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Terms of Reference for the Endline Evaluation for Optimizing Care for Newborns and Children in Afar and Benishangul-Gumuz, Ethiopia project

Summary

Type of Contract (tick the appropriate box)	Consultant Contract	Individual Contractor	**International Institutional Contract X**	LTA
Evaluation Title	Endline evaluation for 'Optimizing Care for Newborns and Children in Afar and Benishangul-Gumuz, Ethiopia'			
Evaluation Purpose	The endline evaluation is looking to understand its achievements and lessons, as well as generating evidence to inform future planning. The evaluation will use the OECD-DAC criteria to assess the relevance, coherence, effectiveness, efficiency, and sustainability of the KOICA project. The evaluation will bring about a clear understanding of the project's contribution to the improved health of newborns and children under 5, particularly in reducing morbidity and mortality. In addition, the evaluation will validate the Theory of Change underpinning the KOICA-supported project, examining whether the assumed causal pathways held true. The evaluation is expected to examine effectiveness and outcome of interventions implemented to improve the newborn and Children health in **Afar, and Benishangul- Gumuz regions**, Ethiopia and document achievements and challenges, providing critical insights into the result of strategies employed. Moreover, it is expected to identify key lessons from design and implementation of the project. In a nutshell, the evaluation aims at addressing both learning and accountability needs.			
Expected fee /cost	USD 55,000			
Location	Ethiopia (Afar, Benishangul-Gumuz)			
Duration	**6 months**			

Start Date	April 2025
Reporting to	Evaluation Manager
Budget Code/PBA **No** **Grant reference** **and WBS**	Implementation and Management of Evaluation 1410/A0/07/006/001/006 SC200293, SM220883, SC22072
PCR, IR and Activity	Evaluation 1410/A0/07/006/001/006
Type	☒ Evaluation (an assessment of an on-going or completed project, programme or policy)
Date of preparation of TOR	March 2025

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1. Introduction

Country Context

With about 126.5 million people (2023), Ethiopia is the second most populous nation in Africa after Nigeria, and one of the fastest-growing economies in the region, with an estimated 7.2% growth in FY2022/23. However, it also remains one of the poorest, with a per capita gross national income of $1,020. Ethiopia aims to reach lower-middle-income status by 2025.[1] The country is characterized by rapid population growth, a young age structure, and a high dependency ratio. Children under age 15 and individuals aged 15–65 account for 47% and 49% of the population, respectively. Only 4% of the population is over age 65. [2]

Ethiopia's economy relies heavily on agriculture and is often punctuated by high poverty rates and inflation. Despite achieving an average GDP growth rate of 10% per year over the past 15 years, the economy faced significant vulnerabilities, including low productivity in the agricultural sector, high unemployment, and substantial import restrictions. The manufacturing sector was underdeveloped, and the country struggled with low foreign exchange reserves and high inflation. Additionally, the economic landscape was influenced by political instability and conflicts, which further exacerbated economic challenges.

In 2024 the country has developed a major macroeconomic reform under the Homegrown Economic Reform Program (HGER), representing a significant shift towards a private-sector-led investment model aimed at addressing longstanding structural issues such as inflation, fiscal pressures, and external imbalances. Key aspects of these reforms include transitioning to a market-based exchange rate to alleviate foreign exchange shortages, strengthening the financial sector, controlling inflation, and improving the business climate. The International Monetary Fund (IMF) has supported these

[1] Ethiopia overview | World Bank

[2] Ethiopia-SPA-.pdf

efforts with a program of nearly US$3 billion, highlighting the international community's recognition of the importance of these reforms.[3]

Ethiopia's demographic structure and rural-urban divide influence its development. The majority of the population lives in rural areas, where access to services is limited due to geographical barriers and a shortage of professionals. Social movements have played a crucial role in advocating for marginalized communities and pushing for systemic change.

Ethiopia has made significant strides in promoting gender equality and protecting human rights through various national policies and legislative reforms. The National Policy on Women (NPW), enacted in 1993, laid the groundwork for gender equality, which was further strengthened by the National Policy on Gender Equality and Women Empowerment (NP-GEWE) currently being finalized. Ethiopia is also a signatory to international treaties such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), reflecting its commitment to eliminating gender-based discrimination. These policies aim to ensure that women and children have equal access to healthcare, education, and economic opportunities, which are crucial for the overall development of the country.

Ethiopia’s health system is structured in line with the federal government system, whereby the Federal Ministry of Health (FMOH) at national level plays a regulatory role, providing technical assistance and guidance to sub-national health authorities, like Regional Health Bureaus (RHB), Zonal and Woreda Health Offices. In addition to its normative and regulatory role, FMOH also runs several referral hospitals in Addis Ababa. The head of a RHB is a member of the regional cabinet chaired by the regional president. Similarly, a Woreda Health Office (WoHo) is accountable to the elected members of a Woreda Cabinet. RHBs and WoHo’s have their own budgets, which provides them with the autonomy to implement health programs, in line with national guidance. The Ethiopian Public Health Institute (EPHI) was established separately to focus on public health emergencies, including surveillance, laboratory services, response, and research.[4]

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[3] A homegrown economic reform agenda: A pathway to prosperity

[4] Health cluster Ethiopia: Strategy 2024-2025

The Ethiopian health sector has developed and implemented successive sector wide plans-known as health sector development or health sector transformation plans since 1997. The latest plan is referred to as **second Health Sector Transformation Plan (HSTP II) and has been implemented since July 2020**. The overarching objective of HSTP-II is to improve the health status of the population through; (i) accelerated progress towards universal health coverage; (ii) protecting people from health emergencies; (ii) woreda transformation and (iv) improve health system responsiveness. Ethiopia has been through several challenges including COVID-19, conflict, internal displacement, and other public health emergencies like cholera during the implementation of Ethiopia's second Health Sector Transformation Plan (HSTP II). Despite these disruptive shocks, the country was able to largely maintain health service provision, a sign that the health system is becoming more resilient.[5]

On the other hand, the Total Health Expenditure (THE) increased from ETB 72 billion (USD 3.1 billion) in 2016/17 to ETB 127 billion (USD 3.62 billion)1 in 2019/20. In the respective fiscal years, this accounts for approximately 4.7 % and 6.3 % of GDP. Ethiopia's per capita health expenditure has grown steadily over the past two decades, from USD 4.502 in 1995/96 to USD 33.2 in 2016/17 and to USD 36.30 (including COVID-19 spending) in 2019/20. The amount is still low compared to the USD 43 average for low-income African countries, and it is far less than the $86 per capita spending the WHO recommended for delivery of essential health services by 2015.[6]

The first 28 days of life remain the most vulnerable period for child survival. According to the UN Interagency group report of 2022, approximately 2.3 million children globally died during the first month of life in 2021, and these deaths constituted nearly 47 per cent of the under-five deaths that took place in the same year. Children in sub-Saharan Africa face the greatest risk of dying during the neonatal period. 98 per cent of neonatal deaths occur in low- and middle-income countries, with 78 per cent in Southern Asia and Sub-Saharan Africa. Eight of the 10 countries with the highest neonatal mortality are in Africa, including Ethiopia.

[5] HSTP-II-MTR-final-report-.pdf

[6] Ethiopian National Health Accounts Report 2019/20

Ethiopia has achieved commendable results in reducing the rate of under-5 mortality (U5MR) from a very high level of **222 deaths per 1,000 live births in 1990 to 59 deaths per 1,000 live births in 2019**, effectively reducing the U5MR by two thirds. Despite this success, the neonatal morality rate (NMR) has remained at 33/1,000 live births.[7] Progress in reducing U5MRs varies significantly across geographic regions, highlighting the issues of equity in access and coverage of MNCH services. According to the EDHS 2016, while nationally U5 child mortality is 67 per 1,000 live births, **125 and 98 U5 child deaths per 1,000 live births** occur in **Afar and Benishangul-Gumuz** region, respectively. Benishangul-Gumuz Region has demonstrated progress in recent years, though Afar is still plagued by a very poor reproductive, maternal, and neonatal health profile.[8]

The country's health system faces challenges related **to equity** in terms of geographic location, socio-economic status (including wealth), and education in terms of both access and use of key maternal, newborn, child and adolescent health interventions. Poor people living in rural and pastoralist areas, and the less educated and illiterate, are less likely to have access to and utilize health services.

