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Evaluation of South Asia's Current Community Health Worker Policies and System Supports, and their Readiness for Community Health Workers' Expanding Roles and Responsibilities within Post-Astana National Primary Health Care Strengthening Plans

1. BACKGROUND AND JUSTIFICATION:

The roles of Community Health Workers globally and historically

Community health workers (CHWs) are the backbone of primary health care systems. These cadres have expanded access to essential services to households living in urban, peri-urban, rural and hard to reach communities (when appropriately trained, supervised and supported with job-aids and uninterrupted supplies). Most countries developed CHW programs 40 years ago after the Alma Ata Conference on Primary Health Care (PHC). Policies defined their role primarily as community engagement and health promotion. They were often volunteers operating at village level. They tended to work under the supervision of the health teams working within the lowest health facility level within countries' district health systems. They were assigned limited catchment areas and restricted sets of health interventions, mostly aimed at promoting maternal, child and family health at community and household level (including family planning, nutrition and WASH). Originally most CHW programs were set up to extend health promotion services in communities. As unpaid volunteers, CHWs could communicate government-sanctioned health promotion messages to their neighbors, and form a bridge between communities and health services.

A great expansion of CHW programs occurred soon after the launch of the Millennium Development Goals. Most CHW programs made noticeable investments to expand use of CHW-led community-based service delivery. This was primarily focused on high impact interventions for young child survival. This scale-up of community programs was primarily donor-driven. The patchwork of services that communities gained access to was not uniform either within districts or between sub-national areas. CHW-supported strategies were focused primarily on expanding access in rural and hard to reach areas through task shifting. CHW programs were less developed for the fast-growing peri-urban communities. Focus was particularly on access and implementation strength monitoring. Less focus was given to building and maintaining quality assurance of primary and referral level care.

Although the intrinsic value of CHW programs is widely recognized, various evaluations have found the core components to ensure the functionality of CHW programs to be weak. Training, supportive supervision, supply chain management for community based health services, and information management systems needed strengthening. In-country initiatives need to be harmonised within national frameworks for better coherence and to achieve synergies.

While CHWs were fast expanding, so there were concurrent government-led expansions of health facility networks over the same period. This was particularly notable in countries where administrative and political decentralization advanced rapidly, because advocacy for health infrastructure proved to be attractive. In some countries or localities, health infrastructure expansion resulted in services that had previously been delegated to CHWs being pulled back to health facilities, often without applying good change management practices.

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Given the high donor dependence of many health sector programs, the ability of operational level public health sector teams to ensure that all CHWs under their supervision were trained on and remained accountable for the delivery of standardized integrated packages of community health services was next to nil. The same was true for their ability to ensure the smooth roll-out of new PHC systems with clear CHW accountabilities and sustainability plans. As CHW programs and the contexts within which they operated evolved, important changes occurred in the workforce profile – such as gender and educational level. Whether attrition rates and retention strategies affected male and female CHWs equally has not been sufficiently studied.

The important role of Community Health Workers in South Asia

As a result of this history, countries in South Asia (as elsewhere in the world) have large numbers of CHWs whose training, duties and retention schemes form a rich and confusing tapestry. Across South Asia, CHWs play a substantial role in PHC: through individual counselling; in community education and engagement; in the establishment of trust-based bridges between communities and health service planners and providers; and, in the facilitation of evidence generation and use at the micro-community level. Most are female CHW cadres developed to support promotion of desirable family planning, maternal and child health, immunization, nutrition, sanitation and hygiene practices. Due to insufficient funding, village based volunteers were replaced by volunteers or minimally remunerated CHWs with assigned catchment areas covering multiple villages. Neither they nor the health centers they were affiliated with provide either the range of services or the quality of care that is acceptable for the Primary Health Care (PHC) reforms underway.

