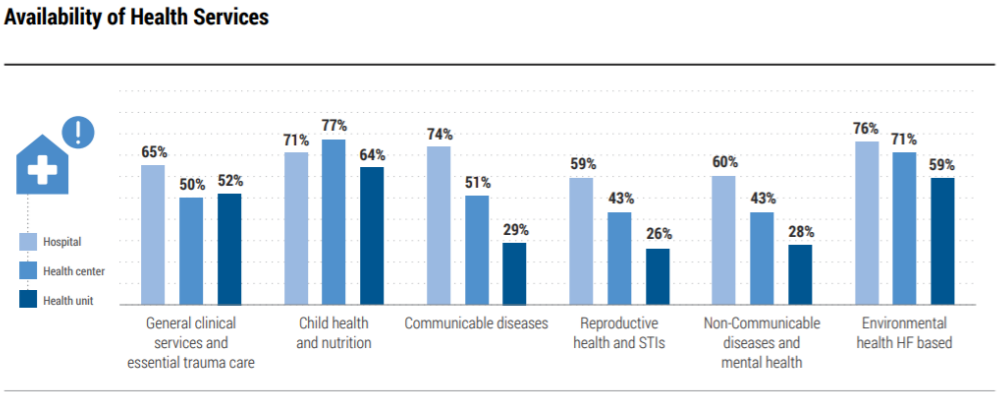
Terms of Reference – Evaluation of Scale-Up of the Minimum Service Package (MSP) at the Primary Health Care Level in Yemen

Background Regarding

Overview of the Health Situation in Yemen[1]

1. Over five years of humanitarian crisis, conflict, and severe economic decline have taken an enormous toll on the Yemeni population. According to the 2021 Humanitarian Needs Overview, 20.7 million people (approximately 66% of the population) need humanitarian assistance, including 12.1 million people in acute need who urgently require immediate assistance to survive. The situation is expected to deteriorate further over the course of 2021.

2. In particular, the crisis has devastated the health system in Yemen, leaving it at the brink of collapse. Twenty million people in Yemen require assistance to ensure adequate access to healthcare, including 11.6 million who are in acute need of assistance, including health and nutrition assistance. At least one child dies every 10 minutes in Yemen because of preventable diseases. Health worker density is 10 per 10,000 population, compared to a WHO benchmark of 22 per 10,000. There are no doctors in 67 of Yemen's 333 districts. Only 51% of health facilities are fully functional. The restrictions on of Yemen's air, land, and seaports have restricted the importation of life-saving medical supplies into the country, further impeding access to adequate treatment. Many patients must resort to purchasing their own medicines and supplies. The depreciation of the Yemeni riyal further exacerbates the issue, driving up costs incurred for healthcare and making it inaccessible for many Yemeni people. Poor vaccination coverage, high levels of both acute and chronic malnutrition, critical water shortages and related poor hygiene, a collapse of sanitation systems, and massive population movements and displacement have given way to a surge in the spread of communicable diseases. The ongoing cholera and diphtheria outbreaks particularly highlight the detrimental impact of the failing health system. Nearly 370,000 suspect cases of cholera were reported in 2020, with 504 associated deaths; this is a significant decline compared to 2019, but still poses a risk of resurgence. Additional pillars of the health system that have been shaken due to the crisis include the "brain drain" of skilled Human Resources for Health (HRH), with many districts lacking doctors and critical medical specialists. A weak and decentralized Health Information System impedes access and availability to data, which in turns affects capacities to properly manage the health system.



[2]

Yemen's Minimum Service Package

3. Following the inception of the Health Sector Reform strategy[3], the Yemen Ministry of Public Health and Population (MoPHP) adopted the District Health System approach in 2002. The following year, a first draft of the "National Model of Primary Health Care Services Package" was produced, which became the "Essential Service Package for the District Health System"4 (ESP) in 2004. However, the ESP proved to be aspirational for the context

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[1] Yemen Humanitarian Needs Overview 2021
[2] ibid
[3] MoPH 2000. Health Sector Reform in the Republic of Yemen. Strategy for Reform.
[4] MoPHP 2004. Essential Service Package for the District Health System. Part One: Service Standards and Input Standards.

5.

at the time; it was never implemented as such and has remained a reference document, some of whose standards and guidelines have been implemented piecemeal over the years[5].[6]

4. In 2016, amid the gravest humanitarian crisis in decades, the Yemen Health Sector identified the ESP as a potentially useful tool to improve coordination among the many external humanitarian health service providers. A number of working groups were created and workshops with ample participation of MoPHP and stakeholders were held both in Sana'a and Aden. The result was a "Basic Health Services Package"[7]. While an aspirational package of health services is useful to keep a long-term vision, in the short and medium-term a more practical tool was necessary. Rather than a fully-fledged package, a much shorter list consisting exclusively of those health interventions that the system must be able to provide in a relatively short period of time (between some months and a few years) was extracted to be used for planning, coordination, target setting, funding and monitoring. Thus, a selection of the most cost-effective interventions –in the context of Yemen—of the ESP has been extracted to compose the MSP, which is later translated into facility standards following the Health Resources Availability Monitoring System (HeRAMS) standard approach.[8]

5. The MSP is a compendium of accessible health services corresponding to the Disease Control Priorities (DPC)-3 Highest Priority Package, selecting the most critical, relevant, cost-effective, and affordable interventions suited for Yemen. It is designed to sustain and strengthen health system functionality, while meeting the immediate health needs amidst acute conflict. The MSP reinforces the critical leadership role of the government at all levels (central, governorate, and district), while engaging key stakeholders such as WHO, UNICEF, and NGO partners. The MSP targets the District Health System, focusing on improving accessibility of health services at the primary and secondary levels and strengthening referral mechanisms for all levels of care.

