



## TERMS OF REFERENCE

### End-of-Project evaluation for Unitaid's investment in Perennial Malaria Chemoprevention (PMC)

<b>Disease:</b>	<b>Malaria</b>
<b>Programmatic Priority</b>	Introduce and optimize prevention tools: Chemoprevention and vaccination
<b>Investments in scope</b>	<ol style="list-style-type: none"> <li>1. The Plus Project – perennial malaria chemoprevention (PMC) – previously known as intermittent preventive treatment in infants (IPTi)</li> <li>2. Supply Grant Output 1: Improved global supply of quality assured SP for IPTi</li> </ol>

## PURPOSE OF THESE TERMS OF REFERENCE

These Terms of Reference (TOR) serve as an overall framework for the services to be provided by the Contractor pursuant to the Request for Proposal (RFP 2025.06).

## DESIRED TIMEFRAME

Requested start date: 31<sup>st</sup> March 2025  
 Expected completion date: 27<sup>th</sup> June 2025

## TERMS OF REFERENCE

### 1. Background

**At the beginning of this investment:** In 2019, children under the age of five represented 67% of the estimated 409,000 global malaria deaths. Approximately 54% of these child deaths occurred in children younger than two years old. The World Health Organization (WHO) Africa Region bears the majority of the global malaria burden, accounting for 94% of the estimated 229 million malaria cases and 94% of malaria-related deaths. It is estimated that 24 million children in this region (11% of total cases) were infected with malaria, with 12 million experiencing moderate anemia and 1.8 million suffering from severe anemia. Analysis from the Global Burden of Disease study indicates that 36% of malaria cases in children under five occur in those under the age of two.

Since 2010, the WHO has recommended the use of sulfadoxine-pyrimethamine-Intermittent preventive treatment in infants (SP-IPTi)<sup>1</sup> given at three contacts of the Expanded Programme on Immunization (EPI) during the first year of life (through the diphtheria, pertussis, and tetanus (DPT)<sup>2</sup>, DPT3, and measles 1 vaccinations) in moderate-to-high transmission where SP resistance is not high (defined as a prevalence of the pfdhps 540 mutation below 50%). SP-IPTi has been shown to decrease cases of clinical malaria by 30% and anemia by 21% in the first year of life and is highly cost effective. Uptake of SP-IPTi within policy has remained extremely low due to multiple access and adoption barriers including restrictive policies, low demand, limited access, and insufficient supply. Until recently, only one country, Sierra Leone, had adopted this strategy beginning in 2016.

Given this context, in 2021, Unitaids Board approved investments in two related projects.

- The first, a US\$ 35.5 million funding for a project named The Plus Project, which aimed to generate evidence and promote the uptake of perennial malaria chemoprevention for children. Led by Population Services International (PSI), the project began in August 2021 and runs until October 2025, with a possible extension to March 2026. It is implemented in Benin, Cameroon, Cote d'Ivoire, and Mozambique.
- The second, an amendment and a costed extension to an existing project previously approved by Unitaids Executive Board to respond to the growing market-need for quality-assured malaria products, in 2017 called MMV Supply Grant<sup>2</sup>. The costed extension amendment of the MMV Supply Grant added a fourth output namely Output 4: Improve global supply of quality assured sulphadoxine-pyrimethamine (SP) for intermittent preventive treatment for infants (IPTi). The objective for output 4 was to support the development and submission of dossier for WHO prequalification for at least two additional manufacturers developing a SP D scored tablet formulation, in two dosage strengths (500/25mg for >10kg and 250/12.5 mg for the 5-10kg infants).

The Plus Project addresses critical access gaps in malaria prevention by focusing on expanding access to and adoption of effective malaria chemoprevention strategies. Its aim is to provide evidence for smooth delivery through EPI platform, collaborate with partners to increase demand, and work with users and policymakers to encourage wide adoption. Additionally, the Plus Project working with MMV Supply Grant – Output 4 will bring quality-assured paediatric SP products to market, ensuring they are appropriately designed for the target population, thereby addressing longstanding innovation and availability.