Remarkable progress has been made over the 40 years between the Alma Ata and the Astana declarations. However:

- Socio-economically depressed communities are disproportionately affected by a higher burden of a wider range of illnesses and their health needs remain largely unaddressed. The Astana declaration therefore reiterated the need for promotive, preventive, curative, rehabilitative services and palliative care to be made accessible to all.
- Too many vulnerable individuals, families and communities fall into deep poverty due to health conditions that are largely either preventable or more likely to have better outcomes if diagnosed and treated early. The global health community therefore reaffirmed the need to accord higher priority to community based health promotion and disease prevention, early diagnosis and care at the PHC level. They also decried the system-wide inefficiencies and the poor accountability of service providers that maintain the levels of out-of-pocket health expenditures highest among those who can least afford them, in exchange for what is strikingly fragmented, poor quality care.
- Severe shortages and markedly uneven distribution of health workers are a major impediment to the attainment of the ambitions stated in the Astana declaration, especially at the PHC level and in areas where communities are socio-economically depressed.

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In South Asia, the burden of disease is highly complex:

- The MDGs' reproductive, maternal, newborn, child and adolescent health (RMNCAH) agenda is still unfinished and must remain core to the SDGs agenda.
- Non-communicable diseases (NCDs) have been rising rapidly due to rapid urbanization and profound lifestyle changes.¹ Efforts to address this threat to life-expectancy, and national socio-economic development, were constrained by the need to keep government and donor investments focused on attainment of MDG targets. The SDGs call for an accelerated return to principles of a more holistic PHC approach. This is also supported by influential lobbies, including professional associations, that are championing greater investments in the prevention and control of NCDs especially at the primary health care level.^{2,3} This is particularly important as the number of children, adults and elderly affected by NCDs grows rapidly.
- South Asia countries are still grappling with the need to strengthen prevention and control of infectious and communicable diseases⁴ as they also carry a new burden of NCDs across all urban and rural communities. They also face silent public health crises in fast-growing peri-urban slum communities where unhealthy urban living conditions exacerbate already unfavourable social determinants of health⁵.

Community Health Workers' readiness for the needs of today and tomorrow

In 2018, the Astana Declaration reaffirmed Primary Health Care as the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being. It squarely sets PHC as the route to universal health coverage (UHC) and the health-related Sustainable Development Goals. It reiterates the urgent need to build sustainable PHC systems that are people-centered, responsive to community needs, holistic in scope, and able to engender socio-cultural changes among communities and providers to promote and preserve good health and well-being.

As life expectancy of populations in low and middle-income countries improves and changing diets and lifestyles increase the burden of non-communicable diseases (NCDs), some governments and donors are planning to increase the access of communities to prevention and care of NCDs at primary health care level. As the size of at risk populations in need of guidance and care before,

¹ Ghaffar et al (2004) Burden of non-communicable diseases in South Asia. Available online from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC383378/pdf/bmj32800807.pdf>

² Tripathy JP. Partnerships in noncommunicable disease prevention and control. *Int J Non-Commun Dis [serial online]* 2017 [cited 2018 Nov 8];2:102-6. Available from: <http://www.ijncd.org/text.asp?2017/2/4/102/225981>

³ C. ANGKURAWARANON ET AL. URBANIZATION AND NON-COMMUNICABLE DISEASE IN SOUTHEAST ASIA: A REVIEW OF CURRENT EVIDENCE. *PUBLIC HEALTH*, VOLUME 128 , ISSUE 10 , 886 - 895 [ONLINE] 2017 [ACCESSED 8 NOVEMBER,2018]. AVAILABLE FROM <HTTPS://WWW.SCIENCEDIRECT.COM/SCIENCE/ARTICLE/PII/S0033350614001954>

⁴ UNESCAP (2017) *Achieving the SDGs in South Asia: Key Policy Priorities and Implementation Challenges [Online]* 2017 [Accessed 8 November,2018]. Available from https://www.unescap.org/sites/default/files/Session_6_Michael_Williamson_Achieving_the_SDGs_in_South_Asia_Key_Policy_Priorities_&_Implementation_Challenges.pdf

⁵ GHOSE BISHWAJIT SOCIAL DETERMINANTS OF INFECTIOUS DISEASES IN SOUTH ASIA. *INTERNATIONAL SCHOLARLY RESEARCH NOTICES* VOLUME 2014, ARTICLE ID 135243, [ONLINE] 2014 [ACCESSED 8 NOVEMBER,2018]. AVAILABLE FROM <HTTPS://WWW.NCBI.NLM.NIH.GOV/PMC/ARTICLES/PMC4897585/PDF/ISRN2014-135243.PDF>

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during and after emergencies increases, governments and partners are recognizing that CHWs are key to building resilient PHC systems in fragile contexts.