Additionally, several critical gaps in the healthcare system demand urgent attention. Many hospitals fail to meet national standards due to **drug and supply shortages, insufficient medical staff,** and **limited skills** among clinical and laboratory personnel. **Referral systems** are poorly coordinated, **essential newborn care** at delivery facilities is inconsistent, and **delays** in care-seeking for sick children under five are common. Inadequate transportation for **referrals and poor communication** between facilities worsen these challenges. Service quality for sick newborns and children remains suboptimal, and **insufficient monitoring** by Regional Health Bureaus (RHBs) **alongside unreliable data** further hinder progress. Addressing these issues is vital to improving healthcare outcomes for newborns and young children.

Community Based Newborn Care (CBNC) was initially introduced by the government and partners in 2013 within the existing Health Extension Programme (HEP), Primary Health Care Unit (PHCU), and Integrated Community Case Management of Newborn and Childhood Illnesses (iCCM)

[7] Ethiopian Mini DHS 2019

[8] Ethiopia DHS 2016

platforms, with the objective of **strengthening the PHCU and HEP** in delivering high-quality MNCH services through efficient and **effective linkages between health centres (HCs) and health posts (HPs)**. With the CBNC, **health extension workers (HEWs)** can manage the major causes of newborn death at the community level. However, these initiatives have not been scaled up in the pastoralist communities of Ethiopia. Moreover, gaps in quality of care persist at all levels from HP up through hospital level more broadly, in terms of care of mother and newborns around delivery, as well as care for sick newborns and children. The CBNC project made remarkable achievements in terms of building the capacity of health care providers and improving the availability and utilization of child and newborn care services at community and health facility levels.

The Universal Declaration of Human Rights and the Convention on the Rights of the Child are foundational documents that outline the rights and protections for all individuals, particularly focusing on the most vulnerable populations. The United Nations has established these and additional international frameworks to protect human rights and child rights The Beijing Platform for Action and the Sustainable Development Goals (SDGs) further emphasize the importance of gender equality and the empowerment of women and girls as essential components of sustainable development. These international policies provide a robust framework for Ethiopia to align its national strategies and ensure that the rights of women and children are upheld.

UNICEF operates on the principle that every child has the right to survive and thrive, the basis of which is rooted in the Convention on the Rights of the Child. Children are human beings and are the subject of their own rights. The CRC sets out the rights that must be realized for children to develop to their full potential. By working in collaboration with the Ethiopian government and other international partners, UNICEF strives to create a supportive environment where every child and mother can thrive. In addition, through its Gender Action Plan (2022-2025) and the Gender Policy (2021-2030), UNICEF aims to integrate gender equality across all its programs and initiatives.

2. The Object of Evaluation

Project history

The government of the Republic of South Korea had previously supported a Community Based Newborn Care (CBNC) project between 2015 and 2018 in seven zones of Ethiopia, of which three

were in Benishangul Gumuz benefitting a total of 150,000 pregnant women and their newborns each year.

CBNC was initially introduced by the Government of Ethiopia and partners in 2013 within the existing Health Extension Programme (HEP), PHCU, and iCCM platforms, with the objective of strengthening the PHCU and HEP in delivering high-quality MNCH services through efficient and effective linkages between health centres (HCs) and health posts (HPs). With the CBNC, health extension workers (HEWs) can manage the major causes of newborn death at the community level. However, these initiatives have not been scaled up in the pastoralist communities of Ethiopia. Moreover, gaps in quality of care persist at all levels from HP up through hospital level more broadly, in terms of care of mother and newborns around delivery, as well as care for sick newborns and children. The first KOICA/UNICEF CBNC project made remarkable achievements in terms of building the capacity of health care providers and improving the availability and utilization of child and newborn care services at community and health facility levels in the seven selected zones in Benishangul-Gumuz, Southern Nations, Nationalities and Peoples, and Oromia regions.

Building on the experience from the first CBNC and to tackle the remaining challenges of newborn and child health in Benishangul-Gumuz Region, the *Optimizing care for newborns and children in Benishangul-Gumuz and Afar Regions, Ethiopia* was developed in 2018, in consultation and through an iterative process involving FMoH, RHBs, KOICA (Korea, International Cooperation Agency) and UNICEF. Given the success in Benishangul Gumuz, this programme expands beyond zones to the **whole of Benishangul Gumuz**. This project based on the success of the last project and ensured that the whole region has full-service coverage for under five years children and newborns. There was an increased focus on improved service quality to ensure that the services are effective in improving the health of women and under five years children.

The Optimizing Care for Newborns and Children Project

The project committed to contribute to accelerating progress for newborn and child health by increasing the availability of and access to high-quality maternal, newborn and child services in **Afar and Benishangul-Gumuz regions between 2020 and 2024**. Its specific objectives are:

1. Improve quality of integrated MNCH care and treatment at primary health care units (PHCU) and hospital levels
2. Increase MNCH service utilization at PHCU and hospital levels through community-based solutions
3. Ensure availability of adequate and sustainable supply of essential MNCH drugs, supplies, equipment for health facilities through advocacy to utilizing the Sustainable Development Goal Pool Fund and Global Fund grants for HIV/AIDS, Tuberculosis & Malaria, and gap filling by the project support
4. Improve ownership, governance and sustainability of newborn and child health programmes in the public health system
5. Strengthen data, monitoring, and learning systems at woreda and zonal levels

The three key outcomes for the project were:

- Increased quality of maternal, newborn, and childcare
- Improved MNCH service utilization by communities
- Improved ownership and evidence-driven governance of the MNCH programme by the public health sector

Below major activities are described under the specific objectives:

Objective I: Improve quality of integrated MNCH care and treatment at primary health care units (PHCU) and hospital levels

- Capacity building for healthcare providers: these were determined after assessing which trainings have been provided to health care workers and what gaps exist in areas of iCCM, IMNCI, basic emergency obstetric and newborn care (BEmONC), essential newborn care (ENC), kangaroo mother care (KMC), and infection prevention and control (IPC)
- Clinical mentorship and coaching: clinical mentorship and coaching to reinforce quality of care, including case management for newborn and child health problems
- Establishing Quality Improvement (QI) initiatives at health facilities and communities: a culture of quality fostered, empowering PHCUs and hospitals in the target woredas to provide improved evidence-based care during childbirth and the immediate postnatal period, as well

as appropriate services for sick newborns and children using the 'plan-do-study-design' approach to problem identification and change management

- Supporting the operationalization of the Mobile health and nutrition teams (MHNTs) and Sustainable Outreach Strategy (SOS) in Afar region

Objective II: Increase MNCH service utilization at PHCU and hospital levels through community-based solutions

- Multi-sectoral Community Engagement to increase demand and utilization of services: this includes enhancing health seeking behaviour through effective communication of available services to communities and encourage utilization of services, women's empowerment to make positive choices about their and their children's health through the involvement of governing bodies as well as other sectors, and collaborating with community leaders as close partners to access the care-seeking beliefs and preferences of the community
- Improving referral linkages: to ensure timely, appropriate referrals and a seamless continuity of care to very sick newborns and children to higher health care centres in order to avert mortality.

Objective III: Ensure availability of adequate and sustainable supply of essential newborn and child health drugs, supplies, equipment and laboratory reagents for health facilities

- Supplies and supply chain management of essential medicines and commodities: the project planned to reinforce and support the existing supply chain systems through data, regular quantification exercises, integration of MNCH with the integrated pharmaceutical logistics system (IPLS) and strengthening regional supply hubs.
- Making essential lifesaving medicines, supplies, equipment, and laboratory reagents available through advocacy efforts to provide essential support to fill gaps in procurement

Objective IV: Improve ownership, governance and sustainability of newborn and child health programmes in the public health system

- Benchmark learning visit for facility-based newborn care: learning visit to benchmark care of sick and small newborns in a country that has mase significant strides. This in turn will inform implementation and planning at national and regional levels.
- Integrated woreda-based health sector planning to include newborn and child health at all levels: advocacy at zonal, woreda and facility levels to ensure inclusion of MNCH indicators in their respective plans and performance monitoring schemes.
- Integrated supportive supervision and consultative review meetings

Objective V: Enhance data, monitoring, and learning systems at woreda and zonal levels

- Health management information system (HMIS) and data use for decision making following the health sector transformation plan the project supported the health information revolution.
- Operational research: operational and implementation research carried out to test, document, and sharpen MNCH service delivery and utilization.
- Epidemiological surveillance woreda: There is a need for more precise, accurate, and efficient data on morbidity and mortality of children under five and newborns in Afar and Benishangul-Gumuz regions. The selected epidemiological surveillance woredas (two woredas in each region) are continuously assessed to support accurate recording on the conditions of newborns and children under five. This was planned with three prongs; promoting better insight on morbidities and mortality; trailing the use of more precise, bottom-up, counting-based data collection; and establishing a learning site for new innovations and interventions.

