I Background and Context

Uzbekistan became a lower-middle income country in 2010 with a child population over 10 million. Despite reported decrease in national income poverty rates from 26.1 percent in 2004 to 15 percent in 2012, there are still some disparities particularly in rural areas and in Karakalpakstan, Kashkadarya and Surkhandarya regions.

It has been estimated, that in 2012 Uzbekistan spent 5.9% of its gross domestic product (GDP) on health. Public expenditures accounted for 53% of health expenditures and remaining 47% are funded from the out-of-pocket expenditures. The government provides guaranteed basic benefit package that covers primary care, emergency care and care for ‘socially significant and hazardous’ conditions, including major communicable diseases and some non-communicable conditions.

In 2013, the UN Inter-agency Child Mortality Report estimated under-5 mortality at 43, with infant mortality at 37 and neonatal mortality at 14 per 1,000 live births. The official data from State Committee on Statistics (SCS) reports under-5 mortality at 13.4 per 1000 live births, with infant mortality at 9.8. Infant mortality rates are higher in rural areas and among children from the poorest quintile. The most prominent disparities are found between regions. Likewise, the UN Maternal Mortality Rate Estimation Interagency Group reported MMR at 36 per 100,000 live births in 2013, while official sources reported MMR at 20 per 100,000 live births.

There are a number of factors that contribute to discrepancies between the national and international estimates, including that Uzbekistan does not use the WHO recommended international life-birth definition (ILBD). In January 2014 the Ministry of Health (MOH) issued a decree (#21) on adoption of the international life-birth definition (ILBD) in Uzbekistan. However, the ILBD yet to be applied to the data reported by the national statistics.

High maternal and neonatal mortality rates, despite high coverage of antenatal care and skilled attendants at birth, suggest major issues with quality of healthcare services. According to 2013 official data, child mortality has reduced from 12.5 per 1,000 live births in 2008 to 9.8 in 2013. However, neonatal mortality did not change significantly. Likewise, according to 2010 WHO data, around 49 per cent of maternal deaths are directly related to obstetric factors or incorrect management of complications. The UN Committee on the Rights of the Child that the quality of maternal, perinatal and early neonatal care in Uzbekistan is inadequate. The results of baseline assessment of maternal and child care services in 2013, showed that the healthcare system needs to be strengthened to provide adequate quality of continuum of care. In addition, the concept of quality monitoring is relatively new to the system; there is no clear set of quality indicators, milestones and targets on quality of healthcare services.

Lack of proper knowledge on good child-rearing practices to support children’s survival, early development in the families and especially the capacity of carers to recognise danger signs of childhood disease is another factor contributing to infant and child mortality. There is little recent data available

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1 Uzbekistan Millennium Development Goal Report 2015
2 The average of government spending as percentage of GDP in WHO European region was 8.3 percent.
3 Health Systems in Transition, Uzbekistan, WHO 2014
5 GoU and UNICEF Uzbekistan, Multiple Indicator Cluster Survey (MICS), 2006.
7 Unicef SITAN 2014
8 United Nations, CRC/C/UZB/CO 3-4 Concluding observations on the combined 3rd&4th periodic reports of Uzbekistan, 2013
9 United Nations, CRC/C/UZB/CO 3-4 Concluding observations on the combined third and fourth periodic reports of Uzbekistan, adopted by the Committee at its sixty-third session (27 May-14 June 2013), available at http://www2.ohchr.org/english/bodies/crc/docs/co/CRC-C-UZB-CO-3-4.pdf
but, for example, in 2006 only 15 per cent of carers were able to recognise two symptoms of pneumonia.\textsuperscript{10}

In addition, there are some public health issues affecting child survival, growth and development. UNICEF global estimates for 2008-2013 show stunting at 20 per cent and underweight at 4 per cent among young children. Stunting and underweight is more prevalent among children from poorest quintile.\textsuperscript{11} According to 2012 nationwide household survey, anaemia was a moderate health problem using WHO criteria, with 34.4 per cent prevalence of anaemia among women of reproductive age.\textsuperscript{12}

