Terms of Reference

UNICEF Afghanistan

April 2025

Impact Evaluation of the Health Emergency Response (HER) and Novel Financing Arrangement (NFA) Programme 2022-2025

Table of Contents

1. Summary

UNICEF Afghanistan is commissioning the Impact Evaluation of the Health Emergency Response (HER)/Novel Financing Arrangement (NFA) Programme, specifically focusing on primary health care (PHC) interventions through the Basic Package of Health Services (BPHS), Essential Package of Hospital Services (EPHS), and High-impact Value-Added (HIVA) health services. The evaluation will assess the impact and added value of the HER/NFA programme on Afghanistan's health system and its contribution to meeting beneficiaries' needs. This will serve as a critical tool for incorporating best practices, fostering continuous learning, and ensuring the programme's adaptability to better serve children, women, and families in Afghanistan.

These Terms of Reference (ToR) describe the primary purpose, objectives, scope, tentative evaluation questions, proposed methodological approach, associated risks, and qualifications of external consultants required to undertake this impact evaluation between A timeline of around four months (~17.5 weeks) is envisaged for the evaluation, between May 2025 and August 2025, with preliminary analysis to be shared by June 2025.

2. Background and Rationale[1]

A. Healthcare programme in Afghanistan

Afghanistan grapples with a multifaceted humanitarian crisis stemming from prolonged conflict, widespread internal displacement, mass migration, livelihood loss, escalating poverty, a severe drought, heightened food insecurity, malnutrition, and their devastating intersections with disease and mortality. The challenges are further compounded by the onset of the COVID-19 pandemic and concurrent outbreaks of diseases like measles, dengue fever, and acute watery diarrhea.

Despite these adversities, Afghanistan has made commendable improvements in its Primary Health Care (PHC) system over the last two decades. Significant enhancements in health service coverage and population well-being have been achieved through the implementation of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS). The number of operational health facilities surged from 498 in 2002 to 2,725 in 2017, while the presence of skilled female health workers in these facilities escalated from 25% to an impressive 95.2%.[2] Community Health Workers (CHWs) also saw a substantial increase from 2,682 in 2005 to 29,596 in 2017.[3] There was a notable rise in skilled birth attendance (SBA) from 4% to 59% in rural areas, along with a substantial improvement in antenatal care (ANC) coverage from 8% to 61% between 2013 and 2018. However, immunization coverage remained relatively stable during the same period.[4]

The initiation of the Community-Based Health Care (CBHC) Programme in 2003 by the Afghan government was a pivotal step toward extending health services to remote regions through active community involvement. This programme, integral to the BPHS, aligns with Afghanistan's overarching PHC system and is executed by BPHS contractors. In 2019, the introduction of the Community Health Roadmap marked a crucial framework aimed at implementing PHC at the grassroots level. Nevertheless, based on recent implementation experiences and the changing landscape within communities, certain aspects of the programme, such as the scope of operations and incentivization mechanisms, warrant reconsideration. Furthermore, better integration with community-based nutrition programmes is imperative to establish a comprehensive Community-Based Health and Nutrition Programme (CBH&NP).

[1] The section is primarily based on information available from the health section, Health Emergency Response (HER) programme documents, and Health Sector Transition strategy 2023-2025.

[2] Ministry of Public Health. (2017). Health Management Information System Data.

[3] Ministry of Public Health. (2017). Community-based Health Care Data.

[4] NSIA and KIT Tropical Institute. (2019). Afghanistan Health Survey 2018. Available at: https://www.kit.nl/wp-content/uploads/2019/07/AHS-2018-report-FINAL-15-4-2019.pdf

Commencing in early 2004, the Ministry of Public Health (MoPH) initially oversaw the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) via a 'contracting out' approach. Non-governmental organizations (NGOs) were contracted as Service Providers (SPs) to administer services at the provincial level. However, following the shift in authorities in August 2021, the responsibility for BPHS and EPHS contracting transferred to the United Nations (UN), specifically managed by UNICEF. Since assuming this role, UNICEF has maintained collaborative efforts with SPs and other private sector entities to sustain and broaden the availability of fundamental health services. Their focus has been on enhancing care quality and fostering equitable access to health services.

In 2021, the national health policy and strategy underwent updates, including a review of BPHS and EPHS, resulting in a proposed updated framework termed the "Integrated Package of Essential Health Services" (IPEHS). However, due to the political transition in August 2021, these revisions were not formally launched. Subsequently, the de-facto authorities (DfA) introduced a slightly modified National Health Policy but have yet to adopt a revised National Health Strategy or updated service package. Notably, since 2010, the BPHS package has remained unchanged, despite the country's epidemiological shifts and evolving disease burdens. The intended periodic review, typically every 3-4 years, has not been implemented. For instance, the current BPHS package lacks interventions for noncommunicable diseases (NCDs) despite the country's disease burden and lifestyle-related risk factors.

Given the evolving landscape, ongoing discussions between the Ministry of Public Health (MoPH) and UNICEF highlight the necessity to reconsider the service package, integration levels among diverse community health and primary healthcare facility types, and the alignment between mobile clinics and health facilities. In October-November 2022, a preliminary technical mission involving experts from UNICEF's headquarter, regional office, and specialists in PHC, community health, and external health systems conducted a technical support mission in Kabul. This initiative encompassed field visits to Bamyan and Mazar-i-Sharif, aimed at providing support to the country office in evaluating the current status of these programmes.

The key findings stemming from the mission are summarized as follows:

- The current PHC system/strategy primarily focuses on maternal, new-born and child health (MNCH) without reflecting the epidemiological transition that is resulting from an increase in non-communicable diseases (NCDs, e.g., diabetes and hypertension), mental health needs, adolescent health, and trauma care, amongst others.
- Fragmented health systems, with weak coordination and alignment between health facilities and mobile health and nutrition teams (MHNTs) are functioning individually without standardized services, linking with facilities or geographic demarcation.
- The existence of various community platforms, including health shura, education shura, community development councils, Elders, family health action groups, CHWs and community health supervisors, serve as the foundation of community systems.
- There is little evidence on the performance and quality of care provided by CHWs.
- Gaps of harmonized and coordinated strategy on increasing access in “white areas”[5] without basic social services, including health and education.

Despite significant improvements in healthcare coverage and outcomes, a considerable unfinished agenda persists in Afghanistan's healthcare landscape. Challenges such as disparities in healthcare utilization and outcomes, substandard service quality, fragile health infrastructure, inefficiencies in health services management, inadequate access to all components of the Basic Package of Health Services (BPHS), deficient referral systems for secondary and tertiary care, poor stakeholder coordination, supply shortages, limited capacity in both public and private sectors, scarcity of skilled healthcare professionals, and insufficient accountability and community engagement continue to pose significant hurdles.

[5] The underserved populations reside in areas labeled as "white areas," indicative of limited or no healthcare provisions.

