Evaluation of UNICEF Work in Public Health Emergencies

Terms of Reference (ToR) – 5 August 2021

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1. Background

The UNICEF Evaluation Office located in New York Headquarters (HQ) provides global leadership and oversight of the evaluation function in the organization. As such, it manages independent, corporate evaluations and evaluation syntheses, provides technical assistance and quality assurance for evaluations commissioned at the decentralized level (country and regional offices, as well as other divisions in HQ offices), develops evaluation methods, and reports to the UNICEF Executive Board.[1]

The work of the Evaluation Office is guided by the Global Evaluation Plan, an Executive Board-approved document. As part of that plan, the Evaluation Office will conduct an evaluation of UNICEF work in public health emergencies (PHE). This evaluation addresses a priority area and falls under multiple goal areas per UNICEF's strategic plan including primarily Goal Area 1: Every child survives and thrives as well as Goal Area 4: Every child lives in a safe and clean environment. The Evaluation Office seeks an institution to support the Evaluation Office in conducting the evaluation of UNICEF's work in public health emergencies. Although part of the Global Evaluation Plan 2018-2021, this evaluation is scheduled for submission to UNICEF's Executive Board in 2022.[2]

2. Context

Currently, the global community is in the midst of a Public Health Emergency of International Concern (PHEIC) following the spread of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2, or "COVID-19") virus. The scale and impact of the COVID-19 pandemic is unprecedented. PHEIC declarations have recently become increasingly visible to the public due to several other outbreaks such as Ebola virus disease (EVD) or Zika.

Public health emergencies, the most common of which are infectious disease epidemics,[5] have long posed substantial global risks, which are magnified for those in low-income or humanitarian settings. The annual number of outbreaks has increased more than threefold since 1980. Climate change, mass population movements, urbanization, economic globalization and protracted crises heighten the risk of public health emergencies and pandemics.[3] Children face particular risks, especially those who live in fragile settings. These include increased exposure to violence, exploitation, and abuse; stigmatization; lost access to basic health and social services resulting from the death or hospitalization of a parent or caregiver, disruption of services or diversion of resources to outbreak control; and loss of access to education due to school closures.[4] Infectious disease epidemics account for six of the ten leading causes of death in low-income countries[5] and present a continued risk of emergence or reemergence across regions.[6]

In addition to representing threats to human health, infectious diseases are often key agents of poverty. For example, the COVID-19 pandemic has caused devastating economic and social disruption[7], and has profoundly impacted lives, learning, basic well-being, and future productivity. The crisis has also severely

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[1] United Nations Children's Fund, <https://www.unicef.org/evaluation>, accessed 10 December 2020.

[2] This evaluation was initially scheduled for submission to UNICEF's Executive Board in 2021. However, in the COVID-19 pandemic context, different real-time exercises (e.g. COVID-19 learning evaluation and COVID-19 Real Time Assessment) solely focusing on UNICEF's response to COVID-19 have been prioritized in 2020, which have delayed the start of this evaluation.

[3] United Nations Children's Fund, Public Health Emergencies - Situation Analysis, Working draft, December 2020.

[4] United Nations Children's Fund, Public Health Emergencies – Situation Analysis, draft, UNICEF, December 2020.

[5] World Health Organization, 'The top 10 causes of death', December 2020.

[6] Gedif Meseret Abebe, 'Emerging and Re-Emerging Viral Diseases: The Case of Coronavirus Disease-19 (COVID-19)', 29 June 2020.

[7] International Labor Organization, Food and Agriculture Organization, International Fund for Agricultural Development and World Health Organization, 'Impact of COVID-19 on people's livelihoods, their health and our food systems', joint statement, 13 October 2020.

tightened external financing conditions for countries across the income spectrum, disrupting trade, supply chains, and investment flows.[8]

2.1 Recent PHEs and their impact on children

The Democratic Republic of the Congo (DRC) faced three outbreaks of **Ebola virus disease (EVD)** between 2018 and 2020, including the second largest Ebola outbreak in history in North Kivu. The outbreak disproportionately affected women and children, with women accounting for 57 per cent of all cases and children accounting for 30 per cent.

Cholera remains a public health priority in multiple epidemic and endemic areas across the globe and an estimated 1.4 billion people in endemic countries are at risk of cholera. The disease claimed three to five million cases new cases resulting in 100,000 to 143,000 deaths worldwide, with children under five accounting for more than half of the global incidence and deaths. Yemen faced a cholera epidemic that resulted in a cumulative total number of 1.3 million suspected cholera cases between 2018 to 2020, with close to 1,600 associated deaths. Haiti has had over 800,000 cases and nearly 10,000 deaths since 2011 with children under five years representing close to 80% of all hospitalized cases.

There has been a resurgence of **dengue** in tropical and sub-tropical regions resulting from the combined effect of fast-paced urbanization, substandard living conditions, lack of vector control, virus evolution, and international travel. There are an estimated average 400 million cases and an estimated 22,0000 deaths per year.[9]

In the last years, several countries, including Brazil, Nigeria, the Republic of Congo, Ethiopia, and South Sudan experienced significant outbreaks of **Yellow fever**. The disease is estimated to cause an estimated 200,000 cases and 30,000 deaths per year. Other viral diseases transmitted by vectors such as chikungunya fever, West Nile fever, Japanese encephalitis or **Zika virus fever,** which cause serious birth defects and is associated with other pregnancy problems, have seen their geographical spread expanded as the result of climate change and fast-paced urbanization.

Under-vaccination has become a serious public health issue in middle-income countries. For example, across the world, an estimated 169 million children missed out on their routine **measles** vaccination between 2010 and 2017, transforming a disease on the way to being controlled into a global public health emergency. Increased vaccine hesitancy poses substantial risks to containing infectious disease outbreaks.

Poliovirus, which was declared a PHEIC in 2014, continues to be a threat to children. As COVID-19 continues to disrupt immunization services worldwide, transmission is expected to increase in several countries. Failure to eradicate polio now would lead to global resurgence of the disease, resulting in as many as 200,000 new cases annually, within 10 years.[10]

COVID-19 has been one of the most far-reaching PHEs, resulting in the declaration of a global Level 3 emergency[11] by UNICEF in 2020. As of April 2021, there were over 148 million confirmed cases of COVID-19 worldwide, and over 3.1 million deaths.[12] Despite a successful global effort to develop vaccines,

