UNICEF’s response to the Cholera Outbreak in Yemen

Terms of Reference for a Real-Time Evaluation

Background

Two years since the escalation of violence in Yemen, a second wave of fast spreading cholera of unprecedented scale broke out in Yemen in April 2017, endangering the health and lives of people and disproportionately affecting the poor.1 Specifically, in October 2016, the Ministry of Public Health and Population in Yemen announced a cholera outbreak in the capital city of Sana’a, with a total of 11 confirmed cases as of 8 October 2016.2 According to WHO, the total number of suspected cholera cases in Yemen hit the half a million mark in August 2017, with an estimated 2,000 deaths since April, when the outbreak began to spread rapidly.3 While the overall caseload nationwide has declined since early July, particularly in the worst affected areas, the suspected cases of the deadly waterborne disease continue to rage across the country, infecting an estimated 5,000 people per day.4

Yemen’s cholera epidemic, currently the largest in the world, has spread rapidly, with UNICEF and WHO indicating that the reason behind the rapid spread is high rates of malnutrition, food insecurity, collapsing health system, sanitation and clean water systems which in turn are due to the country’s ongoing conflict. The health system is struggling to cope, with more than half of all health facilities closed due to damage, destruction or lack of funds, and shortages in medicines and supplies are persistent and widespread.

As stated above, the situation is aggravated by high rates of severe food insecurity and malnutrition. Children suffering from severe acute malnutrition are ten times more likely to die than their healthy peers. Acute malnutrition weakens the immune system, leaving children at an increased risk of diseases. The ongoing conflict, compounded by an economic decline

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2 http://www.emro.who.int/surveillance-forecasting-response/outbreaks/cholera-cases-in-yemen.html
4 ibid
has devastated livelihoods, depleted safety nets, weakened social service delivery, and the population’s ability to access social services.\(^5\)

The following is a joint statement by the UNICEF and WHO Executive directors during a visit in July: "This deadly cholera outbreak is the direct consequence of two years of heavy conflict. Collapsing health, water and sanitation systems have cut off 14.5 million people from regular access to clean water and sanitation, increasing the ability of the disease to spread. Rising rates of malnutrition have weakened children’s health and made them more vulnerable to disease. An estimated 30,000 dedicated local health workers who play the largest role in ending this outbreak have not been paid their salaries for nearly a year."\(^6\)

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\(^6\) https://www.unicef.org/yemen/media_12062.html

Graph One: Source: http://www.emro.who.int/images/stories/yemen/Yemen_Cholera_Response_-_Daily_Epidemiological_Update_-_2017-10-04.pdf?ua=1 as of 4 October
The UNICEF response brings together health, Water, Sanitation and Hygiene (WASH) and Communications for Development (C4D) in an integrated approach at different intervention levels from household, community, facility and institutional levels to central level, for a comprehensive public health approach. The Yemen Country Office has prepared the ‘Integrated Cholera Response, Prevention and System Strengthening Plan’ whose goal is to: contribute to the overall objective of reducing occurrence of Acute Watery Diarrhoea (AWP) plus suspected cholera cases and to minimize the associated morbidity and fatality, through effective prevention and timely response. The UNICEF Strategy is built on 5 key principles – (i) integration of WASH, Health and Communication response, (ii) partnership and coherence with Health and WASH clusters, (iii) a focused approach on priority districts and hot spots, (iv) address the ongoing outbreak (response and control) and (v) prevention of future outbreak (prevention, preparedness and health system strengthening).

Since the start of the outbreak, UNICEF has been working with partners to respond not only to the ongoing crisis, but also to the cholera outbreak. To date, UNICEF has provided safe water to over one million people across Yemen, and delivered over 40 tonnes of lifesaving medical equipment – including medicine, oral rehydration salts, intravenous fluids and diarrhoea disease kits. Additionally, UNICEF is the WASH cluster-lead, C4D adhoc-sector lead, is an active member of the Health clusters, and is part of a Taskforce which discusses status, updates and strategic issues to guide the cholera response. Since the resurgence of the outbreak in April, UNICEF has prioritized hygiene promotion activities, with over 20,000 Community mobilizers currently deployed in districts reaching over five million individuals through partnerships with government ministries and NGOs. Campaigns using national media and social media continue to be used to engage communities by discussing key practices and messages. Cholera brochures have also been printed and disseminated during house-to-house cholera awareness campaigns. In August 2017, a national cholera awareness campaign was implemented by the Ministry of Public Health and Population (MoPHP) with collaboration of UNICEF and WHO, as part of the UNICEF and WHO Cholera Response.