A recent geospatial analysis by WHO Afghanistan revealed that only 75% (28.7 million out of 38.2 million) of Afghanistan's population is served by the country's 4,242 primary healthcare facilities, leaving approximately 25% without access to essential services. Moreover, 9.5 million individuals in 22,181 settlements are categorized as "underserved." These underserved populations reside in areas labeled as "white areas," indicative of limited or no healthcare provisions. The public health system's lack of resources and capacity, compounded by additional expenses for private care and medications, further hinder healthcare access. For instance, auxiliary costs like transportation, particularly burdensome in rural regions, act as barriers to accessing healthcare, exacerbated by the current socioeconomic strain eroding people's savings. Heavy restrictions on women's mobility further impede their access to essential health services, including the deployment of female healthcare workers in remote areas.[6]

For community-oriented Primary Healthcare (PHC) to fulfill its mandate effectively, several critical aspects must be addressed:

- Responsiveness to the population's epidemiological needs.
- Assurance of standardized, high-quality services.
- Enhanced accessibility and affordability.
- Provision of an optimal and appropriate service package.

A robust PHC system ensures that individuals and families connect with reliable healthcare providers and supportive systems across their life cycle. It should offer a comprehensive range of services, from family planning and routine immunizations to the management of acute and chronic illnesses, including surgical emergencies. However, the current PHC system lacks adequate integration of vital services like non-communicable disease management, adolescent health, nutrition, and mental health.

B. Health Emergency Response (HER)/Novel Financing Arrangement (NFA) Programme

The Afghanistan Reconstruction Trust Fund (ARTF), Global Financing Facility (GFF), and the World Bank jointly approved a USD 333 million grant to UNICEF, spanning from May 2022 to the end of December 2023. This funding serves as crucial support for the continuous delivery of Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) in Afghanistan. UNICEF has taken charge of managing the provision of essential primary and secondary healthcare services through the 'contracting out' approach, collaborating with Service Providers (SPs). The primary objective is to augment the utilization and enhance the quality of essential health services provided at public health facilities across the nation.

Although project implementation has transitioned from the Ministry of Public Health (MoPH) to UNICEF, the tools, instruments, and service delivery models through third parties have been sustained and capitalized upon. The project's design incorporates the requisite adaptability to respond to an ever-evolving sectoral landscape. It remains receptive to implementation realities, on-ground challenges, data availability, insights garnered from monitoring activities, and continuous operational learning. Moreover, recognizing its prominent role in the health sector and robust technical capacity in Afghanistan, the World Health Organization (WHO) will assume a pivotal position. WHO's involvement will encompass essential capacity strengthening initiatives, specifically focusing on quality control of medical supplies, bolstering data infrastructure, and fortifying emergency preparedness and response mechanisms.

C. Key programme outputs and packages of UNICEF Health Services in Afghanistan

The programme is structured around four key programme outputs:

[6] WHO Afghanistan. (n.d.). Health Information Hub. Available at: https://dashboard.whe-him.org/index.php/maps-3/
Mohammed, R. N., Khawari, A., Shaguy, J. A., Abouzied, A. (2023). A GIS-based approach to identifying communities underserved by primary health care services—An Afghanistan case study. *Frontiers in Public Health* 11: 1209986. Available at: https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2023.1209986/full

- Management of equitable and uninterrupted delivery of quality Basic Package of Health Services (BPHS) through primary health care (PHC) facilities including district hospitals.
- Management of equitable and uninterrupted delivery of quality Essential Package of Hospital Services (EPHS) through provincial and regional hospitals.
- Management of the provision of value-added high impact interventions for Maternal, Newborn, Child, and Adolescent Health (MNCAH) at PHC and secondary healthcare (SHC) facilities in the respective province(s) in Southern and Western regions.
- Responding to Acute Emergencies.

Additionally, within UNICEF's health service provision framework, there are three distinct service packages: Basic Package of Health Services (BPHS), Essential Package of Hospital Services (EPHS), and a specialized set of high-impact value-added (HIVA) interventions designed to address critical healthcare needs.

Programme Output 1: Management of equitable and uninterrupted delivery of quality BPHS through PHC facilities including district hospitals

Across the country, Basic Package of Health Services (BPHS) is extended via around 3,919 public health facilities as recorded in the Health Management Information System (HMIS) for the year 2022. Among these facilities, the Health Emergency Response (HER) project encompasses 2,411 establishments, constituting approximately 62% of the total. These HER-supported facilities include a range of health facilities such as Reproductive Health Centers (2), Public Hospitals (16), District Hospitals (78), Comprehensive Health Centers (381), Basic Health Centers (772), Sub-Health Centers (1,079), Maternity Waiting Homes (24), Family Health Houses (34), and various other Primary Health Care (PHC) facilities, including those within correctional facilities like prison health facilities (25).

Table 1 provides an overview of the BPHS elements and services.

Table 1: BPHS elements and services

Maternal and new-born care	• Antenatal care • Delivery care • Postpartum care • Family planning • Care of the new-born
Child health and immunization	• Expanded Programme on Immunization (EPI) • Integrated Management of New-born and Childhood Illness (IMNCI)
Public nutrition	• Screening (assessment), prevention, treatment, and management of acute malnutrition • Prevention of chronic malnutrition and micronutrient deficiencies
Communicable disease treatment	• Control of tuberculosis • Control of malaria • Prevention of HIV and AIDS
Mental health	• Mental health education and awareness • Case identification, diagnosis, and treatment
Disability and physical rehabilitation services	• Disability awareness, prevention, and education • Provision of physical rehabilitation services • Case identification, referral, and follow-up
Regular supply of essential drugs	• Ensuring essential medicines are available and well stocked in health facilities and prescribed to patients as required.

All service delivery protocols and trainings must follow guidelines and Standard Operation Procedures (SoPs) established at Ministry of Public Health (MoPH) and partners, for example, package of BPHS and EPHS services and supplies, guidelines on CHWs work, referral mechanisms, IPC guidelines, etc. The Service Provider (SP) will be

expected to manage provision of BPHS at the Primary Health Care facilities, including district hospitals in the respective province(s).

Programme Output 2: Management of Equitable and Uninterrupted Delivery of Quality EPHS Services through Provincial and Regional Hospitals

The Essential Package of Hospital Services (EPHS) is dedicated to enhancing the health outcomes of Afghanistan's population, primarily by reducing maternal, newborn, infant, and child mortality and morbidity, lowering communicable disease incidences, and advancing child health and nutrition. EPHS services adhere to stringent guidelines and requirements, delivered by a proficient cadre of trained healthcare professionals—comprising doctors, midwives, nurses, and laboratory technicians—with robust quality assurance measures in place. EPHS facilities, namely hospitals at the provincial and regional levels, are pivotal in the healthcare ecosystem. They offer outpatient care services and secondary diagnostic and treatment options, functioning as primary referral points for facilities operating under the Basic Package of Health Services (BPHS).

These hospitals, aligning with EPHS guidelines, cater to a spectrum of specialized healthcare services, encompassing gynecology, obstetrics (inclusive of cesarean sections), neonatal care, postpartum care, and management of associated complications. Additionally, they focus on nutrition, orthopedics, trauma care, emergency and surgical interventions, intensive care, management of COVID-19 cases, addressing medical conditions arising from outbreaks and disasters, respiratory and gastrointestinal healthcare, ear, nose, and throat (ENT) services, as well as eye care and dental services. These specialized provisions within provincial and regional hospitals adhere to the specific directives outlined in the EPHS guideline, ensuring comprehensive and specialized healthcare delivery.

Table 2 offers a comprehensive overview of the Essential Package of Hospital Services (EPHS) available at both regional and provincial hospitals.