Detailed outcomes and activities of the project can be found in the annexed results framework. (Annex 2) but a logical framework or theory of change isn't available for the project.

The project kicked off on **14 May 2020** with **an end date on 30th June 2025** and a total budget of USD 9,120,000. The target areas have been **two regions encompassing 11 woredas in Afar and 22 woredas in Benishangul Gumuz (**Project map in Annex 1**).** Direct beneficiaries in Benishangul Gumuz included 189,819 children under five and 282,253 women of reproductive age (15-49) reached through implementation health facilities- 6 hospitals, 59 health centres, and 493 health posts. In addition, in Afar 123,020 children under 5 and 123,020 women of reproductive age were reached through 4 hospitals 45 health centres and 140 health posts.

Currently the project is preparing for close out finalizing ongoing activities, closing operational research activities, documenting best practices and success stories, as well as organizing results dissemination at various levels to discuss way forward.

A stakeholder analysis conducted during design of the project had identified the following major stakeholders with interest and influence in the project.

Stakeholder	Role and engagement
KOICA	KOICA supported the project through provision of resources, technical expertise, advocacy for right holders, supportive oversight and collaborative opportunities
UNICEF	Plays a pivotal role collaborating with donors, government entities and non-governmental partners to deliver results for newborns, children and mothers during the critical moments of a newborn's life in areas health services to prevent mortality and morbidity
Federal Ministry of Health	As a government entity responsible for health care the ministry provides guidance and draw lessons learned from the project to replicate in other interventions
Newborn and child survival technical working groups (NCSTWG)	Provides technical insights and revises the service delivery standards and job aids at federal and regional levels, as required
Regional health bureaus (RHB), Zonal health department (ZHDs) and Woreda health offices (WorHOs)	Are active partners who will involve in planning, implementation and monitoring of the project. Furthermore, the health offices will jointly develop annual workplans to streamline some of the project approaches.

Mothers, caregivers, children, newborns, women, community members	Right holders
Health facilities	As the main sites of implementation these facilities and their staff will play a vital role in the project.
Health facility leadership and health care workers	Primary duty bearers
Implementing partners	Developing a programme cooperation agreement with UNICEF to lead implementation at the grass-root levels. An open communication loop is required with implementing partners for timely change control and successful delivery
Technical advisory committee	Oversight for the progress of the project and provides guidance
Development partners, UN agencies, international and local NGOs, professional associations and academic institutions	Working through forums (e.g. technical working committee and partner forums) and bilateral relationships to synergize efforts around MNCH.

3. Purpose of the Evaluation

The project will come to a close by June 2025. Hence the endline evaluation is timely as it stands at the final phase of the project looking to understand its achievements and lessons, as well as generating evidence to inform future planning. The evaluation will use the OECD-DAC criteria to assess the relevance, coherence, effectiveness, efficiency, and sustainability of the KOICA project. The evaluation will bring about a clear understanding of the project's contribution to the improved health of newborns and children under 5, particularly in reducing morbidity and mortality. In addition, the evaluation will validate the Theory of Change underpinning the KOICA-supported project, examining whether the assumed causal pathways held true.

The evaluation is expected to examine effectiveness and outcome of interventions implemented to improve the newborn and Children health in Afar, and Benishangul- Gumuz regions, Ethiopia and document achievements and challenges, providing critical insights into the result of strategies employed. Moreover, it is expected to identify key lessons from design and implementation of the project.

In a nutshell, the evaluation aims at addressing **both learning and accountability** needs.

Use of evaluation: The evaluation will serve UNICEF, the government of Ethiopia, implementing partners and the donor in various ways for learning and accountability. The evaluation will be used mainly for **learning** and for informing UNICEF's and partners' way forward, particularly in emerging regions facing a multitude of challenges to achieve results for children. The evaluation will be used to identify the best practices and challenges, proposing the mitigation strategies, and informing the future design of similar interventions. The evaluation will also be used for **accountability purpose** to assess if the funds were utilised in the most efficient and effective manner to achieve the intended results for the intended beneficiaries.

Furthermore, it is intended to be used by UNICEF and partners for **learning**. The findings from the evaluation will be used by various stakeholders as input to improve the implementation of the strategies from the project, to inform advocacy efforts and to draw and document lessons on the implementation approach.

Primary users of this evaluation are i) UNICEF who will use the evaluation to inform the future development and adjustments needed to the CBNC project and its outcomes and use findings for advocacy purposes and ii) KOICA who will review the findings both as learning and as part of the overall donor accountability and cost efficiency framework.

Secondary users are right holders, communities, government counterparts (including the Ministry of Health, and regional health bureaus), **implementing partners** (**Emory University**), other key stakeholders, and the wider global community working on bringing the second wave of the child survival revolution, especially in newborn and under 5 children health.

4. Objectives of the evaluation

The overall objective of this final evaluation is to examine the *Optimizing care for newborns and children in Benishangul-Gumuz and Afar Regions* project, to assess its relevance, coherence, effectiveness, efficiency, orientation to impact and sustainability[9]**.** It is aimed to provide learning and provide concrete recommendations through assessing intended and unintended results. In addition, it will help in identifying the best practices, looking at challenges and mitigation strategies to inform future design, and support advocacy efforts for scale-up.

The specific objectives of the evaluation are:

1. To examine the "*Optimizing care for newborns and children in Benishangul-Gumuz and Afar Regions project*" for its outcomes and effectiveness:
    i. and measure the achievement of its objectives and intended outcomes providing the highest attainable standards of health care. The evaluation shall provide insights into whether and to what extent the intended goals and objectives of the project have been achieved with a focus on health equity to mothers from seeking care from various backgrounds
    ii. To evaluate the results in accessibility, quality, and utilization of health services on ensuring timely and appropriate health care for newborns and children, thereby upholding their right to health.
    iii. To assess improvements in the referral systems and staff capacity to provide life-saving support to newborns, infants and children
    iv. To measure the contribution of the project to the achievement of results in reducing morbidity and mortality rates for under 5 children in the target regions.
2. To assess the **relevance** of implemented strategies in improving newborn and child health services in targeted woredas. In addition, the evaluation should look at the alignment of planning and execution with gender, equity and child rights frameworks ratified by the country and upheld by UNICEF

9 The evaluation criteria could be adjusted at inception phase.

3. To assess the design and implementation of the project and propose improvements, by examining what worked well, what did not work well and why including services tailored to address the needs of mothers with attention to gender-sensitive approaches
4. To evaluate the **cost-effectiveness** of the mobile health service by comparing its costs to the benefits in health outcomes, patient access, and cost savings **in Afar**.
5. To assess the **sustainability** of net benefits post-project support and the effectiveness and scalability of across diverse contexts.
6. To assess how well the project fits within the UNICEF and country contexts
7. To produce **actionable recommendations** to inform UNICEF Ethiopia, KOICA, the Government of Ethiopia and other relevant stakeholders in their current and future intervention planning.
8. To propose a comprehensive and effective **Theory of Change** for the project informed by the evaluation's critical analysis, stakeholder engagement process and evaluation findings.

5. Scope of the evaluation

Thematic scope: The evaluation will examine the effectiveness, efficiency, relevance, coherence, and sustainability of the "Optimizing care for newborns and children in Benishangul-Gumuz and Afar Regions project", assess its contribution to provide healthcare of children and document lessons from its implementation.

Gender, equity and child rights dimensions will have to be given adequate consideration, and the evaluation will ideally look at the project with a keen gender and disability lens (for example in looking at how project activities contributed to improving healthcare service to mothers to adapt gender-sensitive approaches that ensures their dignity and comfort or how mothers with disabilities accessed services).

Temporal scope: The evaluation will cover the period between **July 2020 and December 2024**.

Geographic scope: The ambition of the evaluation is to reflect on effectiveness of KOICA supported programme implemented in Afar and Benishangul Gumuz. It will focus on all target regions of the

project. So, the scope of the evaluation is the KOICA project being implemented in eleven woredas in Afar and twenty-two woredas in Benishangul Gumuz.

6. Evaluation questions and criteria

In line with the OECD/DAC evaluation criteria of relevance, efficiency, effectiveness, coherence, and sustainability, this evaluation aims to address the following key evaluation questions to meet the evaluation objectives.

It is to be noted that each criterion will also need to be assessed through a gender and disability lens.