Despite high results achieved in treatment (Diarrheal Treatment Centres / Oral Rehydration Centres etc.), WASH coverage and awareness raising campaigns, there has been another cholera spike recorded (please see Graph One above). Recent data reveal that there has been some decrease in the attack rates in some of the governorates, and an increase in others. Also, the incidence of diarrheal diseases has not been reduced in spite of this response. This raises questions on the effectiveness of the cholera response, and calls for a more in-depth review of the cholera crisis response with a fresh lens, including data accuracy, case definition and management, testing and quality of the containment and prevention strategies.

7 The document “Integrated Cholera Response, ..” which contains the details of the response strategy will be an annex to this ToR .
Purpose and Objectives

UNICEF plays multiple roles in the response, beyond its own programme and within the Humanitarian Country Team architecture. The proposed Real Time Evaluation (RTE) will fulfil both accountability and learning purposes. The RTE will assess the effectiveness of the containment and prevention activities, for which UNICEF has provided leadership in the response, and also consider how far the response has been conducted in an appropriate, coordinated, efficient and timely manner, taking into account that the UNICEF Yemen Country Office (YCO) is also responding to the ongoing humanitarian crisis. The RTE should identify challenges and success factors in the UNICEF’s response, and determine why there has been a surge in some of the governorates, and a reduction in others, despite the high coverage of treatment and of WASH interventions, and awareness raising campaigns. This will support the learning function that should inform improvement of UNICEF’s interventions. Accountability is important, given the substantial human, supply and financial resources UNICEF continues to allocate to the response. The evaluation results should help to show how these resources have been used appropriately, effectively and to good effect, in response to the cholera outbreak.

The RTE will not be able to address issues of impact e.g. it will not answer questions on how many lives have been saved as result of UNICEF’s interventions. In relation to connectedness, the RTE will consider whether the response has established readiness to manage the risk of any resurgence of the outbreak, through preparedness and prevention activities in potentially high risk areas, and how far the organization is preparing the ground to support system strengthening efforts as set out in the Cholera Response Plan. The evaluation will review the coverage of the UNICEF response, the partnerships put in place as well as its management and internal and external coordination.

Intended use and users

The RTE will have a strong utilisation focus, and is expected to capture forward looking lessons, conclusions and recommendations from the response that will be used to strengthen the ongoing response. The primary users of the RTE is the UNICEF Yemen management and programme staff, as well as UNICEF staff in the Regional Office (RO) and Head Quarter (HQ) Divisions supporting the response. Secondary users include government stakeholders, partners and donors. The intended uses of the real time evaluation are:

1. To inform the UNICEF Yemen management in its effort to implement the integrated cholera response, prevention and system strengthening plan. Specifically identify rapid corrective action as appropriate during the ongoing cholera outbreak to better respond to the needs of affected populations in Yemen.
2. To capture the findings and lessons learned to support advocacy efforts, both internally within the country, and externally with relevant partners.
3. The evaluation is also intended to contribute the global knowledge, thus in line with UNICEF’s Evaluation Policy, the final report and management response will be uploaded into UNICEF evaluation database and relevant websites.

Scope

Institutional scope: While noting the multi-agency dimensions in the cholera response, in particular, the role played by other agencies, including WHO, this RTE is limited to evaluating the work of UNICEF and its down-stream partners, in responding to the cholera outbreak. However, this needs to be set within the wider framework of the government and agencies involved and analysis of roles, responsibilities and expectations. Within UNICEF, the evaluation will focus on the work of the country office, but does consider support from RO and HQ.

