**SPECIFIC TERMS OF REFERENCE**

**Final Evaluation of the Health System Strengthening Programme in Zambia**

**FWC SIEA 2018 – LOT 4 – Human Development and Safety Net EuropeAid/138778/DH/SER/multi**

**FED/2019/411-428**

**Contracting Authority: Delegation of the European Union to the Republic of Zambia and COMESA**

[1 BACKGROUND 2](#_Toc23432476)

[1.1 Relevant Zambia background 2](#_Toc23432477)

[1.2 The Actions to be evaluated 6](#_Toc23432478)

[1.3 Stakeholders of the Action 9](#_Toc23432479)

[1.4 Other available information 9](#_Toc23432480)

[2 DESCRIPTION OF THE EVALUATION ASSIGNMENT 10](#_Toc23432481)

[2.1 Objectives of the evaluation 10](#_Toc23432482)

[2.2 Requested services 11](#_Toc23432483)

[2.3 Phases of the evaluation and required outputs 12](#_Toc23432484)

[2.4 Specific Contract Organisation and Methodology (Technical offer) 16](#_Toc23432485)

[2.5 Management and Steering of the evaluation 16](#_Toc23432486)

[2.6 Language of the Specific contract 17](#_Toc23432487)

[3 EXPERTISE REQUIRED 18](#_Toc23432488)

[3.1 Number of experts and of working days per category 18](#_Toc23432489)

[3.2 Expertise required 18](#_Toc23432490)

[3.3 Presence of management team for briefing and/or debriefing 19](#_Toc23432491)

[4 LOCATION AND DURATION 20](#_Toc23432492)

[4.1 Starting period 20](#_Toc23432493)

[4.2 Foreseen duration of the assignment in calendar days 20](#_Toc23432494)

[4.3 Planning, including the period for notification for placement of the staff 20](#_Toc23432495)

[4.4 Location(s) of assignment 20](#_Toc23432496)

[5 REPORTING 22](#_Toc23432497)

[5.1 Content, timing and submission 22](#_Toc23432498)

[5.2 Use of the EVAL module by the evaluators 22](#_Toc23432499)

[5.3 Comments on the outputs 23](#_Toc23432500)

[5.4 Assessment of the quality of the Final Report and of the Executive Summary 23](#_Toc23432501)

[5.5 Language 23](#_Toc23432502)

[5.6 Number of report copies 23](#_Toc23432503)

[5.7 Formatting of reports 23](#_Toc23432504)

[Annex I: Specific Technical Evaluation Criteria 24](#_Toc23432505)

[Annex II: Information that will be provided to the evaluation team 25](#_Toc23432506)

[Annex III: Structure of the Final Report and of the Executive Summary 26](#_Toc23432507)

[Annex IV: Planning schedule 28](#_Toc23432508)

[Annex V: Quality Assessment Grid 29](#_Toc23432509)

[Annex VI: logical framework matrix (logframe) of the evaluated action(s) 33](#_Toc23432510)

[Annex VII: STAKEHOLDER LIST 37](#_Toc23432511)

# BACKGROUND

## Relevant Zambia background

Equal distribution and access to health care, essential drugs and medical materials are a challenge in Zambia, a country covering a vast area of 752,612 square kilometres[[1]](#footnote-2), almost twice the size of Germany and equal to that of Turkey. Zambia has a population of approximately 17.4 million[[2]](#footnote-3) in 2019 (up from 15.5 in 2015) of which 60% resides in rural areas and 40% in urban settings[[3]](#footnote-4). Zambia has one of the highest fertility rates in the world, resulting in a net increase in the population of around 3% per year, or a net increase of approximately 400,000 new citizens during 2015. Due to the average density of only 19 people per square kilometre (Germany = 229 and Turkey = 93), and even lower in rural areas, small quantities of drugs have to be transported over large distances, which is especially a challenge in the rural areas where only 14% of the roads are paved[[4]](#footnote-5).

Zambia is a lower middle-income country with a gross domestic product of EUR 1,346 per capita in 2018 (EUR 1,315 in 2013) compared to EUR 2,862 for Kosovo 2013, Europe’s poorest country, and EUR 25,822 for the EU on average[[5]](#footnote-6). The gross national income has been growing at a robust rate of 6-7% per year during the last decade but was slowing down during 2015 and is today at 3.8% (2018). In 2010 and 2018 agriculture contributed around 9% and 3% of the national income respectively, and industry 32% and 36% respectively (in which the mining of copper and cobalt plays a significant role). In 2018, Official Development Assistance (ODA) amounted to 3.8% of GDP, down from 4.5% in 2010.

Zambia is a relatively peaceful country. Its development agenda, as detailed in Vision 2030 as well as in the Seventh National Development Plan (7NDP), focuses on stimulating economic growth through boosting its competitive potential, and reducing hunger and poverty (the p[overty headcount ratio in 2010 was 64.4% and 57.5% in 2018](http://data.worldbank.org/indicator/SI.POV.NAHC/countries/ZM?display=graph)[[6]](#footnote-7)) with the aim of reaching the status of an upper middle income country by 2030. Furthermore, the National Decentralization Plan, which also includes more autonomy for local governments with respect to primary health care (PHC), was revised and approved in 2013; however, implementation of decentralisation remains slow.

Total nominal expenditure on health has been steadily increasing from ZMW 7.1 billion in 2013 to ZMW 9.7 billion in 2016. However, over the same period the expenditure per capita has fallen from USD 90.33 to USD 58.87 showing that the additional resources allocated for the health sector did not follow the increase in the population[[7]](#footnote-8). Total health expenditure as percentage of GDP has been relatively stable over the years with 4.6% in 2010, 4.7% in 2013, and 4.5% in 2016. Government’s spending has increased from 28% in 2013 to 41% in 2016 and Official Development Assistance (ODA) has fallen during the same period from 57% to 43%. From 2011 to 2013, 95% of the ZMW 7.5 billion provided by the partners was allocated to: HIV; reproductive, maternal, new-born child health (RMNCH) and nutrition; malaria and TB. From 2013 to 2016 out of pocket payment has been fairly constant with 12% in average and so have employers' contribution at 5%. The share allocated for essential medicines and medical materials has doubled, from 7% in 2008 to 14% in 2014[[8]](#footnote-9).

Public health care is financed by the government through an approved budget, of which actual disbursements are normally much less. Public health care provides general coverage with free access to services (the last user fee was abolished in 2012). Although the share of household spending on health was reduced from 28% in 2003 to 7% in 2010, drugs still account for 42% of the USD 14 per capita households spent in 2014[[9]](#footnote-10). In principle, patients do not pay for essential medicines, which are part of the national health care package. However, in the case of stock-outs, patients have to buy out of pocket. With a poverty headcount ratio of more than 60%, and only 4% of the population being covered by health insurance, ill health has a devastating cost implication for the majority of the population who live in poverty. The Government is addressing this issue and a new health insurance system with elements of universal coverage is being introduced gradually since 2017.

Health services are per 1 January 2019 provided by a network of 3,023 health care facilities[[10]](#footnote-11) (see Table 1), consisting of government institutions (78%), Churches Health Association of Zambia (CHAZ) (3%), mining and other industrial companies and private health facilities (19%), delivering a basic benefit package, or a National Health Care Package, within an institutional system consisting of 5 levels. Third Level Hospitals (specialist or tertiary hospitals – THC) consisting of national hospitals as the highest level of referral, each cater for a catchment population of above 800,000 with sub specializations in internal medicine, surgery, paediatrics, obstetrics, gynaecology, intensive care, psychiatry, training and research. Second Level Hospitals (provincial, general hospitals or secondary health care - SHC), serve a catchment area of between 200,000 and 800,000 people, with services in internal medicine, general surgery, paediatrics, obstetrics and gynaecology, dental, psychiatry and intensive care services. Secondary health care hospitals also act as referral for the tertiary health care hospitals. First Level Hospitals (District Hospitals) serve a population of between 80,000 and 200,000 and provide services such as medical, surgical, obstetric and diagnostic services and are the recipient of referrals from the health centres. Health Centres are divided into three levels: Urban Health Centres or clinics (UHCs), serving a catchment population of between 30,000 and 50,000 people; Rural Health Centres (RHCs), with a population of around 10,000 people; and Health Posts (HP) serving an area of approximately 3,500 people (in very rural settings between 1,000 and 7,000 people).

