# **Terms of Reference**

## **Promoting Sustainable Health & Nutrition Opportunities for Marginalised Urban Extreme Poor Population (PROSHOMON)**

## End Line Survey, Health Facility Assessment & Final Evaluation Consultancy 2020

### Organisational Background:

Concern Worldwide began its work in Bangladesh in 1972 and has responded to all major emergencies and implemented numerous programmes for the socio-economic empowerment of extremely poor people across the country. Under the Country Strategic Plan (CSP 2017–2021), Concern Bangladesh has prioritised four programming contexts (Char, Urban, Haor, and Coastal areas), for addressing the underlying causes of extreme poverty through implementation of different programs in Livelihoods, Health, Nutrition, WASH, Education, Climate Change and Adaptation, and Disaster Risk Reduction and other interventions. Concern will continue to focus on addressing urban extreme poverty.

### Country Context:

Bangladesh is experiencing rapid and poorly regulated urbanisation. The number of Bangladeshis living in urban centres is expected to rise from the current 53 million to almost 80 million by 2028. However, there is no formal integrated state healthcare delivery system in urban Bangladesh. Currently the Ministry of Local Government, Rural Development and Cooperatives (MoLGRD&C) is responsible for providing primary health care services through the City corporations and Municipalities, while the Ministry of Health and Family Welfare (MoHFW) is responsible for providing secondary and tertiary level health care, policy and technical guidance. However, due to competing demands, Primary Health Care (PHC) and public healthare not a high priority within the City Corporation and Municipal budget system. In the absence of a well-developed system, healthcare is delivered through a diverse set of state, NGO and private providers. There is little convergence or coordination between these service provision systems. The urban extreme poor suffer most severely from this situation.

#### Urban Programming Context:

In the coming years, rapid urbanisation is expected to continue to increase due to high level of natural population increase and continued rural to urban migration fuelled by rural poverty, landlessness, climate change vulnerability and the large rural-urban wage differentials. Despite the economic progress made by Bangladesh towards attaining middle-income status and achieving many of its Millennium Development Goals, there are widening inequalities across the society. In the urban areas, this manifests itself as large numbers of urban poor being ‘left behind’ in terms of accessing essential health and nutrition care services. Concern’s 2016 Contextual Analysis identifies the urban extreme poor as, pavement dwellers, squatter dweller (living almost in similar circumstances to the pavement dwellers) to the undeveloped slum dwellers to the developed slum dwellers.

### Project background:

The *“Promoting sustainable health and nutrition opportunities for marginalised urban extreme poor population”* (PROSHOMON) project focuses on improving the health and nutrition status of the urban extreme poor by increasing accessibility, coverage, comprehensiveness and sustainability of existing primary health and nutrition services. The project is EU funded, a three-year grant (Feb 2018 – Jan 2021), led by Concern Worldwide and implemented in partnership with SAJIDA Foundation

The project aims to contribute to the Bangladesh Government’s commitments in reaching SDG targets by increasing the Universal Health Coverage (UHC) through a combination of technology and the innovative approach of alternative health financing scheme in a sustainable manner. The project is financing a Smart Health Card for the selected beneficiaries to access free of cost health services from the empanelled facilities.

#### Project Location:

Locations of the project are Feni and Chandpur Municipalities in Chattogram Division. Target Populations under the project are the extremely poor people living in slums, squatter settlements and on pavements in the two municipalities, totalling 65,373 of extreme poor people from 15,000 households with 34,419 in Chandpur and 30,954 in Feni.

### Project Objectives:

The **Specific objective / Outcome** is to improve access to and utilisation of a free essential services package (ESP) of quality primary health care, nutrition and population services by the extreme poor in Feni and Chandpur Municipalities in Chittagong (now Chattogram) Division through the implementation of a SMART Card-based health voucher scheme.

The **Outcome** of the project will be achieved through four interrelated **Outputs** and a set of activities under each output.