Programmatic focus: The ‘Integrated Cholera Response, Prevention and System Strengthening Plan’ reinforces the ‘integrated approach’, bringing together Health, WASH and C4D interventions to the different levels – household, community, facility and institutional level, and central level to ensure a comprehensive public health approach. The RTE will however focus on the following:

1. How UNICEF and its partners have raised awareness and engaged communities in cholera prevention and treatment through sensitization on the importance of hygiene, sanitation, food safety, and care for patients with Acute Watery Diarrhoea (AWD). It will consider how the social mobilization interventions were diversified and tailored to the local behavioural customs; scale and quality of outreach with the various engagement methods (community meetings, household visits, House to House campaigns, media, interpersonal communication at points of service provision), etc. The RTE will also explore the levels of trust and appreciation by households of the profile of those involved in community engagement at the frontline, depending on access and availability of data.

2. Inter-sectorality within UNICEF response and within broader partnerships – focus will be on effectiveness of the coordination and collaboration between the different sectors within UNICEF’s response, i.e. Health, WASH, C4D, as well as between prevention and treatment interventions. The RTE will explore to what extent the interventions implemented in an integrated manner and complement each other, e.g. whether community campaigns in the most affected areas were complemented by provision of appropriate health services, with interventions for ensuring safe water; how coordination was ensured, if not – why not; and degree such integrated approach had a direct effect on challenges faced by UNICEF or its partners.

3. In addition to these priority areas, UNICEF has given close attention to partnerships and coordination, including working with government and other partners in the response; in
the frameworks of the HCT and inter-cluster collaboration, UNICEF is the WASH cluster lead, is the C4D adhoc sector lead; and in other inter-agency forums and bi-lateral coordination (e.g. with WHO). The RTE will consider this important with a view to determining how far achievements were supported or constrained by these factors.

Geographic focus: It is recognized that the outbreak has not been in a particular location, but has affected various localities and shifted over time. The evaluation team will consider the governorates/districts most affected by the outbreak, and at the inception phase establish a methodology for sampling and visiting affected localities.

Resources: While the evaluation will give priority to the programmatic issues noted above, close attention will also be given to human, supply and financial resources as factors supporting or constraining programme delivery. The evaluation will consider issues of human and financial resource mobilisation, deployment and management, including the consequences of utilizing resources from the ongoing crisis to support the cholera outbreak.

Time frame: The evaluation will consider the entire span of the outbreak, giving particular attention to the period from April 2017 when the outbreak resurged, to-date.

Evaluation Questions

The RTE will be framed using the OECD/DAC evaluation criteria and other criteria specific to evaluation of humanitarian action. Specifically, the evaluation questions below will need to be refined by the evaluation team during the inception phase of the RTE process.

1. Appropriateness: To what extent has UNICEF’s response met the needs of women and children in the affected areas? How appropriate has the focus of the social mobilization (Risk Communication and community engagement/C4D), Health and WASH interventions been in reaching the most affected populations? How well have these messages been understood, and have they influenced change of behaviours by household members (e.g. hand washing with water and soap at critical times, water treatment, food handling, and solid waste disposal, care for patients with AWD, seeking medical consultations)?

2. Coordination: How effectively and efficiently has UNICEF fulfilled its sectoral leadership obligations? How effectively has UNICEF coordinated its response with other key actors? Internally, how effective, efficient and timely has coordination between the various sectors been – ie. Health, WASH, C4D, as well as between prevention and treatment interventions? To what extent have the various programmatic interventions complemented each other? For example, were

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community campaigns in the most affected areas complemented by provision of appropriate health services, with interventions for ensuring safe water? How was inter-sectoral coordination ensured, if not – why not?

3. **Effectiveness:** How successful has UNICEF been in achieving the aims set out in the Cholera Response Plan – e.g. the containment and prevention activities for which UNICEF has provided leadership in the response? What factors contributed to success and what factors constrained UNICEF success? To what extent are the results achieved attributable to UNICEF? Were affected communities satisfied that their needs and expectations were adequately acknowledged and addressed? Were the results achieved broadly equitable and were the needs of children and women adequately met?