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[8] The World Bank, 'Decisive Action in an Unprecedented Crisis', 17 April 2020.
[9] Center for Disease control and prevention, 'About Dengue: What You Need to Know', <https://www.cdc.gov/dengue/about/index.html>.
[10] United Nations Children's Fund, UNICEF and WHO call for emergency action to avert major measles and polio epidemics, press release, 6 November 2020.
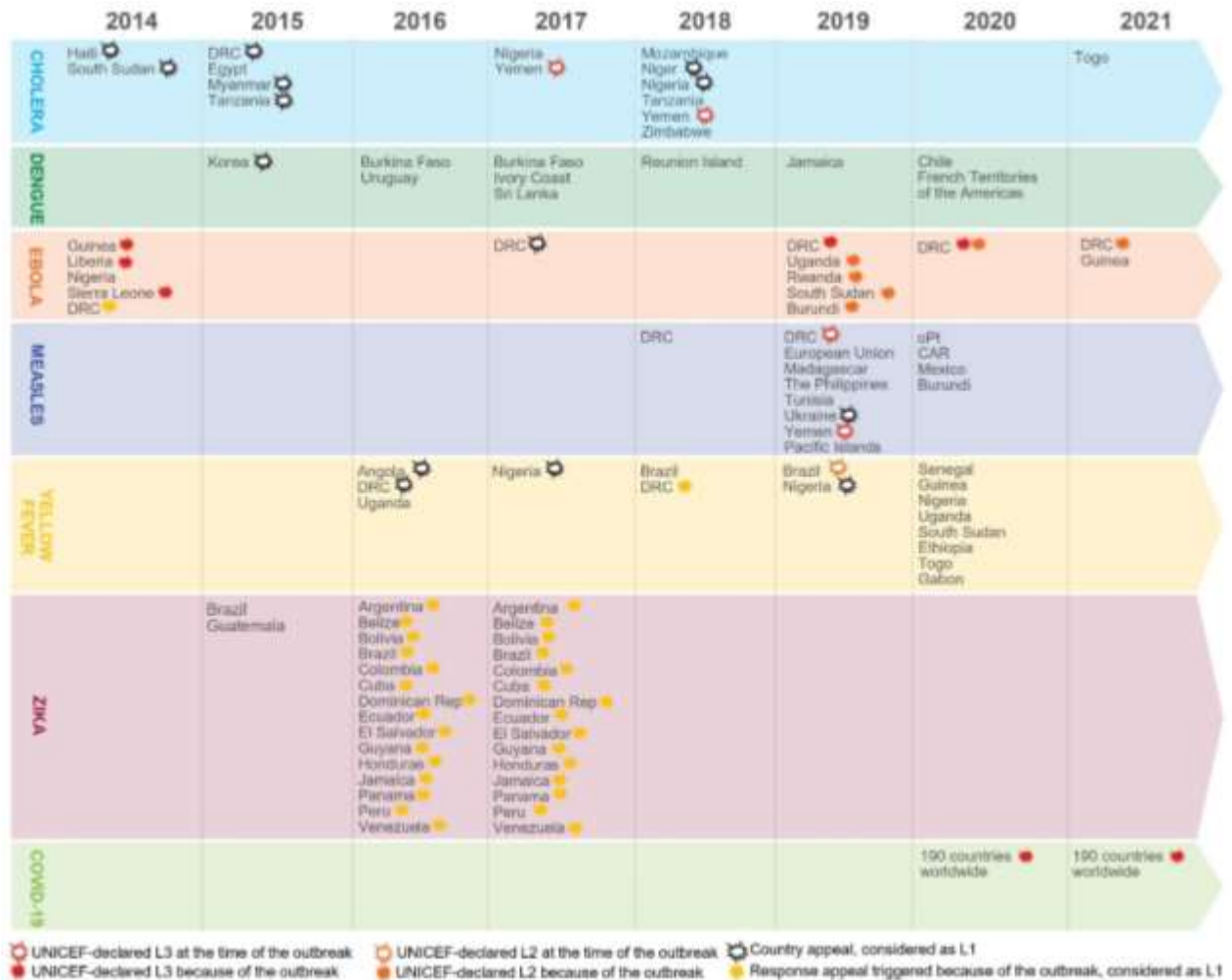[11] The determination of a Level 3 emergency is made based on scale; urgency; complexity; and capacity of regional offices and country offices affected by the crisis.
[12] WHO Coronavirus (COVID-19) Dashboard, <https://covid19.who.int/>, April 2021.

inequities in distribution and the rise of new variants pose risks to containing severe impact of the pandemic in 2021 and beyond.

Figure 1 below depicts a selected set of outbreaks and the associated UNICEF emergency declaration.[13]

Figure 1: Disease Outbreaks since 2014 and UNICEF emergency declarations

	2014	2015	2016	2017	2018	2019	2020	2021
CHOLERA	Haiti, South Sudan	DRC, Egypt, Myanmar, Tanzania		Nigeria, Yemen	Mozambique, Niger, Nigeria, Tanzania, Yemen, Zimbabwe			Togo
DENGUE		Korea	Burkina Faso, Uruguay	Burkina Faso, Ivory Coast, Sri Lanka	Reunion Island	Jamaica	Chile, French Territories of the Americas	
EBOLA	Guinea, Liberia, Nigeria, Sierra Leone, DRC			DRC		DRC, Uganda, Rwanda, South Sudan, Burundi	DRC	DRC, Guinea
MEASLES					DRC	DRC, European Union, Madagascar, The Philippines, Tunisia, Ukraine, Yemen, Pacific Islands	oPt, CAR, Mexico, Burundi	
YELLOW FEVER			Angola, DRC, Uganda	Nigeria	Brazil, DRC	Brazil, Nigeria	Senegal, Guinea, Nigeria, Uganda, South Sudan, Ethiopia, Togo, Gabon	
ZIKA		Brazil, Guatemala	Argentina, Belize, Bolivia, Brazil, Colombia, Cuba, Dominican Rep, Ecuador, El Salvador, Guyana, Honduras, Jamaica, Panama, Peru, Venezuela	Argentina, Belize, Bolivia, Brazil, Colombia, Cuba, Dominican Rep, Ecuador, El Salvador, Guyana, Honduras, Jamaica, Panama, Peru, Venezuela				
COVID-19							190 countries worldwide	190 countries worldwide

⟳ UNICEF-declared L3 at the time of the outbreak   ⟳ UNICEF-declared L2 at the time of the outbreak   ⟳ Country appeal, considered as L1

● UNICEF-declared L3 because of the outbreak   ● UNICEF-declared L2 because of the outbreak   ● Response appeal triggered because of the outbreak, considered as L1

2.2 UNICEF and PHEs

UNICEF has long been engaged in preparedness and response efforts related to disease outbreaks, playing different roles across levels. UNICEF is committed to supporting existing national systems to better prevent, prepare and respond to public health emergencies. This is an important element of and contribution

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[13] UNICEF has a range of policies and procedures intended to facilitate rapid mobilization for humanitarian response to emergency situations. There are three levels of emergency response as follows: Level 1: the scale of the emergency is such that a country office can respond using its own staff, funding, supplies and other resources, and the usual Resident Coordinator/HQs support. Level 2: the scale of the emergency is such that a country office needs additional support from other parts of the organization (HQs, Resident Coordinator and country offices to respond and that the regional office must provide leadership and support. Level 3: the scale of the emergency is such that an organization-wide mobilization is called for.

to the Sustainable Development Goals, including to ensure health lives and promote well-being for all (Goal 3) and to ensure access to water and sanitation for all (Goal 6).[14]

UNICEF's response to Public Health Emergencies is guided by the Convention of the Rights of the Child as well as the Core Commitments for Children in Humanitarian Action (CCCs). The 2020 revision of the CCCs includes specific commitments to UNICEF's work in PHEs, with the Strategic Result "Children and their communities are protected from exposure to and the impacts of PHEs". The commitments, which have corresponding benchmarks, are:

1. **Coordination and leadership**: Effective coordination is established with government and partners.
2. **Risk communication and community engagement:** Communities are reached with targeted messages on prevention and services and are engaged to adopt behaviors and practices to reduce disease transmission and its impact. They participate in the design, implementation and monitoring of the response for ongoing corrective action.
3. **Strengthened public health response**: prevention, care and treatment for at-risk and affected populations: Populations in at-risk and affected areas safely and equitably access prevention, care and treatment, to reduce disease transmission and prevent further spread. Specific attention is given to women and children.
4. **Continuity of essential services and humanitarian assistance**: Essential services and humanitarian assistance are maintained and scaled-up as necessary, and communities can safely and equitably access them.[15]

UNICEF provides leadership in PHE response through its cross-sectoral approach, which brings together health, WASH, Communications for Development (C4D), child protection, supply and emergency programming to address preparedness and response challenges. A Public Health Emergencies team provides technical guidance, outbreak analytics and support at global and country levels. PHE brings together programming in the following areas:

- Health & nutrition
- Infection prevention & control and WASH
- Risk communication and community engagement
- Psychosocial support
- Gender responsive programming
- Supply & logistics support

At the global level, UNICEF works to support national systems to remain child focused in the prevention, detection, preparation and response to PHEs. It does this through key partnerships, providing technical guidance, capacity support and knowledge management for country offices and supporting contributions to national health security plans and international health regulations monitoring. UNICEF is a founding member of the International Coordinating Group on Vaccine Provision with a mandate on global supply of meningitis, yellow fever and oral cholera vaccines.