**Subsequent developments:** In 2022, WHO updated its recommendations by removing the specification for doses and ages, extending the target age group to children beyond one year in high-burden areas, and allowing implementation regardless of parasite resistance. The intervention was renamed from IPTi to perennial malaria chemoprevention (PMC). The intervention then is referred to as PMC-SP in this document.

<sup>1</sup> Subsequently renamed to Sulphadoxine Pyrimethamine for Perennial Malaria Chemoprevention (PMC-SP)

<sup>2</sup> The original MMV Supply Grant worked to increase access to quality assured products for malaria chemoprevention and pre-referral treatment of severe malaria. It included 3 outputs to support development of three quality assured finalized pharmaceutical products namely: Output 1: Sulfadoxine-pyrimethamine (SP) for intermittent preventive treatment in pregnancy, Output 2: Sulfadoxine-pyrimethamine and amodiaquine (SP+AQ) for Seasonal Malaria Chemoprevention (SMC), and Output 3: Rectal artesunate for the pre-referral management of severe malaria and one sulfadoxine API.

**The recent update on the share of malaria burden remains largely unchanged:** According to the 2024 World Malaria Report, children under 5 years old accounted for 74% of the 597,000 malaria deaths in 2023. The WHO Africa Region had 94% of the estimated 263 million malaria cases and 95% of malaria deaths worldwide. The investment decision remains highly relevant and valuable.

## **2. Goal, outcome and outputs**

**The Goal** is to contribute to reducing malaria morbidity and mortality in low- and middle-income countries (LMIC), in particular the high burden to high impact (HBHI) countries.

**The Outcome** is increased access to high quality SP for PMC services among children under 2 years. The investment will address key access barriers by ensuring relevant evidence on the demand and adoption, supply and delivery, and through innovation bring appropriate SP product into use and available to the population that needs it.

**Outputs** from the two projects are:

### **The Plus Project**

<b>Output 1</b>	Co-design and pilot test SP-IPTi+ platforms adapted to focus countries.
<b>Output 2</b>	Demonstration of the impact, operational feasibility, efficacy, effectiveness, and cost-effectiveness of SP-IPTi+.
<b>Output 3</b>	Evidence dissemination and guidance to support transition, wide adoption and scale-up
<b>Output 4</b>	Ensure country-level supply of quality-assured SP for SP-IPTi+.

### **MMV Supply Grant**

<b>Output 4</b>	Improve the global supply of quality-assured sulfadoxine-pyrimethamine (SP) for intermittent preventive treatment for infants (IPTi).
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## Theory of change for the PMC intervention