In 2012, the Ministry of Community Development Mother and Child Health (MCDMCH) became responsible for the provision of primary health care (PHC). PHC was in 2015 transferred back to MoH. PHC includes the facilities from district hospitals down to health posts. These are operated by the original 103 Districts Health Offices (now 110 districts). Secondary and tertiary health care facilities are under the authority of the MoH, where the 10 provincial Health Officers operate the provincial hospitals and the MoH operates the national hospitals. In addition, the Ministry of Defence and the Ministry of Internal Affairs operate their own health facilities.

The government has prioritised an increase in the number of health facilities as is illustrated in Table 1. During the 6-year period from the end of 2012 to the beginning of 2019 the number of health facilities has increased from 1,956 to 3,023, equal to an average of 9% increase per annum (pa). Although, the public sector has added 779 facilities during the period, the highest increase in percentage terms was in the private sector.

Table 1: Number of health facilities (HF) and ownership



Source: Ministry of Health

The profile of the **burden of diseases** in Zambia matches well with the profile of other lower middle-income countries: a high level of communicable diseases and injuries as well as a relatively low level of non-communicable diseases. Data for the burden of diseases for Zambia is provided in Figure 1.

The population is utilising the health system relatively well compared to the regional average, with a high rate of antenatal care visits and immunization. However, there is a low attendance of skilled health personnel at deliveries, as shown in Figure 2. This could impact the delivery of health services, despite the high rate of visits by citizens.

As a result, Zambia has, during the last decade, made significant progress in respect to HIV/AIDS, malaria, under five mortality (from 192 to 89 deaths per 1,000 live births between 1990 and 2012[[11]](#footnote-12)) and maternal mortality. This has also been visible in the improvement in life expectancy which has increased from 57 years in 2012 to 64 years in 2018. However, these improvements have not been sufficient to bring Zambia’s overall health outcome indicators ahead of its regional peers.

|  |  |  |
| --- | --- | --- |
| Figure 1: Overview of burden of diseases |  | Figure 2: Utilisation of health services  |
|  |  |  |

Table 2: Selected overall outcome indicators





## The Action to be evaluated

|  |  |
| --- | --- |
| Titles of the Action to be evaluated | Financing Agreement (FA) of the Health System Strengthening Programme (HSSP) |
| Budgets of the Action to be evaluated | FA HSSP: EUR 18 million  |
| CRIS numbers of the Action to be evaluated | FA HSSP: FED/2013/023-203 (all works, supply, programme estimate, grant and service contracts with their CRIS numbers are listed in the table below) |
| Dates of the Action to be evaluated | From 20/12/2013 to 31/07/2020 (N.B. the FA has recently been extended until 20.06.2021. However activities under the FA are expected to completed by 31/07/2020). |

The **Overall Objecti**ve of the Financing Agreement (FA) for the Health System Strengthening Programme (HSSP) is to improve the health status of people in Zambia in order to contribute to the socio-economic development of the country [see the Logical Framework Matrix (Logframe) included in annex VI]. The Objectively Verifiable Indicators (OVI) are: a) Maternal Mortality Rate, b) Infant Mortality Rate, and c) Life Expectancy at Birth.

There are two **Specific Objectives (SO)**:

* **SO1**: Improvement of availability of quality assured essential medicines in public and private health care and contribute to rational and correct use of essential medicines in Zambia, with OVIs related to: a) Increase in availability of essential medicines, b) Increase in quality, and c) Improvement in rational use.
* **SO2**: Support the MCDMCH[[12]](#footnote-13) and MoH with policy development and implementation. The OVIs for SO2 are: a) Number of policies and strategies under implementation supported by the programme, b) Annual budgetary allocation for the drug supply and c) Number of pharmacists specialised in the public sector.

There are four **Expected Results** as follows:

* **Result 1**: ZAMRA is effectively executing its quality control and regulatory functions, with six OVIs: a) Status of improved organisational capacity, b) Status of the new NMQCL and ZAMRA's headquarters, c) Improvement of quality management, d) Status of increased capacity in licensing, surveillance and enforcement, e) Status of improving the Market Authorisation (MA) capacity, and f) Status of improving regulations.
* **Result 2**: Improved effectiveness and cost-efficiency of the pharmaceutical procurement and supply management system, with the following OVIs: a) Status of the MoU for the gradual transfer of procurement to MSL, b) The existence of and progress on the action plan towards certification as procurement agent, c) Status of MSL's capacity strengthening plan (CSP) and overall strategic plan (SP), and d) Number of pallets of medicines and medical supply handled by MSL annually.
* **Result 3**: Progress towards rational drug use (RDU), with the following OVIs: a) % of health facilities with functioning Pharma-Therapeutic Committees, b) % of health facilities with access to up-to-date standard treatment guidelines, c) Number of people in procurement and supply chain management (PSCM) whose skills and knowledge on RDU have improved through successful completion of on-line masters in a relevant field, and d) Evidences on rational use improved in Zambia: Institutional drug use study conducted.
* **Result 4**: The MoH and the MCDMCH[[13]](#footnote-14) have developed the required capacities and policies in the areas of Health Information System[[14]](#footnote-15), financing and other strategic areas, with the following OVIs: a) Status of the PSCM technical working group (TWG), b) Existence/use of a M&E framework on PSCM and, c) Number of health-related policies/strategies developed/updated with support from HSSP.

As described above the HSSP combines measures for improving logistics with actions for strengthening pharmaceutical regulation and building the capacity of three key government agencies: Ministry of Health (MOH), Zambia Medicines Regulatory Authority (ZAMRA) and Medical Stores Limited (MSL). The Action focused on strengthening management systems in the Zambia health system by strengthening strategic and institutional capacities.

One of the key outputs is the construction of a National Medicines Quality Control Laboratory (NMQCL) and ZAMRA’s office premises. The aim of the laboratory is to provide support to the functions of ZAMRA by providing modern analytical services, advice and investigations in order to ensure the conformity of pharmaceutical products and allied substances such as medical devices, herbal products, cosmetics etc. The aim is to set standards thereby safeguarding public health.

Another key output is the award of a grant to MSL for the construction of the modern warehouse and offloading bays to improve storage and distribution of medicines and other allied products. The grant was subject to the condition by the EU that the MOH gradually transfers the role of procurement to MSL, enabled partly by the Memorandum of Understanding (MoU) signed between MoH and MSL and partly by the foreseen Bill on The National Medical Store Agency.

The above description of the programme is based on the existing Logframe, which is included as Annex VI. The Logframe was updated following recommendations from the Results Oriented Mission (ROM) that took place in July 2017, and is the version that is included as Annex VI. It is understood that it is standard practice for the evaluators to reconstruct the intervention logic during the Inception Phase of the final evaluation in order to define an appropriate methodological approach, to finalise the evaluation questions, and to identify the most suitable indicators.

