I. Background:

Every child has the right to the best possible start in life. The conditions of a child’s birth and the environment in which the child spends the first few years of its life are critical in determining his or her survival, healthy growth, and development. Within this context, access to health, nutrition, water, and sanitation services with continuum of care are vital to children’s survival and development. It is in the first few years of life that most brain development occurs and children learn to sense, walk, think, play, and communicate. For these reasons the choices made and actions taken on behalf of children during this critical period affect not only how the child develops but also how a country progresses.

Maternal and Child Survival and Development

Ghana has made good progress in reducing childhood mortality in the last 5 years. The current under five mortality rate stands at 60/1000 live births (GDHS 2014), which was 82/1000 live births in 2011 (MICS 2011). However, as programs have become more effective in addressing under-five mortality, the proportion of mortality occurring in the neonatal period (first 28 days after delivery) has stagnated and stands at 29/1000 live births. Currently neonatal deaths constitute about 60 per cent of infant deaths and 48 per cent of deaths in children under 5 years of age in Ghana. Indicators for neonatal mortality rate (NMR) have not improved much in the past 10 years. In addition, slow improvement in maternal health in Ghana continues to impair new born and child health survival and development. Over 50 per cent of these neonatal deaths are believed to take place at home, often unseen and uncounted. Available data suggest that the three most important immediate causes of neonatal deaths are infections (31%), asphyxia (27%) and preterm birth (29%). Simple and cost-effective interventions for prevention and treatment of most of these and other causes of neonatal death are available and global estimates suggest two thirds of new born deaths could be averted through high coverage of these interventions.
Basic Education

Basic education was declared compulsory, free and universal in 2005. The national net enrolment rate for primary education increased from 55.6 per cent in 2003/4 to 83.6 per cent in 2009/10. Ghana is also committed to pre-school education. The approval of the comprehensive Early Childhood Development (ECD) policy in 2004, which made kindergarten free and universal, increased the net enrolment rate in pre-school from 34.4 per cent in 2003/04 to 58.7 per cent in 2009/10. However, nearly 300,000 children of primary school age are still not enrolled and over a third of children in the kindergarten age range (from four to five years of age) are not benefitting from a pre-school education, according to the government. Moreover, although disparities among the population in accessing education are being reduced, they continue to exist along regional, socio-economic and gender lines. The quality of education in Ghana has declined over the years partly due to the rapid, substantial expansion of school enrolments over the past decade. Fewer than 60 per cent of primary school teachers have had proper professional training. The national pupil-teacher ratio is one teacher to 34 pupils, and in the Upper East region there are as many as 48 pupils per teacher. Pupil-teacher ratios of 60:1 are not unknown in some rural districts, where classroom construction and improvement lags more than in other areas. Corporal punishment is widely practiced and high rates of teacher absenteeism reduce the time students spend on learning. Systems are lacking to make teachers more accountable and to promote more involvement in school management by parents and the communities. The poor quality of education is reflected in the low academic achievement. Only 14 per cent of grade six students are proficient in mathematics and only 36 per cent attain proficiency in English, according to the 2009 National Education Assessment.

GHS/GES -UNICEF –KOICA Partnership

UNICEF, with funding support from the Korean International Cooperation Agency (KOICA) entered into a three and half years (2013 July-2016 December) partnership with the Ghana Health Service (GHS) and Ghana Education Service (GES) in the Northern Region (NR) and Upper East Region (UER). UNICEF provides technical and direct financial support to the GHS/GES to ensure the implementation of a package of interventions aimed at improving maternal, newborn and child health and education within the framework of the life cycle approach in these two regions.