6. Initially launched in 2016 through a pilot program led by the MoPHP, the MSP was developed as a strategy for driving the restoration of essential health services in a fragile and conflict-affected context, while also providing a realistic model for the post-conflict reconstruction of Yemen's national health system. Shortly after the launch of the pilot project, a tripartite agreement between WHO, UNICEF, and the World Bank was signed to commence implementation of the Emergency Health and Nutrition Project (EHNP), driven by the MSP strategy. Working in close collaboration with Governorate Health Offices (GHOs) and District Health Offices (DHOs), UNICEF and WHO identified priority health facilities, and specified the required inputs to deliver the most essential services. Further, UNICEF is working with the MoPHP to extend the reach of primary health care services beyond health facilities and into communities, through outreach and mobile team services and a community systems strategy focused on preventive, curative, and referral services.

UNICEF Yemen's Support to Primary Health Care and the MSP

7. The Emergency Health and Nutrition Project (EHNP) is a multi-year partnership between the World Bank, UNICEF, and WHO with the objective of preserving health, nutrition, water, and sanitation systems in Yemen in light of the ongoing conflict and humanitarian crisis. Designed in 2016 and launched in early 2017, the project has completed four years of implementation and is currently planned to continue through June 2022, though most activity implementation will end between June 2021 and December 2021.

8. Within the health and nutrition component of the partnership, UNICEF is supporting GHOs and DHOs to ensure primary health care facilities, outreach and community-based services are capacitated to implement the MoPHP's MSP. Through the EHNP, UNICEF supports 1,970 primary health care facilities throughout all 23 governorates in Yemen with a package of operational budgets, medicines and supplies, equipment, per diems, training, and supervision to provide essential life-saving health and nutrition services. It also supports outreach services, mobile teams, vaccination campaigns, community health workers and community volunteers to expand the coverage of

1. MoPHP 2004. Essential Service Package for the District Health System. Part Two: Management Guidelines.

[5] An Essential Service Package (ESP) For Yemen. A draft for discussion and development. 2016

[6] Yemen Minimum Service Package: A transitional alternative to an aspirational Essential Service Package. May 2017.

[7] حزمة الخدمات الصحية الأساسية (الخدمات الصحية) 2017

[8] Yemen Minimum Service Package: A transitional alternative to an aspirational Essential Service Package. May 2017.

primary health care services, and provides health system strengthening support to the MoPHP, GHOs and DHOs. The theory of change is below:

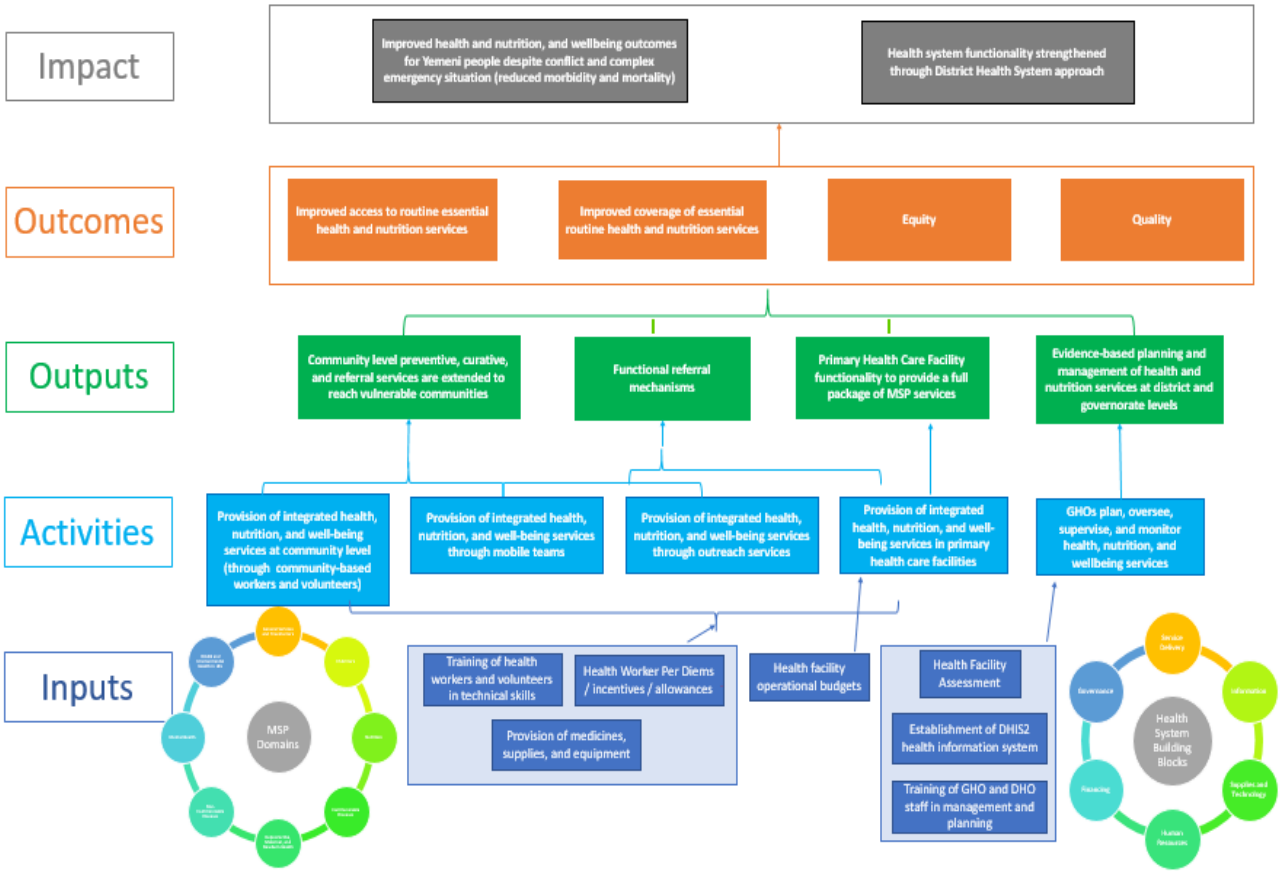

Figure 1: MSP Theory of Change

9. The EHNP is the first and longest-running project that has supported implementation of the MSP at scale. Further, based on the experiences of the EHNP, other donors have become interested in supporting the MSP. Similar support is now being provided through other donor-funded projects9 covering up to 2,500 primary health care facilities throughout Yemen. And given its mandate to focus on maternal, newborn, and child health services at all levels, all of UNICEF's work at the primary health care level also contributes to the implementation of the MSP, even if channelled through a more vertical program-centred approach.

10. While the MSP has been rolled out at significant scale across various levels and with support from UNICEF and other partners, it was never fully costed, and thus the funding needs to implement it are not clear. UNICEF has initiated a cost-benefit analysis of its own investments into the MSP, which has revealed that between the beginning of 2017 and the end of 2020, UNICEF's investments in the MSP have amounted to around $100 million. While this is not a formal costing of all the needs to implement the full package at scale across all levels, it gives some indication of the levels of funding that would be required to do so.

Challenges in MSP Implementation and Justification for an Evaluation

11. Implementing partners of the MSP, such as WHO, UNICEF, and NGOs have faced numerous challenges in their implementation of MSP projects, which in turn may limit the efficacy of the MSP strategy. Security constraints

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[9] Through support from DFID, KSA, the EU, GAVI, and Government of Japan

and importation restrictions limit capacities to reach vulnerable populations; humanitarian agencies struggle to reach many areas to supervise and monitor progress.

12. The massive volume of supplies needed to implement MSP also proves problematic, particularly in light of limited international supplier capacities to meet the needs, as well as restrictions to move supplies into and around Yemen.

13. Programmatically, the biggest challenge is perhaps ensuring that all building blocks of the health system are targeted. Certain pillars, such as Service Delivery, have been prioritized, whereas other health systems aspects have proved more challenging and complex – for example, reducing financial barriers to accessing healthcare, supply chain management, and data and information management. Additionally, health worker capacity building has not been addressed in a holistic way. In-service trainings for health workers continue to be provided through vertical program-specific approaches. Through the EHNP, UNICEF has attempted to introduce an Integrated Supportive Supervision (ISS) model through which GHOs and DHOs form integrated teams that supervise health facilities on the quality of services across the MSP and including looking at issues such as data and information management, supply chain management, and medical waste management in the primary health care facilities. While this has been noted to some extent, evidence of its effectiveness is limited and MOPHP buy-in at leadership levels is low.

14. Additionally, some components of the MSP prove to be more difficult than others. While domains such as the Expanded Program of Immunization (EPI), community-based management of acute malnutrition (CMAM), and maternal, newborn, and child health (MNCH) are more familiar to the district health system, the provision of mental health and psychosocial support (MHPSS) and non-communicable diseases (NCD) services is newer for the Yemeni health system, particularly at district level. As such, capacity is more limited to initiate and sustain these services, requiring additional efforts and capacity building.

15. In 2019, the EHNP partners, led by WHO and closely supported by UNICEF and the World Bank, launched a process of reviewing the MSP strategy and implementation. After an initial international meeting with Yemeni and global experts in April 2019 and subsequent in-country consultations, the review process stalled due to competing priorities and political complexities. The Coronavirus pandemic and deteriorating humanitarian situation in Yemen in 2020 have further deprioritized the review of the MSP. Despite this context, UNICEF continues to promote health system preservation and strengthening along the humanitarian-development nexus, with its investments in the MSP at the core of its system strengthening agenda. UNICEF also continues to coordinate with its partners, including WHO and the Ministries of Public Health and Population, on the need to revisit a review of the MSP. In the meantime, an internal evaluation of UNICEF's own work in this area is an important learning opportunity for UNICEF and will provide a significant step forward in a country-wide multi-stakeholder process.

Purpose and Objectives

Purpose

16. The purpose of the evaluation is to document lessons learned and inform planning for further implementation of the MSP. The findings will be used to inform program design for upcoming funding cycles and generate an evidence base to inform resource mobilization, building an 'investment case' for UNICEF's work on the MSP beyond its usual mandate (focusing in MNCH). It may also provide an opportunity to further inform the MSP review process, to be led by WHO in collaboration with UNICEF and the MoPHP, and to refine and possibly redesign the MSP strategy. Learnings may also be shared with other countries in similar contexts. UNICEF has invested significant resources into the MSP scale-up, and an evaluation is now required to examine those investments and adjust them as necessary. The evaluation will benefit health-related planning, as well as inform further improvement. It will also benefit UNICEF and other UN agencies, as well as WHO and MoPHP and other partners, for future program planning, coordination, and resource advocacy and allocation. It will also systematically generate evidence on primary health care as a part of the MSP in Yemen, assessing the effectiveness of the programme in achieving its stated objectives. Besides the assessment of the intended effects of the program, the evaluation also aims to identify potential unintended effects.

