

UNICEF Pacific Multi-Country Office (MCO)

Terms of Reference (ToR)

Evaluation of the health and nutrition program outcome – multi-country evaluation

1. Background and Justification

1.1 General Background

The Pacific islands subregion presents unique challenges and opportunities. It has a population of some 2.45 million, 40 per cent of whom are under age 18, and is spread across 14 countries and territories¹ in an area equivalent to 15 per cent of the earth's surface. The countries have small, culturally diverse populations, high levels of environmental vulnerability and limited income sources, all of which challenge their ability to ensure sustainable, equitable human development.

Tackling the causes of child mortality remains a priority for most Pacific Island Countries and Territories (PICT), with strengthened emphasis needed on neonatal and infant mortality. The magnitude of maternal deaths is unknown in half of the countries. Where data exists, stunting represents the most critical childhood nutrition issue in the Pacific demanding a focused strategic approach. Climate-related hazards represent a critical element in the Pacific, with implications on health services delivery.

Data suggest some progress with maternal mortality and significant progress with under-five mortality in the past decade. However, seven countries have under-five mortality rates (U5MR) above the Sustainable Development Goals target of 25 per 1,000 live births by 2030. An estimated 1,700 children died before age five across the 14 Pacific island countries in 2016². The major causes of neonatal deaths are infection, birthing complications, preterm births and congenital diseases. Of the seven countries with data, maternal mortality varies widely, from 30 to 124 deaths per 100,000 live births in Fiji and Tonga, respectively.

Significant data gaps exist on malnutrition. The available information shows stunting of children under-five is highest in Republic of Marshall Islands (35 per cent), Kiribati (15 per cent), Tonga (2.2 per cent), Solomon Islands (32 per cent), Vanuatu (29 per cent), and Nauru (24 per cent). In general, the coverage of essential nutrition interventions, including infant and young child feeding practices, de-worming and iron supplementation for pregnant women and children under-five, are low in all countries.

Obesity prevalence among women aged 15-64 ranges from 23 per cent in Vanuatu to 68 per cent in Tokelau, while overweight prevalence ranges from 32 per cent in Fiji to 90 per cent in Samoa. While data is scarce, high levels of childhood overweight and obesity were found in Tonga (17.3 per cent). High to very high levels of overweight and obesity (47 per cent to 8 per cent) were found among adult females in the Federated States of Micronesia, Fiji, Kiribati, Samoa, Solomon Islands and Vanuatu.

¹ Cook Islands, Fiji, Kiribati, Republic of Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu

² UNICEF Multi-Country Programme Document, 2017.

High adolescent birth rates, women's poor health and nutritional status, limited supply, utilization and quality of health services, particularly for remote and vulnerable populations, along with limited availability of community-based outreach and referral systems, contribute to poor maternal, neonatal and child health. Gaps exist in health policy, planning, budgeting, staffing, operational guidance, updated protocols and supply chain management. Health-seeking behaviour remains a challenge requiring new approaches to community and health worker capacity-building to strengthen the quality of healthcare services.

UNICEF focuses on five major changes necessary to overcome key health system bottlenecks that contribute to high rates of neonatal and early infant deaths and levels of stunted and overweight children: (a) strengthened policies and legislative frameworks and their monitoring and enforcement; (b) enhanced planning and coordination mechanisms for health and nutrition, including linkages with WASH, early childhood development and social protection; (c) enhanced knowledge and skills of caregivers to adopt critical health, nutrition and care practices, supported by efforts to bring about shifts in social norms and sociocultural habits; (d) improved delivery and monitoring of quality facility and community health and nutrition care services; and (e) strengthened capacity of health care systems to plan for, adapt to and recover from disasters and longer-term climate changes. UNICEF works closely with ministries of health in collaboration with the Asian Development Bank (ADB), NGOs, Pacific Community, Rotary, United Nations Population Fund (UNFPA); and World Health Organization (WHO).

Across all countries, UNICEF undertakes technical collaboration with ministries of health for policy formulation, analysis of human resource capacities and financial flows, improving health information systems, management of health commodities, evidence-based advocacy to promote strengthened investment in child and maternal health and nutrition, and co-leads the nutrition sub-cluster to strengthen coordination capacity. In five countries whose child and maternal health and nutrition indicators are worse off – the Federated States of Micronesia, Kiribati, the Marshall Islands, Solomon Islands and Vanuatu – UNICEF supports a comprehensive health systems-strengthening approach. By providing technical and financial assistance, UNICEF strengthens the quality of service delivery both at the facility level and with community-based approaches. Through the 1,000 days approach, UNICEF promotes high impact interventions to reduce stunting – including micronutrient supplementation, breastfeeding and complementary feeding, treatment of acute malnutrition, and sanitation, hygiene, stimulation and care practices. UNICEF supports actions to enhance parents' and caregivers' knowledge of and ability to practice safe, caring and protective behaviours.