The following suggested evaluation questions will be reviewed and revisited during the inception phase, and additional, more detailed sub-questions are anticipated. The evaluation team is expected to review each question for evaluability. The final criteria and questions should be designed to ensure the collection of data related to disability-inclusion, child rights and gender responsiveness.

Evaluation Criteria	Evaluation Questions
RELEVANCE	To what extent is the project responsive to the needs of the targeted regions, communities and health facilities to bring about change in pertinent health parameters for newborns and children?
	To what extent did the intervention design continue to remain sensitive to the needs of the target population and to the context of target areas under changing circumstances?
	Was the project able to adopt relevant international, national, and institutional frameworks that guide the integration of gender, child rights, disability inclusion, and equity during its planning and implementation
COHERENCE	Has the project worked well with other interventions undertaken by governmental and non-governmental counterparts implementing CNCB interventions?
	To what extent the programme coordinated with other relevant stakeholders and aligned with other UNICEF programmes?

EFFECTIVENESS	To what extent has project achieved intended or unintended outcomes? Are the programme interventions successful to improve access to healthcare services for mothers and children?
	To what extent the project been successful in improving the quality of health services and strengthening referral systems?
	How has the utilization of MNCH services (maternal, newborn, and child healthcare services, including community awareness and engagement initiatives) within the target woredas changed during the project period? Were gender-sensitive approaches adopted?
	What was the level of availability of essential drugs? Were essential drugs distributed equitably to care-seekers from various backgrounds, especially during stock-outs?
	To what extent were the capacity building activities for healthcare providers successful? In which ways the capacities were built and to what extent are being utilized after the end of the project?
	What level of contribution has the programme made to reduce neonatal and under-5 mortality rates in target regions?
EFFICIENCY	How optimally have resources been utilized? What inefficient use of resources could have been avoided?
	When comparing the cost and benefit observed in health outcomes, how cost-effective have mobile health services been in Afar compared to stationary-based services?
SUSTAINABILITY	To what extent are the net benefits from the programme likely to continue after the programme support ends and under which circumstances?
	Have health systems been strengthened to ensure the sustainability of gains made by the project?
	What factors could contribute to or hinder the potential scalability of the CBCN services in various contexts of the country?

7. Methodology

Evaluation Approach

The evaluation is expected to use mixed methods through a non-experimental approach, focusing on measuring outcomes and process tracing of programmes. Therefore, design based on the Most Significant Change (MSC), or Outcome Harvesting (OH) are strongly recommended. The evaluation will apply mixed methods, with systematic triangulation of findings from desk reviews, household surveys, health facility assessments, key informant interviews (KIIs), and focus group discussions (FGDs) to ensure robustness and reliability.

Furthermore, the evaluation should have a sound methodology to shed light on the results achieved by the KOICA project in the two regions.

It is recommended to employ context conscious, innovative, participatory and child-friendly evaluation methods throughout the evaluation process.

Methods and data collection

The project has meticulously collected monitoring data on key activities, often disaggregated by gender, woreda, and health facility, and indicators were tracked at outcome, output and activity levels across implementation years. For skills targeted by training, coaching, and mentorship, baseline, midline, and endline assessments have been conducted to demonstrate improvements in skillsets. These assessments provide valuable insights into the effectiveness of capacity-building efforts over time. Additionally, the programme team has undertaken specific studies and operational research to measure various aspects of the project, ensuring a thorough assessment of its components.

Beyond project-specific data, beneficiaries reached through the intervention are systematically collated by participating health facilities. This includes detailed records of treated morbidities, health outcome statuses, referrals, and health education outreaches. The integration of such diverse data sources allows for a holistic evaluation of the project's impact.

The project has a well collected monitoring data on key activities undertaken often disaggregated by gender, woreda and health facility. For skills targeted by training, coaching and mentorship work in

the baseline, midline and endline assessments were undertaken to show improvement in skillset. The programme team has also undertaken assessments measuring specific aspects of the project. In addition to project specific data beneficiaries reached through the intervention is collated by the participating health facilities as well as treated morbidities, health outcome status, referrals and health education outreaches.

Depending on the approach chosen, it is expected that the evaluation team use at least one or several **of the following data collection methods with both duty bearers and right holders**:

- Key Informant Interviews (KIIs) with federal ministry of health, donors, regional/zonal/woreda health bureau officials, implementing partners, mentors, and mobile team coordinators including UNICEF programme team – both during the inception and the data collection phases
- Individual interviews with institutional leaders and key stakeholders at local level, including service providers
- Focus Group Discussions (FGDs) with community representatives/leaders, mothers/caregivers, frontline workers under similar sections, vulnerable community members including women and persons with disabilities, health extension workers, Women's Development Army members (WDAs) etc.
- Facility observation with clear and explicit criteria and data collection tools
- Secondary analysis of programme planning documents and project proposals/concept notes, monitoring and financial data (at output level, targets achieved) mainly from implementing partners reports and field visits monitoring, training manuals and other relevant toolkits, mentorship guides, health facility morbidity and mortality data, project operational research and studies, relevant law and government policies and strategies (such as Ethiopian national strategy for newborn and child health; National health sector strategic plan; Ethiopian health sector transformation strategic plan; and Health Sector Medium-Term Development and Investment Plan), UNICEF strategic documents and publicly available sectoral research reports and studies.
- Quantitative data collection through health facility-based survey of healthcare providers and health consumers /clients.

In Afar the project is implemented in eleven woredas and 4 hospitals, 45 health centres and 140 health posts; and twenty-two woredas in 6 hospitals, 59 health centres and 493 health posts in Benishangul Gumuz. **Considering time, budget, and security constraints**, it will not be possible for the evaluation team to visit all of the health facilities which are part of the KOICA project. For this reason, during the inception period the evaluation team can discuss the approach with **UNICEF programme and evaluation managers to sample a few representative facilities for data collection.**

The data analysis methods expected are mainly narrative and thematic analysis (and possibly content analysis) of the primary qualitative data collected through KIIs and FGDs, as well as descriptive statistics of secondary data. Quantitative data can be analysed through descriptive analysis, examining relationships, time series analysis, statistical trends analysis, and cost - effectiveness analysis-specifically for mobile health care services in Afar. The bidding company are expected to suggest data analysis methods to answer the evaluation question in their proposal, and to refine them during the inception phase.

The consulting firm **will review the documentation related to the project**, **can revise questions or propose additional evaluation questions, and may suggest a different design method and tools to answer the proposed evaluation questions**. The team will propose a provisional methodological design within the bid (including detailed cost estimates). The methodological design will include: an analytical framework; sampling, a strategy for collecting and analysing data; a series of specifically designed tools; and a detailed work plan. It is expected that evaluation approach and data collection and analysis methods are human rights based, child rights based and gender sensitive, and that evaluation findings/analysis will be **disaggregated** as much as possible (by gender, ethnicity, age, disability, etc.). This can be achieved through an early engagement of stakeholders from diverse backgrounds in the evaluation process; prepare evaluation questions that address child rights, gender and disability perspectives; using mixed-methods to capture a comprehensive picture of the circumstances; develop gender-sensitive tools and ensure their accessibility to persons with disabilities; use human rights sensitive, gender transformation focused, and disability inclusive languages in all deliverables and communications etc.

The main elements of the method will be further developed during the inception phase in line with the agreed evaluation questions (including assumptions to be assessed, indicators, data collection tools and analysis approach) and analytical framework in consultation with the stakeholders.

Limitations and Risks

Throughout the lifecycle of the project **the target areas have undergone changes** that could potentially impact the results achieved through the interventions. The two emerging regions of Benishangul Gumuz and Afar have been affected by inter-communal conflicts and war raging in neighbouring countries, such as the conflict in Sudan. This had made accessing some targeted areas difficult and shifted the Government's (as well as other stakeholders') priorities **towards humanitarian response**. In addition, communities have also been barred from accessing services at healthcare facilities.

The current situation of protracted conflict and multiple climatic crisis in the country have presented a risk to programme delivery and hence to evaluation as well. **Accessibility to certain areas**, especially in Benishangul Gumuz, could become an issue during fieldwork. The mapping of interventions, sampling and security analysis will help redirect the fieldwork **to strike a balance between a representative and robust data collection and security of enumerators**. In addition, where in-person data collection is impossible, in consultation with UNICEF, **remote data collection modalities** could be considered. Secondary data sources will be instrumental in such scenarios to cover inaccessible areas and triangulate information.

Second, the target regions have seen cholera, measles, dengue fever and malaria **outbreaks** at various points during project implementation. These had interrupted activities and pulled essential resources away from the project including project staff and time. Especially healthcare workers central to the capacity development initiatives undertaken by the project were stretched thin responding to the public health emergencies.