Over the past decade several major health reforms have been implemented in Uzbekistan under the framework of State Program of Reforming the Health Care System aiming to improve efficiency of health care system and ensure equitable access\textsuperscript{13}. The major focus of these reforms has been on health care provision, improving the infrastructure and hardware component, building the competency of health care providers, and rationalised financing and governance\textsuperscript{14}. The Presidential decree issued in November 2011 “On Measures to further Health Care System Reforms” identified quality of health care services and improvement of maternal and child health (MCH) services amongst the key priorities for 2012 – 2015. Besides, the State Programme (SP) on Strengthening and Development of System of Protection of Reproductive Health of Population, Health of Women, Children, and Adolescents in Uzbekistan for years 2014 – 2018 aims to improve the following major areas: (i) Equity and accessibility of quality medical services; quality of medical and social rehabilitation of children with disabilities and their social inclusion; (ii) Potential of human resources at all levels of the health care system, especially at the level of primary health care; (iii) Infrastructure of health care institutions and available technologies; (iv) Active participation of population in care for mothers and children, adoption of health behaviours, and promoting healthy families; (v) Informational health management systems, coordination and inter-sectoral cooperation.

In order to improve maternal and child health and support Uzbekistan to meet Millennium Development Goals (MDGs 4 & 5), "Improvement of Mother and Child Health Services (IMCHS)" phase I project was designed and implemented in eight regions of Uzbekistan (Samarkand, Sirdarya, Namangan, Dżizzak, Navoi, Surhundarya, Kashkadarya, and Andijan) in 2008-2011, aiming at improving health care providers' skills on quality of care. Project’s Specific Objective was to support the implementation of Uzbekistan's national healthcare reforms through strengthening newborn care and improving the quality of maternal and child health care by developing skills and capacity in prenatal and newborn care at the hospital level and the management of childhood diseases at the primary health clinics.

The expected results of the phase I were: 1) Improved skills of staff on effective perinatal care, newborn and child care in maternities, village level health facilities (SVP) and polyclinics; 2)Improved quality of care during delivery and post natal care in all hospitals and maternity centres; 3)WHO “live birth definition” universally applied; 4)Reporting and monitoring system of births improved; 5)Pre-service curriculum updated and brought in line with training programme (including teacher training), introduction (or piloting is initiated); 6)Public awareness of “best practice in child care in general” is raised.

Phase I “Improvement of Mother and Child Health Services (IMCHS)” project brought scalable and cost-effective solutions to providing equitable access to health services for mothers and children. But more importantly, it gave compelling evidence that an integrated package of newborn and child survival interventions along the continuum of care from pre-pregnancy to childhood can significantly reduce child morbidity and mortality, thus bringing the country closer to attaining Millennium Development Goals 4 and 5.

\textsuperscript{11} United Nations, Common Country Assessment: Uzbekistan, 2014
\textsuperscript{12} GAIN, Report to Assess the Result of National Flour Fortification Programme: LC-LQAS Survey Report, 2013
\textsuperscript{13} Health Systems in Transition, Uzbekistan, WHO 2014
\textsuperscript{14} Health Systems in Transition, Uzbekistan, WHO 2014
With a view to sustain and expand the project phase I achievements, the Ministry of Health decided to take this innovative approaches to a nation-wide scale-up through a second phase of the project to boost the nationwide expansion and focus on institutional strengthening, capacity development and community empowerment for equitable, quality and continuous health care. In July 2012 the Agreement was signed between Ministry of Health, UNICEF and the European Commission to mark the roll out of the IMCHS Phase 2 with a duration of forty two months and it is implemented in the remaining six regions to complete nationwide scale-up: Fergana, Tashkent, Bukhara, and Khorezm Oblasts, the Republic of Karakalpakstan, and Tashkent city.