In 2015, UNICEF launched the Health Emergencies Preparedness Initiative (HEPI) to strengthen the organization's response capacity to a set of priority diseases. HEPI operated in coordination with partners such as the World Health Organization (WHO) and the Centers for Disease Control and Prevention as well as governments, and worked across sectors. Among its activities were the preparation of "packages of support" for priority diseases, including guidance, resources, tools as well as preposition essential supply

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[14] United Nations Children's Fund, Public Health Emergencies - Situation Analysis, Working draft, December 2020.
[15] United Nations Children's Fund, Core Commitments for Children in Humanitarian Action, UNICEF, New York 2020.

items necessary for well-coordinated outbreak responses (see Annex III for the list of documents included).[16]

On the ground, UNICEF partners with communities, governments (especially at the regional/district level), non-governmental organizations, and other UN agencies on PHE preparedness and response.[17] The organization not only provides preventive and curative health services for mothers, their newborns and children but also works across sectors and programme areas with a focus on the rights of the child and emphasizes the vulnerabilities and disparities (e.g. gender and disability) found in both the humanitarian assistance and development space. Key areas of work include infection prevention and control, risk communication and community engagement, psycho-social support, gender-based violence and protection against sexual exploitation and abuse in PHEs and the integration of child case management.

UNICEF operates widely across countries; for example, in 2019, 47 UNICEF Country Offices reported 78 health emergencies, which were primarily outbreaks (Table 1)[18]. In 2020 and primarily due to the COVID-19 pandemic, 105 additional UNICEF country offices reported responses to disease outbreaks compared to the previous year.

Table 1: UNICEF Country Offices reporting outbreak responses, 2019-2020

Region	Number of UNICEF Country Offices		Number of events		Notes
	2019	2020	2019	2020	
East Asia and Pacific (EAP)	8	27	9	29	Measles, Mumps outbreaks, Hepatitis A, polio, COVID-19
Eastern and Southern Africa (ESA)	16	21	23	39	Cholera, EVD, measles, yellow fever, polio, COVID-19
Europe and Central Asia (ECA)	1	21	1	22	Measles, COVID-19
Latin America and Caribbean (LAC)	3	36	3	37	Zika, dengue, cholera, COVID-19
West and Central Africa (WCA)	11	24	24	49	Cholera, measles, EVD, meningitis, Lassa Fever, COVID-19
South Asia (SA)	3	8	3	14	Pneumonia, measles, influenza H1N1, diarrheal disease, COVID-19
Middle East and North Africa (MENA)	5	15	11	21	Measles, cholera, Acute Watery Diarrhea (AWD), Chikungunya, and Dengue fever, COVID-19
Total	**47**	**152**	**78**	**211**	

Source: United Nations Children's Fund, strategic monitoring questions, 2019

2.3   Funding

In 2018 and 2019, UNICEF expended USD 59 and USD 62 million respectively for public health emergencies including disease outbreaks. In 2020, those expenses almost tripled compared to the previous

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[16] United Nations Children's Fund, Health Emergencies Preparedness Initiative, UNICEF, New York, March 2017.

[17] United Nations Children's Fund, Public Health Emergencies - Situation Analysis, Working draft, December 2020.

[18] United Nations Children's Fund, 'Strategic Monitoring Questions for 2019', 2019.

year and reached USD 166 million.[19] The largest expense category is supply delivery and logistics management followed by institutional strengthening of national systems. A similar pattern is found for the period 2014-2018, when spending on supplies constituted 86% of all disease outbreak spending.[20] PHE spending was led by countries grappling with recent outbreaks including Yemen, DRC, Somalia, Nigeria and South Sudan.

In addition to the USD 166 million expenses for PHEs in 2020, COVID-19-related expenditures exceeded USD 750 million across sectors.[21]

2.4 Results reporting

In humanitarian situations, the reporting of PHE results is primarily done through situation reports[22] and a core set of indicators, as well as global annual results reports.[23] Situation report indicators cover a range of sectors including WASH (e.g. access to drinking water, sanitation, hygiene kits), health (e.g. case and vaccination data), nutrition (e.g. severe acute malnutrition rates) and child protection among others. The COVID-19 Global Situation Reports present data on 18 indicators covering risk communication and community engagement, WASH and infection prevention and control, continuity of health service, social protection and child protection.

During the last UNICEF Strategic Plan cycle, the number of health emergencies (epidemic, influenza-human pandemic) UNICEF country offices responded to have been tracked on a yearly basis through the cross-cutting Strategic Monitoring Questions (SMQs).[24]

2.5 Partners

A critical component of UNICEF's PHE work is its collaboration with partners, including chiefly its work and coordination with WHO. Other global partners include the following public health institutions: the United States Centers for Disease Control and Prevention, the Global Outbreak Alert and Response Network, the International Federation of Red Cross and Red Crescent Societies, Médecins Sans Frontières/Doctors Without Borders (MSF), and the Global Task Force on Cholera Control. UNICEF work at the country level is also highly reliant on its work with governments and other national and sub-national public health partners.

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[19] United Nations Children's Fund, Strategic Plan Analysis Cube, 2019.

[20] Since 2018, PHE expenses are tracked through the Specific Intervention Code (SIC) *21-03-18 Public health emergencies, including disease outbreaks.* Expenses can be further disaggregated by Generic Intervention Codes.

[21] COVID-19 related expenses are tracked through the COVID-19 tag, which serves to identity if an activity is expected to contribute towards COVID-19 related results.

[22] The SitRep is the main reporting tool to monitor UNICEF's humanitarian response.

[23] Such as the report on Goal Area 1 or Humanitarian Action.

[24] SMQ-XX-01-Humanitarian-2, "What is the number of humanitarian situations that the country office responded to during the year of reporting by type?" disaggregated by: type of humanitarian situation: Health emergency (epidemic, influenza-human pandemic).

Table 2: Summary of issues and recommendations identified in recent evaluations and studies

UNICEF evaluations and studies conducted between 2010 and 2020 as well as recent interviews have identified a set of preliminary issues and recommendations. While actions have been taken to address some of these, others are still relevant and will be considered within this evaluation.

- Models of **internal leadership and coordination** as well as their effectiveness have varied across PHE responses.
- **Simplified procedures** can help speed a response in a number of ways but **have not been consistently applied**.
- For different reasons, the **deployment of staff** during PHEs was reported as a challenge.
- **Coordination challenges** with other stakeholders during PHEs were raised multiple times. It is recommended that UNICEF re-think its positioning in the changing PHE landscape.
- It was consistently found that **UNICEF C4D** was **not prepared** for disease outbreaks and staffing and capacity needed were underestimated.
- **Accountability to Affected Populations** should appear at the core of UNICEF's work in PHE, although that is not currently the case.
- The **adequacy and responsiveness of UNICEF's operational systems and procedures** for PHEs has been raised repeatedly.
- **Supply and logistics** showed operational efficiency in general, however, unprecedented demand coupled with disruptions in global logistics systems during COVID-19 challenged UNICEF and other partners' ability to provide timely response.
- **Broader effects of PHEs** have not been prioritized enough or early enough, leading to negative effects on children

Additional information about recent UNICEF evaluations and studies appear in Annex II.

3. Purpose and Objectives

Consistent with the UNICEF Evaluation Policy, this evaluation serves interrelated purposes in support of the organization's mandate to support learning and accountability. The evaluation supports learning and decision-making pertaining to recent and on-going challenges that UNICEF confronts with PHEs. The evaluation focus on accountability will involve examining actions taken in accordance with defined responsibilities, roles and performance expectations. This includes an assessment of UNICEF compliance at both the country, regional and global levels with standards such as the CCCs, the Simplified Standard Operating Procedures (SSOPs), the International Health Regulations (IHR), Accountability to Affected Populations (AAP) Guidance, and other relevant agreements.

The overall objective of the exercise is to **assess the extent to which UNICEF is 'fit for purpose' to prepare for and respond to public health emergencies**. The evaluation will aim to provide credible evidence to inform and guide decision-making processes of UNICEF and stakeholders. The more specific objectives are to:

1. Examine the appropriateness and adaptability of UNICEF work in PHEs.
2. Examine efficiency and effectiveness in terms of human and financial resources and capabilities as well as operational policies, procedures and tools in preparing for and responding to PHEs.
3. Assess the coherence and sustainability of UNICEF' work and its synergy with the work of local, national and international actors, including for systems strengthening.
4. Make actionable recommendations that help UNICEF optimize its contribution to public health emergencies.