Such laudable evolution requires careful evidence-informed transition management to ensure that PHC systems can retain and retool existing CHWs and that PHC and CHW related policy reforms are informed by evaluation of ongoing PHC policy reform efforts. This is needed, in part, to ensure that community health systems strengthening reforms within PHC build systems that protect the gains made in the MDG era. As countries move to align their plans to national post-Astana commitments, policy reforms are at different maturity levels but there is a discernable trend toward increasing public health responsibilities of CHWs and a call for strengthening the delivery of integrated family and community health and well-being-centred PHC through teams of CHWs. There is a pressing need for evaluation of current profiles, duties and support systems.

The transition to a more holistic PHC in South Asia will be programmatically complex. It will engender internal competition for limited national and subnational level technical and financial resources. It will put unprecedented pressure on South Asia countries already strained human resources for health, especially in underserved peri-urban and rural areas. It will be most felt in remote and hard to reach areas where PHC service delivery is harder and costlier due to either geographic inaccessibility or fragile programming contexts – and where human resource attrition is highest. Tackling health workforce shortages, maldistribution and performance challenges related to all health-related SDG goals is key to attaining UHC through PHC. CHWs can play a critical role in advancing health protection and promotion and timely care-seeking at the PHC level.

UNICEF Regional Office for South Asia (ROSA) is commissioning this formative evaluation of the readiness of CHW programs for their changing role within South Asia's evolving PHC. There is a need to understand the effort and investments that are needed to help existing CHW cadres transition into effective contributors to the PHC of the future and key policy adjustments needed in different contexts of South Asian countries. The 50th anniversary of Alma Ata needs to find that CHW strengthening strategies put in place post Astana, generated vigorous progress towards SDGs by 2030.

2. OBJECTIVE:

The overall objective is to understand the congruence between the current profiles, policy framework and system support to CHWs, especially those working in the RMNCAH and MNH program areas, and the profiles, policy framework and system support required for successful post-Astana PHC reform and strengthening (ongoing, planned or potential) in South Asia countries.

In October 2018, WHO issued a guideline on Health Policy and System Strengthening to Optimise CHW Programs. This guideline provides a recent and evidence-based framework upon which to

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base country-specific assessments of strengthening needs. In particular, it highlights 15 core components that CHW programs should be examined against, which are organized into three broad areas:

1. Selection, education and certification (selection, pre-service training, curriculum, training modalities, and certification)
2. Management and supervision (supportive supervision, remuneration, contracting arrangements, and career ladder)
3. Integration into and support by health systems and communities (target population size, collection and use of data, types of CHWs, community engagement, mobilisation of community resources, and supply chain)

For this evaluation, this guideline should be used as the framework against which current practices and future needs are presented.

In each of the South Asian countries, the evaluation will answer the following three questions:

1. What are the current profiles, roles and responsibilities, policies and system supports in relation to each CHW cadre?
2. How could the profiles and roles and responsibilities potentially be adapted to best meet countries' Post-Astana ^{aspirations} obligations for delivery of RMNCAH services alongside prevention and control of communicable diseases, prevention and control of non-communicable diseases and improved preparedness and response to health care needs for individual or community emergencies, and what policy and system support improvements are needed to respond to the post-Astana requirements?
3. What prioritized measures can be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre is able to make to PHC?

In addressing these three questions, the evaluation should:

- Evaluate current existing policy and system support in terms of the 15 areas of the WHO guidelines, including a gap analysis, to develop country-specific, prioritized recommendations for action. This should provide insight on how governments and partners can redesign and/or strengthen CHW programs while ensuring that the quality of RMNCAH service delivery is protected and enhanced.
- Identify and prioritize ways in which the WHO recommendation that countries should use a combination of CHW policies selected based on the objectives, context and architecture of each national health system can be translated from vision to action in a manner that creates functional integrated CHW teams within functioning support systems, in decentralized and non-decentralized national political and administrative systems.