Health workforces in the Pacific are small, and because they were redeployed or refocused on COVID-19 preparedness in 2020, including quarantine management, health workers were not as available to deliver essential services. Essential service disruption was compounded by global and Pacific supply chain disruptions for routine and COVID-19 supplies as well as two tropical cyclones and a measles outbreak response. Available information indicates that these disruptions could reverse gains seen in the Pacific on child health and nutrition.

Globally, a key development in normative guidance for primary health care provision, and an outcome of the 2019 World Healthcare Assembly, is the [Operational Framework for Primary Health Care](#) jointly developed by UNICEF and WHO. Published in 2020, this operational framework proposes 14 strategic and operation levers needed to translate the global commitments made in the Declaration of Astana into actions and interventions. It assists countries in fulfilling their commitments to improving primary health care, and therefore will be a key guidance for the UNICEF health and nutrition programme in the Pacific region.

1.2 Programme Background

The UNICEF Pacific Programme of Cooperation 2018-2022 outcome statement for the child and maternal health and nutrition is:

By 2022, children in the Pacific, particularly the most vulnerable, increasingly benefit from quality and resilient health and nutrition services and care practices.

The outcome contributes to achievement of the UN Pacific Strategy Outcome on quality basic services, and directly to the UNICEF Strategic Plan Goal 1 (Every Child Survives and Thrives) as well as supporting Goals 2 (Every child learns) and 4 (Every child lives in a safe and clean environment). In doing so, the outcome contributes towards the longer term Sustainable Development Goals (SDG) 1, 2, 3 and 10. The 2018-2022 indicative resource needs estimated for the outcome area was US\$23 Million at the start of the Programme.

Three outputs contribute to the achievement of the UNICEF Pacific Programme outcome on child and maternal health and nutrition:

Output 1: National capacities enhanced to strengthen quality health and nutrition policy and legislation, particularly in target countries.

Output 2: Health system capacities strengthened to deliver quality health and nutrition services that are adapted to the impacts of climate change, particularly in target countries.

Output 3: Caregivers have improved knowledge and skills to adopt recommended health and nutrition care practices, particularly in target countries.

UNICEF Pacific's work in support of strengthening quality health and nutrition policy and legislation, under output area 1, has spanned capacity strengthening, advocacy, expert technical assistance toward service quality assessments and health system expenditure assessments, coordination and monitoring of health ministry budgeted implementation plans, establishing linkages between relevant oversight bodies and working groups in national early child education, among others. To strengthen quality health and nutrition policy and legislation, UNICEF Pacific adopted a **On Plan, On Budget, On System** approach. This approach is considered innovative and a best practice. UNICEF-supported activities are incorporated into government annual operational plans (AOP) and budget estimates. UNICEF provides a letter of funding commitment for activities supported by UNICEF in AOPs and on how these activities are linked and contribute to government sectoral plans and results. This approach was first initiated in Kiribati, Solomon Islands (SLB), and Vanuatu by three UN agencies (UNICEF, UNFPA, and WHO) implementing the UN Joint Programme for Reproductive, Maternal, Newborn, Child and Adolescent Health. UNICEF subsequently expanded the approach also to include education and WASH programmes and go beyond the three countries. This approach supports UNICEF's ongoing commitment to promote national ownership of Multi-Country Programme activities and ensures that delivery of activities harmonizes with national planning and budgeting systems and procedures. It reduces transactional costs, increases fiscal accountability and transparency, and demonstrates that UNICEF Pacific's contributions and partnerships align with the Paris Principles of Aid Delivery.

To strengthen health system capacities to deliver quality health and nutrition services, output area 2, UNICEF focused on improving service quality and assisting health ministries in Kiribati, Solomon Islands, and Vanuatu to adhere to **national service quality standards**. Strengthening primary health care systems is at the core of UNICEF's approach to improving service quality and building health and nutrition system resilience. Supportive supervision gap analyses completed in Kiribati, Solomon Islands and Vanuatu in 2017 informed the development of guidelines outlining the steps, tools and estimated costs of undertaking horizontal health systems supervision. Supportive supervision was tested in Honiara City and Guadalcanal Province in Solomon Islands followed by visits to 60 health facilities to monitor national service quality standards and identify training gaps. The capacity of 42 health workers and trainers in Kiribati was improved to provide Integrated Management of Childhood Illness (IMCI). Both Kiribati and Solomon Islands successfully advocated inclusion of IMCI training in national nursing school curricula resulting in the delivery of sustained training as

part of national in-service nursing programmes. Guidelines for High Impact Nutrition Interventions (HINI) were finalised for Kiribati, Republic of Marshall Islands (RMI), Solomon Islands, and Vanuatu and under development in Federated States of Micronesia based on country-specific nutrition situation analyses. Training for 34 trainers and 105 health workers resulted in an assessed increase in health worker knowledge in delivery of HINI. In Kiribati, UNICEF provided technical expertise and multi-stakeholder coordination and consultation for the development of the three-year Digital Health Roadmap that aims to help primary health care workers improve the quality of care and child healthcare indicators.