<b>Problem</b>	<b>Public Health Need</b>	<ul style="list-style-type: none"> <li>In 2019, an est. 229 million cases of malaria led to 409,000 deaths, 67% of which were among children under age five.</li> <li>In sub-Saharan Africa malaria occurs in children who are already weakened by other parasitic, viral and bacterial infections; nutritional deficiencies; poverty leading to disproportionate higher levels of child mortality.</li> <li>About 24 million children (11% of total cases in the region) were estimated to be infected; of whom 12 million had moderate anaemia and 1.8 million severe anaemia.</li> </ul>		
	<b>Access Barriers</b>	<ul style="list-style-type: none"> <li>SP-IPTi delivered through the EPI has been recommended by WHO since 2010. It has 30% protective efficacy (PE) against malaria, 21% PE against anaemia in the first year of life and is highly cost effective. However there has been virtually no implementation in the relevant countries (except Sierra Leone) due to barriers related to: <ul style="list-style-type: none"> <li><b>Supply and delivery:</b> Gaps in delivery schedules leaving the child unprotected for several months during the first two years of life.</li> <li><b>Demand and adoption:</b> Restrictive policy guidance for implementation, lack of confidence in SP-IPTi amongst policymakers, healthcare providers and caregivers; lack of evidence of efficacy at different resistance levels, and for children above age one.</li> <li><b>Innovation and availability:</b> Lack of quality-approved taste-masked SP formulations for infants in dosing for different weights.</li> </ul> </li> </ul>		
<b>Conceptual pathway</b>	<b>Input</b>	<b>Outputs</b>	<b>Outcome</b>	<b>Impact</b>
	<ul style="list-style-type: none"> <li>Unitaid funding</li> <li>Country health system human resources and in-kind resources</li> </ul>	<ul style="list-style-type: none"> <li>Co-design and pilot test SP-IPTi+ platforms adapted to focus countries.</li> <li>Demonstration of the impact, operational feasibility, efficacy, effectiveness, and cost-effectiveness of SP-IPTi+</li> <li>Evidence dissemination and guidance to support transition, wide adoption and scale up</li> <li>Improved global supply of high-quality SP for SP-IPTi+</li> </ul>	<p>Increased access to high-quality SP-IPTi+ services among the target group by addressing:</p> <ul style="list-style-type: none"> <li><b>Supply and delivery:</b> IPTi+ delivered through EPI and other platforms suited to country health systems - including into the 2nd year of life</li> <li><b>Demand and adoption:</b> policy guidance and evidence on efficacy, impact, feasibility &amp; effectiveness</li> <li><b>Innovation and availability:</b> Introducing SP drug and packaging appropriately adapted for pediatric use and supported by in-country registration</li> </ul>	<ul style="list-style-type: none"> <li>Lives saved due to malaria (KPI 4.1)</li> <li>Malaria and anemia cases averted (KPI 4.1)</li> <li>Estimated net cost to the health system (KPI 4.2)</li> <li>Household financial savings from malaria treatment costs averted.</li> <li>Reduced chemoprevention inequity in LMICs (KPI 5.1, KPI 5.2)</li> <li>Positive externalities linked to improved child health (e.g., educational attainment) and health system coordination (e.g., efficiencies)</li> </ul>
	<ul style="list-style-type: none"> <li><b>Strategic Risks:</b> Rapid, increased drug resistance renders SP ineffective for chemoprevention.</li> <li><b>Implementation Risks:</b> Weak health systems, including EPI platforms, limits ability to integrate and expand SP-IPTi+ platforms.</li> <li><b>Sustainability/Scalability Risks:</b> Lack of domestic financing and/or committed funding from major funding partners limits ability to scale SP-IPTi+.</li> <li><b>Assumption:</b> Receptivity of stakeholders to the co-design process and strong political willingness among target countries to adopt the intervention.</li> <li><b>Assumption:</b> Willingness among non-focus countries to participate in evaluation components.</li> <li><b>Assumption:</b> Project yields compelling evidence for IPTi+ approaches.</li> </ul>			
	<b>Key risks / assumptions</b>			

### 3. Objectives of the consultancy

Under these Terms of Reference (ToR), the Evaluators will consolidate knowledge on good practices, provide Unitaid with an assessment of the overall success of the project including relevance, coherence, efficiency, effectiveness, impact, sustainability and lessons learned with focus on the extent to which the project has accelerated and advanced the uptake of PMC-SP

The findings of the evaluation will add into Unitaid learning and improvement on designing and managing its investments.

#### **4. Work to be performed**

This evaluation will take place over approximately 3 months. The key evaluation questions, outlined below, are based on [Unitaid's evaluation framework](#), Unitaid's 2023-2027 strategic framework (**Annex 1**) and [Unitaid's scalability framework – abridged version included \(Annex 2\)](#), which underpin all internal and external evaluations. Unitaid's evaluation framework criteria are aligned with the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC) standard evaluation criteria. The evaluation framework was recently revised to align with [Unitaid's new strategy](#) adopted in June 2022. We encourage evaluators to check Unitaid's Evaluation website (<https://unitaid.org/evaluations/#en>) for more details on our evaluations and examples of evaluation reports.