4. **Efficiency:** What costing options were considered for each intervention, and how was the optimum costing option selected? How did actual costs vary from planned costs? How timely or delayed was the response?

5. **Coverage:** To what extent was the affected population adequately identified, targeted and reached by UNICEF and its partners with key Health, WASH, C4D interventions? How successful has UNICEF been in reaching the most vulnerable groups, including children? Which community interventions as seen as most successful, and why?

6. **Connectedness:** To what extent is the UNICEF response to the cholera outbreak contributing to longer-term goal of enhancing preparedness and prevention of future outbreaks, and systems strengthening to improve resilience and capacity to respond rapidly and efficiently?

The above questions will be discussed with the YCO, and modified at the inception phase of the RTE. The availability of data to assess each one of the areas mentioned above has to be first determined during the inception phase, and based on data availability, above questions may need to be modified.

**Methodology and Approach**
Due to the complex context of the country and the ongoing conflict, the RTE will heavily rely on existing information and analysis, and will include undertaking a document review of programme reports, meeting reports, SITREPS, reports from reviews, joint missions, and programme information that is available at the YCO, the RO or within HQ Divisions. The YCO has contracted Third Party Monitors, who have generated useful reports that may be used by the RTE team.
While recognizing the constraints of time, resources, and being sensitive to the continuing burden on all involved in the response, the evaluation process will aim to be systematic and evidence-based, taking care to triangulate and verify data and analysis. If possible, some non-representative, qualitative primary data collection will be undertaken. The evaluation will be focused on utilisation and will aim to engage staff at key moments in the process and generate material in user-friendly formats.

**Limitations of the RTE**

The following limitations of the proposed evaluation can be identified at this early stage:

1. The RTE will not resolve the issue of inappropriate case-count. However, the planned actions to improve case-identification will contribute to better estimate UNICEF’s response to the crisis. If the mentioned planned action has been initiated, a rapid review of the process may be considered.

2. Due to the complex context of the country, the RTE will heavily rely on secondary analysis of existing documentation. Primary data may be collected on small scales using qualitative methods, if evaluation team is given the necessary access and permissions granted for the data collection. Thus, statistically significant results should not be expected.

3. The RTE cannot provide knowledge of the impact of the response, i.e. it cannot be expected to assess how many children’s lives are saved because UNICEF’s interventions; or to fully explain the cholera-cases curve.

4. Visas to Yemen are becoming increasingly more difficult to obtain, remote interviews may be the only option if Visas cannot be obtained for the evaluation team.

**Management and Governance Arrangements**

In keeping with the corporate nature of the UNICEF response, the Evaluation Office will manage the evaluation, in close collaboration with the Country Office, the Regional Office, and relevant HQ Divisions. An evaluation Manager will lead the process, under the guidance of the Evaluation Office Director. The Evaluation Office will commission a team of external consultants to undertake the evaluation, and provide overall management of the evaluation process.

A small Reference Group for the evaluation will be established, and this Team will contribute to ensuring the relevance, accuracy and hence credibility and utility of the evaluation. The Reference Group will have an advisory role, the main responsibility being to review and comment on key evaluation outputs (i.e. this TOR, the Inception Report, reports on emerging findings, the Draft and Final Reports). Final decisions on the evaluation process and quality assurance of outputs rests with the Evaluation Office.
Deliverable and Estimated Timeframe

The Real Time Evaluation will be undertaken over an estimated period of 45 days spread over twelve weeks, from end of November 2017 to end of February 2018. It will involve a mission to Yemen.