Table 2: EPHS services at Regional and Provincial Hospitals

Clinical and Diagnostic Services	• Inpatient services
	  ➢ General and specialized surgical services (operating theatre, anesthesia, recovery room services, and sterilization services)
	  ➢ Obstetrics and gynaecology services (Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency Obstetric and Newborn Care (CEmONC))
	  ➢ Pediatric services (including therapeutic feeding centers)
	  ➢ General and specialized medical services
	  ➢ Ophthalmology and ear, nose, and throat services
	  ➢ Mental health and psychiatric services
	  ➢ Dental services (in Regional Hospitals)
	  ➢ Forensic medicine
	• Emergency department open and staffed 24 hours
	• Outpatient services including dental services.
	• Hospital pharmacy
	• Physiotherapy services
	• Laboratory, blood transfusion services and blood bank
	• X-ray and ultrasound services
	• Endoscopy services
	• CT scan (Kabul only at tertiary hospital level)

The service providers will be expected to manage provision of EPHS at the provincial and regional hospitals in the respective province(s) in the country.

Programme Output 3: Management of provision of high impact value-added (HIVA) interventions for MNCAH

UNICEF is supporting high-impact value-added (HIVA) health services, emphasizing maternal and child healthcare and nutrition across all Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) facilities situated in the nine provinces of Afghanistan's southern and western regions. Specifically, these targeted provinces encompass Herat, Kandahar, Badghis, Farah, Ghor, Helmand, Nimroz, Urozgan, and Zabul. The selection of these provinces was based on two primary criteria: firstly, their low health indicators as per deprivation analysis, and secondly, their recent expansion of access following the political transition.

In addition to inputs allocated for health worker salaries, essential medicines, and operational expenses within the BPHS and EPHS frameworks, supplementary resources are imperative to comprehensively address the health needs of the population. These resources are geared towards facilitating the provision of value-added, high-impact interventions that cater to maternal, newborn, child, and adolescent health at both secondary and primary healthcare levels, extending support to communities as well.

These essential resources and interventions collectively contribute to a more comprehensive and holistic approach to healthcare, particularly focusing on vulnerable groups such as mothers, newborns, children, and adolescents in these specific regions of Afghanistan. The specific services within each of these areas are provided in Table 3 below.

Table 3: Value-added High Impact Interventions (HIVA)

High-impact interventions for maternal and newborn mortality reduction	• Scale up of Misoprostol through health facilities and community health platforms to prevent post-partum haemorrhage (PPH) ensuring adherence to the approved Ministry of Public Health guidelines
	• Expansion of the use of Chlorhexidine for umbilical cord care
	• Scale up of two new family planning methods:
	  ○ Sub-dermal contraceptive implants, offered as postpartum or interval method (first dose: CHW; second dose: self-administered by women in presence of health provider or CHW; third dose: self-administered at home)
	  ○ Sub-cutaneous depot medroxyprogesterone acetate implants inserted by skilled birth attendants at health facilities.
	• Strengthening new-born care at BPHS/EPHS facilities with needful supplies and equipment and training based on needs and capacity assessment
	• Provision and use of Maternal Child Health Handbook (MCH-HB)

Supplies for treatment of severe acute malnutrition (SAM) and for maternal and newborn care	• Provision of supplies including, but not limited to:
	  ○ Ready-to-use Therapeutic Food (RUTF) (supplied by UNICEF)
	  ○ Measurement equipment
	  ○ IEC materials

Addressing MHPSS and adolescent health with a particular focus on adolescent PLWs	• Provision of quality of MHPSS services with provision of essential medicines by dedicated counsellors at BPHS and EPHS facilities and through community-level interventions including MHNT (adding psychosocial counsellors) and CHWs under supervision of dedicated technical supervisor per province from the SP • Urgent adolescent sexual and reproductive health interventions for young people, especially adolescent girls and young women, to increase their access to, and availability and uptake of, SRH services.
Basic WASH facilities and Infectious Prevention and Control (IPC) practice in health facilities	• Undertake assessments to evaluate the needs of health facilities • Work towards ensuring availability of a standard package of water and sanitation facilities at BPHS and EPHS facilities in the province • Focus on facilities that require repair and rehabilitation to achieve standard functionality • Promote Infection Prevention and Control practices
Capacity building for health workers including in-service	• In addition to usual BPHS/EPHS in-service training, there is an ADB project to support but not limited to the following key capacity building activities:

training across various interventions in BPHS/EPHS	○ High Impact Interventions for prevention of post-partum haemorrhage (PPH) with Misoprostol; use of Chlorhexidine for umbilical cord care; and two new family planning methods. ○ New-born care both at facility and community levels ○ Adolescent health and gender training for health workers and CHWs
Community engagement, behavior change and demand generation	• Strengthening health promotion at HFs, ensuring needful equipment (TV, solar panel etc) and health educator at each HF • Production of social and behavioural change communication (SBCC) material • Mass and social media campaigns • Assessment of behaviour change • Interpersonal communication training for health workers and CHWs • Capacity building of local structures • Community engagement interventions through CHWs and community influencers, CSO and NGOs

Building upon the previous Health Emergency Response (HER) Project supported by the ARTF and the ADB-funded project focusing on High-Impact Value-Added (HIVA) interventions, the upcoming ADB project is poised to take over funding responsibilities for ten provinces situated in the southern, western, and central regions of Afghanistan. Notably, Daikundi has been added to the project's coverage area. This initiative aims to:

1. Support the provision of Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) within these ten provinces.
2. Tailor High-Impact Value-Added (HIVA) interventions based on specific needs within these regions.
3. Strengthen project management and implementation through various strategies, including management accompaniment, technical support provided by WHO, robust supervision and monitoring mechanisms, and third-party monitoring conducted both by UNICEF and external partners.

UNICEF initially assumed partial responsibility as the executing agency for the provision of BPHS/EPHS services from November 2021 to June 2022, transitioning to full responsibility from July 2022 to the present. The project will continue the 'contracting-out' modality through Service Provider NGOs from September 2024 through June 2025. Furthermore, an agreement between UN agencies will be established, enabling WHO to offer technical assistance and implementation support in areas where it holds a comparative advantage. The ADB project's scope encompasses targeting 733 health facilities and their associated communities with BPHS/EPHS provisions alongside complementary, need-based, and tailored HIVA interventions. This comprehensive approach seeks to address the specific health needs of these regions, thereby aiming for a more effective and responsive healthcare delivery system.

Programme Output 4: Responding to Acute Emergencies

The Service Provider (SP) is mandated to establish a comprehensive emergency response strategy and plan, designed to meticulously investigate, validate, and efficiently coordinate responses to various emergencies. These encompass a wide spectrum, including natural disasters like earthquakes, floods, droughts, among others, disease outbreaks such as Vaccine-Preventable Disease (VPD) outbreaks, acute watery diarrhea, and other communicable diseases, as well as man-made emergencies like conflicts and mass casualty incidents.

An essential responsibility of the SP involves the maintenance of emergency response committees at provincial, district, and health facility levels. This entails meticulous coordination of emergency preparedness services in collaboration with all pertinent stakeholders well in advance. Furthermore, the SP is accountable for promptly identifying, investigating, and responding to any outbreaks while ensuring immediate reporting to health clusters, the Ministry of Public Health (MoPH), UNICEF, and the World Health Organization (WHO) across all levels.