By way of the life-cycle approach, programme interventions are consciously directed at those stages of the child’s growth where the potential for change and impact are the greatest: namely, 1) the best possible start for children in their early years; 2) a good quality basic education for every child; and 3) an enabling environment for adolescents as they develop their capacities. It aims to break the vicious cycle of poverty that creates and recreates undernourished infants, poorly educated young children, marginalized adolescents, and unsafe and young motherhood, and that fundamentally undermines the fulfillment of children’s and women’s rights. UNICEF’s goal is to create a positive cycle through which each generation can realize a quantum leap in the situation of children and achieve sustained progress in human development. The package of interventions prioritized under this partnership and the technical support provided by UNICEF is described in the table below.
Table 1: Overview of Health and Education components of the programme

<table>
<thead>
<tr>
<th>Support Areas</th>
<th>UNICEF’s Support</th>
<th>Level</th>
<th>Key Actors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Programme</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal health</td>
<td>• Strengthening planning, monitoring and supervision</td>
<td>Regional, District, Sub-District,</td>
<td>RHMT, DHMT, SDHMTs</td>
</tr>
<tr>
<td>Neonatal health</td>
<td>• Support the coordination between GHS and GES for organizing school based health activities;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child health</td>
<td>• Training of sub national actors (hospital staffs and other health professional)</td>
<td>Health Facility, Community</td>
<td>Health Centres CHPS</td>
</tr>
<tr>
<td></td>
<td>• Provision of equipment and materials to health facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Capacity building of Community Health Officers (CHO)/Community Health Nurses (CHN) and peer educators</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Support to conduct community based interventions (home visit by CHO/CHN)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Education Programme</strong></td>
<td></td>
<td>Regional and District</td>
<td>RDEO, DTSTs, Multi-sectoral ECD Committees</td>
</tr>
<tr>
<td>Early Childhood Development (ECD)</td>
<td>• Policy dialogue to ensure linkages with key developments in the education sector;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to basic education</td>
<td>• Strengthening planning, monitoring and supervision at sub national level;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality basic education</td>
<td>• training of sub national actors district education staffs, head teachers, and teachers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Skills trainings</td>
<td>• Support the coordination between GHS and GES for organizing school based health activities;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Strengthening existing community based structure like Community Health Management Committee (CHMC), School Management Committees (SMC) and Parent-Teacher Associations (PTA)</td>
<td>Community and Schools</td>
<td>Community Chiefs, community opinion readers, SMC, PTA</td>
</tr>
<tr>
<td></td>
<td>• Provision of equipment and materials to schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Support to conduct community based interventions (enrolment drive)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Policy and institutional framework**
In line with the 2012-2016 UNICEF Country Programme of Cooperation with the Government of Ghana, the current project was implemented by the Ghana Health Services (GHS) and Ghana Education Services (GES). At the national level, Annual Work Plans (AWPs) were jointly prepared with government technical counterparts, to ensure full alignment with current national health and education policies, strategies and operational plans.
For the GHS, the Regional and District Health Management Teams (R/DHMTs) have been the key planning and implementation arm for this project and further divided into four to five Sub-District Health Management Teams (SDHMTs), which provided care through Health Centers and more basic Community Health Planning and Services (CHPS) Compounds. The SDHMT provided technical support and essential supplies and commodities to a network of community health workers who operated in pairs in all communities in the sub-district. These community health workers implemented interventions. Homebased and health facility based essential newborn care and referral of sick newborns.

For the GES, similarly the Regional and District Education Offices (R/DEOs) are the key implementing partners. The actual implementation and monitoring of programme activities are supported by the District Technical Support Teams (DTSTs) and circuit supervisors. A number of teacher training sessions have been organized at the district or school cluster level depending on the content of the training. For community mobilization activities, multi-sectoral early childhood development (ECD) committees at the district level have played a leading role. All the planned activities have been incorporated in the Annual District Education Operational Plans (ADEOPs).

II. Purpose and utilization of results of evaluation:

Purpose
As the current KOICA partnership on health and education sector is coming to an end in December 2016 there is now a need to determine to what extent the programme objectives have been met and what have been some of the major lessons learnt that can be considered going forward. Therefore, accountability and learning in relation to the health and education aspects of the GHS/GES- KOICA and UNICEF partnership are the two underlying purposes of this evaluation. This will translate into the following four key questions of interest;

1. To what extent have interventions under the KOICA partnership been able to meet the overall programme objectives\(^1\) for health and education?