Specifically, the Evaluators are expected to assess:

- (1) Validity and alignment of the project impact to Unitaid's frameworks and approach. Evaluators will critically review the existing impact models of the investment and update the impact estimates. The estimates would include collective public health impact of the Unitaid's investments in the grant for i) direct impact during grant implementation; and ii) potential impact during the 5-year period following grant closure. The Evaluators are expected to leverage evidence developed through the project including cost and cost effectiveness studies and ensure alignment with Unitaid impact approach
- (2) **Relevance:** is the intervention doing the right things?
  - a. To what extent did the objectives and design of the projects respond to the needs of targeted beneficiaries?
  - b. Have design and implementation approaches been appropriately adapted/course-corrected to respond to any changes in context of the country EPI platforms?
  - c. To what extent is the projects design and implementation identified and addressed issues related to gender, social inclusion and equity in line with Unitaid's overall mission to reach the most disadvantaged populations?
- (3) **Coherence:** how well does the intervention fit in the context of all other malaria interventions and priorities.
  - a. To what degree did the investments fit with other interventions within targeted countries, sectors or institutions (e.g. creating synergies between relevant interventions and consistent with other initiatives/international norms and standards within the same space)? How well does the intervention align with priorities/needs identified by partners/the global disease response?
  - b. To what extent is the investment adding value (and not duplicating efforts or establishing parallel systems)?
- (4) **Efficiency:** how well are resources being used including in the introduction of quality assured products in a timely manner?
  - a. How timely, cost-efficient and cost-effective was implementation
  - b. What factors have been considered to ensure that value for money has been achieved from an efficiency standpoint?
  - c. How well did the grant implementers collaborate with national authorities in project planning, implementation and assessment to promote integration into existing health systems?
  - d. What lesson can we learn related to product development and introduction?
- (5) Assess performance across the **Unitaid Strategic Objectives**

- a. Strategic Objective 1 (primary): Accelerate the introduction and adoption of key health products**
- i. Effectiveness: in the context of the call for proposal is the intervention achieving its objectives per the access barriers identified; how well is the investment catalyzing and promoting global policy adoption and country implementation both in project and non-project countries.
    - a) Innovation and availability: To what extent did the investments accelerate the development of quality-assured SP products fit for children? To what extent was product development needed and was the approach used by Unitaid include the market shaping activities fit to addressing the gap?
    - b) Demand and Adoption: To what extent did the investments facilitate increased demand, adoption and scale up of PMC-SP within target countries and beyond, how impactful and sustainable are these gains and what gaps remain? What have been the main factors influencing readiness for adoption and scale-up? How have the investments contributed to an enabling global environment for scale-up, including generating evidence, normative guidance, tools to support country adaptation and uptake? Specifically, how influential were the investments in generating evidence to inform WHO guidelines on use of PMC-SP?
    - c) Supply and Delivery: How effective are the delivery methods in efficiently and cost-effectively reaching the target population within the project, and how applicable are they beyond the project?
  - ii. Scalability: To what extent have the investments helped establish country readiness for scale-up, including securing ongoing political and financial commitments by national governments and other partners, supportive policies and enhanced health system capacity for delivery, and partnering with civil society?
  - iii. Sustainability: will the proposed approach work and sustain the benefits over a long period?
  - iv. Impact: what difference is the intervention likely to make in respect to the scale-up context?
- b. Strategic Objective 2: Create systemic conditions for sustainable, equitable access**
- i. How well have the investments and Unitaid disseminated knowledge, evidence and lessons learned on equitable access? To what extent has this contributed to generating broader awareness and increased support for these investment areas from other stakeholders?
  - ii. Assess the impact and value add of supporting the regional manufacturing of SP products for PMC
- c. Strategic Objective 3: Foster inclusive and demand driven partnerships for innovation**
- i. To what extent have the investments been responsive to community needs and how effectively have Unitaid and implementers engaged with affected communities in the planning, design, implementation and assessment of activities? Were design and implementation approach appropriately adapted/course corrected to respond to any changes in context? What synergies took place to ensure effective engagement, learning and sharing of knowledge?