D. Rationale

In this context, UNICEF is seeking to commission an evaluation that will generate evidence on the Health Emergency Response (HER)/Novel Financing Arrangement (NFA) Programme by UNICEF Afghanistan, specifically focusing on primary health care (PHC) interventions through the Basic Package of Health Services (BPHS), Essential Package of Hospital Services (EPHS), and high-impact value-added (HIVA) health services. The evaluation with serve as a critical tool to showcase impact and value-add, along with incorporating best practices, fostering continuous learning, and ensuring the programme's adaptability to better serve children, women, and families in Afghanistan.

3. Purpose, Objectives, Use and Scope

The purpose of this impact evaluation is to assess the impact and added value of the HER/NFA programme[7] on Afghanistan's health system and its contribution to meeting beneficiaries' needs. The evaluation will focus on interventions related to Primary Health Care (PHC) through the Basic Package of Health Services (BPHS), the Essential Package of Hospital Services (EPHS), and High-Impact Value-Added (HIVA) health services up to 2025. The evaluation aims to generate evidence on key successes, challenges, and lessons learned. This evaluation will provide evidence-based insights to inform future programming, policy decisions, and resource allocation for strengthening Afghanistan's health system.

More specific **objectives** of the impact evaluation include the following:

- **Impact, comparative value-add of the HER/NFA programme, and achievement of results:** Assess the programme's impact on maternal and newborn survival, including morbidity and mortality and the differences in service delivery outcomes between HER/NFA-supported and non-HER/NFA-supported facilities, including the difference from 2022 to 2024. Evaluate and compare the service delivery, including availability, accessibility, and quality of care, in HER/NFA-supported health facilities (sampled from 2,400 facilities) versus non-HER/NFA facilities (sampled from 1,600 facilities). Evaluate the achievement of results and programme's contribution to maintaining health and nutrition systems and addressing the needs of beneficiaries including those of marginalized and hard to reach communities.
- **Complementarities, differences, and synergies between health service packages:** Examine the complementarities, differences, and synergies between BPHS, EPHS, and HIVA interventions. Evaluate the additional value of a unified and standardized service delivery model. Compare the additional impact of HIVA interventions in provinces where they have been implemented (9 provinces between 2022 and 2023, and 10 provinces in 2024) against provinces where only BPHS and EPHS were in place (25 provinces between 2022 and 2023 and 24 provinces in 2024).
- **Cost-efficiency:** Examine cost-efficiency of the HER/NFA programme and its packages in attaining the expected results and looking at changes over time (e.g., whether the cost-efficiency increased, decreased, or remained the same). This includes an assessment of resources (human and financial), risk management and mitigation measures.

Evaluation use:

The findings and recommendations from the external evaluation will be used to further shape the future of the health programme and packages in Afghanistan. The **primary users** of this exercise are: UNICEF Afghanistan, donors such as World Bank (WB) and Asian Development Bank (ADB) and bilateral donors, implementing partners and service providers, de-facto Ministry of Public Health, WHO Afghanistan, designated service providers, beneficiaries,

[7] The HER/NFA programme encompasses all three service packages (BPHS, EPHS, and HIVA), currently funded by the World Bank in 24 provinces and the ADB in 10 provinces. Please note that before 2024, BPHS and EPHS packages were funded by the World Bank in 34 provinces and the ADB funding HIVA package in 9 provinces under NfA 1.0.

health and nutrition facilities, and healthcare and nutrition professionals. **Secondary users** range widely and cover health and nutrition clusters, other UN agencies and non-governmental organizations in Afghanistan, other de-facto ministries, academic and research institutions, and health policy advocacy groups.

Scope of the exercise:

The **temporal scope** of this evaluation will focus on activities from 2022 until early 2025. The **geographic scope** will cover a sample of basic health and sub-health centres supported by both HER/NFA and non-HER/NFA across provinces of Afghanistan and its regions. The **thematic scope** of the evaluation will also look on various critical aspects, namely packages (BPHS, EPHS, and HIVA), availability, access, quality of care, health outcomes, integration and synergies of health service packages, cost-efficiency, cross-cutting areas (e.g., gender, disability, equity, human rights, climate, and environmental and social safeguards), and monitoring and evaluation.

4. Evaluation Questions

The main indicative evaluation questions are presented herein using the key impact evaluation's themes and followed by indicative hypotheses. It is expected that these will be further refined and agreed upon during the inception phase in consultation with the Evaluation Steering Committee and Internal Technical Working Group.

Table 4: Tentative evaluation themes, questions, sub-questions, and indicative hypotheses

Evaluation Themes	Evaluation Questions (and sub-questions)	Indicative hypotheses (H)
1. Impact, comparative value-add of the HER/NFA programme, and achievement of results	**Q1. What has been the impact and comparative value-add of the HER/NFA programme on targeted health and nutrition outcomes in HER/NFA-supported facilities vis-a-vis non-HER/NFA-supported facilities? What impact HER-supported health facilities had on the availability, accessibility, and quality of healthcare services vis-à-vis non-HER-supported facilities? How have impact, value-add, and key trends evolved from 2022 to 2024?** Q1.1. To what extent has the HER/NFA programme led to improving health and nutrition outcomes such as improving maternal and newborn survival, reducing morbidity and mortality, compared to control areas where the programme was not implemented? What patterns and shifts can be observed in service delivery, health outcomes, and programme effectiveness from 2022 and 2024? Q1.2. What is the overall availability, accessibility, and quality of services delivered by HER/NFA-supported health facilities, and how do they meet the needs of the communities they serve? How effectively has the programme affected access to and utilization of essential health services, particularly for marginalized and hard-to-reach populations? Q 1.3. How does service delivery, including availability, accessibility, and quality of care, differ between HER/NFA-supported health facilities and non-HER/NFA-supported facilities? What differences exist in health service utilization and patient outcomes between HER/NFA-supported and non-HER/NFA-supported facilities? Q1.4. What lessons from the comparison between treatment and control groups can inform future health interventions?	**H1: The HER/NFA programme has significantly improved health outcomes in areas where it has been implemented compared to non-HER/NFA supported health facilities.** **H2: Health facilities supported by the HER/NFA programme have higher service availability, accessibility, and quality compared to non-HER/NFA-supported facilities.** **H3: The HER/NFA programme has significantly reduced disease burden (morbidity) in facility catchment areas where it has been implemented compared to catchment areas of facilities where it has not been implemented.** **H4: The key trends in outcome have significantly evolved from 2022 to 2024.**
2. Complementarities, differences, and synergies between health service packages	**Q2. How does the inclusion of HIVA interventions influence health service delivery and outcomes compared to provinces without them?[8] What are the differences, additional impacts, complementarities, and synergies of integrating BPHS, EPHS, and HIVA interventions? How has the programme's reconfiguration evolved between 2022–2024, and what impact has it had on outcomes?**	**H5: The integration of HIVA interventions with BPHS and EPHS results in better health outcomes compared to areas where only BPHS and EPHS are implemented.** **H6: The programme's reconfiguration between 2022-2023 and 2024 has led to**

[8] As HIVA is still in its early stages with varying levels of implementation, this assessment will also serve as a critical baseline to establish the current landscape, measure initial conditions, and provide a foundation for tracking progress and impact over time.