5. Identify and capture lessons learned and experiences that can be shared to improve UNICEF contribution to PHE responses.

The primary audience for the evaluation includes the UNICEF Executive Board and UNICEF sections at every level responsible for all strategic, design, implementation, coordination, and monitoring-evaluation-learning aspects of public health emergencies (Health, Water, Sanitation and Hygiene (WASH), C4D and Supply). The secondary audience for the evaluation is the following:

- UNICEF divisions, sections and stakeholders interested in or impacted by PHE programming (Education, Child Protection, Communication, Emergency Operations, Supply, Gender, etc.).
- Partners involved in PHEs (e.g. governments, WHO, World Food Programme (WFP), UN Office for the Coordination of Humanitarian Affairs (OCHA), MSF, The Alliance for International Medical Action (ALIMA)).
- Donor agencies that technically and financially support UNICEF's work in public health emergencies and strategic and implementing partners of UNICEF at HQ, regional and country levels, whose efforts have been technically or financially supported by UNICEF.
- Rights holders, primarily in communities and institutions where UNICEF has intervened and might intervene in the future.

3.1 Scope

For the purposes of this evaluation, it is important to distinguish between differing types of emergency events or occurrences in relation to health. This evaluation covers **public health emergencies**. .

Table 3: Emergencies and public health

Health in fragile and humanitarian settings are emergency situations, brought about by conflicts, natural disasters, migration, urbanization, or political and economic instability, and which can result in life-threating circumstances. Emergency responses include support for the health and well-being of those affected.[25]

A public health emergency (PHE) is defined as "an occurrence or imminent threat of an illness or health condition, caused by bio terrorism, epidemic or pandemic disease, or (a) novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents or permanent or long-term disability".[26]

Public health emergencies are distinguished by the health consequences wrought with the potential to overwhelm routine capabilities to address them.[27]

A public health emergency of international concern (PHEIC) is a formal declaration by the World Health Organization of "an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response", formulated when a situation arises that is "serious, sudden, unusual or unexpected", with implications for public health beyond the affected State's national border.[28] Under the 2005 IHR, States have a legal duty to respond promptly to a PHEIC.

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[25] United Nations Children's Fund, https://www.unicef.org/health/emergencies, health in emergencies, <https://www.unicef.org/health/emergencies>, retrieved on 15 October 2020.
[26] World Health Organization, Humanitarian Health Action – emergencies: definitions, <https://www.who.int/hac/about/definitions/en/>, retrieved on 15 October 2020.
[27] Bruce Jennings et al., Emergency Ethics: Public Health Preparedness and Response, Oxford University Press, 2016.
[28] World Health Organization, Emergencies: International health regulations and emergency committees, Q&A, 19 December 2019.

Following previous evaluations of Ebola and cholera interventions, UNICEF made several changes and adaptations in structures related to PHE as well as preparedness and response processes. These included the establishment of a HEPI initiative and a PHE unit, which currently sits within the Programme Group's Health Team. COVID-19 also led to the introduction of revised organizational approaches.

In order to capture these shifts, **the evaluation will examine two phases of UNICEF PHE work.** Phase I will cover the period of 2015-2019 and will be a summative assessment. It is expected to provide a comprehensive, retrospective assessment of UNICEF's work prior to the onset of the global pandemic and to help to set the stage for the assessment of Phase II, including refinement of key questions. Phase II will cover the "COVID-19 period" of 2020-2021, including non-COVID-19 PHEs, and will be both a formative and early summative assessment with a primary learning purpose.

Table 4: Elements of evaluation scope

Geographic	Global (HQ, regional and country levels)
Temporal	Phase I: 2015-2019 Phase II: 2020-2021
Type of PHE	Infectious disease outbreaks at epidemic and pandemic levels
Component	Programme areas engaged in cross sectoral programming, preparedness and response to public health emergencies UNICEF change strategies: (e.g. policy and strategy including positioning/role in PHEs; risk-informed and gender transformative programming; data; fund raising; advocacy and communications; systems strengthening; community engagement, social and behavior change)
Implementation phase	Preparedness, response, recovery, systems strengthening to respond to PHEs

As with all UNICEF corporate-level evaluations, the geographic scope is global, and all regions should be represented in data collection.

The evaluation will cover the years 2015-2021 as well as earlier work for background and contextualization as needed. The evaluation will examine **UNICEF public health emergencies work**[29] across divisions (e.g. Programme Division; Division of Data, Analytics, Planning and Monitoring; Office of Emergency Programmes, Supply Division) and levels (HQs, regional offices, country offices) and all phases of implementation.

3.2 Evaluation questions

The proposed main areas of inquiry for the evaluation are organized around five Economic Co-operation and Development's Development Assistance Committee (OECD-DAC) criteria of relevance, effectiveness, efficiency, coherence and sustainability.[30] The criteria and questions were developed based on a review of previous evaluations and scoping interviews with key staff. The majority of proposed questions relate to both phases. The questions are expected to be reviewed and refined during the inception period.

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[29] For example, in the case of UNICEF response to COVID-19, the *COVID-19 Programme Approach and Prioritization Guidance Note (November 2020),* which includes a set of actions to define priority activities – both to control the spread and mortality of COVID-19 and respond to the socio-economic impact – could be used as a 'framework' for the PHE response.

[30] The OECD-DAC criteria were revised in 2019 and include the five used here as well as impact.

3.2.1 Relevance

The extent to which UNICEF's work in PHEs is aligned with the needs and priorities of affected populations and key stakeholders and adapts as needed.

- To what extent was UNICEF's work in PHEs aligned with country-level needs and priorities?
- To what extent and in what manner did response to PHEs prioritize equity and the needs of the most vulnerable groups?
- Which ways of working supported successful adaptation as public health emergencies evolved and needs and priorities changed? Where were the challenges and if/how were these addressed?

3.2.2 Effectiveness

The extent to which UNICEF work in PHEs achieves its intended results and contributes to key outcomes.

- How effective have UNICEF efforts been in key area of PHE preparedness and response and ensuring a holistic approach across these areas?
  - What have been the main successes and areas for improvement in infection prevention and control to reduce further spread, including in community, school and health service settings?
  - What have been the main successes and areas for improvement in risk communication and community engagement efforts to communicate information on risks, prevention and treatment and supporting positive behaviours? How well has UNICEF combatted rumors and misinformation concerning PHEs?
  - What have been the main successes and areas for improvement in supplies and logistics for public health emergencies?
  - How effective have UNICEF advocacy efforts been in addressing the governance of PHEs, as well as ensuring systematic epidemiological data collection and analysis disaggregated by age and by sex?
- What have been the main hindering and facilitating factors that constrained or hindered responses to PHEs?
- How well has UNICEF supported innovation including product innovation and appropriate use of new technologies to respond to PHEs and mitigate impacts?
- To what extent is UNICEF work in PHEs informed by evidence, evaluation, and research including integrated multi-sector outbreak analytics?

3.2.3 Efficiency

The extent to which UNICEF makes optimal use of its human and financial resources to respond to PHEs.

- To what extent does UNICEF have the right people, systems and structures in place to effectively respond to PHEs?
- How clear and well-aligned are activities and approaches amongst different divisions and offices within UNICEF? How well have HQ and ROs supported country offices in PHEs?
- To what extent were supply operations efficient in providing timely inputs to PHEs, including local and international procurement?
- How efficiently were funds mobilized, allocated and used in recent PHE responses?

3.2.4 Coherence

The extent to which UNICEF designs, implements and monitors its PHE work in coherence and coordination with other PHE actors and utilizes its comparative advantage in PHE.

- To what extent was UNICEF's work in PHEs aligned with activities, approaches and responses of partners at the global, regional and country levels?