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- Consider how the process of strengthening CHW policies and system supports can be made dynamic, responsive to context-specific evidence, linked to social accountability systems, and promote local, area specific, and national learning and innovation.
- Evaluate the extent to which the content of proposed national PHC and CHW related policy adjustments currently articulate effective transition management, to enable CHW cadres to be effectively reoriented into integrated and functional teams that are expected to cover expanding sets of community health services for the Post-Astana vision of community health systems strengthening for universal health coverage.

Two important elements should be incorporated throughout the evaluation:

- RMNCAH focus: In the South Asia region, high importance is accorded to the reduction of maternal and newborn mortality. Every South Asian nation is a signatory to the Global Every Newborn Action Plan and the ambitious RMNCAH goals for 2030. UNICEF ROSA is also looking to the evaluation findings to guide how strengthening of maternal and newborn care, social and behavior care communication and related social accountability mechanisms at the community level can be successfully incorporated within PHC system redesign. The evaluation should consider how the existing contribution that CHWs are making to RMNCAH can be protected, even as their roles potentially broaden.
- Gender analysis: CHW cadres in South Asia are predominantly female, and gender is a critical factor in both the successes and challenges of CHW programs. The evaluation should incorporate documentation of notable gender differences in the selection, education, certification, management and supervision of CHWs. The analysis should assess the likely impact of proposed PHC and CHW policy changes under Post Astana reforms and assist in a more gender responsive redesign of CHW programs especially for CHW cadres responsible for RMNCAH services in particular.^{6,7}

The output of this evaluation will be used to:

- Influence community health systems strengthening plans of South Asia countries. Its findings will inform policy discussions with government counterparts and major UNICEF partners to mobilize and prioritize technical and financial resources to accelerate strengthening of community health systems within ongoing or planned PHC reforms.
- Inform UNICEF's priorities for community health systems strengthening support in each of these countries, and support UNICEF's partnership building and leveraging of technical and financial resources to strengthen the implementation benchmarks for national CHW programs

⁶ Asha George (2007) Human resources for health a gender analysis - A background paper for the Women and Gender Equity Knowledge Network and the Health Systems Knowledge Network of the WHO Commission on Social Determinants of Health [Online] accessed 3 July 2018 available through http://www.who.int/social_determinants/resources/human_resources_for_health_wgkn_2007.pdf

⁷ WHO (2010) Gender, women and primary health care renewal, [Online] accessible through http://apps.who.int/iris/bitstream/handle/10665/44430/9789241564038_eng.pdf?sequence=1

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- Provide content for national governments, and for UNICEF and partners' advocacy and technical guidance to local governments who, in the South Asia context now hold the decision making for PHC priority setting, resource allocations and recruitment of PHC level staff, including CHWs and their supervisors under national decentralization policies.

The evaluation will also support the identification of priorities and sequencing of health systems strengthening initiatives over the next few years and ensure that the organization of training, deployment and supervision of CHWs permits them to function within multi-level PHC teams, as well as be effective members of multisectoral community development teams that address social determinants to support health and well-being.

The proposed evaluation will build on recent research work done on national CHW programs and research on national PHC policies and strategies. In particular, this evaluation will build on recent work done by a USAID-funded study of large scale CHW programs that included five South Asian countries⁸

3. SCOPE OF WORK:

The scope of this evaluation is limited to CHWs, and the policies and system supports that enable and guide their work. Other health workers to whom CHWs relate should be described for context, so that the community level system of which CHWs are a part is clear; but they should not be evaluated (except to the extent that their duties form part of the support structure for CHWs). CHWs are defined as per the WHO guideline.

This evaluation is primarily focused on national level policy (existing and proposed). Subnational policy variations should be secondarily included in contexts where these are important.

The WHO guideline on Health Policy and System Strengthening to Optimise CHW Programs should provide a central framework for this evaluation.

It is within the scope of this proposed policy evaluation to:

- Examine and document any current national reform plans for PHC and Community Health Systems Strengthening, assessing the evidence on which these are based, and consider the potential implications of these for CHWs and their support systems.
- Document the degree to which the private health sector is/will be involved in the expansion of PHC services and any support system strengthening (e.g. accountability systems) needed as a result.