* **Output 1:** A well-designed and effective SMART Card-based health voucher scheme implemented to support extreme poor people in targeted locations to increase their access to a basic package of free Primary Health Care (PHC) including access to quality medicines, nutrition and family planning (FP) services in the targeted municipalities.
* **Output 2:** Increased utilisation of PHC, nutrition and FP services by poor and extreme poor people through increased knowledge on new urban health voucher scheme and availability of services.
* **Output 3:** Improved coverage and quality of existing PHC services by integrating nutrition and addressing other service gaps, including reorganising timings and increased referral linkages between health facilities through re-investment of voucher scheme funds.
* **Output 4:** Strengthened municipality leadership in coordination, financing and sustaining PHC services in targeted municipalities.

See Annex 3 for full logframe with indicators.

PROSHOMON builds on Concern’s previous EU funded Health and Nutrition programme *“Improving health and nutrition status of urban extreme poor in Bangladesh through sustainable health service provision”.* The overall objective of the project was to improve the health and nutrition status of the urban poor in Bangladesh through sustainable service provision, managed through a coordinated, national urban health delivery system. It was a three years project starting from December 2016 to March 2020.

PROSHOMON is the second generation of this project, building on the concept of this service delivery mechanism. Moreover, it has another layer of health service delivery using digital technology - SMART health card-based services.

### Purpose of the Consultancy:

The purpose of the consultancy is to conduct the project end line survey, end line health facility assessment and Final Evaluation.

The end line survey and health facility assessment (which will be done existing tools which were also used at baseline) will capture where relevant gender, age, disability, socio-economic categories, male/female-headed households, location, and facility disaggregated information against each agreed project outcome indicator (see Annexe 3). Results will be used to evaluate target achievement of the indicators and compare the change over three years, thus informing the final evaluation, which will also be undertaken by the consultant(s).

The consultancy has four specific objectives:

1. To capture data and analyse the results for all the agreed logframe indicators that are comparable to the PROSHOMON baseline and mid-line surveys.
2. To assess the relevance, coherence, effectiveness, efficiency and sustainability of the interventions of the project, strategies and implementation process as well.
3. To assess how key cross-cutting issues, relevant to the context were considered during the project design and implementation.
4. To capture best practices and lesson learnt to guide key evidence-based advocacy points for the project organisations and help to shape future similar projects for the Concern Worldwide, SAJIDA Foundation, the EU, other organisation, donors, and ultimately for the government of Bangladesh.

The evaluation will follow a participatory process following the suggested lines of enquiry as outlined in this TOR. Along with focus group discussions, key informant interviews, and community visits, the consultancy will use the baseline, midline and end line household survey data to inform the evaluation. The baseline and midline datasets and basic analysis to date will be provided to the consultant by Concern, along with a detailed description of the sampling methodology employed. As outlined above, the end line data collection and analysis will need to be conducted by the consultant(s), including appropriate tests of statistical significance between the baseline, midline and end line.

Based on the findings and conclusions, the evaluation will provide recommendations, lessons learned and best practices for future programming and advocacy.

### Evaluation Questions:

To meet the above objectives, the following evaluation questions informed by the OECD-DAC[[1]](#footnote-1) criteria should guide the evaluation process design and report write up.

#### Relevance:

* Was there an appropriate contextual analysis carried out to inform programme design, which was based on Concerns Understanding of Extreme Poverty?
* How appropriate were the chosen interventions and project design to the situation and needs of different stakeholders at different levels (micro meso and macro, and considering the needs of men, women and others identified as vulnerable to hazards in the programme area)?
* What contextual challenges did the project encounter, what was done to address these challenges, was this sufficient?
* What was the level of participation of project beneficiaries and non-beneficiaries of the programme? To what extent was accountability to beneficiaries practised/promoted? Was an adequate CRM system in place?