The following contracts comprise the HSSP programme, and should be examined as part of this evaluation:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Contract** | **Title****Contracting party**  | **Nature** | **Contractor signature date** | **End date of activities** | **Currency** | **Amount** **(EUR)** |
| [FED/2014/344-470](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratlm.cfm?action=showfromlist&key=344470)  | Technical Assistance to Medical Stores and Ministry of HealthINTERNATIONAL CONSULTING EXPERTISEGEIE | SERVICE  | 06/11/2014  | 31/01/2016  | EUR | 214,359.16  |
| [FED/2014/350-625](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratme.cfm?action=showfromlist&key=350625)  | Specific ToRs for a Pharmaceutical Sector Expert for Mid-Term Review of Zambia's National Health Strategic Plan 2011-2016JOHN SNOW INCORPORATED | SERVICE  | 27/10/2014  | 30/04/2015  | EUR | 25,700.00  |
| [FED/2015/362-468](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratme.cfm?action=showfromlist&key=362468)  | Health Systems Strengthening – Support to the Ministry Of Health (MoH) And The Zambia Medicines Regulatory Authority (ZAMRA)PROJECT MANAGEMENT LIMITED | SERVICE  | 22/07/2015  | 16/12/2019  | EUR | 4,700,389.00  |
| [FED/2015/362-787](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratme.cfm?action=showfromlist&key=362787)  | PE1 - SUPPORT TO RATIONAL DRUG USE IN ZAMBIAREPUBLIC OF ZAMBIA | PE  | 20/12/2013  | 30/06/2017  | EUR | 548,904.72  |
| [FED/2016/376-696](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratlm.cfm?action=showfromlist&key=376696)  | Technical Audit to support the Zambia Medicines Regulatory Authority (ZAMRA) with Evaluation of Offers and Monitoring the Construction of the National Medcines Quality Control Laboratory and the Office Complex.EURONET CONSULTING | SERVICE  | 01/09/2016  | 05/10/2018  | EUR | 48,755.00  |
| [FED/2016/377-843](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratme.cfm?action=showfromlist&key=377843)  | PE 1 - Zambia Medicines Regulatory Authority (ZAMRA)THE ZAMBIA MEDICINES REGULATORY AUTHORITY | PE  | 20/12/2013  | 14/03/2018  | EUR | 67,376.27  |
| [FED/2016/382-214](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratme.cfm?action=showfromlist&key=382214)  | Construction of the National Medicines Quality Control Laboratory (NMQCL) and Office Complex for the Zambia Medicines Regulatory Authority (ZAMRA)WAH KONG ENTERPRISES LIMITED | WORKS  | 20/12/2016  | 08/02/2019  | EUR | 4,500,000.00  |
| [FED/2017/380-101](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratsv.cfm?action=showfromlist&key=380101)  | Support to Phase 2 of the Master Plan to Improve Storage Capacity and Efficiency at Medical Stores Limited (MSL) in LusakaMEDICAL STORES LIMITED | GRANT  | 13/12/2017  | 13/12/2019  | EUR | 4,822,000.00  |
| [FED/2017/387-218](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratme.cfm?action=showfromlist&key=387218)  | PE2 - SUPPORT TO RATIONAL DRUG USE IN ZAMBIAREPUBLIC OF ZAMBIA | PE  | 20/12/2013  | 31/07/2018  | EUR | 133,802.73  |
| [FED/2018/397-702](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratme.cfm?action=showfromlist&key=397702)  | PE2 - Support to the Zambia Medicines Regulathory Authority (ZAMRA)THE ZAMBIA MEDICINES REGULATORY AUTHORITY | PE  | 20/12/2013  | 30/11/2019  | EUR | 711,858.70  |
| [FED/2018/403-631](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratme.cfm?action=showfromlist&key=403631)  | Supply, Delivery, Installation and Operation Qualification (IQ/OQ) of Chromatographic Equipment, PCs, Printers and Software, including user training, for the new National Medicines Quality Control Laboratory (NMQCL) – Lot 2THESEUS LAB SRO | SUPPLY  | 14/12/2018  | 30/11/2019  | EUR | 171,569.23  |
| [FED/2018/403-688](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratme.cfm?action=showfromlist&key=403688)  | Supply, Delivery, Installation and Operation Qualification (IQ/OQ) of Spectrophotometric Equipment, PCs, Printers and Software, including user training, for the new National Medicines Quality Control Laboratory (NMQCL) – Lot 3Q & T SPA | SUPPLY  | 14/12/2018  | 30/11/2019  | EUR | 180,500.32  |
| [FED/2018/403-709](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratme.cfm?action=showfromlist&key=403709)  | Supply, Delivery, Installation and Commissioning of Laboratory Equipment and other Laboratory Materials for the new National Medicines Quality Control Laboratory (NMQCL) – Lots 5, 6 and 7TECHNICAL ENTERPRISES CO SARL | SUPPLY  | 18/12/2018  | 30/11/2019  | EUR | 451,598.00  |
| [FED/2018/404-207](http://www.cc.cec/EUROPEAID/cris/saisie/contrat/contratme.cfm?action=showfromlist&key=404207)  | Supply, Delivery, Installation and Operation Qualification (IQ/OQ) of Dissolution Testing Equipment, Including User Training, for the new National Medicines Quality Control Laboratory (NMQCL) – Lot 1THESEUS LAB SRO | SUPPLY  | 18/12/2018  | 30/11/2019  | EUR | 89,927.73  |

## Stakeholders of the Action

As mentioned above the three main stakeholders are MOH, ZAMRA and MSL. However, the implementation of the HSSP has been under indirect management with the National Authorising Office (NAO) in the Ministry of Finance and it has been coordinated with the other CPs in the health sector. See the detailed stakeholder-list included as Annex VII.

## Other available information

Following the signing of the FA at the end of 2013 the EUD requested the analysis of the Supply Chain Capacities, Bottlenecks and Way-forward for Improving Access to Essential Medicines and Medical Materials that has provided the analytical framework that together with the National Health Strategic Plans has provided the strategic direction for the implementation of the HSSP.

Steering of the HSSP was conducted based on annual Steering Committee meetings, with the more technical coordination through the monthly Technical Working Group meetings.

Actions undertaken were reported through the eight semi-annual reports issued by the technical assistant (TA) contractor – i.e. the technical/narrative progress reports under contract FED/2015/362-468. Furthermore, the Final Report provides a very good overview of outputs delivered and results achieved.

A Result Oriented Monitoring (ROM) Mission was conducted from 19-27 June 2017. With respect to relevance, the final report concludes that the HSSP is highly relevant as it aligns well with Zambia's priorities and plans as outlined in the National Development Plan and the National Health Strategic Plan. The efficiency was assessed to be appropriate with regard to the implementation modality of the various components – works, supplies and services/technical assistance contracts as well as programme estimates. The ROM noted that the HSSP is implemented under the Indirect Management with ex ante control through the Financing Agreement with the NAO as the contracting authority for this Action. Concerning effectiveness, the ROM concluded that the Action has made good progress towards achieving the expected outcomes, although these were not expressly tracked or reported on due to the lack of outcome indicators; the reports mainly focused on output achievement. The ROM noted that the delivered outputs are satisfactory and highly rated and appreciated by partners. The infrastructure – such as the improved warehouse – was reported to be of good quality, which was directly observable and also rated by the staff. At the time of the ROM the laboratory construction was at a very basic stage, but appeared to be of good quality.

The information to be provided to the evaluators is detailed in Annex II.

# DESCRIPTION OF THE EVALUATION ASSIGNMENT

The evaluation described in this ToR is a final evaluation, detailed as follows:

|  |  |
| --- | --- |
| Type of evaluation | Final  |
| Coverage | Financing Agreement for the Health System Strengthening Programme (FA HSSP) in its entirety |
| Geographic scope | Zambia |
| Period to be evaluated | From 20/12/2013 to 31/07/2020 (N.B. the FA has recently been extended until 20.06.2021. However activities under the FA are expected to completed by 31/07/2020). |

## Objectives of the evaluation

Systematic and timely evaluation of its programmes and activities is an established priority[[15]](#footnote-16) of the European Commission[[16]](#footnote-17). The focus of evaluations is on the assessment of achievements, the **quality** and the **results**[[17]](#footnote-18) of Actions in the context ofan evolving cooperation policy with an increasing emphasis on **result-oriented approaches and the contribution towards the implementation of the SDGs**.[[18]](#footnote-19)

From this perspective, evaluations should **look for evidence of why, whether or how these results are linked to the EU intervention** and seek **to identify the factors driving or hindering progress**.

Evaluations should provide an understanding of the **cause and effect links** between: inputs and activities, and outputs, outcomes and early signs of impact. Evaluations should serve accountability, decision making, learning and management purposes.

The main objectives of this evaluation are to provide the relevant services of the European Union and the interested stakeholders with:

* an overall independent assessment of the past performance of the HSSP paying particular attention to its results measured against its expected objectives; and the reasons underpinning such results;
* key lessons learned, conclusions and related recommendations in order to improve future Actions.

In particular, this evaluation will serve to provide an understanding of the performance of the HSSP, its enabling factors and those hampering a proper delivery of results, so as to inform the planning of future EU interventions and Actions in the same or similar sectors.

The main users of this evaluation will be the EUD in Zambia, the NAO, MoH, ZAMRA and MSL, as well as other CPs operating in the health sector in Zambia.

## Requested services

### Scope of the evaluation

The evaluation will assess the HSSP using the five standard DAC evaluation criteria, namely: relevance, effectiveness, efficiency, sustainability and impact. In addition, the evaluation will assess the two EU specific evaluation criteria:

1. the EU added value (the extent to which the Action brings additional benefits to what would have resulted from Member States' interventions only);
2. the coherence of the Action itself, with the EU strategy for the health sector in Zambiaand with other EU policies, Member State Actions, and Actions of the main donors (i.e. CPs) active in the health sector in Zambia.

