TERMS OF REFERENCE FOR INSTITUTIONAL CONTRACT

(above US$ 2,500)

Title of the assignment	Evaluation of the Nutrition sector's performance in the Rohingya humanitarian response in Cox's Bazar.
Purpose	Evaluate the nutrition sector's performance in the Rohingya humanitarian response before and after the sector's service network "rationalisation".

Location	The evaluation's sites for the fieldwork:
	• The Rohingya camps in Cox's Bazar, Bangladesh:
	  ○ The integrated nutrition facilities of the UNICEF, UNHCR and WFP supporting camps. It is necessary to conduct at least 4 field missions to randomly selected integrated nutrition facilities separately to UNICEF and UNHCR supporting camps and any WFP supporting camps in UNICEF or UNHCR supporting camps[1].
	  ○ The staff of the integrated nutrition facilities, Rohingya and Bangladeshi Community Nutrition Volunteers (CNV), are the primary scope of the evaluation in connection with the range and quality of providing nutrition services through the integrated nutrition facilities (INF). The Rohingya community members (mothers of children under five, pregnant and lactating women, adolescent girls) are complementary objects of the evaluation from the community perspective.
	• The stakeholders of the nutrition sector in Cox's Bazar:
	  ○ Field mission in Cox's Bazar: 1) At least 1 visit to the ISCG, RRRC and the Civil Surgeon offices in Cox's Bazar; 2) At least 1 visit to at least 2 randomly selected international and 2 Bangladeshi implementing partners' offices in Cox's Bazar for communicating with the middle and senior management echelon.

Estimated Duration	The total duration of the contracting period is 7 months which consists of the following phases: • June 2021. Advertisement, selection and contract signing. • August-September 2021. Mobilisation and start of the fieldwork. • September-November 2021. Continuation of the fieldwork and the draft report. • December 2021. The final report and dissemination seminar and closure of the contract.
Reporting to Technical Supervisor of this assignment	• Bakhodir Rahimov, Nutrition Manager, Nutrition Sector Coordinator, Cox's Bazar, Bangladesh. • Andee Cooper Parks, Research and Evaluation Specialist, Dhaka, Bangladesh.
Estimated Budget	US$ 50,000.00

Grant Number & Expiry Date	SM180348 ECHO grant, December 2021
Contract Plan	• 30% of the total fee upon submission and approval of the inception report. • 20% on submission & approval of field implementation report. • 20% of total fee on submission and approval of draft report and validation workshop. • 30% of total fee on submission and approval of final report (including infographics), 10-page summary report, and completion of the dissemination seminar.

1. Background

Cox's Bazar District is currently hosting over 889,400 Rohingya refugees. Nearly all live in 34 congested camps in the district. Out of the total population, there are 160,544 children under five (0-59 months old 78,585 girls and 81,959 boys), 124,517 adolescent girls (10-19 years old) and 42,000 pregnant and lactating women (UNHCR 2020) in the Rohingya camps.

The Humanitarian Needs Overview (HNO) and the Joint Response Plan (JRP) for the nutrition sector estimate the minimum number of direct beneficiaries to reach annually. The sector partners report against the estimated targets for tracking the coverage and accessibility of the life-saving nutrition care the specific programme objectives (OTP, TSFP, BSFP – see more details below). All nutrition services since 2020 are provided in 46 integrated nutrition facilities, which provides all mentioned nutrition services at one stop.

Annually, the nutrition sector partners reach close to 12,000 children under five with treatment against SAM (Severe Acute Malnutrition) through the OTP (Outpatient Therapeutic Programme). Over 46,000 girls and boys under five are the beneficiaries of the TSFP (Targeted Supplementary Feeding Programme for treatment of MAM – Moderate Acute Malnutrition).

Besides that, the BSFP (Blanket Supplementary Feeding Programme for preventing malnutrition using fortified food) reaches over 145,000 children under five and 42,000 pregnant and lactating women monthly. The anaemia prevention programme distributes iron and folic acid for 112,000 adolescent girls and 38,000 pregnant and lactating women.

1.1 Nutrition Sector's members and coordination unit

The UN (UNICEF, UNHCR, WFP), international (ACF, SCI, CWW, WC/M, Care etc.) and national (SHED, SARPV) agencies are the core of the nutrition sector. All international and national agencies under the UN programme partnership, managing the integrated nutrition facilities and providing integrated nutrition-specific and sensitive[2] OTP, TSFP and BSFP service through a "one-stop-shop" approach are the pillars of the sector.

Other agencies outside of the mentioned UN programme partnership are members of the sector. Those members provide nutrition services outside of the nutrition sector's network of the integrated nutrition facilities. The range of those services includes nutrition counselling for pregnant women in the antenatal care facilities, measuring of malnutrition and referral in case of detected malnutrition in pregnant and lactating women (EmONC[3]) and children under five (IMNCI[4]).

The nutrition sector's coordination system unsing the leadership of UNICEF[5] coordinates all of the nutrition sector's members using the ISCG[6] humanitarian response platform. Globally applied cluster is replaced by the sectoral (sector) approaches. The sector-based coordination mechanism is operational since the onset of the current Rohingya refugee crisis in 2017. The overall context and

the setting of the humanitarian response in the Rohingya crisis cannot apply all elements of the humanitarian programme coordination, including channelling and allocating the funds using the Humanitarian Funding (HF) system.

The nutrition sector's coordination unit is responsible for overall coordination and synchronising humanitarian nutrition response in the Rohingya and the host communities. The coordination unit's (hereafter referred to as NSCU) current structure consists of the nutrition sector coordinator, information management officer (IMO), emergency nutrition and government liaison officers. UN Volunteer as a knowledge management officer in 2021. The NSCU gets support and guidance from the ISCG and reports to RRRC using ISCG established channels. Programmatically, the NSCU cooperates with the Civil Surgeon Office through UNICEF in Cox's Bazar.

The structure of the NSCU differed by year depending on the availability of funds and immediate needs of the nutrition sector. For example, in 2019 and 2020, the NSCU had CMAM and IYCF consultants (international positions) and additional emergency nutrition officer. One of the objectives of the formative evaluation is to study the suitability of the structure and roles of each NSCU's member by year and recommend the effective and efficient minimum structure of the NSCU for the following years of the Rohingya response.

1.2 Nutrition Sector rationalisation process

In 2019, the sector initiated the nutrition service's network rationalisation process. The objectives for the service rationalisation included:

1) To prevent increasing service duplication in the Rohingya camps;
2) To optimise the staffing in the nutrition facilities;
3) To provide all services through the “one-stop-shop” services for improving utilisation of full spectrum of nutrition services (i.e. OTP, TSFP, BSFP);
4) To ensure the service continuity for children transferring from OTP to TSFP treatment programme (recovery) and prevention of defaulting SAM and MAM children; and
5) To ensure efficient use of the allocated funds in the Rohingya camps.

The rationalisation process was completed by the end of 2019 and further strengthened in 2020. There were 84 nutrition facilities in the camps in 2019 before the nutrition service network "rationalisation". Only 46 integrated nutrition services provide life-saving integrated nutrition services after the service rationalisation. The term "rationalisation" is used in terms of reference for describing the process of cutting the number of nutrition facilities, concentrating nutrition services[7] under a single roof of the integrated nutrition facilities (INF) through the restructured nutrition service's network in the Rohingya camps.

The partners' locations and handling of the nutrition facilities were reshuffled in the camps because of the service rationalisation. The international and national NGOs (Non-Government Organizations) completed handing over the nutrition facilities by the end of 2019. All nutrition services' registration documents were exchanged between implementing partners according to the rationalisation map. Each camp received one or in some camps two integrated nutrition facilities with OTP, TSFP and BSFP (Blanket Supplementary Feeding Program) services.

By the end of January 2020, there were two Bangladeshi (SARPV (Social Assistance and Rehabilitation for the Physically Vulnerable), SHED (Society for Health Extension and Development)) and four international NGO (Non-Governmental Organisation) (ACF, SCI, CWW, WC/M, WVI) managing 46 integrated nutrition facilities in all camps. ACF and SHED provided services also in the

host communities. Besides that, ACF continues managing the stabilisation centres for Rohingya camps.