2. What were the conducive/enabling factors for achieving programme outputs/targets in health and education?

3. What were the barriers/bottlenecks that did not allow for achievement of programme outputs/targets in health and education?

4. What are some of the major lessons/recommendations that can be distilled from this partnership in relation to health and education going forward?

It should be noted that detailed sub-questions that would be used to answer the key evaluation questions are provided in Annex 1. These sub-questions are based on the OECD/DAC guidelines and are organized by the 5 key attributes for evaluating development projects (relevance, effectiveness, efficiency, impact, sustainability). The table presented below links each OECD/DAC evaluation attribute (and hence their corresponding sub-questions from Annex 2) to the key evaluation questions of interest and thus should be used as a guiding framework to answer the evaluation questions.

---

\(^1\) As stipulated in the 2013-2016 KOICA Results Matrix for both health and education components (see Annex 2). Note: The health component had a thorough baseline conducted whilst the education component only had a partial baseline.
<table>
<thead>
<tr>
<th>OECD/DAC Attribute 2</th>
<th>Key Evaluation Questions</th>
<th>Question 1 (achievement of objectives)</th>
<th>Question 2 (conducive/enabling factors)</th>
<th>Question 3 (barriers/bottlenecks)</th>
<th>Question 4 (lessons/recommendations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevance – the extent to which the health and education programme was suited to the priorities and policies of the target groups, recipient and donor:</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Effectiveness – a measure of the extent to which health and education programme attained its objectives</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficiency – this measures the outputs – qualitative &amp; quantitative in relation to inputs</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact – the positive and negative changes produced by the health and education programme, directly or indirectly intended or unintended</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sustainability – the main impacts and effects resulting from the programme of activities on the local social, economic, environmental and other development indicators. This examination should be concerned with both intended and unintended results</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Utilization of results**

This evaluation is commissioned by UNICEF through KOICA funding to ensure accountability and learning in relation to the programme of activities implemented under this partnership. Results of the evaluation will highlight lessons for creating more effective, efficient and sustainable systems and structures to improve the quality of health and education services – with particular relevance for the Northern Regions. Depending on their nature and relevance, the lessons and recommendations will be used by UNICEF Ghana to inform program design in the new Country Programme (2018-2022). The final report will be shared with the programme partners – MoH/GHS, MoE/GES, UNICEF, KOICA and other development partners to strengthen current interventions and inform policies and strategies.

2 See Annex A for the detailed list of sub-questions proposed under each of the five OECD/DAC evaluation attributes of interest
III. Scope of the evaluation:

Guiding Framework
As a guiding framework for evaluating development projects, the OECD Development Assistance Committee’s (DAC) guidelines will be considered. The five key attributes for evaluating development projects should be directly linked to the corresponding key evaluation questions as suggested in the table above. Furthermore, Annex 1 – highlights sub-questions of specific interest to the KOICA partnership that should be used as a guide during inception to further prioritize and define with the health and education team.

Programme Timeframe:
The evaluation will be limited to the intervention timeframe of July 2013 to September 2016.

Geographic Focus:
The geographic focus of the evaluation should cover the areas of implementation of the project in the two regions (Northern and Upper East Region) of Ghana with particular focus on districts/sub-districts and corresponding health facilities/schools where the health and education programme activities had been implemented.

Data sources:
A mix of both primary data collection and secondary data collection should be considered to answer the key evaluation questions. The table below further highlights primary and secondary data sources for the health and education components.