	Q2.1. How do BPHS, EPHS, and HIVA interventions complement each other in improving service delivery, health outcomes, and system efficiency? To what extent has the reconfiguration of the programme impacted its outcomes? Q2.2. What additional impact do HIVA interventions have on health service access, quality, and patient outcomes in provinces where they have been implemented compared to those relying solely on BPHS and EPHS? Q2.3. How does the integration of HIVA interventions affect the overall effectiveness, coordination, and sustainability of health service delivery models? Q2.4. What lessons can be drawn from the comparison between provinces with and without HIVA interventions to optimize future health service integration?	**improved efficiency, service delivery, and outcomes.**
3. Cost-efficiency and governance	**Q3. How cost-efficient is the HER/NFA programme in achieving its expected results and looking at changes over time (e.g., whether the cost-efficiency increased, decreased, or remained the same)?** Q3.1. To what extent is the HER/NFA programme cost-efficient in delivering health services and achieving the desired outcomes? Q3.2. How has the cost-efficiency changed over time, has it increased, decreased, or remained the same, and what factors have contributed to these changes? Q3.3. How does the cost-efficiency of the HER/NFA programme vary between different service packages (BPHS/EPHS and HIVA), and how has this evolved over time?	**H7: The HER/NFA programme is more cost-efficient in delivering health services compared to non-HER/NFA-supported facilities.**

5. Evaluation Approach, Methodology, and Ethical Considerations

Employing a **mixed methods approach**, the impact evaluation will collect and analyze both quantitative and qualitative data, enhancing convergence and validity through **triangulation**. The methodology would incorporate **quasi-experimental design with post-only comparison** to assess the impact of the programme by comparing the outcomes of treatment and control groups.[9, 10, 11] Techniques like **propensity score matching (PSM)** and **difference-in-differences (DiD)** will be used to minimize biases, assess causality, and compare outcomes. Before conducting the post-only comparison, PSM will be applied to match treatment and control facilities on similar characteristics (e.g., catchment area, patient load, donor support, types of facilities, geographic location, healthcare infrastructure, etc.). After the matching process, DiD can be used in a post-only context to compare the **average treatment effect (ATE)** between the treatment and control facilities, by analyzing differences in outcomes between both groups after the intervention.[12, 13] **The use of existing secondary and administrative data will be crucial** in providing a robust foundation for identifying patterns and shifts over time from 2022 to 2024. Additionally, leveraging secondary data will enable to conduct a more cost-effective and time-efficient analysis, offering insights into the broader systemic shifts.

Moreover, the impact evaluation is designed to be **utilization-focused**, aiming to inform key decisions and leverage evidence for ongoing programme and organizational enhancements. A **participatory approach** will be adopted, closely engaging key stakeholders to foster meaningful participation and ownership throughout the evaluation process and its outputs. The evaluation will systematically integrate **gender, human rights, disability, climate, ESS, and equity considerations** and **quality of monitoring and evaluation systems** across all stages, encompassing key informant interviews and focus group discussions. The evaluation will ensure that tools, data collection, analysis, and reporting fully integrate cross-cutting issues. Special attention will be given to ensuring the **accessibility of data collection tools**.

Key comparative metrics:

- **Health outcomes**: Compare maternal and newborn survival, reductions in morbidity and mortality, and health service utilization between both facilities and over time.
- **Service delivery (availability, quality of care, and accessibility)[14]**: Assess differences in service availability (e.g., outpatient visits, immunization coverage, ante-natal and post-natal care, and institutional delivery), service quality (e.g., patient satisfaction, provider competencies), and health service accessibility (e.g., distance to facilities, availability of staff) and utilization.

---

[9] SAGE Publications. (2019). *Quasi-experimental and single case designs*. Available at: https://us.sagepub.com/sites/default/files/upm-binaries/89876_Chapter_13_Quasi_Experimental_and_Single_Case_Designs.pdf

[10] Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Available at: https://www.courses.sas.upenn.edu/opus/course/soc-259c/

[11] Harris AD, McGregor JC, Perencevich EN, Furuno JP, Zhu J, Peterson DE, Finkelstein J. (2006). *The use and interpretation of quasi-experimental studies in medical informatics.* Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC1380192/

[12] Rosenbaum, P. R., & Rubin, D. B. (1985). *Constructing a control group using multivariate matched sampling methods that incorporate the propensity score*. The American Statistician, 39(1), 33-38. Available at: https://doi.org/10.1080/00031305.1985.10479383

[13] Angrist, J. D., Pischke, J. S. (2009). *Mostly Harmless Econometrics: An Empiricist's Companion*. Princeton University Press. Available at: https://press.princeton.edu/books/ebook/9781400830391/mostly-harmless-econometrics

[14] The Tanahashi framework defines effective coverage as the outcome of a sequential process, where each stage adds conditional factors that determine health system performance for a given intervention. It measures five key determinants, from availability coverage (service accessibility) to effective coverage (proportion of individuals receiving quality care that leads to health benefits). Identifying and analyzing gaps at each stage helps pinpoint system inefficiencies, address barriers, and guide resource allocation for improvements. The framework will be further examined and incorporated into the inception report.

- **Cost-efficiency**: Analyze the cost-effectiveness of service delivery by HER/NFA-supported facilities and of the HER/NFA programme overall, looking at changes over time (e.g., whether the cost-efficiency increased, decreased, or remained the same).

For the cost-efficiency component, the evaluation will assess different implementation modalities over time while acknowledging the unique context of Afghanistan and the significant variability across provinces, settings, and service delivery models. A direct comparison with other countries may not be feasible and a more context-specific approach, such as pairing similar settings to analyze different NGO, health facility, and service delivery models, will yield more relevant insights.

At a minimum, the following **data gathering methods** are recommended:

- **Desk and Literature Review:** Conduct a systematic desk review encompassing key documents, peer-reviewed journal articles, programme materials, project proposals and reports, and the like.
- **Administrative and Secondary Data:** Utilize administrative and secondary data judiciously, such as HMIS and DHIS 2 databases, UNICEF databases, including MICS, secondary administrative data, third-party monitoring (TPM) data, health facility administrative data, data from other programmes, etc. to optimize efficiency in the evaluation process.
- **Key Informant Interviews (KIIs) and Focus Group Discussions:** Conduct interviews with key decision-makers, technical staff, health stakeholders in Afghanistan, including but not limited to de-factor ministries, health cluster, UN agencies, extenders, service provides, etc. Engage in focus group discussions with community members and healthcare professionals.
- **Observations:** Conduct on-site visits to health facilities, clinics, and community-based service delivery sites for first-hand observations and a contextual understanding of the operational environment.
- **Cost-Analysis:** Perform a thorough cost-efficiency and cost-effectiveness analysis of the health programme and its packages to evaluate resource utilization and the overall economic impact.

Data collected through various tools will be systematically triangulated to ensure robustness.

Suggested sampling is depicted below (the bidders can propose an enhanced sampling strategy and size in the technical proposal, with further refinement during the inception stage to ensure methodological rigor).

For this impact evaluation, a counterfactual analysis will be constructed to assess the difference in health and nutrition service delivery outcomes between treatment and control facilities. The treatment facilities will consist of a sample of basic health and sub-health centres that are supported by the HER/NFA programme. These facilities will be drawn from the 2,400 HER/NFA-supported health facilities. The control group will include comparable basic health and sub-health centres located within 1,600 non-HER/NFA health facilities. Propensity Score Matching (PSM) will be employed to match control and treatment facilities based on similar baseline characteristics to ensure comparability between the two groups.