- ii. How well did the investments and Unitaid add value and maximize alignment/coherence and synergies with global partners, governments, in-country stakeholders, and CSOs during planning, implementation and assessment to promote adoption and scale-up within existing health systems?
  - iii. To what extent did implementers and the Unitaid secretariat contribute to further development of global alliances/partnerships to support scale-up and sustainability of products supported through the investment?
  - iv. To what extent did implementers and the Unitaid secretariat contribute to continental and regional priorities
- (6) Suggest comprehensive, actionable recommendations based on key findings and conclusions so that Unitaid can integrate lessons learnt. We expect the evaluators to spend the required level of effort for this crucial piece of the evaluation report.
- (7) In addition, the evaluators are requested to explore the following key areas that stood out during the project implementation, capture key lessons and formulate recommendations:
- a. **Delays that led to extensions:** While the COVID-19 pandemic caused expected delays, other factors also led to the need for project extensions. For instance:
    - i. **Protocol development and approval:** Analyze the situation and identify actions that Unitaid or the grantees could have taken to avoid this issue. What steps can Unitaid take in the future to prevent similar delays?
    - ii. **Product development:** The process leading to submission of manufacturing data to WHO pre-qualification took longer than planned. Furthermore, the approval after submission to WHO pre-qualification also took longer. Assess if there are actions that Unitaid and grantees could have done to mitigate these delays.
  - b. **Regional manufacturing:** Support to Output 4 of the MMV supply grant continues Unitaid's strategic investment in strengthening Regional Manufacturing. Document the learning experience for future investments, particularly focusing on how well the investment considered an end-to-end approach, including market shaping to ensure competitiveness.
  - c. **WHO's Conditional Recommendation on PMC:** Considering the latest WHO recommendation on PMC (2022) is a conditional recommendation supported by moderate certainty evidence, please provide an evaluation of the feasibility for scaling up this intervention amidst other competing malaria priorities.
  - d. **Decision support tool:** One of the key deliverables of the project is a decision support tool to support countries make informed decisions on the value and sub-national deployment of PMC. Provide an assessment, in general of tools such as these that are developed by project and their sustainability after project ends. What should be Unitaid's consideration be when investing in tools that requires ongoing support when project ends? Is there an ongoing role for Unitaid after project closes?
  - e. **Important evidence available post-project:** Some of the important evidence from the project will be available after support to country level activities has ended. How well has the project prepared to ensure this evidence influences policy making even after its conclusion? What lesson can Unitaid take from this experience to enhance its future investment?

## **5. Evaluation methodology, place of work, and management**

*Methods:* The evaluation methodology will involve a combination of document reviews and qualitative interviews (key informant interviews, focus group discussions/workshops) with the relevant stakeholders. For the document review, evaluators will undertake a review of the grants using grant documents such as: Project Plan, Logframe, Annual and Semi-Annual Reports, evaluation reports, publications, presentations and abstracts from conferences, tools and guidelines developed by the project, and any other grant-related material. Suggested participants for key informant interviews and focus group discussions are provided in Section 6.

*Place of work:* Evaluators will work remotely and will be required to travel or use country-level staff in two of the project countries, namely Côte d'Ivoire and Mozambique<sup>3</sup>. Progress in the remaining countries where country visits will not be done will be assessed through a desk review plus teleconference interviews (as appropriate). The Evaluators, in consultation with Unitaïd and grantees, will identify potential stakeholders to interview. It is preferred that the Evaluators have either a regional/local presence in the project countries (especially those targeted for travel) or have access to local counterparts that can assist the Evaluators including in identifying local stakeholders to be interviewed.