II The object to be evaluated
The evaluation will assess the entire “Improvement of Mother and Child Health Services (IMCHS)” Project, Phase 2 of the project as described below and detailed in the logical framework (Annex 1) and the Inception Report summary (Annex 2)

Project Synopsis:

<table>
<thead>
<tr>
<th>Project title</th>
<th>Improvement of Mother and Child Health Services in Uzbekistan – Phase II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total contracted amount</td>
<td>EUR 4,900,000</td>
</tr>
<tr>
<td>UNICEF Contribution</td>
<td>EUR 818,770 (in addition to the EU funding)</td>
</tr>
<tr>
<td>Target country and regions</td>
<td>The Republic of Uzbekistan (Fergana, Tashkent, Bukhara, and Khorezm Oblasts, the Republic of Karakalpakstan, and Tashkent city)</td>
</tr>
</tbody>
</table>
| Project partners | Government of Uzbekistan
WHO Country Office in Uzbekistan |
| Target groups | At national level: Ministry of Health and Republican Medical Institutes
At regional level:
(i) 4 Oblast Health Departments (Fergana, Bukhara, Khorezm and Tashkent), Ministry of Health Republic of Karakalpakstan and Health Department of Tashkent city
(ii) 13269 health care professionals (771 Trainers, 560 Managers, 11938 Physicians and Nurses)
(iii) 12 Rural communities in pilot Oblasts |
| Final beneficiaries | 15.5 million population of Fergana, Bukhara, Khorezm and Tashkent Oblasts, Republic of Karakalpakstan and Tashkent city, including 3.5 million children under the age of 5 years |

The overall objective of the Project is to contribute to the human development in Uzbekistan with special emphasis on Mother and Child Health Care (MDGs 4 and 5). The specific objective is to “support the MoH to implement MCH care sector reforms, increase the quality of MCH care services, and develop the capacity of families to adopt healthy behaviors”.

While more specific information on the intervention logic is provided in the inception report and in the logical framework, the below graph attempts to show the logframe in a concise manner for easy reference as well as to link it with the theory of change logic (using the RBM chain of activities – outputs – outcomes – impact) used in UNICEF’s programming.
The phase two project intent to achieve 2 main results:

**Result 1. Institutional strengthening.** Skills and operational capacity of the Ministry of Health and its three tiers (primary, secondary, and tertiary) have been enhanced to effectively support the health reform process concerning the Mother and Child health services in accordance with international standards.

Activities:

1.1. Support the MoH to establish and operate the Maternal Child Health Coordination Council (MCHCC), its secretariat, and Joint Monitoring Team (JMT).
1.2. Establish a formal certification system and process for the MCH care institutions.
1.3. Elaborate and pilot quality improvement mechanisms for the MCH care institutions.
1.4. Pilot the Health System Strengthening activities in two pilot regions.
1.5. Perform need assessment, elaborate specification of essential medical equipment for provision of quality EPC, NR&ENBC services.

**Result 2. Capacity development and empowerment.** The capacity of health workers to provide quality health services is improved. The capacity of families to adopt healthy behaviors and demand better health services is enhanced.

Activities:

2.1.1. Conduct training and supervision of healthcare providers on maternal, newborn and child survival packages as per the approved standard protocols and guidelines.
2.1.2. Support the MoH to implement the newborn survival, child survival, and nutrition modules in graduate and postgraduate curricula for MCH care professionals.
2.1.3. Train health care system managers to support improvement of MCH care services.
2.1.4. Establish a platform for discussion and exchange of experience and dissemination of the best practices on MCH care sector reform issues.
2.2.1. Establish community based behavior change mechanism based on participatory learning action approach (PLA) under the ownership of selected Mahallas and primary healthcare institutions (SVP).
2.2.2. Develop PLA modules, BCC materials and tools which promote healthy behaviors, including nutrition, national awareness, and visibility activities.

2.2.3. Train patronage nurses and Mahalla Advisors from Women’s Committees to act as facilitators in implementation of community activities.

2.2.4. Create support groups for promoting healthy behaviors and monitoring of outcomes of community based BCC activities.

**Project Partners:**

The main international development partners, their role in healthcare system reform in Uzbekistan, their respective contributions, and collaboration with the project described below:

1. **The World Health Organization (WHO):** The World Health Organization (WHO) Country Office provides technical support to the IMCHS Project Phase II at national level, and in implementation of the health system strengthening of provincial and district health departments in two pilot regions (Namangan and Republic of Karakalpakstan).

2. **The Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ):** The project has collaborated with GIZ through joint activities on quality improvement, piloting of certification of MCH care institutions and BCC community activities in Republic of Karakalpakstan (RoK).