The nutrition sector's coordination unit completed the quantitative analysis of the sector performance before and after the rationalisation[8]. The preliminary internal analysis of the sector performance in 2019 and 2020 showed steady progress in coverage and accessibility of the life-saving nutrition services in 2020 after the sector's service network rationalisation in 2020. The planned formative evaluation will support conclusions on the outcomes of the rationalisation and inform the sector partners about the next steps of the sector's reforms.

1.3 Nutrition Sector in COVID-19 response

The COVID-19 pandemic challenged the sector rationalisation in the first months of operationalisation when it invaded the nutrition sector in March 2020. RRRC[9] announced a total lockdown and almost discontinued field services except those included in the list of critical and life-saving services. Nutrition services were included in that list. However, the nutrition sector partners faced substantial staff cuts entering the camps. The number of staff in the integrated nutrition facilities was cut from five to three, and a very limited number of Bangladeshi community nutrition volunteers were allowed to enter the Rohingya camps. The sector developed COVID-19 nutrition field strategy and service protocols for overcoming the faced challenges.

The rationalisation process was almost completed by the onset of the COVID-19 pandemic in Cox's Bazar. However, some ongoing exchanges of the INF registration and nutrition recording documents between the handed over and exchanged nutrition facilities were completed by the end of February – beginning of March 2020.

There was a range of COVID-19 nutrition modifications implemented through the rationalised network of the nutrition services[10]. The JRP2020 COVID-19 Addendum for the nutrition sector's JRP2020 was developed and implemented within the ISCG-coordinated COVID-19 response. The nutrition sector partners adopted COVID-19 preventive measures, including COVID-19-induced modification for the nutrition programme (CMAM – Community Management of Acute Malnutrition[11], IYCF – Infant and Young Child Feeding[12], GDM – Growth and Development Monitoring[13]) in the Rohingya camps. One of the specific objectives of this proposed evaluation is to review the sector's rationalisation effects on the COVID-19 response.

2. Objectives, Purpose and Expected Results

The primary objective of this evaluation is to **review and analyse of pros and cons of the nutrition sector's service rationalisation**. Therefore, it is suggested to split the analysis into periods of 2018-2019 as pre and 2020 as a post-service network rationalisation. Simultaneously, the post-rationalisation period should be evaluated hypothesising the absence of the rationalisation in the COVID-19 response of 2020 to confirm implications of the sector rationalisation in achieving the JRP2020 COVID-19 Addendum.

There will be both a formative and summative angle to this evaluation. The formative aspect will focus on the setup of the nutrition sector's coordination unit (NSCU) and whether the various guiding framework is aligned with needs and requirements in the context and nutritional goals of the sector. The summative aspect will focus on evaluating the nutrition service provision, quality and coverage in the COVID-19 programme environment (considering the pre-and post-service rationalisation period).

The specific objectives of the evaluation include:

1. Assess the relevance of the HNO, JRP, and HPC[14] approaches for the nutrition sector response in the Rohingya camps considering the needs of children under five, adolescent girls, pregnant and lactating women;
2. Assess the relevance, efficiency, and effectiveness (performance) of the nutrition sector within the overall Rohingya refugee response, reviewing the volume and comprehensiveness of the Joint Response Plan's (JRP) annual achievements in the Rohingya camps, pre and post sector's service network rationalisation periods, and perceptions and data from frontline service providers and beneficiaries;
3. Assess the structure of the Nutrition Sector's Coordination Unit (hereafter referred to as NSCU) for fit for purpose in ensuring the synchronised efforts between all UN programme and implementing partners and the government stakeholders, considering the pre and post sector rationalisation periods and within the COVID-19 response (and post-COVID-19), the actual needs of the sector and goals outlined in the JRP for all beneficiaries, and recommend minimum staffing and funding requirements (aligned by planned achievements of the nutrition sector by the JRP years and factoring in inclusiveness (protection, ECCD, disabilities) and coherence of services);
4. Determine the impact of the nutrition sector rationalisation on the sector's response and beneficiary felt needs, particularly given the COVID-19 pandemic and equity, human rights, and gender considerations;
5. Evaluate the nutrition service provision, quality and coverage in the COVID-19 programme environment, assessing changes brought about by the sector rationalisation process, comparing the actual COVID-19 related results to a theoretical model (hypotheses) in the non-rationalised programmatic setting; and
6. Review sustainability requirements for the nutrition sector rationalisation, considering the post-COVID-19 environment and the need to build resilience in the refugee and host communities for future covariate shocks

The evaluation will discover the pros and cons of the nutrition sector's service network rationalisation by comparing the sector performance between JRP 2018, 2019 and 2020 outcomes[15]. Besides the analysed results between the JRP implementation years (2018, 2019 and 2020), it is expected to split the findings into two main groups: before and after the sector rationalisation.

The obtained data should provide the advantages and disadvantages of the sector rationalisation from the viewpoint of service providers and beneficiaries. Additionally, the results will evidence the advantages or disadvantages of the sector rationalisation for the COVID-19 pandemic response (JRP2020 COVID-19 Addendum).

The obtained results should confirm or reject the viability of the rationalisation in possible other emergencies, infection diseases outbreaks (epidemics and pandemics), including natural or human-made disasters. Lastly, the results from the NSCU's fit for purpose assessment will assist in developing minimum staffing and funding requirements for successful coordinating, facilitating and leading the nutrition sector in Cox's Bazar.

3. Description of Assignment

The formative evaluation should use the recommendation of the Evaluation of Humanitarian Action Guide[16] and combine elements of the summative evaluation for the sector's pre-rationalisation and COVID-19 response in 2020. Remote and virtual means for communication is recommended for all data collection. Only in cases where the data or information is not possible to be obtained otherwise will the in-person data collection be allowed.

The desk review part will be concentrated on the analysis of JRP, HPC and HNO documents 2018-2020, including 4W annual achievements. The results of the desk review will respond to the main questions of the formative evaluation (see the relevant chapters below on OECD-DAC Evaluation questions). The nutrition sector will share the summary of the quantitative analysis (Tableau dashboard[17]) of the sector performance. The role of the evaluation is to complement the report with qualitative analysis and develop a final combined report.

The sector's performance collected from JRP 2018, 2019 and 2020 reports should be reflected and confirmed in the targeted Rohingya communities. The researchers must apply different social survey tools and methodologies to collect maximum information for comprehensive analysis and reporting. It might include but not limited with the individual interviews, focus groups discussions and questionnaires and to target the service providers in the camps (staff of the integrated nutrition facilities), project managers of the implementing NGOs, UN programme partners, ISCG and government institutions (RRRC, the Civil Surgeon Office).

However, the majority of attention should be given to the Rohingya communities in general, caregivers of children under five, adolescent girls, pregnant and lactating women specifically. The scope of the interviews should be concentrated on the sector's performance before and after the service rationalisation. Besides that, it should consider the COVID-19 response in 2020. The elements of the "client satisfaction"[18] and "accountability to affected population"[19] should be used for getting a comprehensive understanding and recording evidence on the nutrition sector's performance in 2018, 2019 and 2020 and constructing the general performance trends from the service receivers' point of view.

The research institution develops the protocol of the evaluation and submits it to UNICEF together with the financial proposal. There are tools, methodologies, questionnaires in the research protocol, and the estimated duration of each milestone's evaluation process, including clear deliverables (see the respective sections below).

The desk review will consider the sector-specific documents only. It includes JRP (Joint Response Plan) 2018, 2019 and 2020 with midyear and final reports and HPC project proposals. Besides that, the nutrition sector's coordination unit will provide additional information consisting of the 4W reports dashboard, different publications from the sector partners and HNO estimations. The desk review must compare the referred documents (plans and reports) and generate the evidence by filtering the sector achievements through OECF-DAC evaluation criteria (see the questions in the relevant sections below).

Distant contact with main stakeholders of the nutrition sector might be prioritised in the COVID-19 lockdown and limited access to the camps. The evaluation team must prepare the protocol with a detailed description of the interview approaches, tools, and methodologies using telephone calls or online meeting platforms (MS TEAMS). The sector's coordination unit will provide the telephone numbers of the nutrition site supervisors, project managers, focal points of the RRRC, camps in charge (CiC) and the Civil Surgeon Offices, donors, and other relevant institutions (ISCG, UN) for setting up the phone calls or MS TEAMS meetings. It will be *impossible* to get the phone numbers or establish online meeting rooms for Rohingya community representatives (caregivers of children under five, adolescent girls, pregnant and lactating women) because of limited mobile phone and mobile internet coverages in the Rohingya camps. Therefore, the proposal should include a cost plan of field missions to Cox's Bazar to visit the randomly selected camps.