#### Coherence:

* Was the programme and associated outcomes relevant, appropriate and strategic to national goals and Concern policies and guidelines (i.e. internal coherence)?
* Was the intervention compatible with other interventions and policies in Bangladesh (i.e. external coherence)?
* Was the invention carried out consistent other actors’ interventions in the same context? This includes complementarity, harmonisation and coordination with others, and the extent to which the intervention is adding value while avoiding duplication of effort.

#### Effectiveness:

* Were the outputs and outcomes achieved and to what degree (assessed through a baseline, midline, end line indicator data comparison, including appropriate tests of statistical significance, monitoring data, and data collected in the evaluation)?
* Was the programme logic well thought through and did the activities lead to the desired outcomes?
* What steps were taken to address issues of inequality and ensure the interests of the most marginalised were taken on board during programme planning, implementation and monitoring? How effective was this?
* Did the programme successfully achieve results in each dimension of extreme poverty as outlined in *‘How Concern Understands Extreme Poverty’* and what are the potential implications of this?
* Did the programme have any unintended and unexpected consequences (positive and negative), and if so have these been addressed in the programme and how?

#### Efficiency:

* Were resources (both human and financial) used well? Could things have been done differently, and how?
* Was the programme Monitoring, Evaluation, Accountability and Learning system fit for purpose?

#### Impacts:

* What indications are there of significant changes taking place beyond the programme - both positive and negative?
* How have the programme interventions impacted differently on men and women (and other vulnerable groups as identified) in the programme area?

#### Sustainability:

* What is the likelihood of households being able to sustain the benefits/supports they received without project support? Who is in a stronger position to sustain these changes, and why?
* Is the exit strategy appropriate? Are project participants and key stakeholders aware of the planned project end?
* How might we do things better in the future? Which findings may have relevance for future programming or for other similar initiatives elsewhere?

#### Cross-Cutting Issues:

* Were the key cross-cutting issues and themes, relevant to the context, factored into the project design and implementation (e.g. equality, protection, HIV/AIDS, partnership, environment, conflict and Disaster Risk Reduction (DRR)? If they were or were not, how did this influence the overall outcomes?

### Evaluation Scoring

The evaluation should consider the five DAC criteria and five cross-cutting issues listed above and provide an appraisal of how well the project has fared against each using the following grading scale, where:

|  |  |
| --- | --- |
| 4 | Outstanding Performance |
| 3 | Performance in line with what would be expected of a well-functioning organisation |
| 2 | Generally acceptable performance but with some clear, and documented, shortcomings |
| 1 | Barely acceptable performance with some major shortcomings and reservations |
| 0 | Totally unacceptable performance or insufficient data to make an assessment |

It is a Concern’s organisational requirement that all development projects are scored against this scale at the final evaluation stage.