3. **The Kreditanstalt für Wiederaufbau (KfW):** KfW has cooperated with the project in implementation of the JMT visits. The project has agreed with KfW/GFA to cover the H-IMCI training activities. KfW/GFA will be responsible for the implementation of training activities in specialized pediatric care, and for the development of related clinical protocols in pilot Oblasts. The project provided trainings on use of Neonatal Equipment (NET) to 14 Children Oblast Hospitals equipped by KfW.

4. **The World Bank (WB):** The project collaborated with the WB Health 3 project through joint implementation of IMCI training activities for doctors and nurses at the Oblast level. It was agreed that the WB Health 3 Project will implement the H-IMCI training activities in the pilot Oblasts of the IMCHS Phase I Project, and will train the nurses from the Oblast Children’s Multi-profile Medical Centres in all Oblasts of Uzbekistan.

5. **The United Nations Family Planning Association (UNFPA):** has cooperated with the project in implementation of JMT and Near Missed Cases Review (NMCR) approach. The project and UNFPA have agreed to implement their activities in different regions, to prevent duplication and overlapping. The project agreed with UNFPA to cover the Effective Perinatal Care (EPC) training activities. UNFPA will be responsible for the implementation of Emergency Obstetric Care (EMOC) training activities. UNFPA has supported an assessment of national perinatal centres in terms of readiness for EMOC by an international consultant. It was agreed that the report of the international consultant had been incorporated into the BAQMCHS as undertaken by the project. In addition, the project facilitated the linkages b/w the UNFPA and LDS Charities to implement the Helping Mothers Survive training (component related to obstetric hemorrhages).

6. **The United Nations Children's Fund (UNICEF):** is seen by Government as the subject-matter expert on mother and child health services and as the convener of partners that support the MCH sector reform. UNICEF is working with the MoH of Uzbekistan to improve access to and quality of health care for mothers and children by working at different levels: policy, system and community. UNICEF is an implementing entity of the IMCHS phase II project in close partnership with MoH and EU Delegation in Uzbekistan.

In December 2012 MOH established (Order No. 359 from December 18 2012) the Maternal Child Health Coordination Council (MCHCC) to coordinates the efforts of the MOH, and relevant national
health institutions (Republican Specialized Scientific and Practical Medical Center of Pediatrics, Republican Perinatal Center, Institute of Health and Medical Statistics) and international partners and donors (EU, UNICEF, UNFPA, WHO, KfW, GIZ, WB) in the area of MCH.

During the implementation of the ‘Improvement of Mother and Child Health Services in Uzbekistan – II Phase’ project, this mechanism also serves as a project Steering Committee, to help position the project within the strategic framework of health sector reform. A secretariat has been established to support the MCHCC’s effective functioning, and two technical working groups are in charge of programmatic and medical education issues

III Rationale for the evaluation
This summative evaluation will come at a time when:

(a) The IMCHS project, phase II will conclude its activities, and
(b) The Country Programme of Cooperation between the Government of Uzbekistan and UNICEF will be finalizing the 2010-2015 cycle and will embark onto implementation of a new 2016-2020 Country Programme.

In this context, the Evaluation offers the opportunity to critically assess IMCHS Phase 2 as a stand-alone project as well as in the broader context of scale up of cost-effective interventions related to the maternal, newborn and child health care and their contribution to maternal and child health and well-being. The findings of the evaluation will be used as a basis for discussions, planning and programming between UNICEF and national actors, as well as by international entities, in particular:

1. The knowledge generated by the evaluation will be used by the Government of Uzbekistan and UNICEF to inform the strategies to be applied in the new Country Programme 2016-2020.
2. The knowledge generated by the evaluation will be used by key relevant stakeholders and international development agencies (MOH, UN Agencies, etc.) represented in the Mother and Child Health Coordination Council (MCHCC) to inform policy making and to further support MCH reform agenda for improving quality of MCH services.