For the field missions, the nutrition sector's coordination unit will negotiate with the RRRC for getting special permission to enter the camps for the evaluators. The list of camps with the basic

background information and the range of the nutrition services will be developed and provided for the evaluation team. However, before visiting the camps, it is essential to share the questionnaire (semi-structured for the face-to-face interview, structured for the online questionnaire), interview protocol (focus group discussion's thematic and content).

In Cox's Bazar town, the evaluators might visit the offices of the UN programme and NGO implementing partners. The missions in the town should also plan to visit the RRRC, the Civil Surgeon and ISCG offices. During the meetings with the implementing international and national NGO, the evaluation team might use the opportunity to understand the capacities of the implementing partners and get more insights about the funding status in 2018, 2019 and 2020, including staffing and service quality dynamics. The evaluators' direct targets in Cox's Bazar are the project managers, member of the SAG (strategic advisory group of the nutrition sector), CMAM[11], IYCF[12] and AIM (Assessment and Information Management) Technical Working Groups (TWG).

The evaluation process from the contract signing to submission of the final report and facilitation of the dissemination seminar would take approximately six months with the following periods:

- Draft protocol, financial proposal, draft questionnaires should be submitted before the signing of the contract.
- After the desk review, the protocol of the evaluation, plan of the field missions, selected camps and interview schedule should be finalised and submitted to UNICEF. The nutrition sector will get approvals from the RRRC and ISCG for visiting the camps, meetings with the camps in charge, Civil Surgeon Office and other government stakeholders.

A proposed timeframe for the evaluation is provided below (see the table). The entire assignment is expected to be completed within six months. This might be subject to change depending on the situation on the ground at the time of the evaluation implementation (including disruption by severe weather events), current pandemic situation and restriction and as per mutual agreement between the evaluation team and managers; however, the technical proposal should reflect this six-month overall implementation period. The bidding team should include a more detailed timeline in the proposal, including review and feedback periods.

Table Evaluation Schedule

INCEPTION PHASE:

Tasks	End Product	Time Frame	Tentative Deadline
Participation in Inception Meetings	Inception meetings with nutrition sector coordination unit, UNHCR, WFP (World Food Programme), UNICEF and government counterparts on assignment and expected results (including what is expected in the Inception Report)	1 week after signing a contract	Week 3 June 2021
Preparation of an Inception Report	Should include: • A review of literature and reports and studies; • A methodology including sampling, key analytical questions, list of data to be collected and their sources (data framework and data list), technical approach, methods of data analysis (and plans), possible data collection challenges and methods of	1 month after signing a contract	By mid July 2021

	overcoming data challenges, work plan detailing activities and timelines • Revised (final) evaluability assessment matrix		

EVALUATION IMPLEMENTATION PERIOD:

Tasks	End Product	Time Frame	Tentative Deadline
Develop Tools for data collection	Development and finalization of data collection tools and protocols, testing and revision of the tools, data collection training manuals and pretesting, as required.	1.5 months after signing a contract	By end of July
Ethical Clearance	Necessary ethical clearance to be obtained prior to initiation of the data collection as well as Refugee Relief & Repatriation Commissioner permission to undertake data collection in the camps	2 months after signing a contract	Mid August
Field teams and training	Selection of teams. Training and orientation of interviewers and supervisors, including on child protection principles and on the prevention of sexual exploitation and abuse.	2 weeks	By end of August
Data Collection Field work	Data collection (survey, focus group discussion and key informant interviews) and supervision	5 weeks (no data collection on Friday)	Mid October
Data analysis, preliminary results report and first draft	• Ongoing data analysis, write up and interpretation of key results and findings. • Submission of preliminary Report (including Exe Sum, revised TOC, and draft recommendations). • Prepare and present preliminary findings to UNICEF and other stakeholders and EU (in validation workshop) • Submit First Draft (adhering to the GEROS reporting standards)	1 month	End of October
Review of first draft and incorporation of comments	• Review of the first draft by UNICEF • Incorporation of comments and production of the second draft. • Development of related infographics.	2 weeks	Mid November
Review of 2nd draft	• Review of second draft by the Reference group (Nutrition sector coordination unit and UNICEF) • Incorporation of comments and production of the Final Report (meeting at least GEROS "Satisfactory" rating) and infographics. • Facilitation of the final dissemination seminar for all sector stakeholders	2 weeks	Mid December

The inception and draft evaluation reports will be shared with the evaluation reference group for feedback (Nutrition sector coordination unit and UNICEF). The UNICEF Regional Office will provide

quality assurance across the entirety of the evaluation milestones. All draft and final reports submitted need to show a clear flow from objectives and purpose of the evaluation, evaluation questions, methods and tools used to collect and gather information, analytical approach, findings, conclusions and recommendations. The reports should aim for conciseness, readability, and visual appeal. Additionally, all data files, data completed tools must be submitted to the Nutrition sector coordination unit and UNICEF at the end of the evaluation.

Nutrition sector coordination unit and UNICEF Bangladesh reserves the right to ensure the quality of products submitted by the external evaluation agency and will request revisions until the product meets the quality standards expressed by the Reference Group.

The technical proposal should have two scenarios. Scenario one should plan the field missions to the Rohingya camps with a full volume of face-to-face meetings and interviews with the identified objects of the evaluation, still considering COVID-19 preventive measures. Scenario two should use the only telephone or remote contact approaches for data collection. A combination approach might also be possible and can be suggested. Travel costs to Cox's Bazar should be budgeted or removed accordingly. The evaluators will receive updates from the NSCU on the COVID-19 restrictions in the camps. The COVID-19 limitations might be lifted before submitting the proposals from the potential contractors, and the appropriate scenario will be selected. UNICEF will reserve the funds to implement scenario one and adjust the allocated budget if only scenario two (or a combination option) is feasible.

4. Deliverables

The evaluation team should submit the ***draft protocol*** and the ***financial proposal*** considering the scenario one and two (see above). The draft protocol should clearly describe the ***methodology, questionnaires*** and approximate timeline referring to the recommendation of the terms of reference. Staff from the NSCU and UNICEF will review the proposals and assess them according to the evaluation proposal's criteria. Besides the mentioned submission documents after the contract signing, the evaluation team is expecting to deliver the following documents:

- The summary of the desk review findings and summary conclusions
- Data collection tools and data analysis plan (DAP)
- IRB submission package and IRB approval letter
- Inception report, including fieldwork schedule
- Field implementation report
- Draft narrative report and validation workshop with key stakeholders
- Final narrative report (and infographics) with presentation and 10-page summary report.
- Dissemination seminar for all nutrition sector's stakeholders.

The timeline is mentioned in the "Description of Assignment". The joint UNICEF Dhaka and Cox's Bazar, the nutrition sector's coordination unit, will review the quality of each deliverable and give recommendations on the areas for emphasising more attention and needs for additional information.

In the case of scenario two development, the dissemination seminar will be online (distant). In both scenarios, the protocol of the seminar with all questions asked and suggestions made must be documented and annexed to the final narrative report (see the "Reporting Requirements").

5. Reporting requirements

There are globally recommended formats for evaluation reports[20] , and the purpose of the terms of reference to ensure that the global standards will be kept for the inception and final editions of the current evaluation. The final report must meet the standards outlined in UNICEF's evaluation quality assessment system, Global Evaluation Reports Oversight System (GEROS). A new scoring template released in April 2021, and this evaluation will be held to that standard. See the GEROS Handbook and Summary for more information.

The joint UNICEF and the nutrition sector's coordination unit team require biweekly progress updates shared via email to the mentioned team members. The progress report might consist of informing about critical milestones, challenges and mitigation plans, and upcoming actions. The timeframe for all deliverables is mentioned in the "Description of the Assignment". The estimated timeframe considers and contains a time buffer for any force-majeure. Therefore, it is not advised to extend the contracting period beyond the end of December 2021.

The detailed final narrative report and presentation must contain the following paragraphs:

- Table of contents, list of annexes/figures/tables, etc.
- List of Acronyms
- Executive summary (2 – 5 pages)
- Introduction & Background
- Methodology, including limitations and ethical considerations
- Results & Discussion
- Conclusion
- Recommendations (short and long term)
- Annexes (finalised data collection tools, IRB approval letter, the protocol of the dissemination seminar, etc.)