### Outputs and Deliverables:

* **Inception report:** Within one week of signing the contract with Concern, the consultant(s) is expected to submit an inception report. This will provide a detailed plan of how the assignment will be carried out. The required structure of the inception report is outlined in Annexe 1.
* **Household survey:** Concern will share the already completed baseline and midline datasets with basic analysis and description of the sampling methodology employed. Concern will also share the end line survey tool which will be pre-loaded on the Concern Digital Data Gathering (DDG) tablets and ready for use. This will be a replica of the baseline and midline surveys. Concern’s M&E team will provide the consultant(s) with training on the use of the DDG system and provide technical back-stop support with the consultant(s) when needed. Concern’s M&E team will also share a detailed overview of the sampling methodology employed for the baseline and midline surveys to ensure that comparability is maintained in the end line. It should be noted that Concern’s DDG system has in-built automated descriptive analysis that allows for disaggregation by any question (e.g. gender of household head). This should be considered by the consultant(s) during the development of the work plan.
* **Health facility assessment:** Concern will share the already completed baseline and midline datasets with basic analysis. Concern will also share the end line health facility assessment tool. This will replicate the methodology of baseline and midline to ensure comparability. Concern’s M&E team will provide a training on the health facility assessment tool to the consultant(s) at the beginning of the assigned task. This assessment data will be collected manually (i.e. on paper). This should be considered by the consultant(s) during the development of the work plan.
* **KII and FGD guides:** The consultant will be required to develop Key Informant Interviews (KIIs), focus group discussions (FGD) and any other data collection guides that will ensure the lines of enquiry will be answered. All draft tools will be shared with Concern for technical review, inputs, and comments. The consultant will incorporate Concern comments into the final version and field test tools before carrying out the assessment.
* **Training:** The consultant will be fully responsible for recruiting and facilitating the training of the assessment team for the household survey, health facility assessment and KII, FGD, etc. The consultant will also be fully responsible for supervising the assessment team in the field.
* **Logistics:** The consultant(s) will be fully responsible for organising transport, accommodation and any other logistical requirements. Where support from Concern or SAJIDA Foundation is required, this needs to be clearly outlined in the Inception Report and will be discussed and agreed upon by all parties.
* **Feedback session:** At the end of the fieldwork, initial feedback and debrief sessions with the project team and Concern and SAJIDA Foundation management team.
* **Final Evaluation Report:** A high quality, analytical evaluation report of maximum 30 pages (excluding annexes and datasets), showing disaggregated findings against each of the indicators of the project result framework both in tabular and descriptive formats. (Please refer to the suggested report template attached in Annex 2).
* Soft copies of the final report (in Word and PDF formats) with complete data set (in Excel format, raw and cleaned) used for the analysis.

### Experience and Qualifications:

**Essential Experience & Qualifications (The consulting firm/lead consultant(s) should have the following):**

* A Masters or higher degree in a relevant field of for health financing, public health and health economics issues.
* At least 10 years of proven experience of conducting final evaluations, mid-term evaluation complex health financing, health system strengthening or public health-related programmes targeting the extreme poor using both qualitative and quantitative data analysis.
* Proven ability to apply a gender equality and inclusion sensitive lens to all work.
* Experience of managing a similar piece of work in urban contexts.
* Excellent English report writing skills.
* Excellent quantitative (Inc. tests of statistical significance) and qualitative analysis and interpretation skills.
* Excellent facilitation skills (Bangla & English).
* Consultant(s)/consulting firm should engage assessment team members with at least three years of hands-on experience of doing similar jobs.
* Willingness to travel and work in though field environments.

**Desirable Experience & Qualifications (In addition to the above, it would be beneficial if the consultant(s) had the following):**

* Successfully completed similar work during the COVID-19 pandemic.
* The consultant(s) have an in-depth understanding and hands-on experience of technology-based micro-health insurance models similar to the PROSHOMON model.

### Documents to be submitted:

The following documents should be submitted to[**recruitment.bgd@concern.net**](mailto:recruitment.bgd@concern.net)

#### For Individual Consultant

* Technical proposal and financial proposal outlining how the consultant will meet the requirements outlined in this Terms of Reference.
* The above should include a short profile of the consultant, highlighting experiences on related assignment with details of the client.
* Short CV (max. 2 pages) highlighting experiences (work as lead investigator) on related assignment completed with detail client name, address, contact persons & communication detail.
* TIN certificate (soft version).
* Evidence of recently completed reports of similar work.
* List of references for recent work of a similar nature.

#### For Consultancy Firm

* Technical proposal and financial proposal outlining how the firm/team will meet the requirements outlined in this Terms of Reference.
* The above should include a short profile of the firm/team, highlighting experiences on related assignment with details of client.
* Lead consultant’s (team leader) CV (max 2 pages) highlighting related work experiences and assignment completed.
* Other Team members’ (Engage in this assignment) CV (max 1 page each) highlighting related task and assignment completed.
* Consultancy Firm legal documents (Certificate, TIN and VAT registration).
* Evidence of recently completed reports of similar work.
* List of references for recent work of a similar nature.