Third, **administrative changes** have impacted the project. Particularly woreda restructuring including splitting of old woredas and establishment of new woredas hampered smooth execution of activities. This disruption persisted until the newly established woreda offices were reorganized, designated staff were appointed, and the offices became fully operational. The transition period

required for these administrative adjustments led to delays and challenges in maintaining the project's momentum.

Another major change that the federal government embarked on was the Ethiopian **comprehensive macro-economic reform in 2024,** with the goal to achieve high and stable economic growth, maintain single-digit inflation rates, and build a globally competitive economic system. This has resulted in **cost escalation of basic services** compromising some project activities, such as reducing the number of beneficiaries from the initial plan.

Provided the tight timeline for the evaluation, it is essential to complete the assessment before the project's closure in June 2025 so that donors receive the report in time to inform their decisions, to build stakeholder confidence, and ensuring adherence to project timelines. Additionally, as the project approaches its closure, there is a heightened risk that primary data sources could be lost for data gathering or transience occurs. Ensuring the evaluation is completed promptly helps safeguard the integrity of the data.

8. Dissemination Plan

A series of knowledge products will be developed from the evaluation report to facilitate dissemination. Learning products will be focused on the needs of key decision-makers, right holders and will be designed with utility at the centre. The specific nature, format and content of each product will be confirmed with key stakeholders and users during inception. Some knowledge products will include:

PowerPoint presentations: that summarizes evaluation findings, conclusions and recommendations to be presented to the evaluation reference group (ERG) and other key stakeholders to facilitate evidence-based decision-making. These slide decks will be developed at the inception stage, for debriefing and after the final report.

Policy brief: this is a short summary of main findings, and a logical communication of recommendations based on conclusions in a maximum of 5 pages. The brief will use professional designed infographics and UNICEF branding.

EVAL-KIDS (Evaluation for Knowledge-Inspired Development Solutions): these are a series of knowledge products that analyse completed evaluation reports and facilitate the uptake of knowledge for programme and policy improvement including resource mobilization.

Dissemination workshop: a workshop engaging primary and secondary users to effectively disseminate findings from the evaluation.

9. Ethical Standards and Guiding Principles

Ethical clearance is to be obtained from an internationally recognised **Ethical Review Board** (based in Ethiopia or abroad) prior to training and fieldwork implementation and in line with the international standards[10] and under the 'Criteria for Ethical Review Checklist' – UNICEF CO will support the Evaluation Team in this task, in collaboration with Regional Office and using the available LTA. The evaluation team is expected to refer to UNEG ethical guidance to evaluation[11] as guiding principle to ensure quality of evaluation process. The evaluation will also follow the UNEG Norms and Standards[12], as well as UNICEF ethical guidelines[13].

For data collection in Ethiopia an authorization will have to be requested also from a federal or regional board. The firm needs to manage this process and the related costs.

It is vital that the Evaluation consultants at all levels fully **comply with the precautionary measures** put in place by UNICEF and the Government of Ethiopia to protect the women and children we serve. It is of utmost importance that the 'do no harm' principle consistently guides this evaluation. The

10 https://www.unicef-irc.org/research/ethical-research-and-children/

11 http://www.unevaluation.org/document/detail/2866

12 http://www.unevaluation.org/document/detail/1914

13 https://gdc.unicef.org/resource/unicef-procedure-ethical-standards-research-evaluation-data-collection-and-analysis; https://www.unicef.org/media/reporting-guidelines

bidding consultants should ensure that a detailed description of measures will be implemented to protect the women, children, and stakeholders we serve.

Some of the documents to guide Evaluation Consultants can be found on the links below:

- United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation in the UN System
- UNEG Ethical Guidelines for Evaluations
- UNEG Code of Conduct for Evaluation in the UN system
- UNEG Gender and Human Rights Guidelines
- UNICEF Guidance on Gender Integration in Evaluation
- UNICEF procedure for ethical standards in research, evaluation, data collection and analysis
- UNICEF-Adapted UNEG Evaluation Reports Standards[14]
- GEROS Quality Assessment System
- Disability-inclusive evaluations in UNICEF: Guidelines for achieving UNDIS standards

In addition, the evaluators will be expected to submit evidence of completion of the UNICEF Prevention of Sexual Exploitation and Abuse (PSEA) training found here: https://agora.unicef.org/course/info.php?id=7380

- UN Secretary General's Bulletin on Special measures for protection from sexual Exploitation and Sexual Abuse
- United Nations Protocol on Allegations of Sexual Exploitation and Abuse Involving Implementing Partners

Below are additional links only accessible to UNICEF Staff. They will be shared once a consultancy firm has been chosen.

- UNICEF Style Book 4.0

[14] The final report is expected to meet the UNEG Evaluation reports standards as well as benchmarks used in UNICEF's Global Evaluation Reports Oversight System (GEROS)

- UNICEF Brand book
- Universalia Checklist for Inception Report
- Universalia Checklist for Final Evaluation Report
- GEROS Checklist for Final Evaluation Report

10. Tasks with timeline

Task	Expected duration	Tentative timeline after contract signature	**Tentative evaluation service provider's workload (in days)**	Deliverables	Responsibility
Kick off and scoping discussions	2-3 days (as needed by the ET)	1 week	7	-	Evaluation manager with evaluation team
Inception report	One weeks	2 weeks	7	Report	**Consultants**
Endorsement of inception report[15]	One weeks	3 weeks			Evaluation manager / RO / reference group
Ethical clearance and fieldwork planning	Two weeks	5 weeks	14	Ethical approval and fieldwork plan	**Consultants**
Field work and preliminary analysis	Five weeks	10 weeks	35		**Consultants**
Preliminary findings presentation	One day	10 weeks	1	Presentation	**Consultants**
Draft report	Three weeks	13 weeks	21	Draft reports	**Consultants**

15 In case the report is not accepted, an additional commenting process might be necessary.

Quality assurance[16]	One weeks	14 weeks			Evaluation manager / RO
Response to the comments / Final report / Copy editing and design[17] Two power point presentations of the evaluation for the two evaluation objects	Three weeks	17 weeks	21	Final reports' PowerPoints	**Consultants**
Dissemination workshop by UNICEF - Evaluation report presentation and management response	Two days	18 weeks	1	Workshop	Evaluation manager to coordinate
			107 days		

The consulting firm will be remunerated based on satisfactory completion of deliverables as specified in the above table. The final payment to the consultancy firm is dependent on the completion of all deliverables and submission of a full report.

11.Estimated duration of contract

6-7 months

16 In case the quality is not satisfactory, the process might take longer and the company to invest extra time.

17 In case the quality is not satisfactory, the process might take longer and the company to invest extra time.

12.Expected Deliverables and payments

The following are expected to be submitted by the consultant based on the agreed upon timeframe. All deliverables will be produced in English.

Inception report

The firm will prepare, submit, and present a brief inception report which details understanding of the task and how the evaluation questions will be addressed. This will ensure that the consultant, UNICEF, and major stakeholders have a shared understanding of the evaluation. An outline for a standard UNICEF evaluation inception report can be found in Annex 3 and the maximum page count should be 30 (excluding annexes).

The inception report is expected to reflect and elaborate on scope of work, approach, methodology, design, analysis, ethical considerations (and eventually sampling procedures and sample size). It is expected to include annexes such as an evaluation matrix (which questions will be answered, how, what are the data sources), data collection tools, received ethical clearance, clear descriptions of activities, work plan with a proposed schedule of tasks, and timeframe. The report will be discussed and agreed upon with UNICEF and key stakeholders.

Fieldwork debriefings and draft evaluation report

Immediately following the fieldwork, UNICEF expects a debriefing on preliminary findings and recommendations. This is to receive immediate feedback after data collection before diving in data analysis to clarify vague areas if any and agree on the format of reporting.

The firm is expected to submit a comprehensive draft evaluation report of maximum 40 pages (excluding annexes) answering all the evaluation questions confirmed in the final inception report. UNICEF will share the draft report to all relevant stakeholders and the regional office. Comments from the stakeholders will then be collected and provided to the firm for incorporation or amendment, as deemed necessary.

Final report

The content, structure and quality of the final evaluation report should meet the requirements of UNICEF standards (see annex 4). For the UNICEF evaluation reports standards[18] please check here. The structure is expected to be as follows: executive summary; background, evaluation object, purpose scope and objectives, methodology, findings, conclusions, lessons learned, recommendations. UNICEF evaluation reports are expected to comply with and are assessed through the GEROS Quality Assessment System[19], the evaluation team is expected to familiarize themselves and comply with the expected standards. The final evaluation report containing the proposed content is expected to be a maximum of 60 pages.