Under output area 3, to promote **knowledge of family care practices** in Kiribati, RMI, Solomon Islands, and Vanuatu, UNICEF Pacific, in collaboration with health ministries, conducted behavioural research, designed strategies for health sector engagement with communities, families, and parents and campaigned to raise awareness about stunting. UNICEF provided to health ministries in Kiribati, Solomon Islands and RMI technical expertise on conducting formative research on nutrition and WASH identifying multi-level factors influencing maternal and child undernutrition, which was a critical first step in designing and implementing interventions. The research results will inform the design of culturally-appropriate, community-informed communication strategies to improve nutrition and WASH in each of the PICTs. In Solomon Islands, the formative research informed the Ministry of Health and Human Services expansion of the national immunization communication strategy to include maternal child health and nutrition. UNICEF provided technical assistance to health ministries in the completion of community engagement guidelines in Kiribati, Solomon Islands and Vanuatu that specify the role and activities of skilled health workers in community engagement, including community mapping, home visits, community dialogue, engagement with local governance structures, accountability to communities, community demonstrations, and outreach services. These guidelines will contribute to an increase in the percentage of caregivers with knowledge of essential family practices. Kiribati has initiated implementation of the guidelines through 20 community health support groups on three islands. The first phase of a nationwide advocacy to reduce stunting in Solomon was launched focusing on improving caregiver knowledge on essential family practices during the first 1,000 days in antenatal care, child feeding practices, and WASH practices.

2. Purpose of the Evaluation

The purpose of this evaluation is to inform the next Pacific Multi-Country Program development by generating evidence for use during the 2021 Strategic Moment of Reflection on how to scale-up models to improve quality of care in the Pacific. The evaluation findings may also contribute to the UN Pacific Strategy evaluation and subsequently the new UN Sustainable Development Cooperation Framework which will also take place this year. The evaluation also aims to foster learning about the innovative approaches to strengthening health and nutrition policy and legislation, and promote accountability of UNICEF to donors and stakeholders in strengthening health system capacities to deliver quality, resilient health and nutrition services. In this regard, the evaluation will take on a combined formative and summative view of components of the UNICEF Pacific health and nutrition program, aiming to inform decision making to improve, select, continue, expand or terminate those components.

The primary audience of this evaluation is the UNICEF Pacific Multi-Country Office (hereafter “UNICEF Pacific”), particularly the Health & Nutrition team, and the Ministries of Health in the Pacific Island Countries and Territories (PICT). The findings and recommendations of the evaluation will be used to adapt or adopt the health system strengthening strategies and interventions in relevant PICT. Secondary audiences are UNICEF Pacific development partners in health and nutrition, including the New Zealand Ministry of Foreign Affairs and Trade (MFAT), Australia Department of Foreign Affairs and Trade (DFAT), Asian Development Bank (ADB), The World Bank, the World Health Organization (WHO), the United Nations Population Fund (UNFPA), and other UNICEF offices and UNICEF Pacific teams. The evaluation will inform their future investments and prioritization and contribute to sectoral knowledge and learning.

The specific objectives of this evaluation are:

- Examine the results achieved by components of UNICEF Pacific Health and Nutrition program, and the enabling and disabling factors that facilitated the results, and analyze the extent to which these results may contribute to program outcomes in different country contexts;
- To validate and reconstruct the theory of change (ToC) of the UNICEF Pacific Health and Nutrition Program – including a visual representation of the ToC along with the narrative commentary - based on program experience and effective approaches that help all children in the Pacific to survive and thrive;
- To identify and document key lessons learned, success and failures, good practices and innovations from implementation of the Health and Nutrition Program by UNICEF Pacific, with a cross-cutting consideration for gender, equity, inclusion and human rights, that can inform the strengthening of health system capacities, at national and subnational level;
- To review the monitoring and evaluation system for effective delivery of the UNICEF Pacific Health and Nutrition program, with a gender equity and inclusive lens, and provide strategic guidance to UNICEF Pacific in strengthening it;

3. Evaluation Criteria and Questions

The Health and Nutrition Program evaluation will apply the OECD DAC criteria of relevance, coherence, effectiveness, sustainability. Due to lack of baseline data for efficiency and because of insufficient time to demonstrate impact, those criteria will not be included. Bidders for this evaluation should propose how equity and gender equality should be included as cross-cutting criteria within the context of evaluation questions. Below is a list of preliminary evaluation questions per criteria. Bidders for this evaluation are recommended to elaborate on their understanding of the questions during the submission of their technical proposals, which will be used for the selection process by UNICEF. The evaluation team would be expected to assess the feasibility of the evaluation questions during the inception phase.