### Duration:

Maximum twelve (12) weeks. The consultant should propose the time required for the assignment based on the proposed methodology.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Tasks** | **W1** | **W2** | **W3** | **W4** | **W5** | **W6** | **W7** | **W8** | **W9** | **W**  **10** | **W**  **11** | **W**  **12** |
| 1. Review relevant programme documents and quantitative datasets and submission of the inception report | X |  |  |  |  |  |  |  |  |  |  |  |
| 1. Submission of an inception report |  | X |  |  |  |  |  |  |  |  |  |  |
| 1. Review existing data collection tools (from baseline), familiarisation with Concern’s Digital Data Gathering (DDG) System, and development of qualitative tools |  | X |  |  |  |  |  |  |  |  |  |  |
| 1. Consultant(s) training of assessment team |  |  | X |  |  |  |  |  |  |  |  |  |
| 1. End line and health facility assessment data collection in Project Locations |  |  |  | X | X |  |  |  |  |  |  |  |
| 1. Initial quantitative data analysis, refining of qualitative data collection tools and cross-checks on lines of enquiry |  |  |  |  |  | X |  |  |  |  |  |  |
| 1. Qualitative data collection & analysis to answer final evaluation lines of enquiry |  |  |  |  |  |  | x | x |  |  |  |  |
| 1. Post fieldwork feedback session with Concern and SAJIDA Foundation |  |  |  |  |  |  |  |  | x |  |  |  |
| 1. Draft evaluation report shared |  |  |  |  |  |  |  |  | x | x |  |  |
| 1. Finalise the report incorporating the feedback from the management of Concern Worldwide |  |  |  |  |  |  |  |  |  |  | x |  |
| 1. Submission of the final report |  |  |  |  |  |  |  |  |  |  |  | x |

### Standard Terms:

#### Duration and Location:

This consultancy is required for a period of **maximum twelve (12) weeks** with Concern Worldwide, Bangladesh, starting from November to January 2020, in Chandpur and Feni.

#### Remuneration/Fee:

Interested bidders are requested to submit their financial proposal along with the technical proposal including the cost of field travel and other relevant costs for the assignment for a period of maximum twelve **(12)** weeks’ consultancy. Inclusive all VAT and Taxes as per the policy of the government of Bangladesh, which shall be deducted at source prior to the payment.

#### Payment:

The consultant will be paid an agreed amount, including vat and tax for the full assigned service. Full payment will be made upon completion of the assignment as per the agreed TOR. The payment mode would be in **three (03)** instalments for the entire assignment against invoices issued by the consultant:

1. The first instalment is 20% after signing of the agreement;
2. The second instalment of 30% of the payment will be made after the submission of the draft report.
3. The remaining 50% will be paid upon satisfactory submission and acceptance of the Final Evaluation report along with all accompanying documents/datasets as specified in the agreement.

Concern will not be liable for any bank charges arising from incorrect bank details being provided to Concern.

#### Accommodation & Food Allowance:

No accommodation, per diem or travel/field costs will be paid in addition to agreed consultancy fees.

#### Copyright and Confidentiality:

Concern Worldwide will have the copyright for all the documents prepared by the consultant(s) including questionnaires, survey formats, case studies, KIIs, FGDs, if any, pictures, videos and the final report with due acknowledgement. No part of the document should be reproduced or published in any manner without the prior written approval of Concern Worldwide. The consultant will maintain the confidentiality of the stated assignment.

#### Concern Worldwide’s Policies and Guidelines:

Concern has an organisational Code of Conduct (CoC) with three Associated Policies; the Programme Participant Protection Policy (P4), the Child Safeguarding Policy and the Anti-Trafficking in Persons Policy. These have been developed to ensure the maximum protection of programme participants from exploitation, and to clarify the responsibilities of Concern staff, consultants (individual/agency) to the programme and partner organisation, and the standards of behaviour expected of them. In this context, consultant (individual/agency) has a responsibility to the organisation to strive for, and maintain, the highest standards in the day-to-day conduct in their workplace in accordance with Concern’s core values and mission. Any consultants (individual/agency) offered a task with Concern Worldwide will be expected to sign the Concern Staff Code of Conduct and Associated Policies as an appendix to their contract of employment. By signing the Concern Code of Conduct, consultants (individual/agency) acknowledge that they have understood the content of both the Concern Code of Conduct and the Associated Policies and agree to conduct themselves in accordance with the provisions of these policies.