Objective

17. The objective of the independent evaluation of the scale up of primary health care under Yemen's MSP is to provide accountability and learning. The evaluation will provide accountability to UNICEF, the MoPHP, local authorities, other UN agencies, donors, communities, private sector partners, and rights-holders with respect to whether UNICEF is fit for purpose and strategically well-positioned to further contribute to Yemen's MSP. It will also provide learning as to the relevance/appropriateness, connectedness/sustainability, coherence, coverage, and effectiveness, of UNICEF's contributions to the primary health care parts of Yemen's MSP and enable the identification of some best practices in contribution to MSPs in general and in Yemeni contexts specifically.

18. More specifically, the objectives of the evaluation are to:

- Assess UNICEF's contributions to the primary health care scale-up under Yemen's MSP and whether the governance, structure, composition, and objectives of the scale-up were appropriate to respond to the need for continuum and continuity of services over the period targeted by the evaluation.
- Undertake analytical (qualitative and quantitative) assessment of UNICEF's progress achieved in scaling up primary health care under Yemen's MSP and examine programme fit and performance – especially in efficiency, effectiveness, quality, and sustainability - identifying key successes, good practices, lessons learned, and gaps / constraints that need to be addressed.
- Provide evidence in service of future programming decisions around the continued scale-up of the MSP
- Determine the degree to which engaged stakeholders, including those who used MSP services, in the primary health care scale-up.
- Examine how UNICEF's role in the primary health care scale up under the MSP has addressed cross-cutting issues such as gender and equity protections.

Scope

19. The evaluation will focus on UNICEF's contributions to the MSP across Yemen during the period January 2018 – June 2021. Given that UNICEF implements the MSP in all governorates and nearly all districts throughout Yemen, the evaluation will aim to generalize findings across Yemen as a whole, but available data may constrain generalizability. The evaluation will include respondents from the whole of Yemen, with differences in geography (urban/rural, highland/lowland) represented over 2-4 districts each in 8-10 governorates in the country. The following criteria should be considered in selecting the sample:

a. Geography (urban/rural, highland/lowland)

b. Economic status

c. Origin or presence of IDPs

d. Quality of existing data for the area

e. Capacity/willingness of GHO/DHO to support evaluation at this time

f. Intensity of conflict in the area

g. Health factors (current/prior outbreaks, nutrition status, coverage of health and nutrition services)

h. Presence of WHO programming for secondary care

i. Marginalization of vulnerable groups

20. The consultant team should elaborate on the sampling criteria in the inception report, and the evaluation will be designed in such a way that the findings can inform lessons learned and recommendations for future implementation throughout the country.

Evaluability

21. A baseline assessment has not been conducted for the MSP in Yemen. Monitoring has been conducted in accordance with agreed indicators per the national health information system and those agreed with the donor(s) and

project partner(s). The absence of a formal baseline assessment limits the ability of the evaluation to determine impact, which is why evaluation questions related to impact were not included in this ToR (see Evaluation Questions, below), but UNICEF does have multiple measures that can stand in for a partial baseline in considering the effectiveness and other aspects of the programme covered by the evaluation questions. However, while there is a monitoring framework, including some proposed indicators, in place for the MSP, the indicators are not tracked systematically. UNICEF field offices and the MoPHP maintain utilization data, and it may also be possible to use HeRAMS data on the availability of services. There is also third-party monitoring (TPM) data, a and HMIS databases from which a partial baseline could be constructed, and some ongoing monitoring data may also be extracted.

Evaluation Questions:

22. The key questions for this evaluation were formulated based on the revised OECD-DAC criteria, as elaborated in ALNAP. The criteria of relevance/appropriateness, connectedness/sustainability, coherence, coverage, and effectiveness been included in this evaluation. In addition, given the current context of Yemen, which faces both conflict and now COVID-19, the criteria selected have been chosen because they are the most manageable criteria that can be employed to answer the key evaluation questions in this context. Given the program's lack of a baseline, the impact criterion has been removed, and efficiency has also been removed due to a concurrent cost-benefit analysis the MSP is currently undergoing. Coordination has also been removed given the specific purpose of this evaluation. However, cross-cutting issues of gender and equity have been integrated into the evaluation criteria. Thus, the evaluation aims to answer the following questions:

Relevance/Appropriateness

a. What is the appropriate scope for UNICEF within the MSP, and to what extent is UNICEF currently working within the scope of its comparative advantage? What are the benefits / trade-offs of supporting aspects of the MSP that are outside of UNICEF's usual mandate?
b. How close is MSP in scope and scale, as currently implemented, to its original plan? What factors have motivated adaptations that have been made?
c. How fit-for-purpose is the MSP's primary health care-level work for the health needs of the people of Yemen, including vulnerable populations? In what ways, if any, does it need further tailoring for national or sub-national needs, based on demographics, epidemiology, and disease burden?

Connectedness and Sustainability

d. Where is the MSP positioned within the Humanitarian-Development Nexus, and how effectively does UNICEF bridge between short-term activities and input-oriented approaches to longer-term sustainable impacts? How can UNICEF leverage its work on the MSP to address issues of trust between communities and the health system?
e. How did the MSP contribute to preparedness and the response to recent health emergencies, including COVID? How did the MSP strategy facilitate the continuity of services in the COVID context?
f. How well are office plans for inputs linked to the MSP vs. being ad-hoc / on request from authorities / driven by vertical program considerations? What effect does this operating approach have on to the sustainability of the MSP?

Coherence

g. How well aligned are UNICEF's interventions with other agencies such as WHO, WFP, UNFPA, health cluster partners in Yemen in supporting continuity and continuum of care? What gaps or duplications need to be addressed?
h. How well do UNICEF's sectors align, coordinate, and complement each other internally to support the MSP?
i. How accountable is UNICEF to local communities? Which stakeholders may be left out of the planning and implementation of UNICEF's work with the MSP?