Table 3: Overview of data sources by type and component

<table>
<thead>
<tr>
<th>Type</th>
<th>Health</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary data</strong></td>
<td>• <strong>Key officials from:</strong> Regional Health Management Team (RHMT), District Health management Team (DHMT), Sub-District Health Management Team (SDHMT), Community Health Planning and Services (CHPS), health facilities, hospitals, Other: Health care providers, (doctors, midwives, community health nurses, sub-district health professionals), community leaders, community volunteers, Red Cross mothers, Caregivers.</td>
<td>• <strong>Key officials from:</strong> Regional Education Offices (REO), District Education Offices (DEO), District Technical Support Teams (DTSTs) and circuit supervisors, Schools, School clusters, CHMC, SMC (School Management Committees), Other: Parent-Teacher Associations (PTA), Teachers, head teachers, KG attendants, circuit supervisors, community leaders, children</td>
</tr>
<tr>
<td>(focus groups and key informant interviews)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Secondary data</strong></td>
<td>Secondary data on MNCH from DHIMS 2, District/Regional reviews and other literatures related to Ghana’s MNCH programming, DHS, other relevant documents.</td>
<td>Secondary data from EMIS, SRC, CFS Checklist, District Activity Reports, and regular programme monitoring for measuring the effectiveness of interventions</td>
</tr>
<tr>
<td>(existing M&amp;E systems, reports, other relevant documents)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Comparison from baseline:

Key evaluation question 1 refers to the Results Matrix and corresponding indicators and targets planned for the project from 2013-2016. For the health component a thorough baseline was conducted in 2013 with available baseline report (Annex 3). However, for the education component only a partial baseline was conducted - as such, missing baseline indicator values will have to be recreated through exploration of available secondary data and potentially through primary data collection (e.g. information interviews with regional education officials on past status).

IV. Process and methodology:

Proposed methodology:

The National Research Institute or University (henceforth Research Institute) based in Ghana will subcontracted through bidding process to conduct this evaluation. The Research Institute should submit the detailed methodology in the technical proposal in line with following evaluation phases.

Evaluation phases:

Phase 1. Inception:

- **For the Health component**, an in-depth desk review will be conducted of the Baseline Report of the health component, programme documents including Results Matrix, available documents related to MNCH, data on MNCH from DHIMS 2, District/Regional reviews and other literature related to Ghana’s MNCH programming, DHS, other relevant documents.
- **For the Education component**, a clear and detailed proposal for reconstructing the baseline using available secondary data including EMIS, SRC, CFS Checklist, District Activity Reports, etc. with consideration for primary data collection should be developed.
- Sub-questions based on the OECD/DAC criteria (Annex 1) should be further defined and prioritized
- Preliminary discussions with the GHS/Deputy Director RCH, PPME, GES, GHS/GES/NR/UER and UNICEF to facilitate a common in-depth understanding of the conceptual framework, refining the evaluation questions and adjusting data collection methods, tools and sources;
- Drafting of Inception report (deliverable 1), including the details of the methodology to be used, an Evaluation Matrix for each finally agreed sub evaluation question (based on Annex 1) and a detailed analysis plan, to be presented to and approved by UNICEF Ghana;

Phase 2. Data collection:

- In alignment with the agreed methodology, the Research Institute will carry out a mix of focus group discussions and key informant interviews. Based on this the consultant will submit a report with the information and findings in relation to the key evaluation questions and sub-questions.
- Field visit to Project Regions and Districts to review – to the extent possible -health facilities (CHPS, Health Centers, District Hospitals including NCU and Tamale Teaching Hospital), schools (KG, Primary, JHS)- documents and records.
- **Field Report** on findings from points one and two above (Deliverable 2). This will include report on results of field work (focus groups/in-depth interviews) with respondents from all levels (regional,
district, sub-district, health facility, community schools) disaggregated by findings for health and education.

- Collection of data from DHIMS/EMIS, project documents for quantitative analysis and reporting at sub-national levels.

3. **Phase 3: Analysis and reporting phase:**

- Following the completion of the fact-finding and analysis phase, the consultant shall make a presentation of the key findings (deliverable 3) in relation to: the extent to which programme objectives were met, barriers/bottlenecks, enabling/support factors, major lessons learnt.

- Once these are discussed and validated by GHS/GES and UNICEF, a draft final report in English shall be shared with key partners for final review and validation (deliverable 4).