IV Objectives of the Evaluation
The main objectives of this summative evaluation are to:

• Assess the relevance, efficiency, effectiveness, sustainability, coherence and, to the extent possible, impact of the project results;
• Identify and document successes, challenges and lessons learnt;
• Provide recommendations to guide: (a) implementation of the next program cycle, and (b) policy level decision making by relevant stakeholders and international development agencies

V Scope of the Evaluation
As mentioned, the evaluation will assess an entire project and will cover most of the Phase 2 implementation period, from July 2012 to December 2015. The geographical scope will include the project target regions (as indicated above), and both national and sub-national levels.

Furthermore, the evaluation will focus on the criteria of relevance, effectiveness, efficiency and sustainability and coherence. The impact will also be assessed, to the extent possible.

One of the limitations that might hinder the evaluation process in some areas is the limited availability of reliable data related to the mother and health services, especially its disaggregation across different vulnerable groups, which may limit the assessment of equity dimensions. Although all efforts have been made to systematically document design and implementation of the project, some project interventions might require collecting additional information that also might hinder the evaluation.
VI Evaluation Questions/Framework

In general, the evaluation should aim at answering the below questions. However, further details will be discussed during the Inception Phase and questions may be fine-tuned based on considerations of evaluability.

Assessing relevance

- To what extent were the project design, strategy and approach appropriate to achieve the set objectives?

- To what extend was the project implemented in partnership with the relevant stakeholders? And at the right level (local, national)?

- To what extent was the project relevant in terms of contributing to improve the health and well-being of mothers and children?

- To what extent was the project inserted into a broader context and designed to contribute to the MCH sector reform?

Assessing effectiveness

- To what extent has the project contributed to achieving (or not) the expected results as per log-frame?

- To what extent the project interventions have been effective in facilitating MCH sector reforms with respect to policy change and quality improvement?

- How effective the project interventions have been in improving service providers’ knowledge and practices in New-born and Child Survival packages

- In the MCH facilities where trained service providers work, to what extent regular practices have been modified with relation to improvement of quality of care? What are the enabling/constraining factors that facilitated/hindered this change?

- To what extent is the M&E system (including supportive supervision) has been effective in reinforcing skills application and tracking progress?

- To what extent have beneficiaries from pilot regions improved their child care and health seeking practices as a consequence of community based activities?

Assessing efficiency

- Has the IMCHS Phase II project used the resources in the most economical manner to achieve its objectives?

- Were the available resources adequate to meet project objectives?

Assessing sustainability

- To what extent do the MOH and other concerned health institutions demonstrate ownership over different project components?

- To what extent the MOH takes the ownership over the New-born and Child Survival packages to ensure sustainability of the achieved results through policy, regulatory framework and capacity development?

- To what extent the communities demonstrate the ownership and capacity to sustain behaviour change component?
Assessing impact
- To what extent have the project activities contributed to achieving (or not) the expected impact level results (mortality, etc)?

Assessing coherence
- To what extent is the project facilitating synergies and avoiding duplications with interventions and strategies promoted by other UN agencies and development partners within the MCH sector and its reform?

In addition to the main evaluation criteria, the evaluation shall also focus on assessing human rights-based approach (HRBA) and relevant cross-cutting issues:
- To what extent and how did the project incorporate the HRBA?
- To what extent and how did the project incorporate gender equality?

VII Methodology of the Evaluation
The evaluation methodology will be guided by the Norms and Standards of the United Nations Evaluation Group (UNEG)15

Evaluability Assessment
This is a preliminary evaluability assessment. At inception stage, the evaluator(s) are expected to conduct a thorough review and analysis of secondary data available in order to identify information gaps and other evaluability challenges and discuss solutions to address these.

In general, the various reports and available data allow for the assessment from the point of view of the different criteria, though assessing contribution to impact may present some challenges especially in terms of impact on specific vulnerable groups. The documents listed below provide background information, baseline, mid-review and end-line quantitative data as well as qualitative information.

Reliability of data, especially disaggregated, is an issue to be taken into account. The UNICEF Country Office will be able to provide more specific guidance on this issue during the inception phase.

While data gaps are not the general rule, in some cases they may hinder evaluability. In these cases, during the inception phase, the evaluation team is expected to agree with the commissioning team on alternative approaches, including the use of less rigorous evaluation designs and/or the selection of the evaluation questions that can indeed be answered.