Coverage

j. To what extent has UNICEF prioritized the most appropriate locations and populations? To what extent did UNICEF's selection criteria enable or hinder the selection of such locations and populations?

k. How has UNICEF managed the trade-offs between coverage (scale) and quality? Which trade-offs have best served stakeholders (including local communities) and which trade-offs have not served stakeholders well?

l. How were the primary affected populations identified and engaged in UNICEF's work with the MSP? How much access to primary health care services have they enjoyed since the start of MSP? Has this changed over time, and how?

Effectiveness

m. How does MSP's primary health care progress compare to its plans? What factors facilitated or hindered its implementation and the achievement of its outcomes? What unintended outcomes has MSP produced?

n. What are some reasons why people don't access care / services, and what changes would encourage and/or enable them to do so?

o. In what ways has the primary health care work under MSP affected Yemen's response to COVID-19?

Stakeholders

23. The following stakeholders have been identified for this evaluation:

- Ministry of Public Health and Population (plus district-level government counterparts)
- Ministry of Religious Affairs
- Communities affected – primary and secondary service users
- Health cluster, including NGO partners
- Health technical working group
- WHO
- Donors
- Third party monitors

Methodology

24. The evaluation will be conducted in accordance with the UNEG Norms and Standards for Evaluation, adopted by UNICEF. Given the nature of the program, data availability, and the current context of COVID-19, this evaluation will make use of existing quantitative data and will only collect new qualitative data, primarily remotely. There are MSP data available; however, there are gaps in the available data. There is no existing baseline study, and data from early stages of the program may be used to attempt to reconstruct one, but the evaluation team should anticipate that existing data will not be adequate to constitute a true baseline.

25. Due to the current security situation in Yemen and the spread of COVID-19, this evaluation will not collect new quantitative data; the evaluation team should anticipate working with gaps in data and mitigating the effects of incomplete quantitative data. The evaluation methodology will be based on the evaluation framework. The selected evaluation team will be requested to refine and submit the final detailed methodology for review by UNICEF at Country Office, Regional Office and NY Headquarters level at the inception phase. UNICEF anticipates that the methodology will include an extensive desk review, given that no additional quantitative data will be collected.

Inception

26. The evaluation manager will organize a briefing for the evaluation team within one week of the signing of the evaluation contract. By the time of the briefing, the evaluation team will receive all documents required for the writing of the inception report and desk review. After the briefing, the evaluation team will have one week to develop the inception report, which should include an elaborated methodology as well as a workplan with timeline and data collection instruments. Requests for additional documents and data should also be begun at this time. After the submission of the inception report, UNICEF will have three weeks to provide feedback and obtain ethical clearance. The evaluation team will then have one additional week to revise and submit the final inception report.

Desk Review

27. The desk review for UNICEF's contributions to Yemen's MSP should be extensive given the inability to collect additional quantitative data in the current circumstances. The desk review should include a review of UNICEF's MSP program records and related data at the national, governorate, and district levels (based on availability). Program managers will provide data that are readily available from various sources, many of which may be in Arabic and may require translation for evaluation team members who do not read Arabic. In addition, the desk review is expected to include secondary data and documents when available. Given the rapidly-evolving situation with COVID-19, methodology for data collection should be re-examined at the end of the desk review to determine whether any data collection (such as focus groups) can take place face-to-face or if all of it should proceed remotely.

Data Collection

28. After final methodology and data collection instruments are finalized at the inception stage, data collection will begin with training of data collectors on the final versions of instruments for this evaluation. This training can take place remotely or in person, in which case it should take place in a physically-distanced setting using appropriate health and safety protocols.

29. All interviews should be remote and focus groups may be limited or impossible due to access restrictions in Yemen due to COVID-19 and the humanitarian situation. Most focus groups and interviews will need to be conducted in Arabic. Data collection itself will consist primarily of interviews conducted remotely with key informants to include MoPHP officials, UNICEF and WHO staff, Health cluster partners, and donor representatives. Focus groups should also be planned, remotely or with appropriate health and safety protocols including physical distancing, with users of MSP services; if it is later deemed by Evaluation Manager in collaboration with the evaluation team impossible to conduct such focus groups, they can be converted to interviews of a selection of intended focus group participants. Focus groups should include users of MSP services, MSP implementers, and Health Cluster members. When organizing both interviews and focus groups, attention will be given to ensure gender balance, geographic distribution, representation of all population groups (eg, people of different ages, abilities, socioeconomic status, ethnic backgrounds) and representation of the stakeholders / duty bearers at all levels (policy / service providers /parents / community). When possible, existing quantitative data should be disaggregated by gender, geographical location, IDP status, and other variables to be finalized at the time of the inception report.

Data Analysis and Reporting

30. Given the sensitive context of Yemen, the evaluation team should pay special attention to data quality control. The evaluation team, working together with UNICEF, will exercise data quality control mechanisms intended to preserve the integrity and confidentiality of the data. Quality control measures should be included in training for enumerators, and this training should cover confidential handling and storage of evaluation data, as well as culturally-sensitive and ethical data collection (according to UNEG standards) and ethical enumerator conduct. Enumerator training should include role plays to give enumerators practice in responding to various challenges in preserving data quality, integrity, and confidentiality. In addition, the evaluation team should record the interviews and focus groups and submit them to UNICEF with the final report. The evaluation team should store the recordings and coded data securely and keep them for 90 days after the submission of the final report. After 90 days, the data should be deleted.