Relevance	<ol style="list-style-type: none"> 1. How does the program logic, objective and design respond to Government health and nutrition strategies and priorities? How responsive is it to changing priorities and needs? To what extent did the program assumptions hold true and what does this tell us about the future program period? 2. How do the program interventions and strategies link to the primary healthcare beneficiary needs in PICT? What needs to be done to make the approach to quality of care more equitable?
Coherence	<ol style="list-style-type: none"> 3. What aspects of the program strategy are most consistent with the new Operational Framework for Primary Health Care? 4. How does the program complement, harmonize, and coordinate with other actors' interventions to strengthen quality health systems in PICTs? How does it add value while avoiding duplication?
Effectiveness	<ol style="list-style-type: none"> 5. To what extent have the objectives of the Health and Nutrition program been achieved? Did the program contribute to the intended and unintended outcome? What other factors contributed to the outcome? <ol style="list-style-type: none"> a. In what ways and under what circumstances has the 'on plan, on budget, on system' approach worked to strengthen quality child health and nutrition policy implementation, legislation, planning and budgeting, in the target countries? To what extent has the approach been adopted by partner agencies and across UNICEF Pacific MCO? b. Where and how has the approach to improve the quality of care for child health and nutrition been effective?

	c. To what extent and how have knowledge and skills to adopt recommended family health and nutrition care practices improved? 6. What kind of monitoring and evaluation framework would be needed for generating valid and comparable evidence for use at different levels in countries where the program is adopted?
Sustainability	7. What are the major enabling or constraining factors for adoption, replication and scale-up of the program components in different country contexts? 8. What can the program do differently to enhance sustainable capacities and resources at the national and subnational level?

4. Scope of Evaluation

The Health and Nutrition program outcome will be evaluated along three output areas: a) the “On plan, on budget, on system” strategy, b) Quality of Care (national quality standards) for child health and nutrition, c) Knowledge of family care practices. As more time is required for the program causal mechanisms to demonstrate impact, this evaluation will not cover impact of the program, rather emphasis will be on generating knowledge about innovative approaches to strengthening health and nutrition policy and legislation. The evaluation will cover the current country program period from 2018 to present. Geographically, each program output area will be investigated in three priority countries - Kiribati, Solomon Islands, and Vanuatu. For investigation of the “on plan, on budget, on system” strategy under output area 1, five additional countries – Niue, Tonga, Tuvalu, Cook Islands and Fiji - will be in the scope of evaluation. It is crucial that the evaluation embraces the views of all key stakeholders, including a fair representation of girls and boys, men and women, especially the most marginalized and disadvantaged.

5. Approach and Methodology

The evaluation will take a combined summative and formative view, with an emphasis on the latter, drawing lessons to inform the next country program and potential adoption and scaling of the program approaches, while also assessing the merit and worth of the program interventions and their contribution to health and nutrition outcomes (direct and indirect; intended and unintended). The evaluation will be non-experimental, although whenever possible, a comparative and external perspective will be sought to assess the evaluation criteria, and identify potential variations in perceptions. The evaluation will be utilization focused, providing continuous and rapid feedback to primary users in the course of the evaluation process. The evaluation will rely on a mix of quantitative and qualitative data collection and analysis. The mixed methods will utilize secondary and primary data sources. The evaluation will be participatory in nature, involving consultations with - and feedback to - concerned stakeholders, including workers on the frontline of improving the health and nutrition of children and vulnerable groups, to ensure their voices are included.

There are mainly three phases in this evaluation:

a) Inception phase

The list of references and documents will be agreed and shared with the selected evaluator. The data will be reviewed and analyzed by the evaluator. The theory of change will be reconstructed, explaining how various health and nutrition interventions produce results that contribute to program outcomes. The methodology for the evaluation will be detailed and finalized during this phase in consultation with UNICEF.

b) Primary data collection

Qualitative and quantitative methods will be used to collect additional evidence to answer the evaluation questions in all priority and additional countries. At a minimum, data collection will draw on the following methods: key informant interviews (KII), focus group discussions (FGD), case studies, and quantitative surveys. KIIs, FGDs and case studies are expected to be accurately

recorded to allow quotes from participants to be used in the evaluation report together with high-quality photos to illustrate the findings. Sampling of informants and selection of regions for the study should be done in consultation with UNICEF.

c) Analysis and reporting

Analysis will systematically respond to the evaluation questions. An evaluation report with conclusions and recommendations based on evidence and learnings will be drafted. Prior to finalization of the evaluation report, a validation workshop will be organized to review conclusions and recommendations with relevant stakeholders to ensure utilization of the evaluation. Following completion and dissemination of the evaluation report, UNICEF will organize a workshop to draw an action plan to respond to the recommendations.

An initial and more detailed methodology is to be submitted by the applicant as part of the technical proposal which will be used as a basis for proposal assessment by UNICEF.