Information sources
The following list includes general information sources related to country context, health sector and the project:

Background/situation monitoring sources:
- Situation Analysis of Children in Uzbekistan (UNICEF, 2013)
- Uzbekistan Common Country Assessment (UN, 2014)
- Statistical Year Books 2012, 2013 year
- Health in Transition, WHO Observatory, 2014
- MICS Uzbekistan 2006
- UNDAF 2010-2015 (Government of Uzbekistan, UN, 2009)

15 UNEG Norms http://www.uneval.org/document/detail/21
UNEG Standards http://www.uneval.org/document/detail/22
Planning and project monitoring sources:
- IMCHS Inception Report
- Project progress reports 1, 2 and 3
- Midterm Review
- Baseline and End-line Health Facility Assessment (BLA)
- Mid-term formative evaluation report
- KAP Baseline and Final Report
- PLA modules

Evaluation Approach
The evaluation will be conducted in a participatory manner and participation of key stakeholders will be ensured in all phases of the evaluation, including the planning, inception, fact-finding, reporting as well as the management response phases. To this extent, an Evaluation management team comprised of representatives of Ministry of Health, EU, WHO, UNICEF Health Section Programme Staff and M&E officer will lead the evaluation throughout the entire process. The Evaluation management team will coordinate overall the involvement of all stakeholders at key milestones through MCHCC (MOH, WHO, UNFPA, KfW, GIZ, WB, and others), to allow general consensus and guarantee ownership over the findings.

The overall evaluation approach will be based on the theory of change spelled out in the logical framework and detailed in the project inception report. Depending on the project component to be measured, the evaluation will have to use different approaches. For Result 1, non-experimental designs are to be preferred. For the component related to health providers in Result 2, a quasi-experimental design should be possible. The community-based component in Result 2, will most probably require a non-experimental design.

Data collection will be based on a multiple method approach, including:
1. Desk review of:
   - Planning documents
   - Monitoring documents, including:
     a. baseline, mid-term and final health facility assessment;
     b. baseline and final KAP study on household behaviours
     c. other monitoring documents and data base (including internal, joint and external monitoring activities);
   - Accessible policy and planning documents on the maternal and child health sector as well as relevant documents on sector’s assessments and capacity gap analysis.
   - Available administrative and survey data on relevant indicators.
2. A mix of In-depth interviews and Focus Group Discussions (while the FGDs may not be the most effective approach due to country-specific social norms, it may still be discussed case by case) to collect qualitative information within key health care providers, health managers, mahalla (community) leaders, caregivers, national course directors, Ministry of Health’s officials, regional governments and regional departments of health, donors and development partners

Triangulation of data (combining qualitative and quantitative data as well as data from a range of stakeholders) will have to be used to increase reliability of findings and conclusions. Adequate measures will be taken to ensure that the process responds to quality and ethical requirements. Interviewees should be protected (e.g. references to information sources should remain confidential and the report will not contain names unless explicit permission is granted).
During the Inception Phase, in consultation with the Evaluation management team, the sample of stakeholders to be interviewed and locations to be visited will need to be defined based on agreed criteria. At this point, the evaluation questions will be refined; the evaluator(s) should also develop a more precise evaluation work plan.

**VIII Work plan of the Evaluation**

The evaluation process will consist of three phases:

1. **Inception phase including:**
   - In-depth desk review of available sources so that the evaluator(s) improve their understanding of related programme areas, involved stakeholders, and the country context
   - Preliminary discussions with the Evaluation management team and other relevant actors, to facilitate an in-depth common understanding of the conceptual framework;
   - More in-depth evaluability assessment
   - Refining the evaluation questions and adjusting data collection methods and sample;
   - Inception report preparation, including: Evaluation Matrix for each finally agreed evaluation question, data collection and analysis methods, sample (list of stakeholders to be interviewed and locations to be visited), and operational plan. The inception report will have to be shared with and approved by Evaluation management team based on the criteria set by UNICEF evaluation quality assurance system.