31. Data analysis should be guided by the evaluation questions, and the final report should be structured around each of the overarching evaluation criteria – relevance/appropriateness, connectedness/sustainability, coherence, coverage, and effectiveness – instead of individually by evaluation question. Analysis should focus existing quantitative data on descriptive statistics, as there is no baseline, and qualitative data should be mined for patterns. Data should be triangulated across sources. In addition, evidence of unintended consequences should be highlighted. Throughout the analysis, whenever possible, existing data should be disaggregated by the variables agreed in the inception report.

32. The final report should be shared with the evaluation technical and steering committees, as well as other stakeholders, as a draft for comments. The draft report should be organized around these criteria and should be comprehensive and provide detailed and specific results and conclusions, as well as clear recommendations. During inception phase, UNICEF and the evaluation team will discuss options for various formats for presenting findings,

which may include presentations targeted to various stakeholders (local / national authorities, Yemen Health and Nutrition Clusters, internal and external global technical audiences, donors, and other stakeholders); policy briefs; one- or two-pagers on selected topics; infographics; or other forms of reporting.

Ethical Considerations

33. Ethical issues and considerations as per the UNEG and UNICEF ethical standards for evaluation should be adhered to. This includes explicit reference to the obligations of evaluators (independence, impartiality, credibility, conflicts of interest, accountability); ethical safeguards for participants appropriate for the issues described (respect for dignity and diversity, right to self-determination, fair representation, compliance with codes for vulnerable groups, confidentiality, and avoidance of harm); and if the evaluation team plans to interview children, the UNICEF procedures for 'Ethical Research Involving Children' should be explicitly referred to. The evaluation team will also integrate gender and human rights considerations into the evaluation, in both the evaluation questions and in the conduct of the evaluation.

Limitations

34. As noted in the evaluability section above, the MSP lacks some aspects of ideal evaluability. The lack of a baseline assessment prevents some components of robust evaluation.

35. Data collection in Yemen requires official clearances. Clearances could significantly delay the evaluation, particularly at the inception phase, and consultants should be prepared for the timeline to change, in some cases by long periods of time, should these clearances be delayed. Consultants should also be aware that data collection instruments may require official review. Flexibility and adaptability will be key factors in the selection of consultants.

36. Given the current security situation in Yemen and restrictions in access, as well as COVID-19, the evaluation will rely on remote data collection to reach a wider geographical scope and to avoid challenges raised by inaccessibility of certain areas due to road conditions and conflict. Selection of samples may rely on convenient and purposive sampling rather than randomized methods. Alternative methods may also be used. However, the evaluation team will have to provide the justifications and framework for the sample selection methods to be used.

37. Visits to Yemen by international evaluators will not be possible. Evaluation teams should include qualified Arabic-speaking team members based in Yemen for data collection and review of the draft report for context.

38. In addition to the access restrictions listed above, given the humanitarian situation of Yemen and the onset of COVID-19, the evaluation team should remain cognizant that the programmatic staff dealing with this evaluation will continue to face heavy workloads and will not be as available to respond to questions as in many other contexts globally under different circumstances. Communication should flow strictly through the Evaluation Manager so as to limit further overloading already-overburdened programmatic staff; the evaluation team should be aware that tight and early coordination with the Evaluation Manager is necessary when questions for program staff arise, and that responses could take a longer-than-average time under the current circumstances.

39. As a result of the constraints listed above, this evaluation will not attempt to cover impact, and will focus on the objectives listed in the Purpose and Objectives section.

Governance

40. The evaluation will be funded and managed by UNICEF in collaboration with partner institutions and donors, with technical consultation with the UNICEF regional office. A steering committee will be established to approve the terms of reference, endorse the inception report and ensure that all deliverables are of the required quality. A technical committee will be established to provide technical inputs on the deliverables. The Evaluation Manager will supervise the evaluation team and act as secretariat to the steering committee. Stakeholders, including the Health cluster and MoPHP authorities, will provide the evaluation team access to data and information and facilitate remote data collection via the Evaluation Manager. The Evaluation Team Leader will manage the evaluation team and serve as the liaison with UNICEF and the steering and technical committees. The Evaluation Manager and Team Leader will hold biweekly calls to facilitate the evaluation and address any challenges that arise. The evaluation will require clearance by an ethical board via the UNICEF MENA Regional Office.