- What has UNICEF's role and position been at the global, regional and country level in PHEs and how well aligned were these to UNICEF's comparative advantage? To what extent did this include a leadership or coordination role?
- To what extent are the roles of UNICEF and lead partner agencies (e.g. WHO, WFP) coherent to PHE responses?
- To what extent has UNICEF worked with internal and external partners to ensure continuity of basic services and essential supplies, including treatment, education, psychosocial support and social protection?
- How coherent were responses to PHEs across the humanitarian/development/peace nexus? What were the drivers and barriers?
- How well have gender, disability, age, AAP and human rights standards and commitments been integrated into PHE responses?

3.2.5   Sustainability

The extent to which the benefits of UNICEF interventions in public health emergencies, including improved preparedness and systems strengthening sustainable beyond the intervention period.

- To what extent did UNICEF contribute to strengthening countries' health systems to address PHEs and improving resilience? What were the factors that supported or hindered this strengthening?
- To what extent did UNICEF contribute to strengthen community systems and community engagement to address PHEs and improving resilience?
- How well did PHE responses align with and strengthen national preparedness strategies?
- To what extent did UNICEF support local ownership and local capacity development?
- To what extent has UNICEF ensured linkages, coherence and mutual reinforcement of its response to PHEs with longer-term development objectives?

4. Evaluation approach

The evaluation approaches include a combination of summative examination (e.g. theory-based with analysis of the intended outcomes, outputs, activities, and the contextual factors) for assessments of Phase I and II work, and formative examination for the assessment of Phase II work, to provide lessons for future programming and have a strong utilization focus. As UNICEF is currently engaged in PHE responses, this evaluation will also utilize available real-time data collection, analysis and feedback, to provide early results and timely information for decision-making before finalization. The evaluation will aim to examine key assumptions driving UNICEF work in public health emergencies, such as its multi-sectoral approach and its position in both the humanitarian and development spheres. The overall frameworks guiding the approach and analysis will include the CCCs as well as the IHR and UNICEF's key standards and commitments for PHE response.

5. Evaluation methods

The evaluation will use a mix of qualitative and quantitative methods to answer the proposed evaluation questions. *Quantitative data* will help to unpack and assess UNICEF's operations and associated trends in outputs and likely outcomes, especially at national and sub-national levels. These include surveys and secondary data analysis. *Qualitative data* will provide the evaluation with insight into direct and indirect roles that UNICEF plays in public health emergencies and key influencing factors in varied contexts and from differing perspectives. Where possible, the evaluation will seek to gather the perspectives of rights holders, including children and youth. *Case studies* will use a mix of qualitative and quantitative methods to maximize the depth of insights into the evaluation questions, provide a comprehensive and granular picture of the actions of UNICEF and partners and their effects, and extract lessons that can be applied

more broadly to PHE programming. The proposed methods are detailed below and will be finalized during the inception period. An evaluation matrix will map each method to the relevant evaluation question.

- *Desk review*: a comprehensive review of supply data, human resources data, financial data, performance monitoring data, progress reports, strategic documents, and review. The review will also examine previous relevant evaluations and management responses and the extent to which recommendation actions were implemented, as part of the Phase I assessment.
- *Key informant interviews*: semi-structured interviews conducted remotely or in-person with internal and external stakeholders at the global, regional and country level, including staff, UN partners, national partners, donors, and non-UN partners. Around 30-40 key informant interviews are expected to cover global and regional stakeholders, and 20-30 are expected for the country case study level. Interviews will allow for in-depth examination of perceptions, relationships, context and key contributing factors to PHE work.
- *Focus group discussions* with community members (travel permitting) in the case study countries, to better understand community perspectives and experiences with UNICEF PHE preparedness and response interventions.
- *Online surveys* of all UNICEF PHE staff and key external stakeholders including partner agencies, governments and civil society. Other forms of remote data collection will be employed as appropriate
- *Case studies* of 4-5 PHEs, selected according to pre-determined criteria. Each case study will follow a common protocol and rely on multiple sources and types of evidence to increase the depth and validity of findings and resulting conclusions, including key informant interviews, focus group discussions, site visits and desk review. As travel to case study locations may be restricted by COVID-19-related regulations, the use of local consultants is expected. Case study selection will be guided by criteria including: type of public health emergency; type of outbreak; regional distribution; relative size of UNICEF human, financial and materials resources; phase of programming and country context. Case studies will provide both an input to the evaluation and act as standalone documents for learning. The case study unit will be the PHE itself, and most will be at country level. Regional and/or global PHEs may be considered as well.

The following cases are *proposed for consideration* based on a timeframe from 2015 to 2019 for Phase I and 2020 to the present for Phase II.[31] Final selection will take place during the inception phase.

Table 5: Proposed case studies for each phase

Phase I				
Disease	**Region**	**UNICEF Emergency level**	**Countries**	**Year(s)**
Ebola	WCA	L3, L2	DRC	2017, 2019-2020
	ESA	L2	South Sudan, Uganda, Rwanda, Burundi	2019
Measles	ECA	L1	Ukraine	2019
	EAP, MENA	-	Tunisia, Philippines	2019
Cholera	MENA	L3	Yemen	2017-2018

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[31] Although the evaluation timeframe is from 2015-2021, the case study selection will focus on PHEs since 2017, where involved stakeholders are more likely to be available for response and lessons reflect more recent structures and policies.

Yellow Fever	WCA	L1	Nigeria, Togo, Gabon, Guinea, Senegal, DRC	2017, 2019
	LAC	L2	Brazil	2018-2019
Zika	LAC	L1	TBD (Brazil, Ecuador)	2017

Phase II				
Disease	Region	UNICEF Emergency level	Countries	Year(s)
COVID-19	TBD	L3	1-2 cases from Phase I to be included, as well as countries coping with simultaneous outbreaks	2020-2021
Cholera	MENA	L3	Yemen	2020-2021
Ebola	WCARO	-	Guinea	2021

5.1 Data analysis

Data analysis will proceed with consolidation of information drawn from each method through use of an evidence matrix which also serves for triangulation. Triangulation both across and within categories of data sources will be a key analytical technique for this evaluation – for example, the results of the online surveys will be compared and triangulated with the opinions and experiences related by key informants in the field case studies. UNICEF welcomes the use of diverse and innovative evaluation methods and this will be considered in the selection of evaluation proposals. Qualitative Comparative Analysis or process tracing, for instance, could be considered. This said, the following methods of data analysis and synthesis are encouraged to be used:

Expected areas of analysis include:
- Descriptive analysis to identify the contexts, interventions and characteristics of programming.
- Content analysis of documents to identify common trends, themes and patterns in documents, interviews and focus group discussions, using coding and other qualitative analysis methods.
- Quantitative analysis of closed-ended online survey questions and secondary data sources, including descriptive and inferential statistics. Detailed analysis of performance monitoring data.
- Contribution analysis to determine the extent to which UNICEF contributes to PHE outcomes accounting for the role of partners, examine influencing factors, and identify gaps and reasoning for gaps.

Each component analyzed will be synthesized to form the evaluation findings and conclusions. The inception paper will detail the analysis plan for each method as well as the overall approach to the triangulation and synthesis.

5.2 Methodological limitations

There are several limitations expected for this evaluation, which are described below. Mitigation strategies are to be discussed and detailed in the evaluation inception paper.
- Limitation to travel/remote data collection: the COVID-19 pandemic has necessitated a new way of working, with heavier reliance on remote data collection. This has limited the ability to obtain community-level perspectives, and also prevents evaluation teams from conducting direct observation at the national and sub-national level. The use of local evaluation capacity in case study countries is strongly encouraged as a mitigation strategy, if travel restrictions remain in place during the data collection period. Use of innovate remote monitoring methods will also be expected.

- Development of a comprehensive change model: the ability of the evaluation to take a theory-based approach is predicated on the availability of a working theory of change for UNICEF PHE work. At the time of writing, this theory of change for UNICEF PHE work was still in development. If not finalized before the inception period, the selected team will be expected to develop of a theory of change during the inception phase, based on existing drafts.
- Limited outcome data: the amount, quality and comparability of outcome-level data is expected to be low, meaning the evaluation will rely on utilization of output data in conjunction with the primary data collected through the proposed methods.
- Timeframe: the evaluation focus on outbreaks limits the time period for the case study selection, as staff retention and recall favor more recent PHEs. Case studies have thus been limited to PHEs occurring in 2017 or later.