2. **Data collection phase, including an appropriate mix of data collection methods, as indicated above. This phase will have to be partially conducted in-country.**

Analysis and reporting phase. Following the completion of the fact-finding and analysis phase, a draft report (in English) should be shared with Evaluation management team and submitted for discussion to the Maternal and Child Health Coordination Council (MCHCC). Following the review and comments received, the draft report will have to be finalized and approved by Evaluation management team based on the criteria set by UNICEF evaluation quality assurance system.

The process will be guided by the following schedule (expected to take place in September-November 2015)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeframe</th>
<th>Location</th>
<th>Deliverables</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inception Phase: 13 working days</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preliminary desk review and discussions with UNICEF team</td>
<td>5 working days</td>
<td>Home-based</td>
<td>Inception report</td>
</tr>
<tr>
<td>Refining evaluation questions and in-depth evaluability assessment</td>
<td>3 working days</td>
<td>Home-based</td>
<td></td>
</tr>
<tr>
<td>Preparation of the inception report</td>
<td>5 working days</td>
<td>Home-based</td>
<td></td>
</tr>
<tr>
<td><strong>Data Collection Phase: 19 working days</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-depth desk review to gather secondary quantitative/qualitative data</td>
<td>5 working days</td>
<td>Home-based</td>
<td>Data collection and analysis tools</td>
</tr>
<tr>
<td>Preparation of data collection and analysis tools</td>
<td>5 working days</td>
<td>Home-based</td>
<td></td>
</tr>
<tr>
<td>In-country data collection</td>
<td>10 working days</td>
<td>Uzbekistan</td>
<td>Presentation of preliminary findings</td>
</tr>
<tr>
<td><strong>Analysis and Reporting Phase: 20 working days</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data processing and analysis based on all information collected</td>
<td>10 working days</td>
<td>Home-based</td>
<td>Database of data collected</td>
</tr>
<tr>
<td>Preparation of draft evaluation report</td>
<td>5 working days</td>
<td>Home-based</td>
<td>Draft report</td>
</tr>
<tr>
<td>Consolidating UNICEF comments and preparation of the final report</td>
<td>5 working days</td>
<td>Home-based</td>
<td>Final report</td>
</tr>
</tbody>
</table>
IX Evaluation Management

The Evaluation management team will oversee the management of the evaluation process starting from the development and validation of the present terms of reference, selection of the evaluator(s), liaison between the evaluator(s) and partners / stakeholders involved, ensure quality of the report and determine the management's response to the evaluation findings and recommendations. It will coordinate with key stakeholders through MCHCC at key milestones such as inception and data collection stage, report validation and discussion of findings and recommendations. It will also ensure operational support as required, including support in primary data collection where needed to complement what available from the existing monitoring systems and other documents.

Required qualifications and areas of expertise

The evaluation will have to be conducted by a gender-balanced team comprising a sufficient number of qualifying international evaluators covering the below requirements:

- Team-leader with documented extensive experience (at least 8 full years) in conducting complex development evaluations (having conducted evaluations for UNICEF is an asset, having evaluations positively rated by UNICEF’s quality assurance system is an additional asset);
- Other evaluator(s) with documented experience (at least 5 full years) in conducting development evaluations (having conducted evaluations for UNICEF is an asset);
- At least one team member with proven extensive experience in quantitative and qualitative data collection and analysis;
- All team members with experience of working in developing countries, at least one team member with experience in Commonwealth of Independent States (CIS) (previous work in Uzbekistan is an asset);
- At least one team member with solid knowledge on mother and child health;
- At least one team member with solid knowledge of child rights, HRBA and gender equality;
- Excellent report writing skills in English;
- Good communication skills;
- Fluency in English, fluency in Russian is an asset.

The team should be an international institution and it may be complemented by one or more national consultants for support in translation, organization of the in-country agenda, and interpretation of findings from a country-specific stand point if needed. To this extent, it should be kept in mind that there is no evaluation society in Uzbekistan and it would be more realistic to expect the national team member(s) to be consultants rather than evaluators.

The team is responsible to ensure that the process is in line with the United Nations Evaluation Group (UNEG) Ethical Guidelines http://www.uneval.org/document/detail/102. The evaluator(s) should be sensitive to beliefs, manners and customs and act with integrity and honesty in their relationships with all stakeholders. Furthermore, they should protect the anonymity and confidentiality of individual information. All participants should be informed of the context and purpose of the evaluation, as well as of the confidentiality of the information shared.