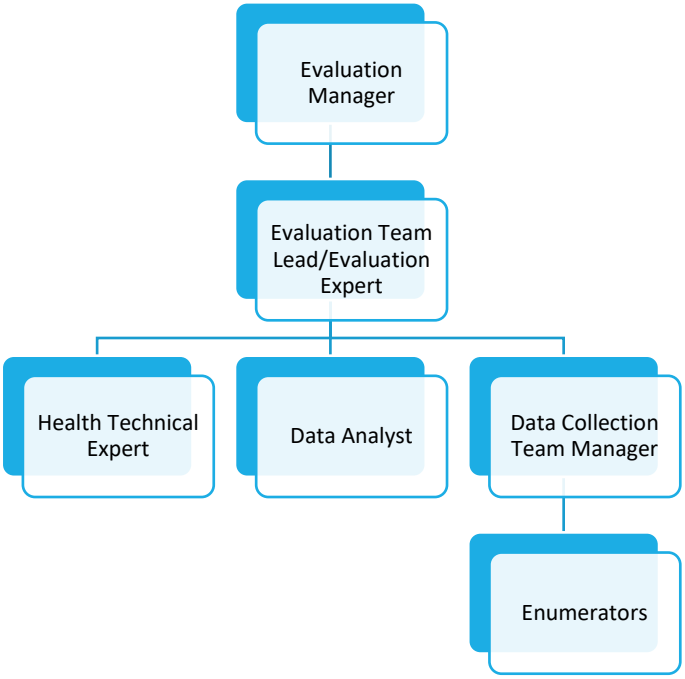

Figure 2: Evaluation Management Governance Structure

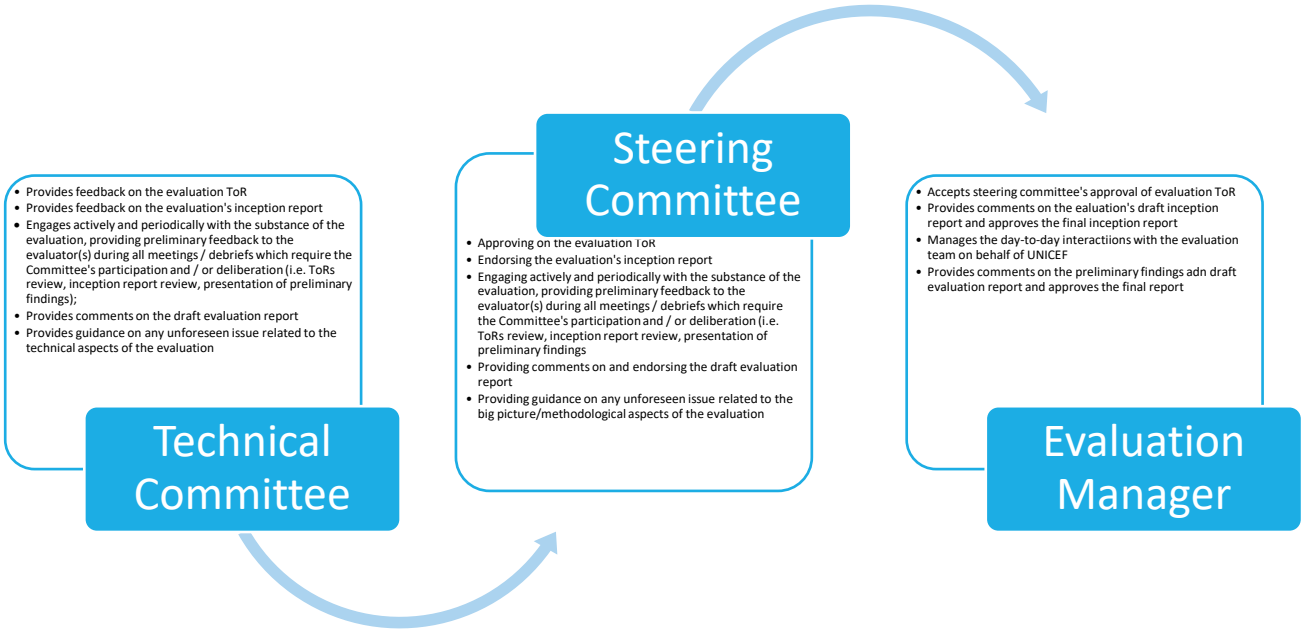

Figure 3: Evaluation Reference Group Roles

Deliverables

41. The contract will have the following deliverables:

1- Inception report outlining the interpretation of ToRs and methodology to be applied (including perceived limitations), ethical considerations, timeframe of assignment and data collection instruments in both Arabic and English.

2- Presentation of preliminary findings. The evaluation team should present the preliminary findings and conclusions to stakeholders in a workshop, probably to be conducted remotely.

3- Draft evaluation report for comments. The draft report should be comprehensive and provide detailed specific results, conclusions and clear recommendations.

4- Completed comments matrix. The completed matrix should be submitted with the final evaluation report.

5- Final evaluation report. Generally, the final report should be within the page limit of 25 pages, plus a standalone Executive Summary and appendices, and should provide detailed and specific results and conclusions, in addition to clear recommendations. However, the structure of the report should be discussed during the inception phase.

6- The evaluation team should submit all the qualitative instruments, raw data (raw qualitative data-original recordings and transcriptions of qualitative data) and datasets used in analysis.

In the table below the timeline is laid out. In several of the stages more than one person would work on the deliverable in parallel.

Task	Timeline	Deliverable	Responsibility

Organize and conduct briefing meeting	1 week		Evaluation manager
Submit inception report with data collection instruments (instruments should be written in English or Arabic and translated to the other)	1 week	Draft inception report with instruments	Consultant
Obtain ethical clearance and provide feedback on inception report	3 weeks		Evaluation manager and steering committee
Revise and submit final inception report	1 week	Final inception report with instruments	Consultant
Conduct desk review and secondary data analysis	3 weeks		Consultant
Train data collectors on approved instruments	1 week		Consultant
Collect data (primarily remotely) and analyse data	4 weeks		Consultant
Present preliminary findings to stakeholders	At the end of previous 4 weeks	Presentation of preliminary findings	Consultant
Prepare draft report	2 weeks	Draft evaluation report	Consultant
Provide feedback on draft report	2 weeks		Evaluation manager and steering committee
Submit final evaluation report with completed comments matrix, raw data, and datasets	2 weeks	Final report with comments matrix, raw data, and datasets	Consultant
Management response	60 days		UNICEF Country Rep

42. The report will follow the UNICEF guidelines and be cognizant of relevant UNICEF and UNEG guidelines for evaluation.

Evaluation Team Composition and Required Competencies

Pre-qualification of the institute

43. The bidding institute should be internationally certificated and should include qualified Arabic-speaking enumerators based in Yemen.

44. The bidding institute should also demonstrate financial credibility. The table below sets out the required skills for team members. Ideally the team will be mixed in terms of gender and cultural backgrounds; it is of particular necessity that the enumerator teams be comprised of members of all genders. The number of days indicated is subject to change depending on the specifics of the consultant company's proposal. A smaller team can be proposed as long as the team has the required skills necessary to answer the evaluation questions.