V. **Expected deliverables:**

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Deliverables</th>
<th>Time Frame in working days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Desk review of available documents</td>
<td>Deliverable 1. Inception report for the formative evaluation with methodology and tools</td>
<td>3 days</td>
</tr>
<tr>
<td>2. Design of the data collection phase (including reconstructing baseline for education component), relative tools and preparation of inception report</td>
<td></td>
<td>4 days</td>
</tr>
<tr>
<td>3. Regional level stakeholders meeting and interviews (including reconstructing education component baseline)</td>
<td>Deliverable 2. Field Visit Report (results from regional stakeholder meetings, in-depth interviews, focus groups) – disaggregated by findings for health and education</td>
<td>3 days</td>
</tr>
<tr>
<td>4. Field work including interviews with service providers, beneficiaries, sampled facilities visit and data collection 4 days for Karaga district, 4days for Buiisa North District, 2days for traveling (including reconstructing education component baseline)</td>
<td></td>
<td>15 days</td>
</tr>
<tr>
<td>5. Analysis of findings (from field work + DHIMS/EMIS) and draft report preparation answering the four key evaluation questions (extent to which programme objectives were met; barriers/bottlenecks, enabling/support factors, major lessons learnt)</td>
<td>Deliverable 3. Power point presentation of the preliminary findings</td>
<td>5 days</td>
</tr>
<tr>
<td>6. Debriefing of findings with GHS, GES, KOICA, and UNICEF</td>
<td>Deliverable 4. Validated final report</td>
<td>1 day</td>
</tr>
<tr>
<td>7. Incorporate comments from key stakeholders and finalization of the formative evaluation report</td>
<td></td>
<td>4 days</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>35 days</td>
</tr>
</tbody>
</table>
VI. Payment schedule:

The total fee will be paid in instalments as outlined below upon submission of specific deliverables which must be approved by the Chief of Health and Chief of Education prior to payment. Payment will only be made for work satisfactorily completed and accepted by UNICEF based on the schedule below. UNICEF reserves the right to withhold all or a portion of payment if performance is unsatisfactory, if work/outputs are incomplete, not delivered of for failure to meet deadlines.

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Estimated Timeline</th>
<th>Estimated no of days</th>
<th>Payment schedule (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inception report for the formative evaluation with methodology and tools</td>
<td>1st-10th Oct 2016</td>
<td>7 days</td>
<td>20%</td>
</tr>
<tr>
<td>2. Field Visit Report (results from regional stakeholder meetings, in-depth interviews, focus groups) — disaggregated by findings for health and education</td>
<td>10th – 31st Oct 2016</td>
<td>18 days</td>
<td>40%</td>
</tr>
<tr>
<td>3. Power point presentation of the preliminary findings</td>
<td>1st – 10th Nov 2016</td>
<td>5 days</td>
<td></td>
</tr>
<tr>
<td>4. Validated final report</td>
<td>10th-20th Nov 2016</td>
<td>5 days</td>
<td>40%</td>
</tr>
</tbody>
</table>

VI. Expected background and experience:

The evaluator from Research Institute should possess following qualification and experience:

**Health Component**

- At least Master degrees in Public Health, Health Policy, Biostatistics or other public health related fields;
- Expertise and proven substantial experience with at least eight years of experience in Maternal Newborn Child health evaluation and surveys;
- Adequate knowledge of and exposure to national health systems;
- Understanding of the Ghana's MNCH situation and current responses in line with the National Newborn Strategy (2014-2018), the National Child Health Policy (2007-2015), Ghana’s Shared Growth and Development Agenda (GSGDA) and Ghana Health Sector Medium Term Development Plan (GHSMTDP);
- Expertise in quantitative and qualitative data analysis and report preparation;
- Experience in conducting assessments with UNICEF/UN or bilateral/multilateral cooperation agencies on MNCH projects is an advantage;
- Critical analytical and conceptual ability; skills in communication and documenting;
- Excellent analytical and report writing ability in English including effective dissemination materials (power point presentations, fact sheets, policy notes etc.);
- Ability to work co-operatively and constructively with national counterparts and stakeholders.
Education Component