6. Payment Schedule

The proposed payment schedule should be synchronised with the protocol of the evaluation and financial proposal. The evaluation activities should be divided into sub-activities and costs according to the recommended payment schedule. It is possible to split the first 30 per cent of the payment into two batches and pay 15 per cent out of the total estimated budget on signing the contract as prepayment:

- 30% of total fee upon submission and approval of the inception report (including data collection tools and DAP).
- 20% on submission & approval of field implementation report.
- 20% of total fee on submission and approval of draft report and validation workshop.
- 30% of total fee on submission and approval of final report (including infographics), 10-page summary report, and completion of the dissemination seminar (as well as all finalised and translated data collection tools and raw and analysed qualitative and quantitative data).

In case of continued COVID-19 restrictions, the dissemination seminar will be online (distant and free of venue charges); however, the seminar should be documented and annexed to the main report.

7. Qualification requirement of the company/institution/organisation

Given the complexity of the assignment, the reputable agency conducting this evaluation should have:

- No less than 8 years of experience in programme evaluation in complex refugee context, with an in-depth understanding of nutrition.
- No less than 8 years of experience in designing, planning, organising, managing and conducting large scale and complex evaluations
- Demonstrated expertise in large-scale research design, methodologies, data validation and data quality assurance
- Technical expertise and experience in gender equality and human rights, including child rights programming, monitoring and evaluation.
- A technical team strong in quantitative and qualitative design, analysis, and synthesis, led by a social scientist/expert having at least 8 years of relevant working experience
- Previous experience with UN agencies, large NGOs and Government
- Field level data collection resource pool who have at least 5 years of experience
- Very strong communication and presentation skills of team members with government and community members
- Demonstrated experience of collecting data in the field on tablets using online platforms, telephonically, and other non-face-to-face modalities
- Ability to work/operate in Bangladesh legally (legal documentation must be submitted)
- Fluency in written and spoken English is required, and Bangla is highly desirable
- Experience working in the emergency setting, preferably previous working experience in Rohingya camps
- Demonstrable knowledge and understanding of relevant policies and action plans of the Government of Bangladesh is an asset

The agency should appoint an English-speaking team leader with at least 10 years of proven work experience in leading similar projects and evaluations that deal with sensitive and confidential information, especially those associated with vulnerable individuals. This team leader manages a diverse team in an emergency, high-stress setting.

In addition, the project leader should:

- Be able to communicate about data collection and data analyses in clear and simple terms
- Able to write clear, brief, analytical reports;
- Boost a track record of undertaking such surveys with reputed organisations, governments, or similar.
- Submit details of projects undertaken and completed, name of the organisations with their contact numbers, year of undertaking and completion, coverage of survey work, etc.

8. Evaluation Process and Method

The proposed evaluation will use recommended formative and summative evaluation approaches, methodologies, and tools and the OECD-DAC criteria to form the basis of the evaluation questions. However, the content of the OECD-DAC evaluation criteria is adjusted to the needs of the nutrition sector in Cox's Bazar, Bangladesh. Therefore, the expected formative evaluation results are sector-specific[21], which might give opportunities for further developing the rationalisation and improving the quality of care.

The summative evaluation aspect will analyse the performance of the nutrition sector, projecting the JRP 2018, 2019 and 2020 results through the perceptions of the frontline service providers and the target beneficiaries. The evaluation will analyse the nutrition sector's performance using the evidence received from the direct sources of the evaluation and triangulate it with the quantitative reports and service achievements. Additionally, the evaluation will take a deep dive into the structure of the NSCU and analyse the role this unit in achieving the JRP targets. The evaluators must

disaggregate the obtained data into two main periods: before and after the sector rationalisation. The data coming in after sector rationalisation should be viewed through the lens of COVID-19, as that time period included the nutrition sector's COVID-19 response.

Using the available qualitative analysis of the sector's performance,[22] the agency will combine the results alongside the formative evaluation results, and finally, produce a comprehensive report. For purposes of scope, the agency should split the Rohingya Refugee crisis periods into three: 1) start and peak of the refugee influx in 2017 and 2018, 2) the service rationalisation process in 2019, and 3) post-service rationalisation period in 2020, which also includes initial and follow up stage of the COVID-19 response in the nutrition sector.

The primary data collection might be conducted remotely and with some safely managed in-person interactions through key informant interviews, in-depth interviews or small focus group discussions, and a survey (combination of the scenario one and two for the service providers' part). Voices of vulnerable participants must be included in this evaluation, specifically: adolescent girls, persons with disabilities, and Rohingya refugees. However, it is unlikely to communicate with the beneficiaries using phone calls or online meeting platforms. Therefore, the field missions should be scheduled for observations and communication with these beneficiaries and the timeline made flexible for doing so in the COVID-19 context. The table below provides more details on the recommended participants by method. COVID-19 preventive measures must be strictly considered for the field-missions[23].

The communities (caregivers of children under five, adolescent girls, pregnant and lactating women in the Rohingya camps) should be asked about the relevance and appropriateness of the programme, views on the services provided, effectiveness and quality of the activities, contributions toward building longer-term resilience, and COVID-19 impacts and recommendations for future work. For collecting field data, the NSCU will work with local authorities to secure the necessary access with UNICEF's support. The bidding team is expected to include more information to demonstrate understanding of and a strong capacity for the evaluation execution, particularly in Cox's Bazar and in the camps.

Table: Participants by Methods

IDIs/FGDs	• Beneficiaries (mothers and caregivers of children under five), pregnant and lactating women, adolescent girls in the camps with a special focus on the most vulnerable (e.g. children under five, adolescents and pregnant and lactating women with disabilities, families without male head). • Rohingya community nutrition volunteers, staff of the integrated nutrition facilities • UN programme partners (UNICEF, UNHCR, WFP) • Implementing international and Bangladeshi NGO partners. For understanding effectiveness difference between nutrition CMAM treatment protocols in the camps and host communities only. The community members in the host communities are not the scope of the proposed evaluation.
KIIs (Key Informants Interviews)	• ECHO donor representatives • Local government officials from the camps: Camp in Charge. • Members of the Strategic Advisory Group of the nutrition sector • Relevant UN agencies (UNHCR, WFP, UNICEF) • RRRC health and nutrition coordinator

	• ISCG staff members (communication, programme) • Key UNICEF, UNHCR and WFP staff in Cox's Bazar levels • Implementing NGO partners working in the camps and in the host communities for discussion about effectiveness of the national and global CMAM treatment protocols.
Survey	• Beneficiaries in the camps and with a special focus on the most vulnerable (including adolescent girls and persons with disabilities). The sampling might be completed with the support of ACF (main survey data provider) using HNO matrix. Wherever possible, beneficiaries will be surveyed in person by the survey team or through the nutrition sector implementing partner staff and volunteers on the ground. It will not be possible to survey Rohingya refugees remotely. • Frontline service providers (Bangladeshi volunteers and the staff of the nutrition facilities) can be contacted remotely by phone. The sector might provide the contact details of all site supervisors and the evaluation team can select any. However, the list of the selected frontline service providers for the interview might be returned to the nutrition sector coordination unit to confirm the phone coverage in the calling time.
Participant observation	• The team might visit any of the integrated nutrition facility in the Rohingya camps for observation and interacting with any of the visitors in the integrated nutrition facility.
Field visit	• Mission to any of the selected camp might be supported. During the field mission, the evaluation team might also meet with other sector representatives (health and food security).

The OECD-DAC criteria will evaluate the relevance, coherence, effectiveness, efficiency, equity/gender equality/human rights, and connectedness/coverage.

The evaluation will seek to answer but is not limited to the following questions corresponding to the OECD-DAC criteria. The bidding team can suggest changes to the evaluability scoring and evaluation questions, as long as the original question is captured and the reasoning behind changes is included. The contracted evaluation team will finalise the matrix during the inception phase, including identification of indicators for each question, means of verification, benchmarks, and assumptions.

Relevance

- Were the JRP, HNO and HPC planning documents relevant to the needs of Rohingya children, adolescent girls, pregnant and lactating women?
- How did the plans and results between the pre- and post-sector rationalisation period align with the needs of the targeted population? Is the size and quality of the network of rationalised nutrition facilities relevant for the emergency nutrition response?
- Was the sector's network rationalisation relevant from the frontline service providers' viewpoint? Are the generated quantitative 4W reports' achievements in line with the perceptions and expectations of the frontline service providers and beneficiaries?
- Is the nutrition sector's coordination unit relevant and fit for purpose (size, competency make-up, structure and partnership representation across UNICEF, UNHCR, WFP) for its responsibilities in coordinating all nutrition sector partners and achieving the JRP targets outlined each year?