In summary the firm is expected to:

1. Develop an inception report with high standard methodologies as per the TOR.
2. Secure the necessary ethical clearance and other prerequisites to conduct the study.
3. Develop a fieldwork plan.
4. Finalize data collection tools.
5. Conduct data collection.
6. Data entry, cleaning and analysis.
7. Write preliminary and final comprehensive report.
8. Consult with UNICEF and other partners throughout the various stages of the assessment.
9. Ensure high-quality implementation is achieved.
10. Following the completion of data collection, cleaned raw data should be submitted to UNICEF.
11. The firm will develop PowerPoint presentation including the main findings from the evaluation object.

18 https://www.unicef.org/evaluation/media/816/file/UNICEF-Adapted-UNEG-Evaluation-Report-Standards.pdf

19 https://www.unicef.org/evaluation/global-evaluation-reports-oversight-system-geros

The schedule of the payment will be as follow:

1. Upon submission of signed inception report, **30 per cent of payment at this stage.**
2. Upon collection of data and draft evaluation report, **30 per cent of payment at this stage.**
3. Upon submission of signed final reports (including a two-page executive summary), PPT, soft copy of data, **40 per cent of payment at this stage.**

Quality assurance

The company that will be awarded the evaluation contract is expected to assure the quality of the key milestone documents delivered by the evaluation team leader; the evaluation team leader is expected to assure the quality of the members' contributions. At the UNICEF level, the evaluation manager assures a first level of quality assurance of key deliverables (mainly inception and final reports) and shares them with the Regional Office for a second level of quality assurance. Once the deliverables are cleared, they are shared with the Evaluation Reference Group for commenting and feedback, as well as with other bodies such as the Programme Management Team (PMT) – inception report – and Country Management Team (CMT) – draft reports.

The ambition is to be able to compete, with the evaluation report, to the UNICEF Best Evaluation[20], hence very high standard are sought.

13. Governance of the evaluation, reporting and supervision

The firm will report to the UNICEF Ethiopia Country Office Evaluation Specialist, who is the evaluation manager. The evaluation manager will be accountable to the country representative and provide quality assurance.

The programme section, health in this case, will appoint a focal point who is well versed in the project and will act as the primary liaison with the evaluation manager and consultancy team. The focal point will be instrumental in providing required information to support the evaluation.

20 https://www.unicef.org/evaluation/best-evaluations

A Reference Group, composed of relevant UNICEF, donor, (possibly) government and other main stakeholders will be established to serve on an advisory capacity / to quality assure the process. The group will be engaged mainly to comment at key milestones moments such as draft evaluation ToR, inception report and draft final report. The members of the reference group agree on a ToR that outlines the group's role and responsibilities including the following:

- Provide inputs in the inception phase to influence the approach of the evaluation, and, where necessary, provide information and institutional knowledge as key informants.
- Participate in ERG meetings and workshops to review evaluation deliverables, provide feedback on emerging findings and co-generate lessons and recommendations. Gather inputs and facilitate links with wider stakeholders in their respective areas of influence
- Assist the evaluation team in accessing literature and documentation; establish communication with other key informants
- Review evaluation products (terms of reference, implementation plan, inception report and evaluation report) and provide written comments to the evaluation team through the evaluation manager.
- Advise on the recommendations of the evaluation to ensure that they are specific and actionable
- Facilitate dissemination of evaluation findings.

14. Evaluation criteria of proposals is the following

Technical – 70 percent

Technical Evaluation Criteria*	Score
Proposed Methodology and Approach 1. Overall response and understanding of ToR clearly explaining the evaluation approach 2. Proposed methodology and workplan (with an emphasis on child-sensitive evaluation approaches)	40

3. Using context conscious, innovative, participatory and child-friendly evaluation methods 4. Ability to engage young evaluators/students for specified tasks related to evaluation	
Experience of Company and Key Personnel 5. Organisational capacity to deliver the work - previous work history with UNICEF evaluations (a good GEROS score will be an advantage) 6. The strength of the proposed team including the related experience of lead and key local consultants (conducting evaluations in child rights, gender equality, education, child protection, adolescent development and participation, and early childhood development).	30
Total	**70**

**Only proposals which receive a minimum of 50 points will be considered further*

Financial – 30 percent

Expected Skill and Qualification

Required: The international firm should have demonstrated experience in conducting evaluations using qualitative and quantitative approaches as well as participatory methods. The firm should have good experience in evaluating community-based health programmes addressing healthcare barriers for newborns, infants, under-5 children and mothers. The team leader must be an experienced evaluator and have an advanced degree (at least master, PhD preferred) in a Health Care stream (Public Health, Global health, Doctor of Medicine etc.) and at least 10 years of experience conducting evaluations in this area. The international firm should partner with a reputable local firm/university. The team leader should have a solid understanding of child rights, child health, child protection, the SDGs issues as well as gender, inclusion, and development issues in Ethiopia, and be very familiar with qualitative and quantitative research methods in development context. The team should be fluent in written and spoken English.

Qualitative researchers should have a minimum of a bachelor's degree and extensive experience in qualitative data collection, including gender-sensitive and participatory methods and reporting. And preferably experts who have done extensive research on the field of study.

Desirable: Experience conducting similar evaluations; excellent analytical and communication skills; ability to work in complex partnerships with researchers, government, and development partners.

The evaluation firm will have to ensure that any possible conflict of interest is assessed and avoided (for example by avoiding hiring evaluators who have been involved in the planning or implementation of the programme). Moreover, the contractors are required to clearly identify any potential ethical issues and approaches, as well as the processes for ethical review and oversight of the evaluation process in their proposal.

Team composition

The below sets out the requirements of the different specialists, as well as the required skills for the different team members. Ideally the team would need to be diverse in terms of gender, cultural backgrounds, thematic and language skills, international and national experts. The team should have experience covering evaluation, health, inclusion, gender and other UNICEF priority areas

Team leader	➢ Relevant master's degree or higher in health care streams (Public health, global health, Medicine etc.). ➢ Experience in leading evaluation teams in developmental and political settings. ➢ Experience in managing evaluations in the UN system. ➢ Been evaluation team leader of at least 7 evaluations. ➢ Good understanding of the child rights agenda and of UNICEF programmes. ➢ Good understanding of integrating gender, disability, human rights into evaluations. ➢ Experience in evaluating community-based programmes especially pertaining to health.

	➢ Experience in evaluations in Ethiopia and the wider region. ➢ Experience, passion and willingness to lead and mentor young evaluators/researcher. ➢ Strong interpersonal skills. ➢ Ability to work with senior officials. ➢ Cultural sensitivity. ➢ Language skills - Proficiency in English; (Amharic desirable).
Thematic expert	➢ Relevant master's degree or higher in health-related fields ➢ Experience in analysing UNICEF programmes. ➢ Experience in working on community-based health care initiatives. ➢ Experience, passion and willingness to guide and mentor young evaluators/researcher. ➢ Strong interpersonal skills. ➢ Ability to work with senior officials. ➢ Cultural sensitivity. ➢ Language skills - proficiency in English and Amharic is a requirement; languages of the targeted regions desirable.
Young evaluators / students	➢ University or recently graduated students from faculties of medicine, public health, health officer, social work etc. ➢ Qualitative research methods in their curriculum of study. ➢ Fieldwork / qualitative data collection experience (right holders' interviews, focus group discussions) desirable. ➢ Capacity to interact with communities, children, and mothers. ➢ Cultural sensitivity. ➢ Language skills - proficiency in English; knowledge languages spoken in the targeted regions are a requirement.

15. General Conditions: Procedures and Logistics

1. The firm will not be provided lodging and/or meals.
2. The firm will work from its own office facilities.
3. UNICEF will not pay DSA in addition to the contract value to the consultants of the firm.
4. The firm should provide its own materials, i.e., computer, office supplies, etc.
5. The firm isn't authorized to have access to UNICEF transport.
6. Flight costs of the consultants working for the firm would be covered by firm.
7. Other transport costs of the consultants working for the firm would be covered by firm.