⁸ MCHIP (2017) Case studies of large scale community health worker programs. [Online] Accessed 16 July 2018 available through <https://www.mcsprogram.org/resource/case-studies-large-scale-community-health-worker-programs-2/>

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- Assess, in brief, the adequacy of alliance building and resource mobilization to sustainably finance proposed PHC/CHSS reforms and expansion of PHC level service delivery.

It is outside of the scope of this policy evaluation exercise to:

- Directly assess the performance, workload or quality of care provided by current CHW cadres (though this would be a desirable future evaluation)
- Assess the efficacy of the composition, competencies and roles assigned to professional health care provider cadres working at the primary health care or at PHC supporting levels.
- Assess the adequacy of the numbers, profiles and competencies of community development teams who are not classified as CHWs by Governments.
- Assess the organization of services, management, reporting and quality assurance of services provided by non-CHW cadres working with CHWs at community level to deliver community health promotive services such as: WASH, early childhood development care, and other related services etc.) or that of their supervisors. Nor will it assess the community service delivery systems of non-health sector development programs.

This evaluation is not specifically intended to document best practices. These may be peripherally noted, but do not form a primary objective of this evaluation.

The evaluation should explicitly reference related recent work (such as cited here⁹). The inception report should make clear how the study design will build on existing work, and not duplicate it.

4. METHODOLOGY

This is a formative evaluation intended to help with the ongoing strengthening and evolution of the PHC components of national health systems. It is not an impact evaluation that seeks to measure the impact of CHWs or the health system as a whole on the health status of the population. This distinction will guide the selection of methods.

Evaluators will use the WHO CHW guidelines as their core reference. The areas of focus can be adapted, if needed, in consultation with an Evaluation Technical Advisory Group that will guide the study design during the inception phase and provide quality assurance oversight during the implementation phase of the evaluation.

Implementation planning for the proposed evaluation:

The formative evaluation will be undertaken in three phases that should be completed within 10 months:

⁹ MCHIP (2017) Case studies of large scale community health worker programs. [Online] Accessed 16 July 2018 available through <https://www.mcsprogram.org/resource/case-studies-large-scale-community-health-worker-programs-2/>

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- Phase 1.** Inception phase: Desk reviews and field research implementation planning;
- Phase 2.** Data collection phase: in five SA countries with large CHW programs;
- Phase 3.** Data analysis, reporting and dissemination phase;

Phase 1

The expected output is an inception report that includes: a thorough literature review; a comprehensive list of national and international references and resources used to frame the study design; proposed qualitative and quantitative research methodology and tools, including a proposed sampling design; field workplans by country along with an outline of specific resource persons and groups to be contacted before and during in-country missions and expected/desired outcomes of the proposed outreach; and, outline structures for each of the Phase 3 products. The specific scope of each national report will be finalized during the inception phase, after consultation with national governments.

Phase 2

The expected output is country-specific quality-assured data files to be used in the phase 3 analysis, including full description of the quality assurance procedures used to process both the qualitative and quantitative information gathered during field implementation.

To supplement the desk reviews of phase 1, in phase 2 the evaluation team will consult the following key stakeholders on CHW programs and PHC reforms:

a) At the national level:

- i. **National decision makers:** MOH, Ministry of Local Government, Ministry of Public Administration, Ministry of Social Welfare, Ministry of Finance;
- ii. **Major technical and financial partners:** Bilateral, Multilateral, iNGOs involved in PHC and Community Health Systems Strengthening and service delivery;
- iii. **National opinion leaders:** Professional associations, and leading academic institutions;

b) At the sub-national level

- i. **Community health workers** working in select urban, rural and hard to reach areas;
- ii. **Sub-national decision makers:** district health authorities and health facility management teams; and decentralized level representatives of the Ministry of Local Government and Ministry of Community Development (where applicable),
- iii. **Sub-national opinion leader:** iNGOs, local NGOs and large CSO involved in PHC and HSS
- iv. **Service provider at the subnational level:** Management of select private health care institutions on their interactions with CHWs, select representatives of community based development workers involved in sectors needed for the multisectoral

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Nurturing Framework for Early Childhood Development (NF/ECD) such as social workers, water development teams.