Coherence

- To what extent is there coherence between the work of the nutrition sector's coordination unit and key humanitarian policies and other development agendas (IASC Transformative Agenda, "Do no harm"," Leaving No One Behind", "Building back safer")?

Efficiency[24]

- Was there a transparent distribution of key actors' roles and responsibilities, including nutrition sector coordination unit staff, programme (UN) and implementing partners (INGO and BNGO) toward achieving objectives?
- To what extent has the nutrition sector partners made good use of the human, financial and technical resources and have made appropriate use of tools (programme and financial management) and approaches to pursue the achievement of HNO, HPC and JRP result cost-effectively?
- Has the HPC and FTS (Financial Tracking Service) done appropriate financial planning and reporting? Was the disbursement and management of funds and reporting done efficiently? Are the established procedures for checks and controls in day-to-day financial management, procurement of goods and services and decision regarding resource allocation clear and fit for purpose?
- How has the rationalisation affected efficiency in staffing, time, implementation, and achievement of current results? (Please consider the mentioned pre and after the sector rationalisation periods).

Effectiveness

- How effectively have the results of JRP 2018, 2019 and 2020 been achieved and to what level of quality (analysed by expected outcomes and outputs and considering differences among vulnerable groups and varying demographics (gender, age, disability, etc.). Do these results of the JRP and HPC match the nutrition realities in the camps? Are there any external factors (including financial obstacles) by the mentioned periods of the sector's evaluation that have affected the successful implementation and achievement of the annual JRP (focusing on prospects for refugee policy or replication)?
- Was the integration of interventions (rationalisation) effectively done? How has the sector's service network rationalisation nature impacted fidelity, quality, and effectiveness of implementing and realising current JRP? Consider differences among vulnerable groups and varying demographics (gender, age, disability, etc.).
- Are the JRP implementation strategies and nutrition interventions fit for the purpose to effectively achieve the planned short- and long-term nutrition outcomes for refugees, particularly the most vulnerable families and children, including the COVID-19 JRP2020 addendum?
- How effective has the NSCU's performance been towards harmonised and coordinated partnerships between UNICEF's, UNHCR's and WFP's field partners, comparing results of before and after rationalisation?

Impact (includes Equity, Human Rights & Gender Equality)

- What was the main impact of the sector rationalisation on the coverage and quality of services, including controlling service duplication and referral pathways? Consider impact on the rights of children under five, adolescents, pregnant and lactating women?
- How well has the nutrition sector and JRP adapted to the COVID-19 situation and reduced its impact on beneficiaries? Have these impacts been equitably achieved?

- What has been the positive and negative primary and secondary long-term effects or transformative changes produced by the nutrition sector service's network rationalisation intervention, whether directly or indirectly, intended, or unintended?
- How well has the HNO, HPC and JRP integrated gender and a human rights lens into the design and implementation? What has been the current effects of integrating the rationalised service network's integrated nutrition facilities and previous nutrition service providing format? How the COVID-19 pandemic affected the equity and gender-related areas of the humanitarian response in the nutrition sector?

Sustainability and Scalability

- How well might the sector rationalisation be sustained in the next coming years? What could be the subsequent phases of the sector rationalisation that might also contribute to sector sustainability and reaching to scale considering the COVID-19 pandemic?
- To what degree, if any, are there indications of sustainability, systemic change, or more resilience among the refugee and host communities in nutrition? How has COVID-19 and other experienced covariate shocks affected this?

Connectedness/Coverage[25]

- To what extent have the nutrition sector's stakeholders[26] have been able to support the beneficiaries, staff and the service providers, local government in developing capacities and establishing mechanisms to ensure ownership and durability long-term?
- To what degree have the major groups among the Rohingya refugees been covered effectively and with quality nutritional services by the nutrition sector? Consider differences among vulnerable groups and varying demographics (geographical area/camp, vulnerability, gender, age, disability, etc.).

9. Quality Assurance and Data Analysis

The agency is required to present a quality assurance plan around each methodology, including design, data collection, storage, entry, analysis, and synthesis. The agency will also propose a detailed Data Analysis Plan (DAP) for the evaluation findings.

10. Limitations

The agency will need to consider and/or provide workable solutions to any identified limitations, including the following: COVID-19 conditions and recent fires affecting four camps may limit the ability of the evaluation agency to interact or collect data equally and ethically from various stakeholders and beneficiaries.

11. Norms and Standards Guiding the Evaluation

This evaluation will be held to UNICEF's highest standards for the conduct of evaluations and research. This means it will abide by the following:

- United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation in the UN System, 2016
- Ethical Guidelines for UN Evaluations
- UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis

The final report is expected to meet the UNICEF-adapted UNEG (United Nations Evaluation Group) Evaluation reports standards as well as benchmarks used in UNICEF's Global Evaluation Reports Oversight System (GEROS).

12. Ethical considerations

It is expected that the proposal will include a section on the expected ethical challenges and issues that the evaluation will need to overcome. The institution/consultant will also be responsible for getting IRB ethical clearance. IRB ethical clearance is needed before quantitative and qualitative data collection, and the proposal should include a clause on how to deal with interviewing adolescent boys and girls in humanitarian settings. The IRB approval letter will need to be attached in the annexure of the final report. The proposal will need to spell out how the UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis will be followed/met, rather than only mentioning that the evaluation will abide by them. In the past, the research design and methodology for the baseline and midline were approved by the IRB.

13. Gender and Human Rights

Evaluation approach and data collection and analysis methods will be human rights-based, including child rights-based and gender-sensitive. All data will be disaggregated by the camps and host community, sex, age, gender, and ability level. The agency/institution/consultant is expected to abide by the UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation and the UN-SWAP Evaluation Performance Indicator.

14. Management and Reporting

The nutrition sector coordination team will manage the study with oversight and direct support of the Research & Evaluation Specialist, SPEAR team in Dhaka and PMR section in UNICEF's Cox's Bazar office.

SPEAR Section will provide technical support while UNICEF Cox's Bazar Field Office will provide coordination support, such as engagement with sectors to identify areas of study, coordination with the implementing partners, and updates with field-level/camp level to facilitate the evaluation implementation and dissemination of results. A designated focal point from the ECHO might also be assigned for convening, coordinating, and supporting the evaluation from the donors' side.

A Reference Group comprised of key stakeholders from the government and other partners will be set up from the evaluation's onset to provide quality assurance to the deliverables. The Reference Group will be consulted on each key milestone of the evaluation (i.e., inception report and draft report) and will give feedback on the deliverables of the evaluation. Evaluation results will also be presented and validated by the Reference Group. The Chief of SPEAR will have the accountability of accepting each deliverable.

After submitting the Inception Report, brief written reports should be submitted weekly by email to the Evaluation Manager by the end of each alternate Thursday.

15. Evaluation Dissemination Plan/Communication Plan

The final report will be followed by a participatory dissemination workshop, where the key stakeholders will finalise the report's recommendations. This presentation will include a maximum of 10 slides in the key findings, followed by the initial recommendations presented for discussion.
A reader-friendly summary report that outlines the key findings, conclusions and recommendations of the evaluation needs to be produced. The agency can choose the format, but it is expected that innovative formats will be used for enhanced readability.

EVALUATION CRITERIA FOR TECHNICAL PROPOSAL

CATEGORY	POINTS
OVERALL RESPONSE * Understanding of, and responsiveness to, UNICEF Bangladesh Office requirements; * Understanding of scope, objectives and completeness of response; * Overall concord between UNICEF requirements and the proposal.	**5**
METHODOLOGY AND DETAILED TIMELINE * Quality of the proposed approach and methodology (quantitative and qualitative separately); * Suitability of the approach: To what extent the methodology is designed in response to the needs of the TOR; * Quality of proposed implementation plan, i.e how the bidder will undertake each task, and time-schedules; *Risk assessment - recognition of the risks/peripheral problems and methods to prevent and manage risks/peripheral problems.	**(35)** 15 10 5 5
ORGANISATIONAL CAPACITY and PROPOSED TEAM * Professional expertise of the firm/company/organisation, knowledge and experience with similar projects, contracts, clients and consulting assignments ***** Team leader: Relevant experience, qualifications, and position with firm; * Team members - Relevant experience, skills & competencies; * Organisation of the team and roles & responsibilities;	**(30)** 10 10 5 5
TOTAL MARKS	**70**

For this RFP, the **Technical Proposal** has a total score of 70 points. Bidders must score a minimum of 49 points to be considered technically compliant and in order for the Financial Proposals to be opened. The financial proposal has a total score of 30 points. The final selection of the bidder will be based on a quality and cost basis as specified in the RFP.