6. Ethical considerations

Case study work may involve data collection from vulnerable children and community members, hence ethical considerations will be of upmost importance in this evaluation. Consistent with United Nations Evaluation Group (UNEG) norms and standards, the UNEG Ethical Guidelines and UNEG Code of Conduct and the UNICEF Procedure on Ethical Standards in Research, Evaluation and Data Collection and Analysis the evaluation will ensure:

- Respect for rights of individuals and institutions: The evaluation team will accord informants the opportunity to participate voluntarily while maintaining their anonymity, and to make an independent decision to participate without pressure or fear of penalty (informed consent/assent). Also, interviewers will assure respondents that information would be confidential, and that reports would be written such that responses/contributions would not be traced back to them. Interview notes and any recordings will be accessible to the team members only.
- Respect for cultural identities and sensitivities: Variances in ethnicities, culture, religious beliefs, gender, disability, age will be respected. As a result, evaluation processes will be mindful of cultural settings, developmental status and evolving capacities/ages of children and other stakeholders, and the needs of the respondents and rights-holders that programmes are supposed to serve.
- Professional responsibilities and obligations of evaluators: The evaluation team will exercise independent judgement and operate in an impartial and unbiased manner. During data collection, any sensitive issues and concerns will be addressed through the appropriate mechanisms and referral pathways. A protection protocol will be in place for each setting where data collection involves children and community members.

As noted above, and as per Evaluation Office standard procedure, the evaluation design will undergo ethical review during the inception phase. Ethical approval will be sought from the UNICEF Institutional Review Board or designated subsidiary prior to implementation. The possibility of seeking in-country approval by the competent national authorities will be studied. The evaluation team will be required to adhere to UNICEF protocols on management of personal and financial data as well as the general terms and conditions of contract.

7. Evaluation management structure

The evaluation will be managed by the Evaluation Office, UNICEF New York HQ. The Evaluation Office is responsible for the quality of the evaluation and ensuring its independence.

The evaluation manager is the primary interface between the Evaluation Office and the evaluation team. The manager role involves day-to-day support to all aspects of the evaluation process, including facilitating access to data, providing input to key methodological and strategic choices, and managing the evaluation

budget. The evaluation manager may participate in key informant interviews and other activities during implementation. The evaluation manger provides a first quality review (i.e. zero draft) of all evaluation tools and deliverables presented by the evaluation team before key deliverables are shared with the Evaluation Reference Group or other stakeholders.

Staff of the UNICEF Evaluation Office are independent from UNICEF management and operations. As part of their guidance and quality assurance role, Evaluation Office will provide quality assurance on all evaluation tools and documents based on the UNEG's and UNICEF's norms, standards, ethical guidelines, processes and tools. This includes assessment of gender, equity and human rights responsiveness of the evaluation. The evaluation team will be familiarized with these and is expected to observe them during the entire evaluation process

An Evaluation Reference Group, bringing together a mix of UNICEF staff (senior and mid-level) will support the evaluation at key moments to ensure that the evaluation benefits from the highest level of technical knowledge and of a diversity of viewpoints. Members will provide substantive technical inputs, will facilitate access to documents and informants, and will ensure the high technical quality of the evaluation products as well as organizational learning and ownership of the exercise. The Evaluation Reference Group may play a role in implementation of management response actions.

8. Quality assurance

The selected firm will conduct **quality control of all outputs (including drafts)** prior to submission to the evaluation manager.

Levels of quality assurance:

- The first level of quality assurance of all evaluation deliverables (including drafts) will be conducted by the **contractor** prior to submitting the deliverables to the review of the evaluation management group.
- The second level of quality assurance of the evaluation deliverables will be conducted by the UNICEF Evaluation Office.
- The third level of quality assurance of the evaluation report will be conducted by the evaluation reference group.

Once approved, the final evaluation report will be submitted to the UNICEF's global evaluation reports oversight system for an independent quality review. The report and the review will be made publicly available.

9. Timeframe and deliverables

The preparatory period for the evaluation took place from February - June 2021, followed by the recruitment period. Once the team is onboard, the evaluation is expected to take about 12 months. An indicative timeline with the main stages of the evaluation appears below. An updated timeline should be presented in the inception report.

Table 6: Indicative timeline

I – Preparatory Phase	
February – June 2021	Scoping for the evaluation (document review, scoping interviews, stakeholder consultations) and finalization of the Terms of Reference
April – June 2021	Setting up governance structure for the evaluation: Evaluation Reference Group
	1st Evaluation Reference Group meeting – Inception meeting

June 2021 – September 2021	Recruitment and selection of the evaluation team, via call for Expression of Interest and Request for Proposals
II – Inception Phase	
October 2021	Development of evaluation framework and evaluation matrix, work plan, and use and influence plan
	Inception report
	2nd Evaluation Reference Group meeting – Discussion of inception report
III – Data Collection and Analysis Phase	
October – November 2021	Phase I document review
	Phase I document review report
November 2021 – February 2022	Document review (continued); online surveys; global key informant interviews field visits with key informant interviews and field observation (if possible), focus group discussions, remote data collection
February – March 2022	Data analysis and triangulation (using the triangulation matrix)
	Zero draft report, covering assessments of Phase I and II
IV – Reporting Phase	
March – April 2022	Further analysis and drafting based on feedback from the ERG
	Sharable draft evaluation
	3rd Evaluation Reference Group meeting – Discussion of draft report and co-creation of recommendations
May 2022	Further analysis and drafting based on feedback from the ERG
	Penultimate draft
May – June 2022	Final corrections
	Final draft evaluation report
V – Dissemination, follow-up and management response phase	
July – August 2022	Finalization of report (final revisions, annexes, copy-editing, design, etc.)
	Release for Management Response
	A master PPT and learning briefs based on the final report
August – September 2022	Creation of management response by UNICEF management
	Sharing of findings, conclusions and recommendations from the report in various fora: blogs, social media, conferences, regional and thematic network meetings, local events in the region, evaluation conferences, etc.
	4th Evaluation Reference Group meeting – dissemination, use and influence of evaluation

10. Payment schedule

Table 7: Payment schedule

Deliverable	Due Date	%
Inception Report	31 October 2021	25
Phase I document review	30 November 2021	15
Shareable draft evaluation report	30 April 2022	30
Final evaluation report	30 June 2022	30

11. Qualification requirements

Bidders may propose their own combination of experts to carry out the proposed work. For each category of expert, bidders are requested to provide both a daily rate and the indicative number of days required for

personnel in each category. Consortia may submit bids, and must supply a single point of contact for contract management.

It is estimated that a team of four individuals could complete the evaluation within this time frame, with in-country and back-office support. The table below includes an illustrative distribution of days across the phases.

Table 8: Illustrative allocation of level of effort across phases

	Inception	Data collection	Analysis	Report/ Finalize	Total
Team Leader	10	10	23	18	61
Senior Expert	10	---	18	13	41
Senior Expert	5	---	15	13	33
Mid-level Expert	5	20	18	11	54
In-country support (National consultants)	10	90	---	---	100
Back-office support	5	8	2	3	18
Total	**45**	**128**	**76**	**58**	**307**

The evaluation will be carried out by a highly qualified, multi-disciplinary team with extensive knowledge and experience in evaluation of humanitarian and development programming. Specific experience in evaluating programming to prevent and respond to public health emergencies will be required.

The team leader should have extensive experience in leading and conducting complex global evaluations, excellent project management skills, and demonstrated experience in implementing and/or evaluating public health emergency preparedness and response. The team leader is expected to be fully engaged and available throughout the evaluation process. At least one senior expert should be a public health emergencies expert, with a degree in a health-related field as well as monitoring & evaluation competencies.