*Management and communication:* The evaluation is managed by Unitaïd's Result team; the Monitoring and Evaluation Manager will be the focal person for all communications. Evaluators will be expected to participate in an inception/kick-off meeting (virtual or in-person at the Unitaïd office in Geneva) and to deliver a presentation of the final findings (virtual or in-person). In addition, the Evaluators will be expected to provide weekly to bi-weekly status updates to the Unitaïd focal point for the evaluation.

## **6. Target respondents**

Target respondents would include (but are not limited to) the following:

- The lead grantees – PSI and MMV
- Consortium partners
  - a. London School of Hygiene and Tropical Medicine (LSHTM)
  - b. Focus Country: Cameroon: Fobang Institute for Innovation in Science and Technology (FINISTECH)
  - c. Focus Country: Cote d'Ivoire: Institut National de Santé Publique (INSP)
  - d. Focus Country: Benin: Centre de Recherche Entomologique de Cotonou (CREC)
  - e. Focus Country: Mozambique: Centro de Investigação em Saúde de Manhiça (CISM)
  - f. Plus 3: Zambia: Tropical Diseases Research Centre (TDRC)
  - g. Plus 3: DRC: the University of Kinshasa (genotyping)
  - h. University of Copenhagen (genotyping)
  - i. University of South Florida (Impact Evaluation)
- Manufacturers (EMZOR, SWIPHA, UCL)
- Chair/Co-Chair of the PMC Community of Practice
- RBM Partnership Country/Regional Support Partner Committee (CRSPC) Team Lead

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<sup>3</sup> Mozambique is also one of the project countries where the MULTIPLY – a PMC project funding by EDCTP (<https://multiplyipti.net/>) was implemented and MMV leveraged the field-testing of user-friendly training material and packaging work for the SP products

- Donors – Global Fund (Secretariat, e.g., relevant Fund Portfolio Managers, Sourcing Team, Malaria Team), President’s Malaria Initiative (PMI).
- In-country partners / stakeholders such as key decision makers at the country level, officials (high and mid-level) at relevant Ministries, in-country PMI representatives, Global Fund Country Coordinating Mechanism (CCM), Global Fund Principal Recipient (PR) and sub-recipients, civil society organizations, community groups, clinicians, laboratory technicians and health facility workers
- Wider stakeholder group(s) that are indirectly involved with the respective grants such as the WHO Global Malaria Programme and WHO Immunization, Vaccines and Biologicals, and other Technical Working Groups
- Relevant staff at the Unitaid Secretariat

The Evaluators are asked to dedicate a bigger proportion of key informant interviews to external stakeholders and partners as opposed to grantees or Unitaid secretariat, and to use focus group discussions (in lieu of individual interviews) where relevant (e.g., Unitaid secretariat, in-country stakeholders).

## **7. Team Composition, qualification and skills**

Bidder shall propose a multi-disciplinary team of 3-4 experienced evaluators, including the team leader. The team leader must have at least 10 years of strong experience leading evaluations of a similar scope and complexity and ideally a strong understanding of market dynamics and interventions to increase access to testing in low and middle-income countries. Core team members should have at least 5 years of individual experience in their respective areas of technical expertise.

The firm and proposed evaluation team should meet the following requirements:

1. Expert knowledge of the malaria field and the challenges related to malaria in LMICs, both community-level, referrals, and different levels of health facilities as it relates to malaria management.
2. Extensive experience in conducting evaluations of grants in the field of malaria policy and guideline revisions both normative and in-country.
3. Demonstrated extensive knowledge of the challenges and options around ensuring access to innovative health products in LMICs.
4. At least one team member with strong expertise in malaria prevention and treatment.
5. At least one team member with strong expertise in collection and analysis of qualitative data.
6. At least one team member with strong expertise in quantitative assessment of public health and economic impact.
7. Expert knowledge of the global health landscape and the dynamics of introducing and scaling up interventions for complex health issues, including new treatment, at national and global levels.
8. Fluency in English is required, and at least one team member should be proficient in French and Portuguese for country assessments.