- Master degree in the field of education, international development, Public Policy, and other related and relevant social sciences;
- At least 8 years of experience spanning evidence-building, monitoring and evaluation, institutional development, policy dialogue, reform of the educational system and organizational development;
- Familiarity with education systems of Ghana;
- Previous work experience with UNICEF or UN System is an advantage;
- Critical analytical and conceptual ability, skills in communication and documenting;
- Excellent analytical and report writing ability in English including effective dissemination materials (power point presentations, fact sheets, policy notes etc.);
- Ability to work co-operatively and constructively with national counterparts and stakeholders

VII. Evaluation and selection criteria of proposal:

A two-stage procedure shall be applied in evaluating proposals received, with firstly, an evaluation of the technical proposal that shall be completed prior to any evaluation of the financial proposal. Only financial proposals from applicant institutions whose technical proposal shall have passed the technical evaluation will be examined. In this light, applicant Research Institutions shall each submit the following required documents to UNICEF:

a. Technical Proposal: Research Institute shall prepare a technical proposal on the basis of the tasks and deliverables (as per the ToR). The proposal shall include the assessment methodology with detailed breakdown of inception phase, proposed scope and data collection methodology. The proposal shall also include a brief explanation of the data analysis methods and report writing. Draft work plan and timeline for the formative evaluation shall be included. The Research Institute shall submit alongside the technical proposal (health and education component) updated CVs of evaluators (health and education) and copies of 2 reports of previous Programme assessments/evaluations conducted by the Research Institute. The shortlisted Research Institute will be invited for the presentation of the technical proposal.

b. Financial Proposal: Expected financial offer with budget breakdown along with consultancy fees in Ghana Cedis in line with UN national consultancy rate, per diem during field work and other relevant costs

The Financial Proposal shall be submitted in a separate file, clearly named “Financial Proposal”. No financial information shall be contained in the technical proposal.

Criteria for Evaluation of Technical proposal

<table>
<thead>
<tr>
<th>Category</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall response</td>
<td></td>
</tr>
<tr>
<td>Understanding of, and responsiveness to proposal requirements</td>
<td></td>
</tr>
<tr>
<td>Understanding of scope, objectives and completeness of response</td>
<td></td>
</tr>
<tr>
<td>Understanding of the subject area</td>
<td>(10)</td>
</tr>
</tbody>
</table>
2. Evaluation design and methodology

- Appropriateness of proposed evaluation design, sampling, and selection of health and education facilities and key informants
- Completeness of proposed methodology, field data collection and data analysis
- Proposed timeline

(20)

3. Proposed evaluation management team

- Principal Investigators/Evaluators (Health and Education): relevant experience, qualifications, and position with Research Institute;
- Co-Investigators/Evaluators (Health and Education): relevant experience in conducting health and education evaluations and qualifications;
- CVs of evaluators for both health and education components.

(20)

4. Technical capacity in evaluation

- Sound experience in health and education evaluation;
- Thoroughness in defining evaluation questions, selection of a scientifically valid sample;
- Appropriate data collection tools/questionnaires;
- Quality control systems
- Other relevant added value

(20)

Total Points

(70)

b) Financial proposal

A detailed evaluation budget as a part of financial proposal should be prepared and submitted together with the technical proposal

<table>
<thead>
<tr>
<th>Category</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial status: Lowest acceptable bidder will receive 30 points</td>
<td>(30)</td>
</tr>
<tr>
<td>Remaining offers will receive a proportional grading as per financial bid presented</td>
<td></td>
</tr>
</tbody>
</table>

VIII. Policy both parties should be aware of:

- Under the consultancy agreement, a month is defined as 21 working days, and service charges are prorated accordingly. The evaluators are not paid for weekends or public holidays.
- They are not entitled to payment of overtime. All remuneration must be within the contract agreement.
- No contract may commence unless the contract is signed by both UNICEF and the Research Institution;
- UNICEF will not provide separate vehicle/fuel, driver or undertake travel arrangements for the Research Institute. These shall need to be arranged by the Research Institute and budgeted in financial proposal;
IX. Intellectual property rights:
UNICEF will be entitled to all intellectual property and other proprietary rights including but not limited to patents, copyrights and trademarks, with regard to data, products, processes, inventions, ideas, know-how, documents and other materials which bear a direct relation to or are prepared or collected in consequence or in the course of the performance of the Contract ("Contract Materials"). The Research Institute acknowledges and agrees that such Contract Materials constitute works made for hire for UNICEF.