The evaluation team will collectively bring the below expertise and experience:
- Extensive experience in conducting complex evaluations for international development organizations with a specific focus on public health emergencies including outbreaks, WASH, and public health.
- Demonstrable experience conducting global evaluations (ensuring a human rights-based approach to evaluation), as evidenced by previous assignments
- In-depth knowledge of evaluation methodologies and mixed-method approaches
- In-depth knowledge of and thematic expertise in the following areas: (i) PHE including provision of health services; (ii) risk communication and community engagement; (ii) WASH and infection prevention and control; (iii) logistics and supply.
- Strong ability to interact with a wide range of stakeholders, particularly on issues that are politically sensitive
- Ability to collect data remotely; presence and use of in-country evaluation capacity is strongly desirable
- Knowledge of the UN system and UN programming at the country level, will bring additional points.
- Demonstrable analytical, communication and drafting writing skills in English.
- Fluency in French (past work experience in French) will be required for the team members leading on the Francophone region/countries remote interviews
- Fluency in Arabic (or use of interpreters) will be required for data collection interviews in the MENA region.

12. 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.

A panel of UNICEF 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.

12.1 Content of the technical proposal

The technical proposal will be in PDF format and must include at a minimum the following elements:

A. Table of contents

B. Request for proposals for services form (page 3 of the Request for Proposals for Services document)

C. 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 report (income statement and balance sheet)
- Number of full-time employees and type (technical experts, administrative and logistics support staff, financial staff, etc.)

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

- Programme evaluations
- Multi-country evaluations or studies/research conducted in Africa and the Middle East
- Public health emergencies-related assignments
- Capacities, including the ability (if a part of the proposed methodology) to locate and manage local partners in the countries included in the list of proposed case studies.

E. List of similar/relevant past and on-going assignments carried out by the proposer in the past 7 years. UNICEF may contact reference persons for feedback on services provided by the proposers.

F. 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.

G. Proposed methodology. It should minimize repeating 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. Required content is as follows:

- Understanding of and comments on the context and rationale for the evaluation, and on UNICEF's action in the area of public health emergencies, notably based on proposers' knowledge, experience and familiarity with the available literature

- 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.
- 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 and criteria to select the final case study countries, as well as the duration of the country visits and the number and profile of evaluation team members participating AND/OR methods to conduct remote data collection in the selected case study countries. Particular attention should be paid to the issues of: management of local partners/consultants; stakeholder availability and participation; access and security constraints; mix of quantitative and qualitative data and methods; data disaggregation, accuracy and triangulation; approaches to data treatment and analysis; and quality assurance.
- 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
- The presence of any local consultants/researchers or others not normally full-time members of the bidding institution should be indicated, with a description of how they will be engaged, trained, supported and supervised.

H. 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 deliverables report, their quality assurance by the evaluation team, UNICEF and the Evaluation Reference Group, and their finalization. It should also take into account the vacation time of evaluation team members.

I. 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.

12.2 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, anticipated travel and interpretation)

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

During any travels that may be undertaken for the evaluation if COVID-19 restrictions are no longer in place, 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/.

13. Assessment of proposals

13.1 Mandatory Criteria

Vendors must provide documentation of proven expertise from 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.

13.2 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 public health emergency preparedness and response	5
	Overall structure of the proposal including conceptual framework for analysis and reporting, including clarity and completeness of the proposal	5
	Adequacy of the technical plan demonstrated through the overall concord between RFP requirements and the proposal submitted	5
	Demonstrated ability to conduct high quality evaluations in various contexts (development and Humanitarian, Low- or middle-income countries) and for UN agencies	5
	Focus, scale/size and scope of past and current evaluations/research implemented, including evaluation types.	5
	Risk assessment - recognition of the risks/peripheral problems and methods to prevent and manage risks/peripheral problems	5
Total Section 1: Overall Response		30
Section 2: METHODOLOGY	Quality of proposed implementation plan, i.e. how to undertake and execute each stage, with proposed project schedules	10
	Quality of proposed approach and methodology for the assignment including for information collection, compilation and analysis	10
	Field office locations in programme countries and/or established partnerships with organisations based in programme countries	5
	Ability to conduct data remotely, including proposed tools and methods for doing so	5
	Demonstrated ability to conduct evidence generation activities ethically. These include description of existing in-house ethical review mechanisms/ teams and/existing partnerships with independent ethical review boards.	5
Total Section 2: Methodology		35
Section 3: QUAL	Quality and relevance of the sample work provided	10

Relevant academic qualifications, skills and years of technical experience of team members, including familiarity with UNICEF, the child rights agenda, public health emergencies, technical data fields and/or international development	15
Oral and written communication skills of the proposed team members, including ability to facilitate and conduct meetings and ability to conduct work in English, French and Arabic (using in house or outsourced resources)	5
Clear description of quality assurance mechanisms to be used by the firm to deliver quality products under this RfP. Includes both in house or outsourced quality assurance	5
Total Section 3: Other Criteria	35
Total Possible Points	100
Minimum qualifying required Score (Total)	70

13.3 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 if field missions are able to be undertaken.
- 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 firms/institutions which obtain the threshold 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)
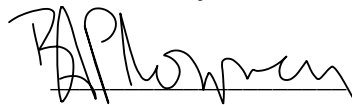
Approvals

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Annex I – PHEIC and UNICEF emergency designation

Outbreaks	PHEIC declarations	UNICEF's declaration and dates		
		L2/L3 activation	First activation	remarks
2009 H1N1 (or swine flu) pandemic	Yes	No	-	-
2014 polio declaration	Yes	No	-	-
2014 outbreak of Ebola in Western Africa	Yes	L3 for Ebola-affected countries (Guinea, Sierra Leone, Liberia)	4 September 2014	
2015–16 Zika virus epidemic	Yes	No	-	-
2017-2018 Cholera/AWD outbreak in Yemen	No	L3 for Yemen	6 July 2015	L3 for complex emergency, including cholera-AWD outbreaks, risks of future outbreak
2018–19 Kivu Ebola epidemic (as of 17 July 2019)	Yes	L3 for DRC	1 August 2017	Scale-up for Ebola+, with the extension of L3
		L2 for cross regional response (Uganda, South Sudan, Burundi and Rwanda)	19 July 2019	
Global COVID-19 Pandemic	Yes	L3	16 April 2020	

Annex II – Issues and recommendations identified in recent evaluations and studies

CCC commitments specific to PHE	Previous evaluations results
Coordination and leadership	**Internal coordination and leadership** *Models of internal leadership and coordination as well as their effectiveness have varied across PHE responses.* • In the West Africa EVD outbreak, leadership became more HQ-based and top-down in nature with the extraordinary involvement of the UNICEF Executive Director and the appointment of a dedicated Global Emergency Coordinator (GEC) with public health expertise. In the evaluation of the Cholera response in Yemen, internal coordination mechanisms were found to work well with good leadership at country and regional levels while support offered by the HQ/Programme Division was stretched. • The recently conducted COVID-19 Learning Evaluation (CLE) underlines the lack of clarity on public health emergencies among regional advisers (emergency, health). Clarification of roles and responsibilities of the PHE team and Health Section for the benefit of regional support is needed to address the issue. Those concerns have also been repeatedly heard from KIs interviewed during the scoping phase. During the COVID-19 crisis, there was also a feeling among country offices staff that there was duplication across many of the requests coming within the organization according to the RTA. • KIs interviewed during the scoping phase thought that there was a need to set the scope when it comes to PHEs. There is at the moment no consensus about what is called an outbreak vs. PHE within UNICEF. **HR deployments** *For different reasons, the deployment of staff during PHEs was reported as a challenge.* • In West Africa, UNICEF struggled to mobilize sufficient emergency staff while also addressing duty of care requirements. Initially, the mobilization of human resources was delayed due to an intense fear of Ebola, which limited the number of staff willing to deploy. Thereafter, recruitment for deprioritized activities such as child protection and education were delayed and as a result, these areas did not achieve capacity until early 2015. Once medical protocols were established, country offices felt overwhelmed by surge staff of mixed quality, high levels of staff turnover, and a decreased sense of response ownership overall. • In Yemen, the lack of standby capacity led to a high dependence on 'surge deployments'. However, deployments were often delayed by weeks due to the 'slot ceiling' for international staff and visa restrictions. • KIs interviewed during the scoping phase also wondered whether UNICEF had the right staff to respond to PHEs. They also found the