The evaluation team shall furthermore consider whether gender, environment and climate change were mainstreamed; the relevant SDGs and their interlinkages were identified; the principle of Leave No-One Behind and the rights-based approach methodology was followed in the identification/formulation documents and the extent to which they have been reflected in the implementation of the Action, its governance and monitoring.

The following specific aspects should be evaluated:

* The alignment of the HSSP to the national priorities in the National Health Strategic Plans;
* The relevance of the activities implemented during the HSSP to achieve the results;
* The ability of the partners to translates output into results.

### Issues to be addressed

The issues to be addressed as formulated below are indicative. Based on the latter and following initial consultations and document analysis, the evaluation team will discuss them with the Evaluation Manager[[19]](#footnote-20) and propose in their Inception Report a complete and finalised set of Evaluation Questions with indication of specific Judgement Criteria and Indicators, as well as the relevant data collection sources and tools.

Once agreed through the approval of the Inception Report, the Evaluation Questions will become contractually binding.

Besides formulation of Evaluation Questions (EQs) for the standard DAC and EU criteria (Relevance, Efficiency, Effectiveness, Impact, Sustainability, EU added value and coherence of the Action) the evaluators are specifically requested to suggest EQs for the specific issues mentioned below. To this end it is important that the evaluation is conducted as a global evaluation of the overall programme.

The specific issues to be addressed:

1. The alignment of the HSSP to the priorities in the National Health Strategic Plans;
2. The relevance of the activities implemented during the HSSP to achieve the results;
3. How well the various components of the HSSP contributed to the expected results of the overall programme;
4. The extent to which the components of the HSSP were coordinated in a synergic way;
5. The appropriateness of the governance system of the HSSP and implementation modalities;
6. The ability of the partners to translates outputs into results;
7. The extent to which the ROM recommendations were implemented and with what results.

## Phases of the evaluation and required outputs

The evaluation process will be carried out in five phases as follows:

* Inception
* Desk
* Field
* Synthesis
* Dissemination

The outputs of each phase are to be submitted at the end of the corresponding phases as specified in the synoptic table in section 2.3.1.

### Synoptic table

The following table presents an overview of the key activities to be conducted within each phase and lists the outputs to be produced by the team as well as the key meetings with the Contracting Authority and the Reference Group. The main content of each output is described in Chapter 5.

| **Phases of the evaluation** | **Key activities** | **Outputs and *meetings*** |
| --- | --- | --- |
| **1. Inception Phase***20% of total\** | * Initial document/data collection
* Background analysis
* Inception interviews
* Stakeholder analysis
* Reconstruction (or as necessary, construction) of the Intervention Logic, and/or description of the Theory of Change (based upon available documentation and interviews)
* Methodological design of the evaluation (Evaluation Questions with judgement criteria, indicators and methods of data collection and analysis) and evaluation matrix
 | * *Kick-off meeting with the EUD*
* *Inception meetings with EUD, NAO, MoH, ZAMRA and MSL in person at the EUD in Lusaka*
* Inception Note
* Circulation of Inception Note
* Slide presentation of the Inception Note to EUD NAO, MoH, ZAMRA and MSL
* Updated Inception Note and circulation
 |
| **2. Desk Phase***20% of total\** | * In-depth document analysis (focused on the Evaluation Questions)
* Identification of information gaps and of hypotheses to be tested in the field phase
* Methodological design of the Field Phase
 | * Detailed understanding of the Action
 |
| **3. Field Phase***25% of total\** | * Gathering of primary evidence with the use of the most appropriate techniques
* Data collection and analysis, if defined during a desk phase
 | * *Meetings at different levels with* EUD, *NAO, MoH, ZAMRA, MSL and lead CPs (US Aid, SIDA and WHO)*
* Slide Presentation of key findings of the filed phase
* *Debriefing with EUD in person at the EUD in Lusaka*
 |
| **4. Synthesis phase***25% of total\** | * Final analysis of findings (with focus on the Evaluation Questions)
* Formulation of the overall assessment, conclusions and recommendations
* Reporting
 | * Draft Final Report and circulation
* Executive Summary according to the standard template published in the EVAL module and circulation
* Final Report
* Slide presentation
* *Meeting with* EUD, *NAO, MoH, ZAMRA and MSL in person at the EUD in Lusaka for the Team Leader and via remote teleconference for the other experts*
 |
| **5. Dissemination phase***10% of total\** | * Organisation of the final presentation seminar
* Preparation of dissemination materials
* Design of a colour brochure
* Short film
 | * *Final presentation seminar*
* Brief (max. 20 pages including pictures)
* Film (no more than 5 minutes) showing visual results from the HSSP
 |

### \*Estimated percentage of time to be allocated to each phase

### Inception Phase

This phase aims at structuring the evaluation and clarifying the key issues to be addressed.

The phase will start with a kick-off meeting at the EU Delegation to the Republic of Zambia and COMESA (EUD) with the EUD Evaluation Manager and other EUD colleagues and the evaluators, followed by the inception meeting with the participation of the key partners (EUD, NAO, MoH, ZAMRA and MSL) to be held in Lusaka. These meetings aim at arriving at a clear and shared understanding of the scope of the evaluation, its limitations and feasibility. It also serves to clarify expectations regarding evaluation outputs, the methodology to be used and, where necessary, to pass on additional or latest relevant information.

In the Inception Phase, the relevant documents will be reviewed (see Annex II).

Further to a first desk review of the political, institutional and/or technical/cooperation framework of EU support to Zambia in the health sector, the evaluation team, in consultation with the Evaluation Manager, will reconstruct or as necessary construct, the Intervention Logic of the Action to be evaluated, in order to reflect an updated and shared vision of the intended casual chain underpinning the Action. This reconstruction shall be based on the existing Logframe/Intervention Logic, consultation with key stakeholders and on other key documents of the Action.

Furthermore, based on the Intervention Logic, the evaluators will develop a narrative explanation of the logic of the Action that describes how change is expected to happen within the Action, all along its results chain, i.e. Theory of Change. This explanation includes an assessment of the evidence underpinning this logic (especially between outputs and outcomes, and between outcomes and early signs of impact), and articulates the assumptions that must hold for the Action to work, as well as identification of the factors most likely to inhibit the change from happening.

Based on the Intervention Logic and the Theory of Change the evaluators will finalise: i) the Evaluation Questions with the definition of judgement criteria and indicators, the selection of data collection tools and sources; ii) the evaluation methodology; and iii) the planning of the following phases.

The methodological approach will be represented in an Evaluation Design Matrix[[20]](#footnote-21), which will be included in the Inception Note. The **methodology of the evaluation should be gender sensitive, contemplate the use of sex- and age-disaggregated data and demonstrate how Actions have contributed to progress on gender equality**.

The limitations faced or to be faced during the evaluation exercise will be discussed and mitigation measures described in the Inception Note. Finally, the work plan for the overall evaluation process will be presented and agreed in this phase; this work plan shall be in line with that proposed in the present ToR. Any modifications shall be justified and agreed with the Evaluation Manager.

On the basis of the information collected, the evaluation team should prepare an **Inception Note**; its content is described in Chapter 5.

The Team Leader will present the **Draft Inception Note** to the key stakeholders in Lusaka.

### Desk Phase

This phase is where the in-depth document analysis takes place. The analysis should include a brief synthesis of the existing literature relevant to the Action.

The analysis of the relevant documents shall be systematic and reflect the methodology developed and approved during the Inception Phase.

The activities to be conducted during this phase should allow for the provision of preliminary responses to each evaluation question, stating the information already gathered and its limitations. They will also identify the issues still to be covered and the preliminary hypotheses to be tested.

During this phase the evaluation team shall fine-tune the evaluation tools to be used during the Field Phase and describe the preparatory steps already taken and those to be taken for its organisation, including the list of people to be interviewed, dates and itinerary of visits, and attribution of tasks within the team.

### Field Phase

The Field Phase starts after approval of the Inception Note by the Evaluation Manager.

The Field Phase aims at validating/changing the preliminary answers formulated during the Desk Phase and further completing information through primary research.

If any significant deviation from the agreed work plan or schedule is perceived as creating a risk for the quality of the evaluation or not respecting the end of the validity of the specific contract, these elements are to be immediately discussed with the Evaluation Manager and, regarding the validity of the contract, corrective measures undertaken.