X. Application Procedure:
The Research Institute shall submit electronically the technical proposal in Word-processing Format and financial proposal in Spreadsheet format along with CVs of evaluators and all other required documents indicated in this TOR, all accompanied by a scanned copy of a signed submission letter, to reach UNICEF Accra by 20 September, 2016, Email to mkumar@unicef.org or mailed to: Supply and Procurement Manager, UNICEF, and P.O. Box 5051, Accra-North

Prepared by:
Name: Hari Banskota, Title: Health Specialist  
Name: Miyo Hamaya, Title: Education Officer

Reviewed by:
Name: Victor Ngongalah, Title: Chief of Health & Nutrition
Name: Aarti Sainjhee, Title: Chief of Education
Name: Kailash Balandran, Title: M&E Officer
Name: Emmanuel Otoo, Title: Supply and Logistic Officer

Approved by:
Name: Rushnan Murtaza, Title: Deputy Representative

Signature: ___________________________ Date: 6 / 09 / 2016
Signature: ___________________________ Date: 6 / 09 / 2016
Signature: ___________________________ Date: 6 / 09 / 2016
Signature: ___________________________ Date: 6 / 09 / 2016
Signature: ___________________________ Date: 07 / 10 / 2016
Signature: ___________________________ Date: 07 / 09 / 2016
Signature: ___________________________ Date: 21 / 09 / 16
Annex 1: Evaluation Criteria

Relevance:

- Are the objectives of the KOICA programme and corresponding health and education interventions keeping with locally (considering health facility, community, schools) defined needs and priorities?
- To what extent is the KOICA-funded programme on health and education interventions responsive to the regional specificity and context?
- Are the interventions in the programme suitable and adequate to achieve the objectives? Do they reflect the best available evidence?
- To what extent was the intervention relevant in terms of advocating for and facilitating the improvement of the quality of health and education services?
  - To what extent were the training and mentorship components of the project appropriate in responding to capacity building needs of the different levels of service providers?
- To what extent was the intervention relevant in terms of contributing to improve the quality of health and education services?

Effectiveness:

Regional level:

- To what extent have the interventions achieved the objectives? Are the overall programme and interventions adequate to realize the programme objectives? (Performance)
- Were the programme and interventions planned, managed, and implemented well? Is there an effective coordinating mechanism? What is the frequency of information dissemination between the various intergovernmental units? Is the capacity of service providers at the regional, district, community/facility level adequate to support delivery of good quality health and education service? (Governance and systems)
- How adequate are the monitoring practices and information sources? What is the extent of alignment/integration with the GHS/GES monitoring systems? (Monitoring)
- To what extent has the project contributed to strengthen the capacity of regional health management teams and district health management teams for planning, informed decision making and prioritization of newborn health as per the National Newborn Strategy and Action Plan (2014-2018), Regional Action Plan on Newborns and other national guidelines and protocols?
- To what extent has the project contributed to the strengthening of districts’ capacity to carry out decentralised planning and monitoring through the development and implementation of the ADEOPS, SPAMS, and SPIPs?

Service providers’ level:

- What is the perceived effect of the intervention on improving service providers’ knowledge and skills? To what extent were the mechanisms and processes used in building the capacity of service providers perceived to have been effective in influencing their practice positively?
- To what extent have trained service providers (individuals) modified their regular practices? Which are the enabling/constraining factors that facilitated/hindered the application of the learned skills?
- To what extent are the interventions perceived to have contributed to improve the quality of health and education services? Which are the enabling/constraining factors that facilitated/hindered service delivery?
- How effective are the mechanisms and processes used to conduct training and capacity building? (the
effectiveness of timing, contents, resource persons, trainee/trainer ratio, etc.) Are INSET held by trained teachers at cluster and school level?