#### Responsibility & Lines of Communication:

The consultant (s) will report to Concern’s PROSHOMON Programme Manager and liaise with Financial Services Coordinator-PROSHOMON and Research and M&E Coordinator to receive technical guidance, feedback and support to organising field study. The Concern H&N Consortium Manager and Programme Director will provide strategic guidance to the consultant(s) to accomplish the assignment with the utmost standard. During agreement of the inception report, a clear communication and management plan will be mutually agreed between Concern, SAJIDA Foundation and the consultant(s).

#### Safety and Security:

It is a requirement that the consultant will comply with Bangladesh security policy and in-country security procedures. Failing to comply will result in immediate termination of the contract. Considering COVID -19 risks, where feasible remote trainings and meetings will be the first priority. However, in instances where community visits or face-to-face meetings are required, must ensure that all necessary COVID-19 safety measures are undertaken, including adequate physical distancing, the wearing of face masks and material to ensure high levels of hand hygiene. Considering COVID-19, the work plan will need to be flexible and have built-in contingency plans that can be activated through mutual discussion with Concern and the partners on the ground. This will be especially important for activities that require fieldwork and face-to-face interactions. The consultant(s) and all those recruited by the consultant(s) are responsible for their own health care and will not be covered under Concern Worldwide insurance policies.

**Annexe 1: Structure of Inception Report**

* Introduction
* Understanding of Concern and programme
  + Activities, log frame, intended beneficiaries, partners, monitoring plan, etc.
  + Note: this should not be a direct replication of documents provided by Concern. A brief description of the consultants understanding of the programme is expected. Any areas of Concern or confusion should be highlighted.
* Evaluation Design and Methodology
* The objective of the study
* Methods
* Sampling methodology and sampling frame
* Data collection plan
* Analysis Plan
* Limitations
* Detailed Work Plan (including any support needs from Concern for each activity)
* Staffing Plan
* Risk Assessment (including how COVID-19 risks will be managed)
* Budget

**Annex 2: Final Evaluation Report Structure**

* Executive Summary (2-3 pages in length)
* Introduction
  + Background
  + Project Overview
  + Evaluation Objectives
  + Lines of Enquiry
* Methodology
  + Evaluation design
  + Data collection methods
  + Sampling methods
  + Training of Evaluation team
  + Field Work
  + Data Management and Analysis
  + Limitations
* Findings and discussion\*
  + Relevance
  + Coherence
  + Effectiveness
  + Efficiency
  + Impact
  + Sustainability
  + Cross Cutting Issues
* Conclusions and Lessons Learnt
* Recommendations and Management Reponses
* Annexes
  + Agreed ToR
  + Agreed Inception Report
  + Final Qualitative Data Collection Tools
  + Final Quantitative Data Collection Tools (Concern to provide)
  + Evaluation schedule including lists of site visits and KIIs and FGD conducted
  + Detailed Breakdown of Sample Size & Population by Community Level (Consultant to do for qualitative, Concern to do for quantitative)
  + Results tables with detailed disaggregation (as required)