The present COVID-19 pandemic poses a challenge for data collection and consultations utilizing traditional methods. During the eight month span of the evaluation the situation will likely change. As such, in the inception phase, the evaluation team will need to provide several scenarios regarding access - possibilities for travel to and within countries, access to stakeholders, among other risk considerations - and propose innovative approaches to data collection including use of remote and online technologies to mitigate those risks. Bidders for this evaluation should insert a short section in their proposal on headline thoughts on how they would carry out the evaluation against access scenarios and constraints.

The evaluation needs to adhere to [UNICEF Evaluation Policy](#); to [UNICEF procedure for ethical standards in research, evaluation, data collection and analysis](#); to [UNEG Ethical Guidelines](#); to [UNEG Norms and Standards for Evaluation](#); and to [UNICEF Evaluation Report Standards](#). Further, the evaluation approach, data collection and analysis methods must be human rights based, including child rights based and gender sensitive, and evaluation data to be disaggregated by sex, age, socio-economic status, and disability. At the core of the ethical principles to be followed during the evaluation is to ensure doing no harm to children, parents or other participants in the evaluation. The evaluation team will be expected to apply for and obtain ethical clearance. The evaluation firm will need to outline any ethical considerations in their proposal and inception report.

6. Description of assignment, deliverables, time frame, and payment schedule

ACTIVITIES	DELIVERABLES	TIME ESTIMATE (from start of contract)	PAYMENT SCHEDULE
1. INCEPTION: DESK REVIEW & CONSULTATIONS			
a. Desk review of relevant program documents, reports, and secondary data; Stakeholder analysis;	Summary of desk review findings; List of sources;	Week 1-2	25% (1 st tranche)
b. Reconstruct Theory of Change (ToC) and Results Framework (RF); ToC Validation workshop;	ToC/RF	Week 3-4	
c. Prepare inception report (incl. desk review, revised ToC/RF, evaluation matrix, methodology, work-plan, data collection tools), in accordance with UNEG quality guidelines, and present it to the Reference	Draft inception report	Week 5-6	

Group (RG);			
d. Finalize inception report including feedback from the RG, and ethics review board;	Final inception report ³	Week 9-10	
2. DATA COLLECTION AND VALIDATION			
a. Obtain ethics approval to commence data collection;	Approval letter from ethics board	Week 11-12	25% (2 nd tranche)
b. Logistical arrangements for field work, with support of Health&Nutrition Section		Weeks 13	
c. Pilot tools, conduct data collection, field work, action learning;	Data and interview summaries	Week 14-18	
d. Organize validation workshop to validate data collection results, preliminary findings and recommendations;	PowerPoint presentation, meeting minutes	Week 19	
3. REPORTING AND DISSEMINATION OF RESULTS			
a. Processing and analysis of the collected data, and drafting of the interim report, including the M&E framework	Summary of initial evaluation findings;	Week 20-22	25% (3 rd tranche)
b. Preliminary findings workshop with partners	Presentation of findings; meeting notes;	Week 23-24	
c. Prepare and submit first draft of evaluation report for UNICEF (CO and RO) and RG review	Draft evaluation report	Weeks 25-26	
d. Prepare and submit second draft of evaluation report including feedback received and prioritize recommendations;	2 nd Draft report	Week 29-30	25% (4 th tranche)
e. Submit and present final report, conforming to UNICEF Evaluation Reports Standards and the GEROS Quality Assessment System, along with other products to reference group and Rep for clearance and acceptance	Final report ⁴ (max 45 page, 30,000 words, excl annexes), infographics, 2-page brief, PowerPoint presentation	Week 33-34	

³ Max 15-20 page/12,000 words, excluding annex;

⁴ Maximum 45 pages/30,000 words, excluding annexes and executive summary; prepared according to the UNICEF Style Guide and UNICEF Brand Toolkit, and UNICEF standards for evaluation reports as per GEROS guidelines;

Other interim deliverables are:

- Minutes of key meetings with the Evaluation Management Team and the reference group.
- Copy of data collected in the course of the evaluation.

The reports and all collected and produced data and materials by the evaluation team remain the exclusive property of UNICEF.

7. Management and Oversight

The evaluation team will operate under the supervision of an Evaluation Management Team (EMT), who will be responsible for the day-to-day oversight and management of the evaluation, including management of the evaluation budget, assuring independence of the evaluation and its alignment with UNEG Norms and Standards and Ethical Guidelines, providing quality assurance, checking that the evaluation findings and conclusions are relevant and recommendations are implementable and propose improvements to the recommendations if required. The EMT will also contribute to the dissemination of the evaluation findings and following-up on the recommendations with a management response. The EMT comprises of the Multi-Country Evaluation Specialist and the program officer in the Health and Nutrition Section.