During the field phase, the evaluation team shall ensure adequate contact and consultation with, and involvement of the different stakeholders, including EUD, NAO, MoH, ZAMRA, MSL and lead CPs (USAID, SIDA and WHO). Throughout the mission the evaluation team will use the most reliable and appropriate sources of information, respect the rights of individuals to provide information in confidence, and be sensitive to the beliefs and customs of local social and cultural environments.

At the end of the field phase, the evaluation team will summarise its work, analyse the reliability and coverage of data collection, and present preliminary findings in a meeting with the EUD, NAO, MoH, ZAMRA and MSL.

At the end of the Field Phase an **Intermediary Note AND a Slide Presentation** will be prepared; its content is described in Chapter 5.

### Synthesis Phase

This phase is devoted to the preparation by the contractor of **two distinct documents**: the **Executive Summary** and the **Final Report**, whose structures are described in the Annex III; it entails the analysis of the data collected during the desk and field phases to answer the Evaluation Questions and preparation of the overall assessment, conclusions and recommendations of the evaluation.

The evaluation team will present, in a single Report with Annexes, their findings, conclusions and recommendations in accordance with the structure in Annex III; a separate Executive Summary will be produced as well, following the compulsory format given in the EVAL module (see Annex III).

The evaluation team will make sure that:

* Their assessments are objective and balanced, statements are accurate and evidence-based, and recommendations realistic and clearly targeted.
* When drafting the report, they will acknowledge clearly where changes in the desired direction are known to be already taking place.
* The wording, inclusive of the abbreviations used, takes into account the audience as identified in art. 2.1 above.

The evaluation team will deliver and then present, in Lusaka, the **Draft Final Report** to the Reference Group, including EUD, NAO, MoH, ZAMRA and MSL, to discuss the draft findings, conclusions and recommendations. One day of presence is required – as minimum – by the team leader while the other experts may participate remotely.

The Evaluation Manager consolidates the comments expressed by the Reference Group members and sends them to the evaluation team for the report revision, together with a first version of the Quality Assessment Grid (QAG) assessing the quality of the Draft Final Report. The content of the QAG will be discussed with the evaluation team to verify if further improvements are required, and the evaluation team will be invited to comment on the conclusions formulated in the QAG (through the EVAL Module).

The evaluation team will then finalise the **Final Report** and the **Executive Summary** by addressing the relevant comments. While potential quality issues, factual errors or methodological problems should be corrected, comments linked to diverging judgements may be either accepted or rejected. In the latter instance, the evaluation team must explain the reasons in writing. After approval of the final report, the QAG will be updated and sent to the evaluators via EVAL Module.

### Dissemination phase

Since all the key stakeholders would have the possibility to provide comments on the final report during the synthesis phase, this phase includes the evaluators' dissemination of the **Final Report** and the **Executive Summary.**

In addition, 300 copies of a **high quality full colour brochure** (maximum 20 pages including pictures) and a **professionally edited video** (maximum 5 minutes) should be produced, highlighting the main findings of the evaluation and results achieved. To this end the Framework Contractor should include in its offer a budget for a maximum of EUR 8 000 for the **colour brochure** and a maximum of EUR 15 000 for the **video**. The budget for the **dissemination seminar** (approx. 100 persons) should not exceed EUR 7 000.

## Specific Contract Organisation and Methodology (Technical offer)

The invited Framework Contractors will submit their specific Contract Organisation and Methodology by using the standard SIEA template B-VII-d-i and its annexes 1 and 2 (B-VII-d-ii).

The evaluation methodology proposed to undertake the assignment will be described in the Chapter 3 (Strategy and timetable of work) of the template B-VII-d-i. Contractors will describe how their proposed methodology will address the cross-cutting issues mentioned in these Terms of Reference and notably gender equality and the empowerment of women. This will include the communication action messages, materials and management structures.

In addition to the Final Report, the evaluation results will be disseminated through a seminar (approx. 100 persons), a **colour brochure**[[21]](#footnote-22)(300 copies)and a 5 minute video, following recommendations from the evaluation team and under the supervision of the evaluation contractor. In the technical offer, the framework contractor is expected to indicate how they will ensure that the main messages from the evaluation will be duly reflected in the dissemination outputs.

## Management and Steering of the evaluation

### At the EU level

The evaluation is managed by the Evaluation Manager of the EUD; the progress of the evaluation will be followed closely with the assistance of a Reference Group consisting of members of EU Services and representatives from NAO, MoH, ZAMRA and MSL.

The main functions of the Reference Group are:

* To define and validate the Evaluation Questions.
* To facilitate contacts between the evaluation team and the EU services and external stakeholders.
* To ensure that the evaluation team has access to and has consulted all relevant information sources and documents related to the Action.
* To discuss and comment on notes and reports delivered by the evaluation team. Comments by individual group members are compiled into a single document by the Evaluation Manager and subsequently transmitted to the evaluation team.
* To assist in feedback on the findings, conclusions, lessons and recommendations from the evaluation.
* To support the development of a proper follow-up action plan after completion of the evaluation.

### At the Contractor level

Further to the requirements set in the art. 6 of the Global Terms of Reference and in the Global Organisation and Methodology, respectively annexes II and III of the Framework contract SIEA 2018, the contractor is responsible for the quality of: the process; the evaluation design; the inputs and the outputs of the evaluation. In particular, it will:

* Support the Team Leader in its role, mainly from a team management perspective. In this regard, the contractor should make sure that, for each evaluation phase, specific tasks and outputs for each team member are clearly defined and understood.
* Provide backstopping and quality control of the evaluation team’s work throughout the assignment.
* Ensure that the evaluators are adequately resourced to perform all required tasks within the time framework of the contract.

## Language of the Specific contract

The language of the specific contract is to be English.

# EXPERTISE REQUIRED

## Number of experts and of working days per category

The table below indicates the minimum number of evaluators and the minimum number of working days (overall and in the field), per category of experts to be foreseen by the Contractor.

|  Category of experts | Minimum number of evaluators | Total minimum number of working days (total)  | (Out of which) minimum number of working days on mission |
| --- | --- | --- | --- |
| Cat I | 0 | 0 | 0 |
| Cat II | 3 | 130 | 48 |
| Cat III | 0 | 0 | 0 |

The exact composition of the team is to be established by the framework contractors in their offer. As an indication, the Framework Contractors could consider proposing a team composed of a Team Leader (Cat II), an experienced expert in in supply chain management (Cat II) and an experienced expert in quality assurance of medicines (Cat II). In the preparation of the financial offer, the Framework Contractor is expected to reflect the local market fees in case the expert(s) is (are) hired on the local market.

The Team Leader (to be identified in the Organisation and Methodology and in the Financial Offer) must possess a demonstrable senior evaluation expertise coherent with the requirements of this assignment and must provide no less than 64 working days, out of which 18 in the field.

## Expertise required

**3.2.1 Minimum requirements of the Team Leader – Cat. II expert: (i.e. essential requirements that must be met)**

Qualifications and skills

* At least a taught Master’s degree in International Development, Monitoring & Evaluation, Public Health or a similar relevant area; in its absence, the expert should have a Bachelor's degree plus at least 36 months experience in International Development, Monitoring & Evaluation, Public Health or a similar relevant area (in addition to the general monitoring and evaluation experience indicated in the first bullet under "professional experience").

Professional experience

* At least 72 months cumulative experience in the monitoring and evaluation of development projects, of which 12 months should be in the health sector.
* At least four previous, mid, final or ex-post evaluations as a Team Leader.
* Must have led at least two other evaluations of a similar nature, size and complexity.
* Previous experience with EDF procedures as demonstrated by working in least three EDF funded projects, including the use of Programme Cycle Management and the Logical Framework.

**3.2.2 Minimum requirements of the other Cat. II experts: (i.e. essential requirements that must be met by each expert unless indicated to be met by the team)**

Qualifications and skills

* At least a taught Master’s degree in Pharmacy, Health Logistics, Public Health, Chemistry, Microbiology, or similar relevant area; in its absence, the expert should have a Bachelor's degree plus at least 36 months experience in Pharmacy, Health Logistics, Public Health, Chemistry, Microbiology, or similar relevant area (in addition to the experience indicated in the first or second bullet under "professional experience").