**\*All DAC criteria to be scored as outline in TOR**

**Annex 3: Project Log frame**

| **Objective(s)/Output(s)** | **Results chain** | **Indicators** |
| --- | --- | --- |
| **Overall objective: Impact** | To improve the health and nutrition status of the urban poor and extreme poor by increasing accessibility, coverage, comprehensiveness and sustainability of existing primary health and nutrition services in urban areas in Bangladesh. | **O1.1** Reduction of maternal mortality ratio for urban poor in line with government targets by 2021  **O1.2** Reduction under 5 child mortality for urban poor in line with government targets by 2021  **O1.3**  Improved nutritional status of urban poor children under 5 years of age in line with government targets by 2021 |
| **Specific objective(s):**  **Outcome(s)** | **Oc:** To improve access to and utilisation of a free package of essential quality primary health, nutrition and population services by the extreme poor living in Feni, and Chandpur Municipalities in Chittagong Division through implementation of SMART Card based voucher scheme | **Oc1.1** Percentage of households in which a member needed healthcare within the past 5 months and sought treatment from an appropriate health facility  **Oc1.2** Number of service contacts of extreme poor with NGO health facilities  **Oc1.3** Average level of satisfaction with the services provided by the PHC |
| **Outputs** | **Op 1**: A well-designed and effective SMART card based Health Voucher scheme implemented to support extreme poor people in targeted locations to increase their access to a basic package of free Primary Health Care (PHC), nutrition and population / family planning (FP) services in the targeted municipalities. | Op 1.1 Number of SMART card based digital Health voucher scheme designed including all ESP services in two municipalities  Op 1. 2 Number of municipalities with operational voucher scheme implementation processes  Op 1.3 Number of voucher redemption processes operationalised  Op 1.4 Number of empanelment mechanisms functional  Op 1.5 Number of municipalities with fraud control mechanism established  Op 1.6 Average level of beneficiary satisfaction with the quality of the scheme. |
| **Op2:** Increased utilisation of PHC, nutrition and FP services by the extreme poor through increased knowledge on new urban health voucher scheme and availability of services. | Op 2.1 Percentage of children age 0-59 months with chest related-cough and fast and/or difficult breathing (acute respiratory infection) in the last 2 weeks who were taken to an appropriate healthcare facility or provider (PHC)  Op 2.2 Percentage of children aged 0-23 months whose births were attended by skilled health personnel  Op 2.3Percentage of mothers of children age 0-23 months who had four or more antenatal visits provided by skilled health personnel during the pregnancy with their youngest child  Op 2.4 Percentage of mother with children age 0-23 months who received a post-natal visit from skilled health personnel within two days after birth  Op 2.5 Percentage of households that sought family planning services from an appropriate health facility in the past 5 months  Op 2.6 Percentage of households that sought integrated nutrition services from an appropriate health facility in the past 5 months |
| **Op3**: Improved coverage and quality of existing PHC services by integrating nutrition and addressing other service gaps including reorganising timings and increased referral linkages between health facilities through re-investment of voucher scheme funds. | Op 3.1 Number of workshops conducted to review existing services and voucher scheme  Op 3.2 Number and percentage of NGOs in targeted locations that have integrated nutrition services in their facilities  Op 3.3 Percentage of staff of targeted PHC facilities who have been trained to integrate nutrition services  Op 3.4 Percentage of staff of targeted PHC facilities who have been trained on free basic package of services under health voucher scheme  Op 3.5 Number of evening clinic established in the targeted 2 municipalities  Op 3.6 Percentage of PHC facilities using quality checklist on quarterly basis – 5 ‘S’ model  Op 3.7 Number of vertical referrals of patients from PHC facilities to secondary or tertiary facilities  Op 3.8 Percentage of targeted PHC facilities have an established complaint response mechanism (CRM) |
| **Op4**: Strengthened municipality leadership in coordination, financing and sustaining PHC services in targeted municipalities. | Op 4.1 Number of quarterly meetings organised by municipality with service providers to review the performance of voucher scheme and health scheme  Op 4.2 Number of municipalities that have developed a cost sharing plan  Op 4.3. Number of municipalities organised meeting with private sector to secure CSR fund  Op 4.4 Percentage of budget for voucher scheme allocated under health sector |

1. <http://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf>

   <http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm> [↑](#footnote-ref-1)