In addition to the general sampling strategy for treatment and control groups, specific attention will be given to evaluating the impact of HIVA interventions. The evaluation will compare outcomes between provinces that have implemented HIVA interventions (9 provinces between 2022-2023 and 10 provinces in 2024) and those that have only implemented BPHS and EPHS (25 provinces between 2022-2023 and 24 provinces in 2024). The selection of HIVA-implemented provinces will be based on the availability of data and the degree of implementation, ensuring that the comparison is between provinces where HIVA interventions have been fully integrated versus those with only the basic packages. This sampling strategy will also include the HIVA-implemented facilities, allowing for the comparison of health outcomes, service quality, availability, and accessibility between HIVA and non-HIVA areas. The evaluation will assess whether HIVA interventions provide additional value and improvement over the health services offered under BPHS and EPHS.

The sampling will include both rural and urban areas, with particular emphasis on marginalized and hard-to-reach populations, ensuring a comprehensive representation of diverse demographic and geographic groups where

health facilities exist. This approach will guarantee that the evaluation reflects variations in service availability, accessibility, and outcomes between urban and rural settings, as well as across provinces with differing levels of healthcare infrastructure.

A stratified random sampling technique will be used to select the health facilities, ensuring that diverse geographic and socio-economic contexts are adequately represented. Facilities will be selected proportionally based on population size, health service needs, and the overall healthcare delivery context within each province. This sampling methodology will ensure that the sample is representative of the entire spectrum of health service delivery across Afghanistan. To strengthen the validity of comparisons between intervention and non-intervention areas, the evaluation will account for potential confounding factors that could impact the results. For example, if control areas receive funding or resources from other donors, it may reduce the measurable differences between the two groups. This will be systematically assessed and addressed in the analysis.

The sample size will be determined based on the total number of basic health and sub-health centres within each group, taking into account factors such as population density, health service access, and variations in service needs. Cochran's formula will be applied to determine a statistically representative sample of beneficiaries within the catchment areas of the selected healthcare facilities. The final sample will be statistically powered to detect significant differences in outcomes between the treatment and control groups, thereby providing a reliable estimate of the HER/NFA programme's impact on maternal and newborn health, service quality, and overall health system strengthening.

Further technical discussions are needed to determine the most effective methodologies for utilizing and integrating existing datasets such as MICS, DHIS 2, and similar sources. Additionally, exploring potential gaps and complementary data sources will be crucial for a more comprehensive understanding of the evolving trends. The evaluation will also explore utilization of LiST, which involves selecting key "tracer" interventions from the BPHS, EPHS, and HIVA packages, such as immunization, antenatal care (ANC), and emergency obstetric care (EOC), and estimating their effective coverage before and after implementation, as well as across intervention and non-intervention areas.

Anticipated risks in the management of this evaluation, along with corresponding mitigation measures, are documented in the table below.

Table 5: Risks and mitigation measures

Risk	Risk Mitigation Measure
Challenges with availability of data and its quality	In case of data availability and quality challenges, primary qualitative data collection would be further encouraged. Utilization of various data collection tools can mitigate this challenge. Moreover, the evaluation management team will close work with the health section and key stakeholders to mitigate this challenge.
Bias in the control group selection due to non-comparable characteristics between the treatment (HER-supported) and control (non-HER-supported) groups	A robust PSM process will be applied with a broad range of covariates to ensure the groups are well-matched. Additionally, auxiliary data from sources like MICS and DHIS 2 will be used to cross-check the representativeness of the control group, and any discrepancies will be addressed through further matching or refinement of the control group. A stratified sampling approach will also be used within the control group to ensure that different regions and healthcare contexts are adequately represented. Ongoing monitoring of the groups will help identify and correct any emerging imbalances, while sensitivity analyses will test the robustness of the findings. By implementing these strategies, the risk of bias in the control group will be minimized, ensuring a more reliable assessment of the HER programme's impact on health outcomes.
The short timeframe for the exercise	In case of challenges with the timeframe proposed, the evaluation phases could be overlapped. For instance, during the inception phase, data collection and

	documentation review can be commenced so as not to lose traction between the evaluation phases.
Limitations faced by female field staff to carry out primary data collection	In case of challenges, prioritization of the safety and security of female field staff is important. The evaluation team will conduct risk assessments and ensure that fieldwork locations are secure and accessible. Moreover, establishing a system for continuous monitoring and feedback to promptly address any emerging challenges faced by female field staff is critical. This can involve regular check-ins, feedback sessions, and adjustments to the data collection plan based on their experiences.
Limitations of available secondary data	Given the gaps in existing secondary data, incorporating primary qualitative data collection, will allow to fill these critical information gaps and generate robust evidence.

The evaluation team will be expected to follow UNICEF standards on evaluation ethics and quality, UNEG Ethical Guidelines for Evaluation, and UNEG Code of Conduct, as well as with UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation.[15] The process will include the following mechanisms:

- Respecting gender and human rights principles throughout the evaluation process, including the protection of confidentiality, the protection of rights, the protection, dignity and welfare of people, and ensuring informed consent.
- Data validation will take place at all levels with participants' consent.
- Maximizing the degree of participation of stakeholders in the evaluation itself wherever feasible and a commitment to using participatory approaches in conducting the case studies.
- Ensuring proper data disaggregation by gender, disability, equity, and human rights-relevant factors.
- Ensuring that evaluation products use gender-sensitive, disability-inclusive, and human-rights language.
- Ensuring privacy protocols and compliance with all legal data management rules and considerations.
- Practicing the 'do no harm' principle during the exercise.

The evaluation team will have access to critical internal data and perspectives. These must be held with the utmost confidentiality. Likewise, the willingness of internal and external stakeholders to speak to these issues critically will depend on the provision of absolute confidentiality. The selected applicant must sign the non-disclosure agreement, abide by UNICEF's security protocols, and ensure that sensitive data is protected.

Furthermore, ethical clearance must be obtained during the inception period before any data collection with human subjects begins. The ethical clearance letter should be attached in the annexure of the final report. All data collected through this assignment, reports and dissemination materials are the intellectual properties of UNICEF and shall not be used for purposes other than those approved by the registered Institutional Review Board during the ethical clearance.

6. Management and Governance Arrangements

Management team and contract supervision

Supervisor/Approving authority: An Evaluation Specialist will manage and supervise the exercise (i.e., Evaluation Manager). S/He may delegate oversight duties to other persons for portions of the work but will retain overall approving authority.

The standard UNICEF evaluation quality control protocols and processes will be in place to ensure close management through the exercise.

[15] These references are available at the following link: https://www.unicef.org/evaluation/resources

Management team (MT): The Management Team (MT) will be composed to support the exercise. The team will consist of the Evaluation Manager and representatives from the health section and UNICEF Regional Office in South Asia. The roles of the MT will be to:

- Meet regularly to offer insights on issues under discussion, and provide guidance, technical input, and quality assurance.
- Review and approve all deliverables, including the inception report, emerging evidence summary presentations, and final report.

The Management Team will be closely engaged in the process. The decisions will be participatory; however, the final approving authority will be under the Evaluation section, per the Evaluation Policy.

Steering Committee/Reference Group (RG) and Internal Technical Working Group: Both groups will be created to support the consultants and the management team in an advisory capacity. The former group will consist of the internal and external stakeholders at the management level, while the latter will focus on the technical expertise in UNICEF. The roles will be to:

- Offer insights on issues under discussion, especially in the inception phase where the methods, design, and data to be sought are to be determined.
- Review all deliverables, including the inception report, emerging evidence summary presentations, and final report.
- Participate in workshop-style meetings for the presentation and discussion of emerging findings, for validation and to provide further comments.