Policy both parties should be aware of:

1. Under the consultancy agreements, a month is defined as 21 working days, and fees are prorated accordingly. Consultants are not paid for weekends or public holidays.
2. All remuneration must be within the contract agreement.
3. No contract may commence unless both UNICEF and the consultant or contractor sign the contract.
4. For international consultants outside the duty station, signed contracts must be sent by fax or email. Signed contract copy or written agreement must be received by the office before Travel Authorisation is issued.
5. No consultant may travel without a signed travel authorisation prior to the commencement of the journey to the duty station.
6. Consultants will not have supervisory responsibilities or authority on UNICEF budget.

Intellectual property rights (Insert this text or modify it based on discussions with government counterparts).

All intellectual property rights in the work to be performed under this agreement shall be vested in the (GOE and UNICEF), including without limitations, the right to use, publish, translate, sell or distribute, privately or publicly, any item or part thereof. The (GOE and UNICEF) hereby grants to the Recipient Organization a non-exclusive royalty-free license to use, publish, translate and distribute, privately or publicly, any item or part of the work to be performed under this Agreement

for non-commercial purposes upon approval of UNICEF for each publication or use. Neither the Recipient Organization nor its personnel shall communicate to any other person or entity any confidential information made known to it by (GOE and UNICEF) during the performance of its obligations under the terms of this Agreement nor shall it use this information to private or company advantage. This provision shall survive the expiration or termination of this Agreement.

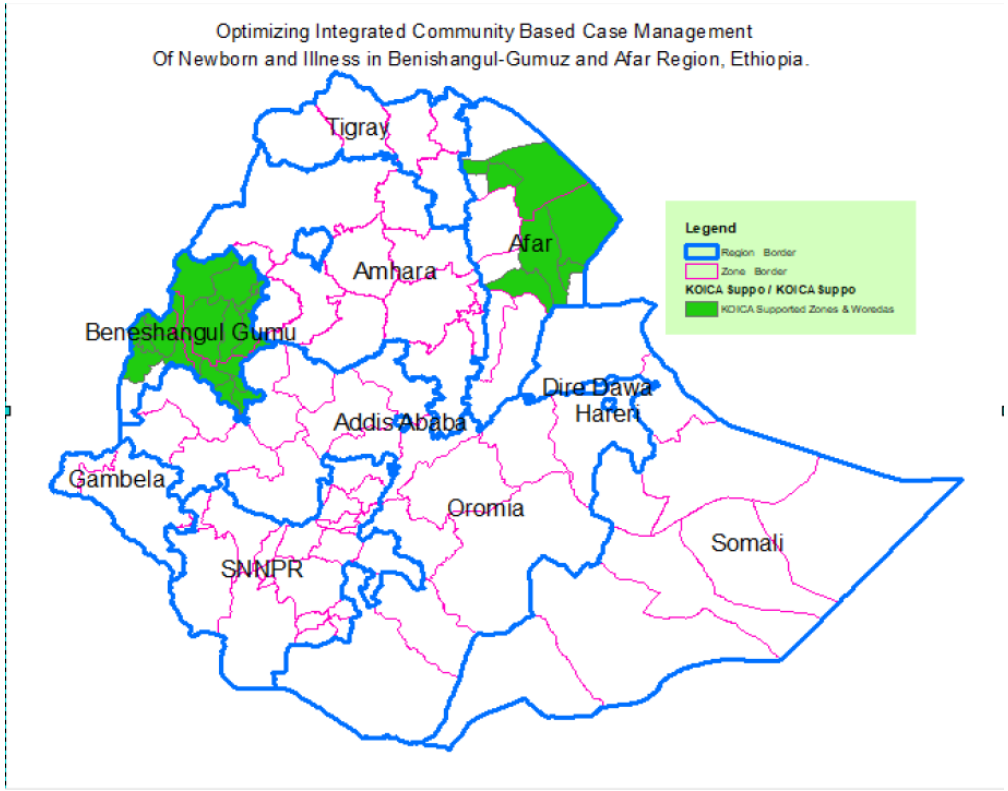
The core reports will be issued by the evaluation firm noting in the acknowledgements sections institutions and persons who have made major contributions to their authorship. Once the official report is cleared consultants will be free to work further on those papers for publication in peer reviewed journals upon consultation and approval from UNICEF. Consultants will provide the steering committee members with raw data, corrected/verified data once cleaned and programming files that permit replication of results from assessment report.

Data collected for the assessment is the property of the Government of Ethiopia and UNICEF country programme. Master versions of the data, coding protocols and programming code permitting replication of results of core assessment reports will be kept by the programme. Copies of the data will be distributed to researchers with the permission of the steering committee with a view to helping to disseminate learning derived from the data sets.

16.TOR prepared, reviewed and approved by:

	Prepared by	**Endorsed by**	**Reviewed by**	**Approved by**
Title	Evaluation officer	Chief of Health	Chief of Supply and Procurement	Evaluation Manager
Name	Maryamawit Solomon	Daniel Negmera	Srikanth Srinivasan	Mussarrat Youssuf
Signature				
Date				

Annex 1: Project Map



Annex 2: Results Framework

Catetory	Indicator	Responsible Party	Means of Verification	Baseline	Target
				2020	2024
Outcome 1					
1. Increased quality of maternal, newborn and child care	Mortality after admission to NICUs decreased	UNICEF/Emory/RHBs	DHIS2 & Survey reports (The aggregate & average of the 2020/2021 DHIS2 report)	12%(Could be further revised when plausible data is available)	8%
	The proportion of births attended by skilled birth attendants in health facilities increased	UNICEF/Emory/RHBs	DHIS2 & survey reports	45% (The aggregate & average of the 2020/2021 DHIS2, 2019 Mini EDHS ,and 2020 project baseline survey reports (could be further revised)	60%

Output	Activity	# of HPs that provide iCCM service	UNICEF/Emory/RHBs	Training reports & regular programme implementation reports	0	446 HPs providing iCCM service
1.1 Health facilities providing iCCM/IMNCI service	1.1.1. Trainings of HEWs on the revised and merged iCCM and CBNC training guidelines	# of HEWs trained on iCCM	UNICEF/Emory/RHBs	Training reports & regular programme implementation reports	0	1206
	1.1.2. IMNCI case management and mentorship/coaching skill trainings for HWs	# of HWs trained on IMNCI	UNICEF/Emory	Training reports and regular programme implementation reports	0	478
	1.1.3. Operationalization of MHNTs/SOS in the Afar region	# of MHNTs/SOSs supported	UNICEF/Afar RHB	Regular programme implementation reports	0	20

Output	Activity	# of HCs, hospitals and HPs supported with QII	UNICEF/Emory/RHBs	Training reports & regular programme implementation reports	0	76 HCs, 13 Hospitals & 495 HPs
1.2 QI initiatives established at health facilities and communities	1.2.1. Programme specific and QI coaching and mentorship	Number of hospitals, HCs, HPs team received post-training support	UNICEF/Emory		0	2436
	1.2.2. Engagement of kebele representative and communities on MNCH quality improvement initiatives	# of community QI members trained on basic principles of QI	UNICEF/Emory/RHBs	Training reports and regular programme implementation reports	0	2995
	1.2.3. Implementation of MNCH quality improvement (QI) at health facilities level,	Number of health facilities team trained on basic principles of QI	UNICEF/Emory/RHBs	Training reports and regular programme	0	494

	including supporting and coaching QI teams in establishment, group learning, and action planning			implementation reports		
	1.2.4. Gap filling of MNCH essential medicines, supplies, equipment and job-aids based on gap assessment	Session of procurement of essential medicines/equipment and printing of job-aids	UNICEF/Emory	Procurement and printing report	0	2
	1.2.5. Clinical mentorship and QI coaching capacity building	# of HWs trained basic clinical coaching	UNICEF/Emory	Training reports & regular programme implementation reports	0	349

	1.2.6. Catchment based mentorship and post training follow-up	# of hospitals and health center received standard mentorship	UNICEF/Emory/RHBs	Training reports & regular programme implementation reports	0	396
Output	Activity	# of HWs who completed training course(s) on BEmONC, ENC, NBC, & NICU	UNICEF/Emory/RHBs	Training reports & regular programme implementation reports	0	178 ENC/NBC & 52 NICU
1.3 HWs trained on ENC, NBC and NICU services	1.3.1. Integrated performance review and clinical mentoring meetings (PRCMM)	# of HC and HP team participated	UNICEF/Emory/RHBs	RM & regular programme implementation reports	0	1520
	1.3.2. BEmONC training to midwives and nurses	# of HWs working in the health center/hospital trained on BEmONC	UNICEF/Emory	Training & regular programme implementation reports	0	390