<table>
<thead>
<tr>
<th>Deliverable (Level of Effort)</th>
<th>Due by</th>
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<tbody>
<tr>
<td>Inception report (5 Days)</td>
<td>27 Nov 2017</td>
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<tr>
<td>Field Work (16 Days)*</td>
<td>03 to 18 Dec</td>
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<tr>
<td>Presentation at exit meeting (included in above)</td>
<td>18 Dec 2017</td>
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<tr>
<td>Data analysis (5 Days)</td>
<td>5 January 2018</td>
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<tr>
<td>First Draft Report without recommendations (7 Days)</td>
<td>12 January 2018</td>
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<tr>
<td>Second Draft Report with suggested-draft recommendations (5 days)</td>
<td>02 Feb. 2018</td>
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<tr>
<td>Workshop on finalizing recommendations (3 Days)</td>
<td>09 Feb. 2018</td>
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<tr>
<td>Final report (4 Days)</td>
<td>20 Feb 2018</td>
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* Based on assumption that Visas can be obtained on a timely basis for the evaluation team.

Evaluation Team Composition and required Competencies

We are looking to recruit a team of three external (Individual) consultants to conduct the Real Time Evaluation for the UNICEF’s Response to the Cholera Outbreak in Yemen. Qualified Individuals (preferably applying as a Team) that have the capabilities to meet the following requirements, and are available for the evaluation period indicated, are invited to submit an application. Individual contracts will be issued to each team member. The estimated level of effort required is presented in the next section of this ToR.

a) A team leader with extensive evaluation experience in humanitarian approaches and programmes, experience in public health would be an advantage. The team leader should have at least twelve years of experience in leading evaluations and excellent writing and communication skills in English.

b) One senior consultant with evaluation experience in humanitarian approaches and programmes. The senior consultant should have at least eight years of experience in evaluations of humanitarian action and good writing and communication skills in English.

c) The team leader and senior consultant together should have the following range of competences, preferably in conflict settings:

   i. familiarity with UNICEF emergency operations, especially in Public Health Emergencies, WASH and C4D interventions
ii. experience and knowledge of approaches to community care, including infection prevention and control

iii. familiarity with methods and approaches to C4D including social mobilisation and community engagement

iv. ability to undertaking back-office analysis (e.g., desk review, analysis of timeline data, analysis of funding resources, etc.).

v. knowledge of evaluation methods

vi. sound knowledge of English; knowledge of Arabic will be an added asset

d) A national consultant with comprehensive knowledge of Yemen, and familiar with participatory methods and techniques to promote consultations with communities affected by the outbreak. The national consultant should have experience in qualitative data collection and analysis, including leading Focus Group Discussions; seeking view of affected community, and monitoring of programme implementation.

The team leader will work on the evaluation full time from start to finish, and in a timely and high-quality manner. S/He will be responsible for managing and leading the evaluation Team, undertaking the data collection from UNICEF and available sources; analysis, conducting the participatory workshops, as well as report drafting, report finalization and dissemination. Other team members will be responsible for carrying out data collection from UNICEF and available sources, analysis, and drafting elements of the report.

Estimated Level of Effort

- Team Leader – 45 Days
- Senior Consultant – 25 Days
- National Consultant – 25 Days

How to apply:

The Application Package should include the following:

a) Cover letter, indicating you are applying for the Consultancy to undertake: ‘The Real Time Evaluation of the UNICEF’ Response to the Cholera Outbreak in Yemen’

b) Candidates should indicate in the email subject the position they are applying for: e.g. Team Leader; Senior Consultant; or National Consultant; and the name the RTE. Example provided below:

Email Subject: Application to undertake the ‘Real Time Evaluation of UNICEF’s Response to the Cholera Outbreak in Yemen’ – Team Leader
c) Updated CV/Resume, and completed Personal History Profile (P11); (a blank P11 can be found at http://www.unicef.org/about/employ/files/P11.doc)

d) A sample report of a similar exercise/subject or an evaluation report, with a clear indication of the applicant’s contribution in the report; (hyperlinks to the document are preferred)

e) Availability and daily fee.

The application should be transmitted via email by **November 3, 2017**, at the very latest, using the following email: evalofficeapplications@unicef.org, with copy to jmwangi@unicef.org and lolsen@unicef.org. For any questions or clarifications, kindly contact: Jane Mwangi, Evaluation Specialist; jmwangi@unicef.org; with copy to Koorosh Raffii, Senior Evaluation Specialist, Humanitarian; kraffii@unicef.org.