16. Routing for approval of the ToR

Routing for approvals	Name	Signature & Date
Prepared by Sector Coordinator of the assignment	Bakhodir Rahimov, Nutrition Sector Coordinator, Cox's Bazar	17 May 2021
Reviewed & endorsed by Technical Supervisor of the assignment/Chief of SPEAR	Andee Cooper Parks, Research & Evaluation Specialist/ OIC SPEAR UNICEF Bangladesh	Andee C. Parks 17 May 2021
Procurement Review by Chief of S&P/Procurement Manager	Bakhtiyor Sharipov, Chief of Supply and Procurement, UNICEF Bangladesh	20 May 2021
Reviewed & endorsed for approval by Chief of Requesting Section/Field Office	Ezatullah Majeed, Chief of Field Office, Cox's Bazar, UNICEF Bangladesh	19 May 2021

Approved by Deputy Representative for program/Chief of Operations for Operations	Veera Mendonca, Deputy Representative, UNICEF Bangladesh	Veera Mendonca Deputy Representative UNICEF, Bangladesh 20.05.2021

NOTE:

- TOR related to Research, Evaluation and Study should be included in Office IMEP and reviewed by SPEAR Section.
- TOR related to Programme Communication for Development should be reviewed by C4D Section.
- TOR to develop Communication material and to arrange Event should be reviewed by CAP Section.
- TOR related to the development of software or related to ICT should be reviewed ICT Section.

17. Evaluability Assessment Matrix

Eval Obj.	*Evaluation Criteria*	Evaluation Question	Source(s) of Data	Methodology	Evaluability Assessment (Low-Med-High)
1	*Relevance*	• Were the JRP, HNO and HPC planning documents relevant to the needs of Rohingya children, adolescent girls, pregnant and lactating women? • 'frontline'	JRP, HPC, HNO J-MSNA reports, JRP2020 COVID-19 Addendum KII/FGD with the frontline service providers and the service's beneficiaries (mothers and caregivers of children under five, clients of the nutrition services)	Desk review Interviews (individual and in small groups, telephone or virtual)	Very high
2	*Relevance*	• How did the plans and results between the pre- and post-sector rationalisation period align with the needs of the targeted population? Is the size and quality of the network of rationalised nutrition facilities relevant for the emergency nutrition response? • Was the sector's network rationalisation relevant from the frontline service providers' viewpoint? Are the generated quantitative 4W reports' achievements in line with the perceptions and expectations of the frontline service providers and beneficiaries?			
3	*Relevance*	• Is the nutrition sector's coordination unit relevant and fit for purpose (size, competency make-up, structure and partnership representation across UNICEF, UNHCR, WFP) for its responsibilities in coordinating all nutrition sector partners and for achieving the JRP targets outlined each year?			
3	*Coherence*	• To what extent is there coherence between the work of the nutrition sector's coordination unit and key humanitarian policies and other development agendas (IASC Transformative Agenda, "Do no harm"," Leaving No One Behind", "Building back safer")?	JRP, HPC, HNO J-MSNA reports, JRP2020 COVID-19 Addendum KII/FGD with the frontline service providers and the service's beneficiaries	Desk review and KIIs	High

Eval Obj.	*Evaluation Criteria*	Evaluation Question	Source(s) of Data	Methodology	Evaluability Assessment (Low-Med-High)
			(mothers and caregivers of children under five, clients of the nutrition services) ECHO reports and interviews		
3	*Efficiency*	• Was there a transparent distribution of key actors' roles and responsibilities, including nutrition sector coordination unit staff, programme (UN) and implementing partners (INGO and BNGO) toward achieving objectives?	JRP, HPC, HNO J-MSNA reports, JRP2020 COVID-19 Addendum KII/FGD with the frontline service providers and the service's beneficiaries (mothers and caregivers of children under five, clients of the nutrition services) ECHO reports and interviews	Desk review and KIIs	High
2	*Efficiency*	To what extent has the nutrition sector partners made good use of the human, financial and technical resources and have made appropriate use of tools (programme and financial management) and approaches to pursue the achievement of HNO, HPC and JRP result cost-effectively?	HPC, 4W reports FTS Interviews	Desk review and KIIs	High
		Has the HPC and FTS (Financial Tracking Service) done appropriate financial planning and reporting? Was the disbursement and management of funds and reporting done efficiently? Are the established procedures for checks and controls in day-to-day financial management, procurement of goods	FTS, 4W reports, JRP reports	Desk review and KIIs	High

Eval Obj.	*Evaluation Criteria*	Evaluation Question	Source(s) of Data	Methodology	Evaluability Assessment (Low-Med-High)
		and services and decision regarding resource allocation clear and fit for purpose?			
		How has the rationalisation affected efficiency in staffing, time, implementation, and achievement of current results? (Please consider the mentioned pre and after the sector rationalisation periods).	Interview with the site supervisors of the integrated nutrition facilities and the project managers of the implementing partners	KIIs	Very high
2	*Effectiveness*	How effectively have the results of JRP 2018, 2019 and 2020 been achieved, what level of quality (analysed by expected outcomes and outputs and considering differences among vulnerable groups and varying demographics (gender, age, disability, etc.). Are there any external factors (including financial obstacles) by the mentioned periods of the sector's evaluation that have affected the successful implementation and achievement of the annual JRP (focusing on prospects for refugee policy or replication)?	JRP, 4W reports and interviews with the main stakeholders of the nutrition sector	KII FGD	High
		Was the integration of interventions (rationalisation) effectively done? How has the sector's service network rationalisation nature impacted fidelity, quality, and effectiveness of implementing and realising current JRP? Consider differences among vulnerable groups and varying demographics (gender, age, disability, etc.).	JRP plans and reports and achievements. Interviews with the service providers Interview with the Care International (UNICEF partner). SMART, SQUEAC and other surveys and reports	Desk review Interviewees, KII, IDIs/FGDs	High

Eval Obj.	*Evaluation Criteria*	Evaluation Question	Source(s) of Data	Methodology	Evaluability Assessment (Low-Med-High)
		Are the JRP implementation strategies and nutrition interventions fit for the purpose to effectively achieve the planned short- and long-term nutrition outcomes for refugees, particularly the most vulnerable families and children, including the COVID-19 JRP2020 addendum?	SMART, SQUEAC and other surveys and reports JRP reports by year (before and after the service rationalisation) Interviews	Desk review Questionnaires (including electronic) Survey, IDIs/FGDs, KIIs	High
3	*Effectiveness*	Whether the nutrition sector's coordination unit was well structured for effective coordination of all nutrition sector partners for reaching the JRP targets by year?	Interview with the nutrition sector's main stakeholders including donors and ISCG	IDIs/FGDs, KIIs,	High
4	*Impact*	What was the main impact of the sector rationalisation on the coverage and quality of services, including controlling service duplication?	4W reports by year, JRP plans and reports (midyear and annual). UN programme and implementing partners.	IDIs/FGDs, KIIs, Desk review	High
		How well has the nutrition sector and JRP adapted to the COVID-19 situation and reduced its impact on beneficiaries? Have these impacts been equitably achieved?	Staff, NGO and government partners, JRP documents, spot checks of IPs, donor reports, financial statements, grant utilisation reports	IDIs/FGDs, KIIs	High
4		What has been the positive and negative primary and secondary long-term effects or transformative changes produced by the nutrition sector service's network rationalisation intervention, whether directly or indirectly, intended, or unintended?	JRP reports, 4W reports, interviews with key stakeholders	IDIs/FGD/KII	Medium