Professional experience

* **At least one member of the team:** At least 48 months of experience in developing and implementing pharmaceutical testing laboratory quality management systems (QMS) for medicines and allied substances within a medicines regulatory environment (preferable), or the pharmaceutical industry.
* **At least one member of the team:** At least 48 months of experience as a medicines supply chain expert. Experience/knowledge in at least three of the following areas is required: i) large-scale medicines warehousing and distribution and operations; ii) knowledge of pharmaceutical infrastructure and distribution; iii) medical stores operations; iv) and supply change management in the public health sector.
* At least two mid, final or ex-post evaluations during the past 5 years[[22]](#footnote-23).

**3.2.3 Additional requirements of the entire team of Cat. II experts: (i.e. not essential requirements but preferred)**

* Experience in developing countries, particularly the Sub-Saharan African Region, is an added advantage.

**3.2.4. Language and other skills of the team:**

* English: all CAT II experts must possess at least a level C1 expertise.
* Excellent communication skills.
* Excellent computer skills (MS Office: Word, Excel, PowerPoint or similar).

Languages levels are defined for understanding, speaking and writing skills by the Common European Framework of Reference for Languages available at <https://europass.cedefop.europa.eu/en/resources/european-language-levels-cefr> and shall be demonstrated by certificates or by past relevant experience.

**The European Union pursues an equal opportunities policy. Gender balance in the proposed team, at all levels, is highly recommended.**

## Presence of management team for briefing and/or debriefing

The presence of member(s) of the management team is **not** required for briefing or debriefing purposes.

# LOCATION AND DURATION

## Starting period

Provisional start of the assignment is August 2020.

## Foreseen duration of the assignment in calendar days

Maximum duration of the assignment: 180 calendar days

This overall duration includes working days, week-ends, periods foreseen for comments, for review of draft versions, debriefing sessions, for dissemination activities and distribution of outputs, including the colour brochure and the video.

## Planning, including the period for notification for placement of the staff[[23]](#footnote-24)

As part of the technical offer, the framework contractor must fill in the timetable in the Annex IV (to be finalised in the Inception Report). The ‘Indicative dates’ are not to be formulated as fixed dates but rather as days (or weeks, or months) from the beginning of the assignment (to be referenced as ‘0’).

Sufficient forward planning is to be taken into account in order to ensure the active participation and consultation with government representatives, national/local or other stakeholders.

## Location(s) of assignment

The assignment will take place in Lusaka, Zambia. No field visits are foreseen.

**Table 2: Indicative breakdown of days (to be adjusted in the Organisation & Methodology as the Contractor sees fit)**



# REPORTING

## Content, timing and submission

The outputs must match quality standards. The text of the reports should be illustrated, as appropriate, with maps, graphs and tables; a map of the area(s) of Action is required (to be attached as Annex).

List of outputs:

|  | **Number of Pages *(excluding annexes)*** | **Main Content** | **Timing for submission** |
| --- | --- | --- | --- |
| **Inception Note**  | 10 pages | * Intervention logic
* Stakeholder map
* Methodology for the evaluation, incl.:
* Evaluation Matrix: Evaluation Questions, with judgement criteria and indicators, and data analysis and collection methods
* Consultation strategy
* Analysis of risks related to the evaluation methodology and mitigation measures
* Work plan
 | End of Inception Phase |
| **Draft Final Report**  | 20 pages | * **Cf. detailed structure in Annex III**
 | End of Synthesis Phase |
| **Draft Executive Summary – by using the EVAL online template**  | N/A | * **Cf. detailed structure in Annex III**
 | End of Synthesis Phase |
| **Final report**  | 20 pages | * Same specifications as of the Draft Final Report, incorporating any comments received from the concerned parties on the draft report that have been accepted
 | No more than 2 week after having received comments to the Draft Final Report. |
| **Executive Summary – by using the EVAL online template**  | N/A | * Same specifications as for the Draft Executive Summary, incorporating any comments received from the concerned parties on the draft report that have been accepted
 | Together with the final version of the Final Report |

## Use of the EVAL module by the evaluators

It is strongly recommended that the **submission of deliverables** by the selected contractor **be performed through their uploading in the EVAL Module**, an evaluation process management tool and repository of the European Commission. The selected contractor will receive access to online and offline guidance in order to operate with the module during the related Specific contract validity.

## Comments on the outputs

For each report, the Evaluation Manager will send to the Contractor consolidated comments received from the Reference Group or the approval of the report within 21 calendar days, with the exception of the final report, for which comments or approval will be given within 30 calendar days. The revised reports addressing the comments shall be submitted within 5 calendar days from the date of receipt of the comments, with the exception of the draft final report for which 14 calendar days are granted. The evaluation team should provide a separate document explaining how and where comments have been integrated or the reason for not integrating certain comments, if this is the case.

## Assessment of the quality of the Final Report and of the Executive Summary

The quality of the draft versions of the Final Report and of the Executive Summary will be assessed by the Evaluation Manager using the online Quality Assessment Grid (QAG) in the EVAL Module (text provided in Annex V). The Contractor is given – through the EVAL module - the possibility to comment on the assessments formulated by the Evaluation Manager. The QAG will then be reviewed following the submission of the final version of the Final Report and of the Executive Summary.

The compilation of the QAG will support/inform the compilation by the Evaluation Manager of the FWC SIEA’s Specific Contract Performance Evaluation.

## Language

All reports shall be submitted in English.

## Number of report copies

Apart from their submission - preferably via the EVAL Module - the approved version of the Final Report will be also provided in 10 paper copies and in electronic version at no extra cost.

## Formatting of reports

All reports will be produced using Font Arial or Times New Roman minimum letter size 11 and 12 respectively, single spacing, double sided. They will be sent in Word and PDF formats.

Annexes

# Annex I: Specific Technical Evaluation Criteria

**SPECIFIC TECHNICAL EVALUATION CRITERIA**

**Request for Services n. 2019/410-028**

**FWC SIEA 2018 - LOT 4**

**EuropeAid/138778/DH/SER/multi**

**Contracting Authority: Delegation of the European Union to the Republic of Zambia and COMESA**

1. **Technical evaluation criteria**

The Contracting Authority selects the offer with the best value for money using an 80/20 weighting between technical quality and price[[24]](#footnote-25).

Technical quality is evaluated on the basis of the following grid:

|  |  |
| --- | --- |
| **Criteria** | **Maximum** |
| ***Total score for Organisation and Methodology*** | ***40*** |
| * Understanding of ToR and the aim of the services to be provided
 | **10** |
| * Overall methodological approach, quality control approach, appropriate mix of tools and estimate of difficulties and challenges
 | **15** |
| * Technical added value, backstopping and role of the involved members of the consortium
 | **5** |
| * Organisation of tasks including timetable
 | **10** |
| ***Score for the expertise of the proposed team***  | ***60*** |
| ***Overall total score*** | ***100*** |

1. **Technical threshold**

Any offer falling short of the technical threshold of 75 out of 100 points, is automatically rejected.

1. **interviews during the evaluation of the offers**

During the evaluation process of the offers received the Contracting Authority reserves the right to interview by phone one or several members of the proposed evaluation teams. If phone interviews are to take place, then they will be tentatively carried out during the period from 28/11/2019 to 06/12/2019.

# Annex II: Information that will be provided to the evaluation team

* Financing Agreement including approved riders
* Contract with PM Group Ireland for provision of TA, including addendums and AOs
* Analysis of Supply Chain Capacities, Bottlenecks and Way-forward for Improving Access to Essential Medicines and Medical Materials, Poul Thim, EU November 30th 2015
* National Health Strategic Plan 2014-2017
* National Health Strategic Plan 2017-2021
* Minutes from annual Steering Committee Meetings
* Minutes from Monthly Technical Working Group Meetings
* Minutes from Monthly Health Cooperation Partners Meetings
* Six Months Interim Reports (under contract PM Group TA contract FED/2015/362-468)
* Final Report (including electronic access to all outputs) (of PM Group TA contract FED/2015/362-468)
* Result Oriented Monitoring (ROM) Report
* Final reports and main outputs from all HSSP contracts

# Annex III: Structure of the Final Report and of the Executive Summary

The contractor will deliver – **preferably through their uploading in the EVAL Module** - **two distinct documents**: The **Final Report** and the **Executive Summary**. They must be consistent, concise and clear and free of linguistic errors both in the original version and in their translation – if foreseen.

The Final Report should not be longer than the number of pages indicated in Chapter 6. Additional information on the overall context of the Action, description of methodology and analysis of findings should be reported in an Annex to the main text.