7. Evaluation Schedule and Deliverables

A timeline of around four months (~17.5 weeks) is envisaged for the evaluation, **from May 2025 and end of August 2025, with preliminary results to be shared by June 2025.** The evaluation team should allocate reasonable effort to ensure the timely submission of all the deliverables. The proposed organization of the evaluation phases is as follows:

Inception phase (two weeks): During this phase, the evaluation team is expected to gain a deep understanding of the proposed documentation, assess possible information gaps, refining the scope, methods, and critical stakeholders. The main deliverable for this phase will be a short inception report, presenting a detailed description of the final scope; revised methodological approach, including any data collection and analytical instruments; preliminary evidence from the initial desk review and critical informant consultations; as well as the structure of the final report and an updated timeline for deliverables. It is expected that a short meeting will be planned with the Steering Committee/Reference Group and Internal Technical Working Group for the presentation of the inception report plan and discussion.

Data collection and analysis phase (seven weeks):

Additional documentation, secondary and primary data will be collected using instruments previously piloted during the inception phase. The main deliverable for this phase is all data gathered is analyzed, including preliminary data, stored in a secure repository, cleaned, and processed to ensure the anonymity of key informants**. A presentation with emerging findings is also expected during this phase. Meetings with the Steering Committee/Reference Group and Internal Technical Working Group will be scheduled.**

Report drafting and dissemination phase (eight weeks): The main deliverables for this phase are the preliminary draft of the final report and the final agreed report. In addition, it is expected that the main findings, conclusions, recommendations, and lessons learned will be presented to the Steering Committee/Reference Group and other

relevant stakeholders, with a stand-alone Evaluation Brief and PowerPoint to be delivered. Additionally, it is anticipated that the firm will submit the evaluation for publication in peer-reviewed journals.

Other interim products are:

- Minutes of key meetings with the Reference Group;
- Monthly progress reports;
- Copy of the anonymised data collected during the evaluation;
- Manuscript for publication in peer-reviewed journals; and
- Presentation materials for the meetings with the Steering Committee/Reference Group and Internal Technical Working Group. These may include PowerPoint summaries of work progress and conclusions to that point.

8. Required Qualifications and Experience of the Evaluation Team

Evaluation Team: Qualifications and experience required

The team conducting this evaluation is expected to include three (or four) team members: one team leader and two (or three) other team member(s). The bidders are welcome to share different team configurations based on the terms of reference for the review.

Team Leader: Senior Evaluation Specialist

Expected responsibilities:

- Direct all parts of the impact evaluation, directly accountable to UNICEF.
- Coordinate and supervise the evaluation team's work in their contributing roles.
- Ensure the quality of the process, outputs, methodology and timely delivery of all products.
- Take direct responsibility for all deliverables being of satisfactory quality.
- Ensure that the deliverables emerge promptly, following a high-quality, in-depth analytical process and ongoing consultation with the UNICEF Evaluation Manager, the Management Team, and the Reference Group.

Key qualifications:

- At least ten years of professional experience in leading evaluations, research, or other formative and summative exercises in international cooperation, public health, emergency context, humanitarian and development assistance.
- Minimum an advanced degree [Master's Level] in a relevant field across the social sciences, with an advantage given to degrees or major emphases in evaluation or related evidence fields.
- Extensive experience working with multilateral or intergovernmental organizations.
- A good understanding of the public health and humanitarian emergency response mechanisms.
- Proven experience in leading exercises similar in scope to the present task.
- Demonstrated ability to supervise an evaluation team at the talent and experience level required.
- Excellent written and oral communication skills in English and another UN language.

Team Member(s): Evaluation Specialist / Data Scientist (minimum 1)

- The Evaluation Specialist/Data Scientist will support the Team Leader / Senior Evaluation Specialist, providing substantive feedback ***based on experience and skills that complement the team leader's skills, knowledge, and competencies***.

Key qualifications:

- More than five years of professional experience in evaluations, data science, research, or other impact evaluation exercises in international cooperation, public health, emergency context, humanitarian and development assistance.
- A work history, as a mid-level team member, in international cooperation, public health, humanitarian and development assistance, with work conducted in UN or international development environments seen as a significant advantage.
- Experience with MICS, HMIS, and DHIS II data is required.
- Ability to support documentation review, data gathering, and analysis, including managing interviews/consultations with key informants.
- Ability to lead on one or more elements of the work as a complement to the strengths of the team lead.
- Excellent written and oral communication skills in English and another UN language.

Team Member(s): Health Expert (minimum 1)

- The Health Expert/Specialist will support the Team Leader / Senior Evaluation Specialist, providing substantive feedback on the health sector, particularly on public and community health.

Key qualifications:

- More than ten years of professional experience in health sector, particularly public and community health, emergency context, humanitarian and development assistance.
- A work history in international cooperation, public health, humanitarian and development assistance, with work conducted in UN or international development environments seen as a significant advantage.
- Experience with MICS, HMIS, and DHIS II data is required.
- Ability to support documentation reviews, data gathering, and analysis, including managing interviews/consultations with key informants.
- Ability to lead on one or more elements of the work as a complement to the strengths of the team lead.
- Excellent written and oral communication skills in English and another UN language.

9. Payment Schedule

Bidders can propose a payment schedule based on the following deliverables:

- Approved Inception Report: approx. two weeks after signing the contract;
- Approved presentation on emerging findings: approx. 9 weeks after signing the contract;
- Approved preliminary draft of the final report: approx. 15 weeks after signing the contract;
- Approved final report, presentation, and other materials: approx. 17.5 weeks after signing the contract.

10. Requirements for Technical and Financial Proposals

Proposals will be evaluated based on a combination of technical and financial considerations including the need to meet the mandatory criteria. The technical quality of the proposals will account for 70 per cent of the final score; financial proposals will account for 30 per cent. Under this RFPS the Combined Technical and Financial Score with weightage 70:30 applies.

A panel of specialists will review the technical proposals first; only proposals that meet the mandatory criteria and receive a minimum of 70 points during the technical evaluation will be considered further. Proposals that pass the technical stage will then receive a financial score and the two will be added together.

A. Table of contents.

B. Presentation of the bidding institution or institutions if a consortium, including:

- Name of the institution.
- Date and country of registration/incorporation, and location of offices or agents.
- Summary of corporate structure (detailed organogram), business areas, corporate directions, experience, and values.
- Past two years' annual turnover (in US dollars).
- Past two years' audited financial reports (income statement and balance sheet).
- Number of full-time employees and type (technical experts, administrative and logistics support staff, financial staff, etc.).

C. Short narrative description of the bidding institution's experience and capacity in the following areas:

- Impact evaluations conducted for international development organizations and emergency settings.
- Previous evaluations of public and community-based healthcare, focusing on the areas of healthcare packages, and the like.
- Capacities, including the ability to conduct this exercise.

D. List of similar/relevant past and on-going assignments carried out by the proposer in the past 5 years. UNICEF may contact reference persons for feedback on services provided by the proposers.

E. Full reports or preferably links to full reports listed as examples of relevant past and on-going assignments of the proposer (at least 3), on which the proposed key personnel directly and actively contributed or authored.