Eval Obj.	*Evaluation Criteria*	Evaluation Question	Source(s) of Data	Methodology	Evaluability Assessment (Low-Med-High)
4	*Impact &' Equity, Human Rights & Gender Equality*	How well has the HNO, HPC and JRP integrated gender and a human rights lens into the design and implementation? What has been the current effects of integrating the rationalised service network's integrated nutrition facilities and previous nutrition service providing format? How the COVID-19 pandemic affected the equity and gender-related areas of the humanitarian response in the nutrition sector?	JRP, interview with the gender hub of ISCG	KIIs	Medium
6	*Sustainability and Scalability*	How well might the sector rationalisation be sustained in the next coming years? What could be the subsequent phases of the sector rationalisation that might also contribute to sector sustainability and reaching to scale considering the COVID-19 pandemic?	UN programme and implementing partners	IDIs/FGDs, KIIs	Medium
		To what degree, if any, are there indications of sustainability, systemic change, or more resilience among the refugee and host communities in nutrition? How has COVID-19 and other experienced covariate shocks affected this?	UN programme and implementing partners	IDIs/FGDs, KIIs	Medium
5	*Connectedness and coverage*	To what extent have the nutrition sector's stakeholders have been able to support the beneficiaries, staff and the service providers, local government in developing capacities and establishing mechanisms to ensure ownership and durability long-term?	Interview with the frontline service providers in the integrated nutrition facilities, UN programme, INGO and BNGO (Bangladeshi), ISCG	IDIs/FGDs, KIIs	Medium
		To what degree have the major groups among the Rohingya refugees been covered effectively and with quality nutritional services by the nutrition sector? Consider differences among vulnerable groups and varying demographics (geographical area/camp, vulnerability, gender, age, disability, etc.).	Interviews with the clients of the nutrition services in the camps	IDIs/FGDs, KIIs	Very high

18. Additional Information

[1] There are 35 camps and 46 integrated nutrition facilities in the Rohingya camps providing the outpatient therapeutic services (OTP) under UNICEF and UNHCR support. The OTP services provide life-saving services for the children in Severe Acute Malnutrition (SAM). There are 27 camps under the UNICEF and 8 camps under the UNHCR programme providing the OTP services for children under five. The WFP supports the Targeted Supplementary Feeding (TSFP) and Blanket Supplementary Feeding Programme (BSFP). The TSFP programme treats Moderate Acute Malnutrition (MAM) children under five, pregnant and lactating women. The BSFP programme prevents malnutrition in children under five, pregnant and lactating women.

[2] Multi-sectoral Approaches to Nutrition, UNICEF, https://www.unicef.org/Brief_Nutrition_Overview.pdf

Nutrition-Specific and Nutrition-Sensitive Interventions, Tom Arnold, https://www.karger.com/Article/Pdf/452392

[3] Monitoring emergency obstetric care, Handbook, WHO, UNFPA, UNICEF, AMDO, https://apps.who.int/iris/bitstream/handle/10665/44121/9789241547734_eng.pdf

[4] Integrated Management of Newborn and Childhood Illnesses (IMNCI), WHO, https://apps.who.int/iris/bitstream/handle/10665/42939/9241546441.pdf;sequence=1

[5] Global Nutrition Cluster https://www.nutritioncluster.net/

[6] Inter Sector Coordination Group, ISCG in Cox's Bazar https://data.humdata.org/organization/inter-sector-coordination-group

[7] The Integrated Nutrition Facilities (INF) provide OTP[1], TSFP and BSFP integrated services for children under five, pregnant and lactating women and also supports implementing mass campaigns (vitamin A supplementation, Iron and Folic Acid supplementation, mass MUAC screening)

[8] Nutrition sector's service performance before and after rationalization, presentation with core findings, conclusions and recommendations, internally unpublished, April 2021.

[9] Office of the Refugee Relief and Repatriation Commissioner, is a Bangladesh government agency under the Ministry of Disaster Management and Relief responsible for providing relief to Rohingya refugees in Bangladesh and plan their eventual repatriation to Myanmar, https://en.wikipedia.org/wiki/Office_of_the_Refugee_Relief_and_Repatriation_Commissioner

[10] The community nutrition screening dropped in March 2020, right after the COVID-19 lockdown in Rohingya and host communities. Compared with March 2019, community nutrition screening dropped by 50 per cent and more. The sector forecasted further decline of nutrition screening and the subsequent treatment programme, therefore developing nutrition-specific interventions.

To fill the urgent gap in community nutrition volunteers, the sector hired Rohingya volunteers and intensively trained for running community nutrition screening programme. Over 600 Rohingya young men and women were hired and received hands-on training. By the end of 2020, the COVID-19 situation was comparatively stabilised; therefore, Bangladeshi community nutrition volunteers have been returning to their positions in the camps. There are 60 per cent of Rohingya and 40 per cent of Bangladeshi community nutrition volunteers screen communities in the nutrition outreach programme by the mid of 2021.

At the peak of the COVID-19 pandemic in the camps, the sector faced a deep lockdown. Despite hiring Rohingya nutrition volunteers, the nutrition screening and admission to OTP and TSFP programme were decreased. The sector introduced the Mother Led MUAC approach, which engaged mothers and caregivers of children under five in nutrition screening and self-referral to the nearest nutrition facilities.

A child's recommended complete anthropometric measurements are discontinued because of COVID-19 social distancing and no-touch recommendations. Only MUAC (Mid Upper Arm Circumference) measurement remains a primary screening and diagnostic tool. The MUAC SAM and MAM cut-offs were reviewed and extended in Rohingya nutrition response according to the GNC (Global Nutrition Cluster) recommendations in the COVID-19 pandemic. With that extension, we wanted to increase admission rates dropped since the end of March 2020 and ensure that no child is left behind the nutrition programme.

Because of the COVID-19 lockdown and the limited number of nutrition services providers in the integrated nutrition facilities, we decided to merge the BSFP programme with the General Food Assistance. We predicted the possible challenges of the merging and increase of BSFP monthly coverage. However, it was agreed to take the risk and ensure that every eligible child and PLW received BSFP supplies to prevent malnutrition. The doubled ration was distributed, and the coverage of BSPF increased up to 120 per cent of a monthly target. From the end of November 2020, the BSFP was disintegrated from GFA (General Food Assistance) and returned under the integrated nutrition facilities roof.

The nutrition sector also developed the protocol to treat COVID-19 positive SAM children hospitalised in SARI ITC. In the nutrition sector, we agreed that COVID-19 in SAM child is accepted as a complication and must receive in-patient treatment in stabilisation centres. In agreement with IOM and MSF (SARI ITCs are under IOM and MSF support), health sector partners allocated isolated beds in the SARI ITC for SAM children under five.

The CMAM TWG developed the SAM treatment protocols for SARI ITC staff and gave the COVID-19-case-management team orientation sessions to cascade the protocol into the COVID-19 treatment hospitals. MSF has solid SAM treatment protocols; therefore, we paid more attention to IOM-supporting SARI ITC. No child with SAM has been reported positive for COVID-19.

With ECHO support, the nutrition sector's coordination unit also procured new tools and disposables for setting up the isolation units for COVID-19 suspected SAM children with nutrition complications in the stabilisation centres under ACF management. Nasogastric tubes, kitchen utensils, measurement cups and other equipment with a total cost of USD (United States Dollars) 15K were procured and handed over to ACF's stabilisation centres. The stabilisation centres are ready to admit COVID-19 suspected SAM children if SARI (Severe Acute Respiratory Infection) ITCs (Inpatient Therapeutic Centers) are overloaded.

The sector partners also were ready to provide nutrition treatment for SAM elderly persons. If COVID-19 positive older person falls into SAM, the nutrition sector partners were prepared to admit him or her to the nutrition treatment programme. However, there was not any COVID-19 positive SAM older person diagnosed.

[11] Community Management of Acute Malnutrition, WVI, https://www.wvi.org/sites/default/files/Community_Based_Management_of_Acute_Malnutrition_Project_Model%20%281%29.pdf

[12] World Health Organisation. Infant and Young Child Feeding, 24 Aug 2020, https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding

[13] UNICEF, Key practices: monitoring growth and development, https://www.unicef.org/uganda/key-practice-monitoring-growth-and-development-child

[14] JRP – Joint Response Plan; HNO – Humanitarian Needs Overview; HPC – Humanitarian Progrramme Cyclone; all are the essetnaial documents for planning, implementation, monitoring and reporting the humanitarian response in the Rohingya refugee crisis.