Consideration for appropriate representation with regards to gender and a broad mix of backgrounds, skills and perspectives is desirable.

## **8. Deliverables**

The evaluation will run over the span of 3 months, with deliverables to be submitted within the following indicative timeline:

<b>Deliverable</b>	<b>Due date</b>	<b>Duration (13 weeks)</b>
<b>1. Kick-off</b>	<b>31<sup>st</sup> March 2025</b>	
2. An inception report outlining the process for the evaluation including methodology, overarching theory of change, draft evaluation tools (with tailored evaluation questions and sub-questions), a work plan and timeline and a list of interviewees	<b>11<sup>th</sup> April 2025</b>	<b>2 weeks</b>
3. Data collection & impact analysis <ul style="list-style-type: none"> <li>- Document reviews</li> <li>- Country visits/remote data collection</li> <li>- Validation of existing grant impact methodologies &amp; further elaboration (as needed) of methodology to assess public health and economic impact</li> </ul>	<b>9<sup>th</sup> May 2025</b>	<b>4 weeks</b>
4. First draft evaluation report submitted for review and comment by Unitaid	<b>23<sup>rd</sup> May 2025</b>	<b>2 weeks</b>
5. Second draft evaluation report that incorporates Unitaid feedback to be shared with Unitaid and the grantee	<b>06<sup>th</sup> Jun 2025</b>	<b>2 weeks</b>
6. A virtual or in-person presentation to Unitaid (and partners) Secretariat on key findings and recommendations	<b>20<sup>th</sup> June 2025</b>	<b>2 weeks</b>
7. Final evaluation report	<b>27<sup>th</sup> June 2025</b>	<b>1 weeks</b>

The final evaluation report will be available to the public on the Unitaid website ([www.unitaid.org](http://www.unitaid.org)). Unitaid reserves the right to redact sensitive or confidential information prior to publication of the final evaluation report.

## **9. Budget**

Unitaid receives financial contributions from sovereign and not-for-profit philanthropic organizations to deliver its mandate. Unitaid receives no assessed contributions. Bidders are, therefore, requested to propose the best and most cost-effective solution to meet Unitaid requirements, while ensuring a high level of service.

All bidders should submit their proposed budget in the Financial Proposal (Annex 5 of the RFP). As mentioned under section 5 of this ToR, it is preferred that firms have either a regional/local presence in the project countries or have access to local counterparts that can assist the evaluators to minimize the need for international travel, in line with Unitaid's effort in reducing carbon footprints related to the procurement activities.

**10. Payment terms and schedule**

<b>Basis for Payment</b>	<b>Payment Percentage</b>
1. Upon satisfactory submission of the inception report and acceptance by Unitaid	20% of Professional Fee
2. Upon satisfactory completion of First draft evaluation report and acceptance by Unitaid	30% of Professional Fee
3. Upon satisfactory completion of virtual presentation to Unitaid and partners	30% of Professional Fee
4. Upon satisfactory completion of Final evaluation report and acceptance by Unitaid	20% of Professional Fee
5. Payment for other costs (if any)	Based on actual delivery

For professional fees, payment will be made following satisfactory completion of the ToR and of corresponding detailed invoices, along with a Financial Statement (using the template to be provided by Unitaid) detailing the actual level of effort incurred and breakdown of travel expenses.

For travel costs (subject to agreement with Unitaid), payment will be made in accordance with WHO rates and upon submission of invoices indicating actual travel costs with proof of payment. Evaluators are responsible to organize all logistics of travel, including hotel booking and local transportation. All travels must be arranged in the most economical way, in line with Unitaid's effort in reducing carbon footprints related to the procurement activities.

### ANNEX 3: Unitaid’s Scalability Framework