An evaluation Reference Group (RG) will be established composed of the Chief of Health and Nutrition, Regional Health and Nutrition Adviser, Chief of Social Policy, a representative of the UNICEF Research, Evaluation, Studies & Ethics Committee (RESEC), relevant UNICEF Pacific Field Offices. The RG will provide comments and substantive feedback to ensure the technical quality of key evaluation products, including methodology and design, evaluation instruments, inception and final reports. The RG will also assist in identifying internal and external stakeholders to be consulted during the evaluation process, participate in review meetings organized by EMT and the evaluation team as required, play a key role in learning and knowledge sharing from evaluation results, contribute to disseminating the findings of the evaluation and follow-up on the implementation of the management response.

Key stakeholders, including representatives of MOH and key officials in selected countries, other UN agencies and multilateral agencies, will be invited with a stronger role as members of the evaluation Steering Committee (SC), to not only advice, but also provide guidance to the evaluation.

8. Evaluation Team Profile and Qualifications

For this assignment, UNICEF Pacific seeks an institution that has a good track record and extensive experience in planning and conducting evaluations in line with the UNEG Norms and Standards, particularly in the field of primary health care. A multidisciplinary, gender balanced, and culturally diverse team (maximum of 3) has added advantage. The evaluation team lead should meet the following qualifications at the minimum:

- Extensive evaluation experience (at least 15 years) with an excellent understanding of monitoring and evaluation principles and methodologies, including capacity in an array of qualitative and quantitative data collection – including remote methods - and analytical methods; Specific evaluation experience with health and nutrition programs is strongly desired, but secondary to a strong mix-method evaluation background, as long as the health and nutrition expertise of the other team members is harnessed to ensure the team's collective understanding of the issues related to child health and nutrition programming;
- An advanced university degree (Masters or higher) in international development, public health or sciences, or similar qualification with sound knowledge of health systems and child health;
- Strong commitment to delivering timely and high-quality results, i.e., credible evaluations that are used for improving strategic decisions; Proven experience with UNICEF program evaluations is highly desirable;

- Knowledge of the challenges and issues in development, including gender equality and human rights, and vulnerability in the Pacific Island Countries and/or Small Island Developing States will be an asset;
- Strong team leadership and management track record, excellent interpersonal and communication skills, demonstrated adaptability and flexibility, client orientation, ethical practice, initiative, concern for accuracy and quality;
- Ability to concisely and clearly express ideas and concepts in written and oral form in English;

Above all, the qualified applicant(s) must demonstrate commitment to deliver the final products in line with the set TOR within the agreed timeline.

With the present travel restrictions imposed in the response to the COVID-19 pandemic, the applicant may propose an adaptive approach, including in team composition, to allow remote and local data collection.

9. Duration and place of work

The duration of the contract is for a total of 34 weeks. The anticipated period is from May to December, and may change based on when the selection process is completed.

UNICEF will facilitate the arrangement of meetings and workshops with partners as required and will provide logistic and financial support as necessary.

10. Proposal Submission

The written **technical proposal** must be in PDF format and include the following elements as a minimum requirement:

- a. Request for proposals for services form (provided above).
- b. Presentation of the bidding institution or institutions if a consortium (maximum two institutions will be accepted as part of the consortium), including:
 - Name of the institution;
 - Date and country of registration/incorporation;
 - Summary of corporate structure and business areas;
 - Corporate directions and experience;
 - Location of offices or agents relevant to this proposal;
 - Number and type of employees;
 - In case of a consortium of institutions, the above listed elements shall be provided for each consortium members in addition to the signed consortium agreement; and
 - In case of a consortium, one only must be identified as the organization lead in dealing with UNICEF.
- c. Narrative description of the bidding institution's experience and capacity in the following areas:
 - Evaluation of health and nutrition interventions;
 - Previous assignments in developing countries in general, and related to health and nutrition programs, preferably in the Pacific region;
 - Previous and current assignments using UNEG norms and standards for evaluation;
 - Relevant references of the proposer (past and on-going assignments) in the past five years; UNICEF may contact references persons for feedback on services provided by the proposers;
 - Samples or links to samples of previous relevant work listed as reference of the proposer (at least three), on which the proposed key personnel directly and actively contributed or authored. Work involving remote data collection methods would be particularly relevant;
- d. Methodology. It should minimize repeating what is stated in the ToR. There is no minimum or maximum length. If in doubt, ensure sufficient detail.

- e. 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).
- f. Evaluation team:
 - Summary presentation of proposed experts;
 - Description of support staff (number and profile of research and administrative assistants etc.);
 - Level of effort of proposed experts by activity (it must be consistent with the financial proposal); and
 - Detailed CV of each expert proposed to carry out the evaluation.