The evaluator(s) are allowed to use documents and information provided only for the tasks related to these terms of reference.

X Deliverables, including Structure of the evaluation report

As described in the last column of the matrix in “Work Plan of the evaluation”, the expected deliverables are the following:

- Inception report – to be delivered 13 working days from the start of the contract;
- Data collection and analysis tools - to be delivered 23 working days from the start of the contract;
- Presentation of the preliminary findings - to be delivered at the end of the in-country mission, 33 working days from the start of the contract;
• Draft report - to be delivered 48 working days from the start of the contract;
• Final report - to be delivered 53 working days from the start of the contract.


The report should include:
• Executive summary,
• Description of the object of the evaluation (including theory of change and relevant information),
• Purpose of the evaluation, evaluation scope, objectives and criteria
• Description of the evaluation methodology (including evaluability assessment, limitations and ethical issues),
• Findings broken down by evaluation criteria,
• Conclusions and lessons learned,
• Recommendations,
• Annexes, including: Terms of Reference, data collection tools and other relevant information.

The quality of final evaluation report will be assessed by external independent company in the framework of UNICEF Global Evaluation Reports Oversight System (GEROS).

XI Procedures and logistics

The evaluators will be assisted with logistics related to the assignment. During in-country visits, they will be provided with office space, vehicle for site visits and official meetings, logistic support for meetings and VISA procedures. Laptops or computers will not be provided.

XII Payment schedule

Payments shall be made as follows:
• 30% will be paid upon submission of the Inception Report;
• 40% will be paid upon presentation of the preliminary findings;
• 30% will be paid upon submission of the Final report;

Please note: in compliance with national Uzbek laws, no cash will be paid in the country

XIII Resource requirements

The rate per day of professional fees will be in accordance with the complexity of the TOR and the level of the expertise required, which is estimated at P4 and P3 level.

Tentative budget for internal planning purposes estimated based on a team of 3 evaluators (1 team leader at P4 level, 2 team members at P3 level):

<table>
<thead>
<tr>
<th>Cost category</th>
<th>Cost description</th>
<th>Total, USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee Team Leader – P4</td>
<td>$ 500 x 50 days</td>
<td>$ 25,000</td>
</tr>
<tr>
<td>Fee Team Member 1 – P3</td>
<td>$ 400 x 40 days</td>
<td>$ 16,400</td>
</tr>
<tr>
<td>Fee Team Member 2 – P3</td>
<td>$ 400 x 35 days</td>
<td>$ 14,000</td>
</tr>
<tr>
<td>Travel (ticket)</td>
<td>Round trip ticket cost (by air) $2000 x 3</td>
<td>$ 6,000</td>
</tr>
<tr>
<td>Travel (DSA)</td>
<td>$190 x 30 nights (24+trip)</td>
<td>$ 5,700</td>
</tr>
<tr>
<td>Terminal expenses</td>
<td>$120x3</td>
<td>$ 360</td>
</tr>
<tr>
<td>National consultant</td>
<td>$ 1000 x 2 people</td>
<td>$ 2000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>$69,460</strong></td>
</tr>
</tbody>
</table>
Funding source:

**PCR:** By the end of 2015, children and mothers benefit from quality and increasingly inclusive social services for children; the country fulfills the remaining observations of the CRC on independent monitoring, data collection, resources for children and environmental health

**IR:** By 2015, the health system provides quality services for mothers and children in line with adopted legislative and normative frameworks aligned with international standards Indicators

**Grant:** SC 120407

XIV Remarks and reservations

UNICEF reserves the right to withhold all or a portion of payment if performance is unsatisfactory, if work/outputs are incomplete, not delivered or for failure to meet deadlines.

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Candidates interested in the consultancy should submit a proposal with approximate methodological proposal, estimated cost, time line, and resume of the evaluators who will take part in evaluation process.

In order to access the Annexes the mentioned in the present Terms of Reference, please contact Tanzilya Shirvanova at tshirvanova@unicef.org. Proposals should also be submitted to the same email address.

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