**Final beneficiaries’ level:**

- To what extent do beneficiaries perceive any overall change in the quality of health and education services as a consequence of the intervention?
- To what extent have beneficiaries been reached by project communication and social mobilization interventions, like community durbars, mother support groups, and community based agents?
- To what extent do beneficiaries report an improvement in their newborn care and health seeking practices (ANC, institutional delivery, PNC, well baby clinic) as a consequence of improved counselling by CHO/CHN, CBA, Red Cross mothers and mother support groups?
- To what extent do beneficiaries demonstrate a positive change in attitude towards education (such as regular pupil/teacher attendance, community support to schools and active patronage of education) as a result of the intervention?

**Efficiency:**

**Regional level:**

- Were the allocated resources used efficiently to achieve the project objectives? Were the available resources adequate to meet project needs?
- Have the specific socio-economic realities typical of a deprived district affected the amount of resources spent on the project?
- What are the main factors driving the costs? Is this a cost-effective way to obtain the expected results, especially with reference to professional development of service providers and support at the district and facility level?

**Service providers’ level:**

- To what extent do ongoing training and capacity building (including joint monitoring and supervision) represent an efficient tool to achieve the intended results of the project?
- To what extent have the supply items (equipment and furniture) improved the quality of health and education services?
- To what extent has the collaboration between GHS and the GES contributed to improved health and education services?

**Final beneficiaries’ level:**

- To what extent was the home-based post-natal care system implemented by CHO/CHN in accordance with the national protocol perceived to be an efficient mechanism to reach the target groups?
- To what extent has the use of newborn care units for sick child improved the delivery of newborn care services?
- To what extent is the INSET training perceived to be an efficient mechanism to improve the quality of teaching and learning?


**Sustainability:**

**Regional level:**

- To what extent regional authorities (GHS and GES) demonstrate ownership of the different interventions implemented in this programme for newborn survival and education issues?
- To what extent has GES adapted the CFS and child-centred and gender-sensitive teaching methodologies at the regional and district levels?
- To what extent has the programme been successful in establishing processes and systems that are likely to support the continued implementation of the strategy and interventions at the regional and district levels?
- Who are the key actors, sectors, and partnerships with potential to play a more significant role in supporting quality education delivery at the regional and district level?
- To what extent do RCC/GHS, DHMT, GES, District Assembly demonstrate the ownership and capacity for resource mobilization to be able to self-support and consolidate the achievements and the expansion of the interventions?

**Service providers’ level:**

- To what extent has the capacity building component of the intervention developed stronger institutions and processes, as opposed to developing capacity at individual level? What are the bottlenecks and barriers that hinder the capacity of service providers to continuously provide quality and equitable services?
- To what extent are the commitment and motivation of CHO/CHN and community volunteers (CBAs) that were enhanced through the project perceived to last, for a continued provision of home-based services to mothers and their newborn babies?
- To what extent can the present commitment and motivation of teachers and PTAs that were enhanced through the project be considered to be strong enough to sustain continued provision of quality of education?
- Are all the stakeholders involved, willing and able to continue the education activities of the project on their own?

**Final beneficiaries’ level:**

- To what extent are the behavioral changes among beneficiaries on essential newborn care perceived to be sustainable and expected to last? What are the bottlenecks and gaps along the continuum of care that hinder the capacity of mothers and caregivers to access and use quality MNCH services for themselves and their children?
- To what extent can the knowledge and skills acquired by beneficiaries on key health behaviors (health screening, hand washing with soap, de-worming) and life skills be considered to be strong enough and sustainable? What are the bottlenecks and barriers?

**Coherence:**

- To what extent is the project contributing to and in line with national policies and priorities for health and education programming in Ghana?
- To what extent is the project aligned with and contributing to the donor’s (Government of Korea) development assistance policy?
- To what extent has the project given due importance on donor’s (Government of Korea) visibility in line with UNICEF’s donor visibility guidelines?
Annex 2: Project Results Matrix (2013-2016) – Attached

Annex 3: Baseline for Health Component: Attached