The **financial proposal** must be fully separated from the technical proposal. The financial proposal will be submitted in hard copy. Costs will be formulated in USD\$ and free of all taxes. It will include the following elements as a minimum requirement:

- a. Overall price proposal; and
- b. Budget by phase and by cost category (incl. personnel costs, international flights, internal transportation, DSA, translation services, report editing, and overheads).

11. Evaluation Criteria of Technical Proposal for Institutions

The evaluation procedure will focus on both technical and financial suitability. The weights of 70% and 30% shall be applied for technical and financial compliance respectively.

Only firms scoring at least 70% of the maximum score during technical evaluation will be considered for financial evaluation.

TECHNICAL PROPOSAL EVALUATION		
CRITERIA	POINTS	UNIT OF ANALYSIS
Overall response		
1. Understanding of the assignment	5	Evidence of in-depth knowledge of the key issues and concepts underpinning this evaluation (3) Demonstrated thorough understanding of the ToR, its objectives, scope and deliverables (2)
2. Alignment of proposal with the ToR	5	Overall concord between ToR needs and proposal (3) Explanation of a fully tailored and innovative approach for this evaluation (2)
Experience of institution and evaluation team members		
3. Range and depth of experience with similar projects (reference to similar contracts)	10	Information on similar activities having been undertaken by the institution going to be involved in this evaluation (6) Recent and current contracts with similar agencies (UN, NGOs) using UNEG Norms and Standards (4)
4. Team leader (relevant experience and qualifications)	10	Number of years of relevant professional experience in delivering quality evaluations of health and nutrition interventions, and preferably in the Pacific (2) Experience in health systems or similar (1)

		Experience in theory of change and M&E framework development (2) Experience as evaluation team leader or manager (1) Quality of written report sample (2) Relevant academic qualifications (2)
5. Team members (relevant experience and qualifications)	10	Numbers and years of relevant professional experience in health and nutrition programming in developing countries (4) Relevant technical expertise in in collecting and analysing quantitative and qualitative data (4) Relevant academic qualifications or training certificates (2)
Proposed methodology and approach		
6. Implementation plan, operational methodology	20	Description of the proposed process for conducting the quantitative and qualitative data collection including the tools that will be used (7) References to relevant data and information sources (3) Description of data analysis (3) Other creative, innovative referenced ideas for methodology/tools and presentation of findings (7)
7. Timeframe	5	Adherence of the proposed timeframe and workplan of the ToR (3) Adherence to all the milestones outlined in the ToR (2)
8. Potential constraints and risks	5	At least two considerations and/or risks outlined (3) Description of methods to manage/mitigate these constraints/risks (2)
Sub-total - Technical Proposal		Max 70 points
FINANCIAL PROPOSAL EVALUATION		
CRITERIA	POINTS	UNIT OF ANALYSIS
9. Price proposal	30	The maximum score (i.e. 30 points) assigned to the proposal with the lowest price. All other price proposals receive scores in inverse order using following formula: $\frac{(\text{max score} \times \text{lowest price proposal} (\$))}{\$ \text{price of proposal}} = \text{score for price proposal} (x)$
Sub-total - Financial Proposal		Max 30 points
Technical+Financial Proposal		Max 100 points

12. UNICEF penalty clause

UNICEF reserves the right to withhold up to 30% of the total consultancy fee in the case that the deliverables are not submitted on schedule or do not meet the required standards.

13. Proprietary rights

Copyright and ownership of all documents produced will remain with UNICEF Pacific.

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Date: 19 April 2021

Verified by: Wendy Erasmus, Chief of Child Survival and Development
Date: 19 April 2021

Approved by: Deputy Representative
Date: 19 April 2021

Annex:

1. THEORY OF CHANGE

The theory of change of change for the interlinked priority deprivations “children in the Pacific – particularly in their first year of life – are not having their right to survival met” and “up to one-third of children aged under five years in Pacific island countries are stunted, and not having their right to healthy and optimal nutritional status and development met” describes the change pathway to move from this current situation, to a desired scenario where **“all children in the Pacific survive and thrive”**, where they have access to high quality health and nutrition services and where they will benefit from positive care practices. In this scenario, they will have a diversified diet in a food secure household; they will drink clean water, eat clean food, and their house and its environs will be clean and safe.

The overarching theory of change states that:

IF the enabling environment for child health is strengthened, AND health systems are strengthened improving the supply and quality of services, AND awareness and demand are increased, particularly amongst families with the most vulnerable children, AND resilience to the impacts of climate change is created within the health system, AND equity targeting identifies those children and women who are most vulnerable, THEN more children, and women, particularly the most vulnerable, will be able to utilize high quality, resilient, health services and they will practice positive behaviours and care practices. The theory of change also states that IF this outcome is achieved THEN children in PICTs, particularly the most vulnerable, will increasingly survive and thrive.

Each of the main contributing immediate causes identified in the causal analysis also have specific more detailed theories of change, which were synthesized into the overarching higher level theory of change above.