Phase 3

The expected outputs are:

1. Eight separate country specific evaluation reports with recommendations that can be taken forward through in-country advocacy with governments and development partners. The eight reports will be presented in a standardized format and may contain some common core material.
2. A summary regional report on CHW program reforms and Post-Astana community health service delivery strengthening needs. This product will be used for regional and global direction-setting and advocacy. It will need to include recommendations for strengthening cross-cutting areas such as gender, social and behavior change communication, community engagement and social accountability. It should include a focus on RMNCAH.
3. A summary regional report on gender analysis of CHW policies, implementation strategies and experiences documented in the evaluation study sites. This product will be used for regional and global advocacy and will need to include recommendations for strengthening management of gender concerns in CHW training, supervision, mentoring, performance and incentive management for community based CHWs.

5. DURATION:

It is expected that the proposed evaluation will take 12 months. An indicative timeline for the key activities and deliverables is shown in section 7.

6. WORKING LOCATIONS:

The consultancy will be based in the offices of the selected institution. Staff members will need to make in-country visits as indicated below.

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7. DELIVERABLES:

Tasks	Expected deliverables	Proposed Timeframe	Proposed Payment schedule
1 Kickoff meeting	Revised TORs and draft evaluation workplan, including list of cadres by country to be included	Mid-February 2019	
2 Inception Report	6 weeks after the kick-off meeting	Mid-March 2019	20%
3 Field Missions:			
i) Afghanistan	Field Mission to Afghanistan	March – June 2019	
ii) Nepal and Bhutan	Field Mission to Nepal & Bhutan		
iii) Bangladesh	Field Mission to Bangladesh		
iv) India	Field Mission to India		
v) Pakistan	Field Mission to Pakistan		
vi) Sri Lanka and Maldives	Field Mission to Sri Lanka and The Maldives		
4 Data analysis and report of initial findings	Draft country reports of qualitative and quantitative research	15 August 2019	
5 Refinement of reports after country review	Final versions of eight country reports with qualitative and quantitative data	15 October 2019	40%
6 Production of two summary regional reports:	a) Reports on CHW program reforms and Post-Astana community health systems strengthening needs in the evaluated areas of the eight South Asia countries.	Mid-November, 2019	30%
	b) Report on gender analysis of CHW Policies and strategies and of field level findings in the evaluated areas of the eight South Asia countries.	End-November, 2019	
7 Consultancy close-out	Final close-out summary report	15 December, 2019	10%

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Payments will be made on acceptance of the deliverables listed in section 7, with amounts as indicated in the final column.

9. PLANNED BUDGET AND FUNDING SOURCE

WBS	Grant	Total Contract Value
297R/A0/10/001/006/001	Non- grant (BMA)	USD 220,000

10. CONTRACT SUPERVISION:

The contract will be supervised by Dr Paul Rutter, Regional Health Adviser, UNICEF Regional Office for South Asia. Dr Luula Mariano, MNCH specialist, will act as the primary liaison between the selected institution, UNICEF, and the Technical Advisory Group.

11. QUALIFICATIONS AND EXPERIENCE REQUIRED:

1. Only institutions with a proven track record in analyzing health systems strengthening needs in low and middle-income countries with large scale CHW programs will be considered. Prior experience in working in South Asia will be a strong asset.
2. Profile of the institutions should be one that:
 - a. Has a strong track record in policy analysis for health systems strengthening, and for evaluation of CHW programs;
 - b. Has proven experience in evaluation of PHC level health systems strengthening for RMNCAH and especially in the field of maternal and newborn health care;

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- c. Has or can secure the services of resource person(s) with proven experience in gender analysis for health systems, especially as related to human resources for health;
3. The key personnel should:
- a. Has a strong track record in policy analysis for health systems strengthening, and for evaluation of CHW programs;
 - b. Have proven experience in evaluation of PHC level health systems strengthening for RMNCAH;
 - c. Be able to commit a level of effort that will ensure success of this evaluation.