	1.3.3. Capacity building health workers, including medical capacity of Assosa and Dupti hospitals on basic and advanced newborn NICU	# of HWs trained on NICU	UNICEF/Emory	Training & regular programme implementation reports	0	129
	1.3.4. NBC/ENC training for health workers	# of HWs trained on NBC/ENC	UNICEF/Emory	Training & regular programme implementation reports	0	178
	1.3.5. Infection prevention training for healthcare providers	# of HWs received training on infection prevention	UNICEF/Emory/RHB	Training & regular programme implementation reports	0	178
Outcome 2						

2. Improved MNCH service utilization by communities		The proportion of children aged 2 to 59 months who were reported to have an acute respiratory infection, fever, or diarrhea in the past two weeks who received appropriate treatment increased	UNICEF/Emory/RHBs	DHIS2 & Survey reports	40% (aggregate -proportions of children treated for diarrhea with ORS and zinc, & symptoms of acute respiratory infection/pneumonia case advice treatment sough from the healthcare provider)- source project baseline 2020 and EDHS 2016 reports)	55%
Output	Activity	# of kebeles involved in the multi-sectoral community engagement to improve the MNCH services	UNICEF/Emory/RHBs	Training reports & regular programme implementation reports	0	421
2.1 Enhanced multi-sectoral community engagement	2.1.1. Health post open house session and bi-annual festival	# of community groups participated in the community festivals	UNICEF/Emory/RHBs	Training, SS, RM & regular programme implementation reports	0	28415

to increase demand and utilization of services	2.1.2. Engaging religious, clans and community elders	# of religious, clans and community elders participated in the community dialogue related to women empowerment	UNICEF/Emory/RHBs	SS, RM & regular programme implementation reports	0	14701
	2.1.3. Support PHCUs to conduct pregnant women's forums and use the platform for newborn and child health care seeking	# of pregnant women & WDA participated	UNICEF/Emory/RHBs	SS, RM & regular programme implementation reports	0	10200
	2.1.4. Engaging Kebele command post for community mobilization	# of kebele command post engaged in community mobilization	UNICEF/Emory/RHBs	SS, RM & regular programme implementation reports	0	460
	2.1.5. Strengthen the WDA activities through community-	# of kebele supported to strengthening CBDDM	UNICEF/BG RHB	SS, RM & regular programme	0	480

	based data for decision-making with HEWs			implementation reports		
	2.1.6. Conduct community commentators meeting to transmit health messages using Dagu* in Afar	# of community commentators meeting conducted	UNICEF/ Afar RHB	SS, RM & regular programme implementation reports	0	4
Output	Activity	# of sick newborns and children who requires a referral and are referred to receiving health facility	UNICEF/Emory/RHBs	Training reports & regular programme implementation reports	0	75%
2.2 Strengthening referral system for sick	2.2.1. Bottleneck analysis confirming referral gaps	# solutions tested for referral	UNICEF/Emory/RHBs	SS, RM, training & regular programme implementation reports	0	2

newborns & children and PNC	2.2.2. Gap filling for bottlenecks (e.g., communication protocols, referral vouchers, etc.)	Two rounds of printing of referral vouchers and job-aids	UNICEF/Emory	Printing report	0	2
	2.2.3. Support and equip maternity waiting homes	# of maternity waiting homes/HCs supported	UNICEF/RHBs	SS, RM & regular programme implementation reports	0	76
Outcome 3						
3. Improved ownership and evidence-driven governance of the MNCH programme by the public health sector		# of Epidemiological surveillance areas developed to demographic surveillance sites (DSS) - in both regions - that provides precise, accurate, and efficient data on morbidity and mortality of children	UNICEF/Emory/RHBs/Universities	Regular programme implementation reports	0	2

		under five and newborns – 4 woredas				
Output	Activity	# of Woredas health offices that included key MNCH activities in the woreda annual plan	UNICEF/Emory/RHBs	Training reports & regular programme implementation reports	29 (Reported that MNCH indicators were included in the woreda plan. However, the quality of data was an issue)	29 (woredas divided into urban and rural, it reached 42)
3.1 Woreda health offices that included key MNCH activities (including iCCM/NICU) in the woreda	3.1.1. Orientation conducted in all woredas at zonal level involving PHCUs, WorHOs and key decision-makers to ensure the inclusion of key MNCH indicators in their plans and	# of zones and woredas oriented with the inclusion of MNCH indicators in the annual work plan	UNICEF/Emory/RHBs	Orientation & regular programme implementation reports	0	29

annual health sector plan	performance monitoring schemes					
	3.1.2. Joint work planning	# of AWP planning and reviewing workshop conducted	UNICEF/Emory/RHBs	SS,RM & regular programme implementation reports	0	5
	3.1.3. Capacity-building for governance, leadership and management	# of health program leaders participated	UNICEF/Emory/RHBs	Training & regular programme implementation reports	0	215
	3.1.4. Capacity building data reporting and use	# of hospital staff trained on NICU/KMC data management and recording	UNICEF/Emory	Training & regular programme implementation reports	0	130
	3.1.5. Zonal/woreda consultative review	# of RHB, ZHD, WorHO, Hos, HC staff participated in the review meeting	UNICEF/Emory/RHBs	RM & regular programme	0	205

	meeting on MNCH including iCCM/NICU			implementation reports		
	3.1.6. Supportive supervision and mentorship training provided	# of HEWs trained on QI, mentorship, coaching & SS	UNICEF/Emory	Training & regular programme implementation reports	0	1438
	3.1.7. Review meeting guidelines and integrated SS checklist developed	Review meeting guidelines and integrated SS checklist developed	UNICEF/Emory/RHBs	Guidelines and checklist	0	1
	3.1.8. Regional/zonal/learning sessions and joint supportive supervision	# of RHB, ZHD, WorHO, Hos, HC staff participated in the learning sessions	UNICEF/Emory/RHBs	Learning session report	0	105
	3.1.9. Establish reproductive, maternal,	# of PHCU staff oriented with scorecard	UNICEF/Emory	Training & regular programme	0	1980

	newborn, child health Scorecard			implementation reports		
	3.1.10. IPLS training for HEWs and health workers	# of PHCUs staff trained on IPLS	UNICEF/RHB	Training report	0	663
	3.1.11. Strengthen and scale-up of the CHIS at all level	# of HPs supported in the scaleup of CHIS	UNICEF/RHB	Orientatioin, SS, RM & regular programme implementation reports	0	473
	3.1.12. Experience sharing among zones and woredas integrated woredas integrated with annual regional level review meeting	# of experience sharing visit conducted	UNICEF/RHB	Visit report	0	8
	3.1.13. Project baseline and endline surveys	# of surveys and dissemination workshops	UNICEF/Emory/ABH	Dissemination and survey result reports	0	4

	and facility rapid assessment and dissemination of the key findings of the surveys					
	3.1.14. Joint field visits by TAC	# of field visits by TAC	UNICEF/Emory	Joint field visit report	0	4
	3.1.15. Operational research	Number of operational research conducted	UNICEF/Emory	Research report	0	2
	3.1.16. Prospective assessment in selected epidemiological lab woredas	# of woredas supported to establish epidemiological lab	UNICEF/Emory/RHBs/Universities	Regular programme implementation reports	0	2
	3.1.17. Benchmark/exposure visit	# of visit held	Visit report	UNICEF	0	1

Annex 3: Table of contents for an inception report

List of Acronyms

1. Introduction

2. Evaluation Context

2.1 National Context

2.2 UNICEF Programme in Country/Region

3. Evaluation Purpose

4. Evaluation Objectives

5. Evaluation Scope

5.1 Thematic Scope

5.2 Geographic Scope

5.3 Chronological Scope

6. Evaluation Framework

6.1 Evaluation Matrix

7. Methodology

7.1 Evaluation Approach

7.2 Data collection methods and tools

7.3 Sampling strategy

7.4 Data analysis and quality assurance

8. Dissemination and Communications Strategy

9. Evaluation Workplan

10. References

11. Annexes

Annex 4: Table of contents for a final evaluation report

List of Acronyms

1. Title page
2. Table of contents
3. Executive Summary, including the purpose of the evaluation, key findings, conclusions and
4. recommendations in priority order (3-4 pages)
5. Background/context of the evaluation, including a description of project interventions, log
6. frame/results matrix (Theory of Change), if available
7. Purpose and objectives of the evaluation
8. Scope of the evaluation
9. Limitations and mitigation strategies
10. Evaluation criteria and key questions
11. Methodology (including ethical review)
12. Findings per criteria
13. Lessons learned
14. Conclusions and recommendations, explicitly linked to the findings