Child Nutrition: IF children have access to high impact nutrition interventions⁵ AND their exposure to infections and unhygienic and contaminated environments is reduced AND food security is guaranteed, AND communities are equipped with knowledge and skills to provide stimulation and responsive care, THEN children will be well nourished within the first 1,000 days AND children will be more likely to survive and thrive.

IF mothers receive information on the benefits of early and exclusive breastfeeding, AND the community support environment (husbands, grandmothers, employers) is conducive, AND health workers are knowledgeable and offer a positive breastfeeding attitude during the prenatal and postnatal period; AND health workers have the skills to support positive breastfeeding practices in the health facility and in the community, AND legislation and policy protects early and exclusive breastfeeding and is enforced; THEN children will be better nourished.

IF food production improves in both its diversity and its quantity, AND markets are strengthened to enable food to reach the most vulnerable, AND value chains are strengthened to expand access to nutritious and safe food throughout the year, AND household incomes increase, THEN the quantity and the diversity will be improved, AND THEN children will be better nourished.

IF children are spaced, AND women’s workload is reduced, AND mothers education is improved, AND teenage pregnancy is reduced, AND violence against women and children is reduced, AND parents knowledge on infant and young child feeding practices improve particularly on the frequency of feeds, AND cultural taboos are overcome, AND food handling and personal and environmental hygiene practices improve, THEN, children will be better nourished.

Infectious Disease: IF children are immunized against killer childhood diseases, AND childhood illnesses are well managed (ARI, diarrhoea, malaria, dengue), AND environmental measures control vectors, AND families have access to sufficient clean water, a toilet and practice good personal and environmental hygiene, THEN the nutrition status of children will improve and THEN infant and child mortality will fall.

IF knowledge of childhood illness is improved in communities, AND families take action to prevent childhood illness, AND when children fall sick, families recognize the signs and take early action to treat illness, AND primary health facilities have staff, medicines and medical supplies to prevent and treat childhood illness, THEN childhood illness will reduce and be less severe.

⁵ High impact nutrition interventions are evidence based nutrition interventions directed at both the mother and the child and encompass management of acute malnutrition, micronutrient and dietary supplementation including deworming, breastfeeding and complementary feeding, disease prevention and management including improved hygiene.

Neonatal mortality: IF the quality and coverage of services for newborn care improves, AND caregivers (mothers, community health personnel, family members, primary health care professionals) take action on newborn danger signs, AND preventive and promotive maternal health and skilled delivery is improved, THEN neonatal mortality will reduce AND THEN children are more likely to survive and thrive.

Maternal Health: IF adolescent fertility is decreased, AND improved quality and coverage of preventive and promotive care for pregnant and lactating mothers makes motherhood safer, AND the quality and coverage of skilled delivery and emergency obstetric care is improved THEN women will survive and thrive AND THEN their children are more likely to survive and thrive.

IF pregnant women receive ANC in the first trimester, AND receive ANC at least four times during their pregnancy, AND benefit from high impact maternal nutrition interventions, AND delivery is attended by a skilled attendant trained in basic emergency obstetric and newborn care, AND take action to prevent and treat vector borne diseases (malaria, dengue), AND high risk pregnancies are identified early, AND birth plans outlining actions to be taken in emergency are followed, THEN fewer women will die in childbirth, AND THEN children will survive and thrive.

IF the public health system has strong leadership and is well governed (planning, budgeting, regulation, supervision), AND there is sufficient quantity of qualified and supervised health personal deployed to the highest risk areas, AND health information is accurate, timely and used for decision making, AND health commodities are sufficient, decentralized, and timely, AND the lowest level of health delivery has adequate and timely financial resources, AND health workers deliver quality MCH services, THEN there will be better and more equitable access to health services contributing to better women's and children's health and leading to a decrease in child mortality.

IF health systems are prepared for (supplies, human resources, financial flows, data) emergencies including those caused by extreme weather events (cyclone, drought, flood), AND they are prepared to respond to emerging diseases (malaria, dengue) and malnutrition, AND they are prepared for an increase in population due to forced migration, AND they respond to crises early, THEN children will cope better and recover quicker from the effects of climate related shocks.

There are **three main assumptions** which are inherent to the achievement of the overarching change theory should they continue to remain true.

- Governments in the PICTS remain committed to pursuing improved health of their populations;
- Parents and caregivers are willing to apply their knowledge and skills gained about positive health, nutrition and care practices;
- Bilateral donors remain engaged and financially supportive of a systems approach to improving health and nutrition.

Three major risks have been identified which would block the change pathway from occurring in the event of their happening. In line with the risk management approach, each of these have been identified as major, with both a high level of likelihood and high level of impact.

- Unstable political environment at country level;
- Competing financial demands, due to economic instability and changed Government priorities;
- Limited capacity and availability of human resources;
- Natural disasters and emergencies hinder implementation and increase costs.