The presentation must be properly spaced and the use of clear graphs, tables and short paragraphs is strongly recommended.

The cover page of the Final Report shall carry the following text:

‘’*This evaluation is supported and guided by the European Commission and presented by [name of consulting firm]. The report does not necessarily reflect the views and opinions of the European Commission*’’.

|  |  |
| --- | --- |
| **Executive Summary** | A short, tightly-drafted, to-the-point and free-standing Executive Summary. It should focus on the key purpose or issues of the evaluation, outline the main analytical points, and clearly indicate the main conclusions, lessons to be learned and specific recommendations. It is to be prepared by using the specific format foreseen in the EVAL Module. |

The main sections of the evaluation report shall be as follows:

|  |  |
| --- | --- |
| **1. Introduction** | A description of the Action, of the relevant country/region/sector background and of the evaluation, providing the reader with sufficient methodological explanations to gauge the credibility of the conclusions and to acknowledge limitations or weaknesses, where relevant. |
| **2. Answered questions / Findings** | A chapter presenting the answers to the Evaluation Questions, supported by evidence and reasoning. |
| **3. Overall assessment *(optional)*** | A chapter synthesising all answers to Evaluation Questions into an overall assessment of the Action. The detailed structure of the overall assessment should be refined during the evaluation process. The relevant chapter has to articulate all the findings, conclusions and lessons in a way that reflects their importance and facilitates the reading. The structure should not follow the Evaluation Questions, the logical framework or the evaluation criteria. |
| **4. Conclusions and Recommendations** |  |
|  | **4.3 Lessons learnt** | Lessons learnt generalise findings and translate past experience into relevant knowledge that should support decision making, improve performance and promote the achievement of better results. Ideally, they should support the work of both the relevant European and partner institutions.  |
|  | **4.1 Conclusions** | This chapter contains the conclusions of the evaluation, organised per evaluation criterion. In order to allow better communication of the evaluation messages that are addressed to the Commission, a table organising the conclusions by order of importance can be presented, or a paragraph or sub-chapter emphasizing the 3 or 4 major conclusions organised by order of importance, while avoiding being repetitive.  |
|  | **4.2 Recommendations** | They are intended to improve or reform the Action in the framework of the cycle under way, or to prepare the design of a new Action for the next cycle. Recommendations must be clustered and prioritised, and carefully targeted to the appropriate audiences at all levels, especially within the Commission structure. |
| **5. Annexes to the report** | The report should include the following annexes:* The Terms of Reference of the evaluation
* The names of the evaluators (CVs can be shown, but summarised and limited to one page per person)
* Detailed evaluation methodology including: options taken, difficulties encountered and limitations; detail of tools and analyses.
* Evaluation Matrix
* Intervention logic / Logical Framework matrices (planned/real and improved/updated)
* Relevant geographic map(s) where the Action took place
* List of persons/organisations consulted
* Literature and documentation consulted
* Other technical annexes (e.g. statistical analyses, tables of contents and figures, matrix of evidence, databases) as relevant
* Detailed answer to the Evaluation Questions, judgement criteria and indicators
 |

# Annex IV: Planning schedule

This annex must be included by Framework Contractors in their Specific Contract Organisation and Methodology and forms an integral part of it. Framework Contractors can add as many rows and columns as needed.

The phases of the evaluation shall reflect those indicated in the present Terms of Reference.

|  |  | **Indicative Duration in working days[[25]](#footnote-26)** |  |
| --- | --- | --- | --- |
| **Activity** | **Location** | **Team Leader** | **Evaluator …** | **Indicative Dates** |
| **Inception phase: total days** |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Desk phase: total days** |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Field phase: total days** |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Synthesis phase: total days** |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Dissemination phase: total days** |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **TOTAL working days (maximum)** |  |  |  |

# Annex V: Quality Assessment Grid

The quality of the Final Report will be assessed by the Evaluation Manager (since the submission of the draft Report and Executive Summary) using the following quality assessment grid, which is included **in the EVAL Module**; the grid will be shared with the evaluation team, which will have the possibility to include their comments.

|  |
| --- |
| **Action (Project/Programme) evaluation – Quality Assessment Grid Final Report** |

|  |
| --- |
| **Evaluation data** |
| **Evaluation title** |  |
| **Evaluation managed by** |  | **Type of evaluation** |  |
| **CRIS ref. of the evaluation contract** |  | **EVAL ref.** |  |
| **Evaluation budget** |  |
| **EUD/Unit in charge** |  | **Evaluation Manager** |  |
| **Evaluation dates** | **Start:** |  | **End:** |  |
| **Date of draft final report** |  | **Date of Response of the Services** |  |
| **Comments** |  |
| **Project data** |
| **Main project evaluated** |  |
| **CRIS # of evaluated project(s)** |  |
| **DAC Sector** |  |
| **Contractor's details** |
| **Evaluation Team Leader** |  | **Evaluation Contractor** |  |
| **Evaluation expert(s)** |  |

**Legend: scores and their meaning**

Very satisfactory: criterion entirely fulfilled in a clear and appropriate way

Satisfactory: criterion fulfilled

Unsatisfactory: criterion partly fulfilled

Very unsatisfactory: criterion mostly not fulfilled or absent

|  |
| --- |
| **The evaluation report is assessed as follows**  |
| 1. **Clarity of the report**
 |
| This criterion analyses the extent to which both the Executive Summary and the Final Report:* Are easily readable, understandable and accessible to the relevant target readers
* Highlight the key messages
* The length of the various chapters and annexes of the Report are well balanced
* Contain relevant graphs, tables and charts facilitating understanding
* Contain a list of acronyms (only the Report)
* Avoid unnecessary duplications
* Have been language checked for unclear formulations, misspelling and grammar errors
* The Executive Summary is an appropriate summary of the full report and is a free-standing document
 |  |
| **Strengths** | **Weaknesses** | **Score** |
|  |  |  |
| **Contractor's comments** | **Contractor's comments** |  |
|  |  |  |
| 1. **Reliability of data and robustness of evidence**
 |
| This criterion analyses the extent to which: * Data/evidence was gathered as defined in the methodology
* The report considers, when relevant, evidence from EU and/or other partners’ relevant studies, monitoring reports and/or evaluations
* The report contains a clear description of the limitations of the evidence, the risks of bias and the mitigating measures
 |  |
| **Strengths** | **Weaknesses** | **Score** |
|  |  |  |
| **Contractor's comments** | **Contractor's comments** |  |
|  |  |  |
| 1. **Validity of Findings**
 |
| This criterion analyses the extent to which: * Findings derive from the evidence gathered
* Findings address all selected evaluation criteria
* Findings result from an appropriate triangulation of different, clearly identified sources
* When assessing the effect of the EU intervention, the findings describe and explain the most relevant cause/effect links between outputs, outcomes and impacts
* The analysis of evidence is comprehensive and takes into consideration contextual and external factors
 |  |
| **Strengths** | **Weaknesses** | **Score** |
|  |  |  |
| **Contractor's comments** | **Contractor's comments** |  |
|  |  |  |
| 1. **Validity of conclusions**
 |
| This criterion analyses the extent to which:* Conclusions are logically linked to the findings, and go beyond them to provide a comprehensive analysis
* Conclusions appropriately address the selected evaluation criteria and all the evaluation questions, including the relevant cross-cutting dimensions
* Conclusions take into consideration the various stakeholder groups of the evaluation
* Conclusions are coherent and balanced (i.e. they present a credible picture of both strengths and weaknesses), and are free of personal or partisan considerations
* (If relevant) whether the report indicates when there are not sufficient findings to conclude on specific issues
 |  |
| **Strengths** | **Weaknesses** | **Score** |
|  |  |  |
| **Contractor's comments** | **Contractor's comments** |  |
|  |  |  |
| 1. **Usefulness of recommendations**
 |
| This criterion analyses the extent to which the recommendations:* Are clearly linked to and derive from the conclusions
* Are concrete, achievable and realistic
* Are targeted to specific addressees
* Are clustered (if relevant), prioritised, and possibly time-bound
* (If relevant) provide advice for the Action’s exit strategy, post-Action sustainability or for adjusting Action’s design or plans
 |  |
| **Strengths** | **Weaknesses** | **Score** |
|  |  |  |
| **Contractor's comments** | **Contractor's comments** |  |
|  |  |  |
| 1. **Appropriateness of lessons learnt analysis *(if requested by the ToR or included by the evaluators)***
 |
| **This criterion is to be assessed only when requested by the ToR or included by evaluators and is not to be scored. It analyses the extent to which:*** Lessons are identified
* When relevant, they are generalised in terms of wider relevance for the institution(s)
 |  |
| **Strengths** | **Weaknesses** |  |
|  |  |  |
| **Contractor's comments** | **Contractor's comments** |  |
|  |  |  |
| **Final comments on the overall quality of the report** | **Overall score** |
|  |  |