[15] The obtained results of the sector evaluation will guide framing of upcoming JRP 2022 planning, prioritising interventions considering recommendation for the next steps of the sector rationalisation. Besides that, the results of the evaluation will be used for setting up the nutrition services in case of relocation of the Rohingya camps to other areas of Bangladesh. Specific attention will be given to the rationalisation's impact on coverage, quality of the nutrition services and beneficiaries' satisfaction (mothers and caregivers of children under five, adolescent girls, pregnant and lactating women). Whether the rationalisation brought better quality of the services, extended accessibility of the affected population to the core nutrition programme (CMAM[11], IYCF[12]). Could the rationalisation experience from Cox's Bazar serve as a successful model for the global nutrition community.

[16] The Evaluation of Humanitarian Action Guide, ALNAP 2016, https://www.alnap.org/help-library/evaluation-of-humanitarian-action-guide

[17] Nutrition sector, summary 4W reports and trends analysis, April 2021, https://public.tableau.com/views/NS4WDashboard2018-2020/SAMandMAMCU5trendsanalysis?:language=en&:display_count=y&publish=yes&:origin=viz_share_link

[18] Using data to make your humanitarian organisation more client-focused, UNHCR, https://www.unhcr.org/innovation/using-data-to-make-your-humanitarian-organisation-more-client-focused/

[19] Accountability to affected people (AAP), UNHCR, https://emergency.unhcr.org/entry/42554/accountability-to-affected-populations-aap

[20] Developing an Effective Evaluation Report, CDC 2013, https://www.cdc.gov/eval/materials/developing-an-effective-evaluation-report_tag508.pdf. How to perform evaluation – the evaluation report, CIDA 2002 (OECD web), https://www.oecd.org/derec/canada/35138852.pdf

[21] The expected results of this evaluation are documented lessons learned and recommendations from the preliminary (the first year) stages of nutrition service integration for further immediate improvement on the next steps of the nutrition service network rationalisation as well as in future phases. This evaluation will prove a resource for similar contexts focused on resilience building of refugee populations, including learnings around the COVID-19 pandemic and relocation of refugee populations to new geolocations.

The current humanitarian response might support in revising the national CMAM protocols and include a global recommendation in treating SAM and MAM children under five. Natural disasters and global pandemics, including COVID-19, might deteriorate the nutritional status of children under five. Only international recommendation for using therapeutic food might urgently respond and cure SAM and MAM children rapidly growing in any emergencies. It is preferable to understand whether the Government of Bangladesh might consider the Rohingya crisis's experience, the COVID-19 response strategy for the nutrition sector. It is expected to receive constructive feedback about the opportunities for sustainable replication of the sector gains through network rationalisation in other geographical locations if necessary.

[22] Comparative analysis of the nutrition sector performance by year, unpublished report, NS CXB, https://www.evernote.com/shard/s726/sh/e41365bd-91a3-f14b-59f2-1010a5cfe62b/c7f3209e263da4270c63c09e6ba5e93c

[23] The World Health Organization (WHO) declared the COVID-19 a pandemic on 11 March 2020 due to the speed of its spread globally and urged governments to take urgent measures to limit its spread.

National public holiday and lockdown slowed down the overall activities and results of the nutrition sector. The focus has shifted towards a COVID-19 life-saving response. The situation remains fluid, and while moving forward with planning, it is possible that the evaluation will not be executed as planned due to access issues with travel and meetings. The evaluation team should include mitigation strategies for the COVID-19-related restrictions and ethical considerations, incorporate alternative modalities for interaction with beneficiaries and stakeholders, and be ready and equipped to manoeuvre as needed.

Discussions with frontline service providers can be done remotely by phone; however, beneficiaries will need to be surveyed in person. The more extended conversations with refugees need to be done in small groups or individual interviews. It may also be possible to speak to host community beneficiaries over the phone, though this may preference better-off beneficiaries. The contracted agency must have Bangla-speaking staff with the basic knowledge of Burmese (strong asset). Besides that, Bangladeshi citizens who did not travel 14 days before the evaluation are preferable because of COVID-19 restrictions (self-isolation). The contracting agency must follow COVID-19 precautions and, where possible to prioritise the virtual meetings, individual or focus group discussions in small groups when face-to-face meetings are required. All cases should be assessed individually for deciding the methods of communication (face to face or virtual).

[24] The reference documents for analysis of the Efficiency are HPC and FTS repositories (will be provided from the nutrition sector's coordination unit). The JRP 2018, 2019 and 2020 FTS (Finance Tracking System) should be referred and used only. The HPC describes activities by the implementing partner.

[25] Consider a comparison of the results between 2018, 2019 and 2020 periods before (2018 and 2019) and after (2020) the sector's service rationalisation with the additional element of COVID-19 impact (2020) on the nutrition programming through the rationalised integrated nutrition facilities in 2020.

[26] The Rohingya humanitarian response consists of several structures and stakeholders. The ISCG – Inter Sector Coordination Group, is the top of the coordination board for the Rohingya crisis, which connects

humanitarians with the Refugee Relief and Repatriation Commissioner (RRRC) – Government of Bangladesh responsible agency for Rohingya Crisis Response. The nutrition sector's coordination unit reports to the ISCG, as other sectors, and to UNICEF.

Besides the RRRC, the nutrition sector's coordination unit also bilaterally cooperates with the Civil Surgeon office for more programmatic and technical discussions and developing a joint approach in the camps and host communities.

UNICEF in Cox's Bazar is the nutrition sector-leading agency, which also supports the Nutrition sector coordination unit (NSCU). European Union funds NSCU. In 2021 there are five staff in the NSCU, including nutrition sector coordinator (international UNICEF position), information management officer (national UNICEF position), emergency nutrition officer (national post, e-zone third-party contracting agency), government liaison officer (national position, SSA UNICEF consultant) and UN volunteer (national position, knowledge management officer).

However, other positions outside of the core unit and are unpaid from the nutrition sector's coordination unit, covered by the implementing partners' side. The government sector co-lead (GSCL) is a staff member of the Civil Surgeon office. The GSCL ensures coordination of the humanitarian response efforts between the local government and the nutrition sector. The deputy nutrition sector coordinator is a staff member of Care International. There are combined roles of CMAM, IYCF advisers, and TWG lead in the nutrition sector's coordination unit from WC/M and SCI, respectively.

UNICEF, UNHCR and WFP are the core programme partners. ACF, SCI, CWW, WC/Medair, Care International, SHED, and SARPV are the international and national implementing partners in 2021; however, in 2020, there was also WVI funded through the UN channels. Respectively the list of nutrition sector members differed between 2018 and 2019. However, the scope of evaluation must consider the sector's partnership shifts in 2019 and 2020, before and after the sector rationalisation.

In general, the number of partners in 2018, 2019 and 2020 is not dramatically different. From 6 to 8 implementing partners are always in the nutrition sector provide nutrition services through the nutrition facilities under the UN partnership (funding). The main difference between pre and post rationalisation periods are in the number of nutrition facilities in the camp. Besides that, we can also consider the rationalisation brought more connections between:

- The Outpatient Therapeutic Programme (OTP) for treatment of Severe Acute Malnutrition (SAM);
- The Targeted Supplementary Feeding Programme (TSPF) for treatment of Moderate Acute Malnutrition (MAM);
- The Blanket Supplementary Feeding Programme (BSFP) for preventing malnutrition in children under five, pregnant and lactating women;

After the service rationalisation, the OTP, TSFP and BSFP are united under the roof of the Integrated Nutrition Facilities (INF). Therefore, the number of nutrition facilities were cut from almost 86 in 2018 and 2019 to 45 in 2020. This is the essence of the nutrition sector's service network rationalisation.

According to UNICEF's SOP in the partnership management, all procuring programme supplies must be transferred only to the active UNICEF's partners. However, the nutrition sector's coordination unit supports also non-UNICEF partners. The nutrition sector's coordination unit received a vendor registration in SAP Vision for transferring the good for non-UNICEF partners through the nutrition sector's coordination unit to overcome the borders of UNICEF's programme cooperation agreement

ECHO, FCDO (former DFID), USAID, JICA and other donors support the nutrition sector. The implementing partners of the sector receive funds either through the UN programme cooperation or directly from the donors. The estimated humanitarian budget in 2020 was USD39.9M, and in 2021 it is USD42.4M. The nutrition sector collects the UN's consolidated financial reports and some reports from implementing partners – recipients of bilateral funds from different donors. However, received financial information does not fully reflect the funding flows because some implementing partners do not disclose the true position of their funding status and funding flows.