F. Proposed methodology. This should minimize simple repetition of what is stated in the ToR. There is no minimum or maximum length. If in doubt, ensure sufficient detail is provided for UNICEF to be able to judge the technical expertise. The bidder is required to adhere to the outlined design and methodology; however, proposals that include enhancements, innovative approaches, or additional improvements are highly encouraged.Required content is as follows:

- Understanding of and comments on the context and rationale for the evaluation.
- Understanding of and comments on the evaluation scope.
- Comments on the evaluation criteria, key evaluation questions, and areas of particular interest.
- Understanding of, comments on, and in-depth analysis of the aspects of complexity, potential challenges, risks, and ethical issues related to this evaluation exercise. This must include a description of the bidding institution's ethics protocols including data privacy protocols.
- Understanding of and comments on the proposed evaluation design and methodology, with a sufficient level of detail on each phase and activity of the evaluation process, including on data to be collected to answer the evaluation questions, envisaged data collection and analysis methods, the sampling methodology.
- Comments and additional details/suggestions on the deliverables proposed in the ToR if any.
- Comments and suggestions on the management arrangements described in the ToR, if any, and proposed internal management and quality assurance arrangements.

G. Work plan, which will include as a minimum requirement the following:

- General work plan based on the one proposed in the ToR, with comments and proposed adjustments, if any.
- Detailed timetable by activity. It must be consistent with the general work plan and the financial proposal. It must factor in sufficient time for the drafting of the deliverables report, the quality assurance by the evaluation team, UNICEF and the Reference Group, and their finalization. It should also consider the vacation time of evaluation team members.

H. Evaluation team:

- Summary presentation of proposed experts.
- Description of support staff if any.
- Level of effort of proposed experts by activity. It must be consistent with the financial proposal.
- CVs of each proposed expert. For information- senior and intermediate level experts will be asked to sign a statement of exclusivity and availability prior to contract signature; however, at the stage of the proposal submission, the proposed team is expected to be available for the full duration of this assignment.

Content of the financial proposal: The financial proposal must be fully separated from the technical proposal. The financial proposal will be submitted in both PDF and Microsoft Excel format. Costs will be formulated in US dollars and free of all taxes. It will include the following elements as a minimum requirement:

A. Overall price proposal.
B. Budget by phase, by activity, and by cost category (including staff, travel, and interpretation/translation, if part of the methodology).

As per UNICEF procurement procedures, the budget for this evaluation assignment is not disclosed.

During any travel that may be undertaken for the evaluation, costs for accommodation, meals and incidentals shall not exceed applicable daily subsistence allowance (DSA) rates, as promulgated by the International Civil Service Commission (ICSC): http://icsc.un.org/.

11. Assessment of Proposals

Mandatory criteria: Vendors must provide documentation of proven expertise with a UN agency or development partner showcasing the vendor's expertise in designing, managing, administering, and managing complex analysis and strategy development processes. This could include a track record in conducting similar analysis and strategy development processes across a range of development partners for UN agencies or similar type of organization.

Technical criteria: The following criteria will be used in evaluating the technical proposals:

Technical Evaluation Criteria		
Section 1: OVERALL RESPONSE	Demonstrated understanding of the purpose, scope, requirements, and deliverables of this assignment, including of UNICEF work in public and community-based healthcare, humanitarian and development assistance, and the like.	10
	Overall structure of the proposal including conceptual framework for analysis and reporting, clarity and completeness of the proposal. Adequacy of the technical plan demonstrated through the overall concord between requirements, and the proposal submitted. Demonstrated ability to conduct high quality evaluations in various contexts.	10
	Risk assessment - recognition of the risks/peripheral problems and methods to prevent and manage risks/peripheral problems.	5
Total Section 1: Max 25 points ***Minimum qualifying points: 15***		
Section 2: METHODOLOGY	Quality of proposed implementation plan, i.e., how to undertake and execute each stage, with proposed project schedules.	10
	Quality of the proposed/improved evaluation questions.	10

	Quality of proposed approach and methodology for the assignment including for information collection, compilation, and analysis.	15
	Demonstrated ability to conduct evidence generation activities ethically.	5
Total Section 2: Max 40 points ***Minimum qualifying points: 25***		
Section 3: QUALIFICATOINS	Quality and relevance of the sample work provided. Focus, scale/size, and scope of past and current evaluations/research implemented, including evaluation types.	10
	Relevant academic qualifications, skills, and years of technical experience of team members and local partners, including familiarity with UNICEF.	10
	Written communication skills of the proposed team members, including ability to facilitate and conduct meetings and ability to conduct work in English and local languages.	5
	Clear description of quality assurance mechanisms to be used by the institution to deliver quality products. Includes both in house and outsourced quality assurance.	5
Total Section 3: Max 30 points ***Minimum qualifying points: 20***		
Section 4: Sustainability	Clear description of sustainability considerations (SDG Goal 12 and its target 12.7 – Please see Appendix 1).	5
Total Section 4: Max 5 points ***Minimum qualifying points: 2***		
Total Possible Points		**100**
Minimum qualifying required Score (Total Technical Proposal)		**70**

Financial criteria: The following criteria will be used in evaluating the financial proposals:

- The price should be broken down for each component of the proposed work based on an estimate of time which needs to be stated.
- Bidders must complete the financial proposal form, with the daily rate of each team member.
- The price proposal should include separate travel costs.
- The total amount of points allocated for the price component is 30. The maximum number of points will be allotted to the lowest price proposal that is opened and compared among those invited institutions which obtain the required threshold of points in the evaluation of the technical component. All other price proposals will receive points in inverse proportion to the lowest price, e.g.:

Score for price proposal X = (30*Price of lowest priced proposal) / (Price of proposal X)

Award Recommendation

The proposal obtaining the highest cumulative score after adding the scores for the technical and financial offers will be considered as the most responsive proposal. The proposal that offers best value for money and is in the best interests of UNICEF will be recommended for award of the contract.

APPENDIX 1

UNICEF Procedure on Sustainable Procurement

The UNICEF Procedure on Sustainable Procurement is one of UNICEF's responses to the Sustainable Development Goals (SDGs) particularly Goal 12 – "Ensure Sustainable Consumption and Production Patterns" and its target 12.7 – "promote public procurement practices that are sustainable, in accordance with national policies and priorities". Sustainable procurement encompasses three pillars – economic, environmental, and social. Bidders are encouraged to read Sustainable procurement procedure (UNICEF Supply Division).

Each box below has been assigned with 1 point. Last box has been assigned with 2 points. If applicable, please checkmark the box for the following:

❑ Has your company made a commitment to economic pillar (example: policy/ SOP to inclusion of local resources to develop local economy in area of work, including small businesses and businesses owned by marginalized groups). **Please provide relevant policy / certification / SOP to evidence the claim**.

❑ Has your company made a commitment to social pillar (example: policy/ SOP to protecting human rights and labour issues (workers' rights), inclusion of persons with disabilities and gender in the work force). **Please provide relevant policy / certification / SOP to evidence the claim.**

❑ Has your company made a commitment to environmental pillar (example: policy/ SOP to minimize the impact on environment from purchasing, reduction of wastage, reduced CO2 emissions etc.). **Please provide relevant policy / certification / SOP to evidence the claim.**

❑ Please explain how you plan to integrate sustainability measures in the execution of the contract, if awarded to you (250 words):

Appendix II for SDG Goal 12 and its target 12.7 must be duly completed, signed, and returned with the Technical Proposal