It will be the responsibility of the contracted institution to plan, budget and manage any contracts related to the recruitment and oversight of local implementation partners and field related logistics from the start to the completion of the evaluation, in line with guidance provided by the Evaluation Technical Advisory Group.

12. APPLICATION AND EVALUATION PROCESS:

Each proposal will be assessed first on its technical merits and subsequently on its price. In making the final decision, UNICEF considers both technical and financial aspects. The Evaluation Team first reviews the technical aspects of the offer, followed by review of the financial offers of the technically compliant vendors. The proposal obtaining the highest overall score after adding the scores for the technical and financial proposals together, that offers the best value for money will be recommended for award of the contract.

The Technical Proposal should include but not be limited to the following:

- **Methodology**
Detailed Methodology / approach to requirement detailing how to meet or exceed UNICEF requirements for this assignment
- **Company Profile**
Ensure to include information related to the experience of the company as required and outlined in item 9 of this document.
- **References**
Details of similar assignments undertaken in last *three* years including the following information:
 - o Title of Project
 - o Year and duration of project
 - o Scope of Project

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- Outcome of Project
- Reference / Contact persons
- **Work Plan**
Proposed work plan showing detailed sequence and timeline for each activity and man days of each proposed team member
- **Team Composition**
Title and role of each team member and their expected level of effort (without dollar amount)
- **CV's**
CV of each team member (including qualifications and experience)
Ensure to include information related to the qualifications and experience of each proposed team member as required and outlined in item 9 of this document.
- Any project dependencies or assumptions

The Financial Proposal should include but not be limited to the following:

Bidders are expected to submit a lump sum financial proposal to complete the entire assignment based on the terms of reference. The lump sum should be broken down to show the detail for the following:

- **Resource costs**
Daily rate multiplied by number of days
- **Conference or workshop costs (if any)**
Indicate nature and breakdown if possible
- **Travel Costs**
All travel costs should be included as a lump sum fixed cost.
For all travel costs, UNICEF will pay as per the lump sum fixed costs provided in the proposal.
A breakdown of the lump sum travel costs should be provided in the financial proposal.
- **Any other costs (if any)**
Indicate nature and breakdown
- **Copy of the company registration**
- **Recent Financial Audit Report**
Report should have been carried out in the past 2 years and be certified by a reputable audit organization.

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Bidders are required to estimate travel costs in the Financial Proposal. Please note that i) travel costs shall be calculated based on economy class fare regardless of the length of travel and ii) costs for accommodation, meals and incidentals shall not exceed the applicable daily subsistence allowance (DSA) rates, as propagated by the International Civil Service Commission (ICSC). Details can be found at <http://icsc.un.org>






13. EVALUATION WEIGHTING CRITERIA:

Cumulative Analysis will be used to evaluate and award proposals. The evaluation criteria associated with this TOR is split between technical and financial as follows:

- 70 % Technical
- 30 % Financial
- 100 % Total

The attached Annex A provides a detailed breakdown of the evaluation criteria.

14. ENDORSEMENT OF TERMS OF REFERENCE:

Function	Name	Signature	Date	Comment
Submitted by	Paul Rutter Regional Health Adviser		20/12/18	
Cleared by	Samuel Bickel Regional Adviser Evaluation		20 December 2018	Good work!
Reviewed by	Thierry Dentice, Regional Chief of Operations		20/12/18	LTA
Approved by	Inoussa Kabore RD/DRD 		20/12/2018	

ATTACHED:

Annex A – Breakdown of technical evaluation criteria

TERMS OF REFERENCE

Evaluation of South Asia's Current Community Health Worker Policies and System Supports, and their Readiness for Community Health Workers' Expanding Roles and Responsibilities within Post-Astana National Primary Health Care Strengthening Plans

Annex A: Detailed breakdown of the evaluation criteria

Technical criteria	Points to consider	Max points
Company profile	Background and capacity of company matching the required qualifications	20
Key personnel	Relevant experience, qualifications and level of effort	25
Proposed methodology and approach	Detailed methodology and approach detailing how to meet each of the deliverables	25
Financial proposal	Breakdown of costs	30
TOTAL SCORE		100