Team Leader / Evaluation Specialist	• Relevant master's degree (evaluation, development studies economics, social science, etc.) • Minimum of 10 years of experience in leading evaluation teams in the UN system and in politically-sensitive and crisis-affected environments • Demonstrated leadership of 5 evaluations, with participation in at least 20 evaluations, at least some of which are related to public health • Experience integrating gender and human rights into evaluations using social science methodologies • Experience working in humanitarian contexts (preferred) • Good understanding of statistical analysis • Proven ability to produce high-quality reports for a policy audience • Strong interpersonal skills and ability to work with senior officials • Cultural sensitivity, especially as demonstrated through similar assignments in the Middle East • Fluency in English, proficiency in Arabic (preferred)
Public Health Specialist	• Relevant master's degree in public health or related field • Minimum 7 years of experience in analysing health programming • Experience working or researching in humanitarian contexts and familiarity/ background with health in these contexts • Good understanding of gender and equity issues in relation to health and development and the application of gender / equity analysis to policy and planning in health • Strong interpersonal skills and ability to work with senior officials • Cultural sensitivity, especially as demonstrated through similar assignments in the Middle East • Fluency in English, proficiency in Arabic (preferred)
Data Analyst	• Relevant degree in statistics or data management • Experience working with data in a public health sector context • Experience in processing and analysing qualitative and quantitative data from different sources • Experience wrangling, cleaning, and analysing multifaceted complicated data sets • Experience working in humanitarian contexts (preferred) • Cultural sensitivity • Fluency in English, professional proficiency in Arabic
Data Collection Team Manager	• Relevant degree in public health or social sciences • Experience in managing data collection initiatives • Experience conducting quality control of qualitative data collection • Experience in working in humanitarian settings • Experience in recruiting/training enumerators • Strong interpersonal skills and leadership skills to provide oversight and guidance to enumerators • Familiarity with the ethical guidance for research with at-risk populations • Cultural sensitivity • Fluency in Arabic and English
Enumerators	• Relevant degree in public health, social sciences, statistics, data management, or related field • Experience in collecting qualitative data • Experience in working in humanitarian settings • Strong interpersonal skills • Cultural sensitivity • Fluency in Arabic

Payment

45. All interested institutions or group of consultants are requested to include in their submission detailed costs including:

- Daily rate including hours per day
- Additional expenses (interpretation and translation, costs for training data collectors, etc.) to be agreed prior to commencing project
- The consultants would be required to use their own computers, printers, photocopier etc.

46. The total budget for the evaluation is $350,000; the contract will be awarded on a best value-for-money basis. Payment is contingent on approval by the Evaluation Manager and will be made in three instalments:

- 20 percent after the inception report
- 35 percent after the presentation of preliminary findings
- 45 percent on completion of all deliverables and final report to the satisfaction of UNICEF.

Location

47. The work will be home-based, with the potential for some data collection to take place in person in the sampled governorates in Yemen.

ICT Considerations and Data Security

48. The evaluation team will require access to some of the UNICEF internal databases and documents. Where UNICEF engages third parties to conduct monitoring on its behalf, they are obliged to implement appropriate data security measures. UNICEF data, including intellectual property rights, are the exclusive property of UNICEF and the evaluation team has a limited, nonexclusive permission to access and use the data. As provided in the contract, the data will be used solely for the purpose of performing its obligations under the contract. The evaluation team has no other rights under the contract, whether express or implied, to any UNICEF data or its context. To maintain the integrity of stored data, data should be protected from physical damage as well as from tampering, loss, or theft by limiting access to the data.

49. Data stored on paper, such as on data collection tools should be kept in a safe, secure location away from public access, e.g., a locked filing cabinet. Confidentiality and anonymity should be assured by replacing names and other personal information with encoded identifiers.

50. All data collected by the evaluation team at UNICEF's request is the sole property of UNICEF. The consultant agency will hand over all reports and raw data to UNICEF upon satisfactory completion of the evaluation. In terms of disposal, the evaluation data will be retained for a minimum of 3 months after UNICEF approval of the evaluation report and raw datasets. Paper documents will be shredded, and digitally stored information destroyed or securely overwritten. The consultant will be expected to provide UNICEF with a letter confirming that the data has been disposed appropriately. All evaluation data will be stored centrally in one database by the Evaluation section.

Evaluation Process of the Proposal

51. Bidding institutes are requested to submit CVs of the proposal team members and a financial proposal. Assessment will be done based on the CVs of the proposed team members on a pass/fail basis, and then financial proposals of qualified, pre-selected finalists will be evaluated for competitiveness.

Unsatisfactory Performance

52. In case of unsatisfactory performance, the payment will be withheld until quality deliverables are submitted. If the selected organization is unable to complete the assignment, the contract will be terminated by notification letter sent 30 days prior to the termination date. In the meantime, UNICEF will initiate another selection process to identify appropriate candidate.

Conditions and Administrative Issues

53. The contractor will work on its own computer(s) and use its own office resources and materials in the execution of this assignment. The contractor's fee shall therefore be inclusive of all office administrative costs.

54. Granting access to UNICEF ICT resources for consultants/non-staff is considered as 'exception,' and therefore shall only be granted upon authorization by the head of the office on justification/need basis. This includes creation of a UNICEF email address, as well as access to ICT equipment such as laptops and mobile devices.

55. All persons engaged under a UNICEF service contract, either directly through an individual contract, or indirectly through an institutional contract, shall be subject to the UN Supplier Code of Conduct: https://www.ungm.org/Public/CodeOfConduct

56. Please also see UNICEF's Standard Terms and Conditions attached.