	surge system not to work well and allow rapid deployment of staff on the ground.
	UNICEF's positioning and coordination with partners
	Coordination challenges with other stakeholders during PHEs were raised multiple times. It is recommended that UNICEF re-think its positioning in the changing PHE landscape.
	• New coordination structures are being implemented in parallel with the cluster system. For example, due to the health-focused, highly technical nature of the DRC Ebola response, WHO took the coordination lead. Creating new frameworks for collaboration with sister agencies is becoming increasingly important for UNICEF as the coordination systems used in public health responses are changing. The humanitarian review recommended that UNICEF establishes its position in these new systems and advocate for well-coordinated response to address children's needs. Gaps in coordination were also repeatedly heard from KIs in the scoping phase.
	• UNICEF clearly defines its role in public health emergencies, which needs to consider UNICEF's added value and its division of labour with WHO and other relevant agencies.
Risk communication and community engagement	**Communication for Development (C4D)**
	It was consistently found that UNICEF C4D was not prepared for disease outbreaks and underestimated the staffing capacity needed.
	• Evaluation of UNICEF's C4D capacity found that across most country offices, human resources were largely insufficient to meet the needs of the country programme. The seniority level of those leading the C4D function across country offices was also seen as problematic with need for more senior staff (i.e. P4/P5) especially in country offices with large C4D programmes. That evaluation linked the needed UNICEF C4D capacity with increasing demand for UNICEF's lead role in large scale emergencies or emergencies of international concern on communication and community engagement.
	• During COVID-19, many country offices said that they were not prepared to respond to a pandemic or crisis on this level. All regions reported that country offices without prior emergency and humanitarian response experience had additional challenges. The shortage of emergency or skilled staff (particularly in risk communication and community engagement, C4D) was repeatedly cited, though many focus country offices said that the RO was able to provide some support.
	Accountability to affected populations
	Accountability to Affected Populations should be at the core of UNICEF's work in PHE but is currently not.
	• The Humanitarian review highlighted the importance for AAP. While progress is being made, as less than half of UNICEF's country offices manage to achieve more than 50 per cent of the organization's AAP goals, much more needs to be done to ensure quality and predictability in the organization's accountability structures.
Strengthened public health	**Operational systems and procedures**

response: prevention, care and treatment for at-risk and affected populations	*The adequacy and responsiveness of UNICEF's operational systems and procedures for PHEs has been raised repeatedly.* • Corporate initiatives to increase the speed and flexibility of UNICEF's response include the release of Simplified Standard Operating Procedures (SSOPs) in 2012. Evaluations have found that these simplifications reduced the administrative burden and time to deploy staff and contract implementing partners considerably. However, it was also found that the SSOPs are not universally deployed. Some UNICEF country offices with an L3 activation did not make use of the simplifications largely due to staff reluctance to assume financial accountability risks. This was also observed during the response to COVID-19, especially in countries not usually operating in an emergency context. As a result, delayed processing of agreements has slowed the organization's effective response. For public health emergencies, the use of the simplified procedures to acquire critical supplies, expand staff on-the-ground, contract with local partners and access cash-on-hand are both particularly critical and seemingly lacking. **Preparedness/prepositioning of supplies** *Supply and logistics showed operational efficiency in general, however, unprecedented demand coupled with disruptions in global logistics systems during COVID-19 challenged UNICEF and other partners' ability to provide timely response.* • Under HEPI, the prepositioning of supplies enabled quick support to China at the beginning of the COVID-19 outbreak. When supplies were suddenly requested by some 100 countries – at the same time as borders were closing – it posed huge logistical challenges for global supply chains, with demand that far exceeded UNICEF's and partner's capacity. • The Humanitarian Review recommended strengthening or increasing the integration of supply needs in programme planning and response, especially on supply-driven programming in public health emergencies. The same principles and approaches used during the roll-out of the UNICEF Global Minimum Preparedness Standards should be used. It will be necessary to work with the private sector in order to build supply networks and ensure continuity within constrained markets.
Continuity of essential services and humanitarian assistance	**Secondary effects of PHEs** *Secondary effects of PHEs have not been prioritized enough, leading to negative effects on children.* • Experience in West Africa showed that the regional and country offices struggled to collect and analyze the epidemiological data needed to target programme activities and lacked the information/data collection systems needed to detect how Ebola was affecting children. Noted were a lack of real-time information and analysis to inform programme strategies on epidemiology, source reliability, triangulation, meaning and implications. Evaluations have found WHO slow to share epidemiological data and UNICEF too dependent on epidemiological analysis from WHO and that this dependence was detrimental to UNICEF decision-making.

- In West Africa, UNICEF struggled to integrate child protection services, as well as education and other services (e.g. nutrition), into the complete system at community level. Those programme were not sufficiently involved in a sequenced second phase to address Ebola's secondary effects and humanitarian consequences, such as such as stigmatization, increased teenage pregnancy and lack of appropriate care, family livelihoods and access to education. An internal review observed that UNICEF struggled to understand and address Ebola's impact on children and advocate for child protection interventions due to a lack of child-specific data.
- KIs also mentioned several secondary effects of the PHEs that sometimes UNICEF programmes were falling short in addressing them.

Evaluations and studies consulted		
Evaluation	**Period covered**	**Report Publication**
The Humanitarian Review: Findings and Recommendations	n/a	September 2020
Global Evaluation of UNICEF's WASH Programming in Protracted Crises, 2014–19	2014-2019	April 2020
Real-time evaluation of UNICEF's response to Cyclone Idai in Mozambique, Malawi and Zimbabwe	2019	January 2020
Evaluation of the Coverage and Quality of the UNICEF Humanitarian Response in Complex Humanitarian Emergencies	2015-2018	January 2019
Evaluation of the UNICEF Level 3 response to the cholera epidemic in Yemen	2017	June 2018
Evaluation of UNICEF's response to the Ebola outbreak in West Africa 2014–2015	2014-2015	March 2017
Communication for Development: An Evaluation of UNICEF's Capacity and Action	2010-2015	September 2016
Evaluation of UNICEF Supply Division's Emergency Supply Response	2007-2014	January 2015

Annex III – HEPI Packages of Support, by disease categorization

CATEGORIZATION	UNICEF response
Category 1 **PACKAGE**	**Full support package[8]** • Quick Note for senior management and program managers. • Programme Sector Guide (Cross-sectoral technical guidance note, covering all major transmission routes)[9]. • Overarching Guide[10]. • Repository of global and institutional guidance, tools, training materials (e.g. webinars) and other resources. • Repository of risk communication and community mobilization (C4D) messages and communications materials. • Disease specific supply lists, specifications and guidance notes[11]. Pre-positioned stock in sufficient quantities to respond to at-risk population for initial 3-month period[12]. • Note on system (health and social services) and supply chain strengthening with a focus on district and community levels. • Roster of staff for response teams (cross sectoral/divisional) for HR sourcing. • HR staff deployment guide (general guidance including on staff safety, with disease-specific annexes). • Emergency funding appeal checklist. • Market influencing and product innovation.
Category 2 **PACKAGE**	**Basic support package** • Quick Note for senior management and program managers. • Overarching Guide. • Repository of existing global and institutional guidance, tools, training materials (e.g. webinars) and other resources. • Repository of risk communication and community mobilization (C4D) messages and communications materials. • Disease-specific supply lists, supply guidance notes, and long term supply arrangements (but not necessarily additional stock) for select diseases. • HR staff deployment guidance.
Category 3 **PACKAGE**	• Quick Note for senior management and program managers. • Overarching Guide. • Repository of existing global guidance, tools, training materials (e.g. webinars) and other resources. • HR staff deployment guidance.