# Annex VI: logical framework matrix (logframe) of the evaluated action(s)

|  |  **Results chain** | **Indicators** | **Baselines****(2013)** | **Targets****(2019)** | **Sources and means of verification** | **Assumptions** |
| --- | --- | --- | --- | --- | --- | --- |
| **Overall objective:**  | OO: To improve the health status of the people in Zambia in order to contribute to socio-economic development  | 1.1 Maternal mortality ratio1.2 Infant mortality rate1.3 Life expectancy at birth | 591 per 100,000 live births (2007)95 per 1,000 live births (2002)48 years (1998) | 100 (2021)15 (2021)62 (2021) | -Regular health status surveys, data from the health information system and other reports -Seventh National Development Plan monitoring (7NDP) |  |
| **Specific objective(s):****Outcome(s)** | SO1: Improvement of availability of quality assured essential medicines in public and private health care and contribute to rational and correct use of essential medicines in Zambia | 1.1: Increase in availability: Proportion of health facilities with stock-out of essential medicines 1.2 Increase in quality: Number of licensed premises1.3 Improvement in rational use of medicines: Tracking of RDU established and used regularly  | 22% (2014)300 premisesNO tracking exists | 10% (2021)500YES | 1.1-1.2: 7th NDP indicators and targets- Survey reports- PSCM reports- RDU reports | -The Government of Zambia continues to view the health sector HSS Programme as a priority and supports the development of MoH, including possible recruitment of additional senior resources. -HSS Programme budget is sufficient to implement the planned investments. -Procedures do not cause undue delay to constructions and equipment supplies.-MoH to support ZAMRA to meet staffing commitments |
| SO2: Support the Ministry of Community Development, Mother and Child Health[[26]](#footnote-27) and Ministry of Health with policy development and implementation  | 2.1: No of national policies and strategies under implementation, supported by the programme2.2: Annual budgetary allocations for the drug supply 2.3: Number of pharmacists specialised personnel in the public health sector | 0 policies/ strategies735 million ZMW0 persons  | 3 policies developed/ adopted, implemented & monitored1,200 million ZMW100 | -Published or approved policies, strategies, plans, JAR report, mid- and end evaluation reports-Approve job descriptions- Annual budget documents |
| **Outputs** | OP1: The Zambian Medicines Regulatory Authority (ZAMRA) is effectively executing its quality control and regulatory functions | 1.1: Status of improved organisational capacity1.2: Status of the new National Quality Control Laboratory (NMQCL) and ZAMRA's headquarters1.3: Improvement of quality management:-No of internal audits performed per year-No of annual quality management review meetings -Status of improving quality procedures (QP)1.4 Status of increased capacity in licensing, surveillance and enforcement -Status of improving transport capacity for inspectors-No of annual inspections -Status of upgrading the expertise of staff1.5 Status of improving the Market Authorisation (MA) capacity -No of personnel with expertise in Biosimilars-No of MAs assessed annually1.6 Status of improving regulations-No of regulations updated | No business model, inadequate ICT systems and no formal QMS Outdated and ill-equipped lab and HQ.0 audits0 meetingsMissing, deficient or not implemented QPInadequate transport capacity 470 inspectionsExpertise lacking0 staff200 applications0 regulations | Business model developed and adopted, ICT systems established for back-up and recoveryNMQCL constructed, equipped meeting WHO standards and functioning 411 Quality Manual updated, all QP updated and implemented2 Inspection vehicles procured and operating500Expertise developed in GMP, GDP and on medical devices1 staff400 applications4 regulations | -Inspection reports-MoH, ZAMRA and MSL reports- PE reports-STTA reports-Tender documents and implementation reports-Site meeting minutes- Quality reports-Lab audit reports-ZAMRA QPs developed and Implemented-Approved staff training plan -Training reports-Approved guidelines, laws and regulations | - ZAMRA’s laboratory personnel will be available for training.-HSS Programme budget is sufficient to implement the planned construction of the NMQCL and procurement of required laboratory equipment.-ZAMRA will receive MoH and Ministry of Finance support to engage the required amount of skilled staff as per the approved organogram.-No of staff and time dedicated to QMS issues within ZAMRA |
| OP2: Improved effectiveness and cost-efficiency of the pharmaceutical procurement and supply management system | 2.1: Status of the Memorandum of Understanding (MoU) for the gradual transfer of procurement to Medical Stores Limited (MSL)2.2 The existence of and progress on the action plan towards certification as procurement agent2.3: Status of MSL's capacity strengthening plan (CSP) and overall strategic plan (SP)2.4: Status of MSL's central warehouse in Lusaka2.5: Number of pallets of medicines and medical supply handled by MSL annually | No MoU signedNo PlanNo CSP and SP 2013-2017Outdated and inadequate warehousing facilities.22,947 pallets | MoU signed and implementation is on trackMSL in the process of being certificated as procurement agentCSP and SP 2017-2021 developed, formally approved, under implementation and monitored.Warehouse upgraded, equipped, and functioning according to international GDP guidelines 60,000 | - PSCM reports- MoU, SOPs, M&E, CSP, SP and procurement action plan -MSL performance reports- Tender evaluation reports, contract, implementation reports, handover progress reports, performance report of the new store | - Conditions in place at MSL and MoH for the implementation of the MoU-Agreement between all relevant authorities of gradual outsourcing of essential medicines to MSL.-Willingness of partners to move the implementation of the MoU forward |
| **Outputs** | OP3: Progress towards rational drug use (RDU) | 3.1: % of health facilities with functioning Pharma-Therapeutic Committees3.2: % of health facilities with access to up-to-date standard treatment guidelines3.3: Number of people in PSCM whose skills and knowledge on RDU have improved through successful completion of on-line masters in a relevant field3.4: Evidences on rational use improved in Zambia: Institutional drug use study conducted | 25 %35 %0 peopleNO | 100 % (2021)100 % (2021)12YES | - Students diplomas/certificates- Study and report on PTCs, reports on implementation of RDU and PE reports. | Relevant quality data available |
| OP4: The Ministry of Health and the Ministry of Community Development Mother and Child Health[[27]](#footnote-28) have developed the required capacities and policies in the areas of Health Information System[[28]](#footnote-29), Financing and other strategic areas | 4.1: Status of the PSCM technical working group (TWG)4.3 Existence/use of a M&E framework on PSCM4.2: Number of health-related policies/strategies developed/updated with support from HSSP | TWG on PSCM not functioningNon-existent0 policies/strategies | TWG on PSCM is established and meeting quarterlyExists and effectively used3 | - PSCM reports- Approved strategies, implementation plans, minutes of meetings and report on implementation-JAR report | Capacity and resources to implement and monitor the progress in implementation of the strategies |

# Annex VII: indicative STAKEHOLDER LIST (to be refined during inception phase)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
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1. Central Statistic Office, Zambia. [↑](#footnote-ref-2)
2. Central Statistic Office, Zambia. [↑](#footnote-ref-3)
3. World Bank: Zambia at a Glance [↑](#footnote-ref-4)
4. https://www.cia.gov/library/publications/the-world-factbook/ [↑](#footnote-ref-5)
5. http://data.worldbank.org/country/. The exchange rate EUR/USD per 31/12 2013 was 0.72633 [↑](#footnote-ref-6)
6. http://data.worldbank.org/country/ [↑](#footnote-ref-7)
7. Health Financing and Expenditure in Zambia, DFID 2019, page 2 [↑](#footnote-ref-8)
8. Zambia Health Sector Mid-term Review 2014, Health Financing Thematic Report, 2014. 2015, Collins Chansa, Chitalu Chama-Chiliba and Edit V. Velenyi. Page 16 [↑](#footnote-ref-9)
9. Household Expenditure and Utilization Survey 2014 [↑](#footnote-ref-10)
10. The 2012 and the 2019 List of Health Facilities in Zambia. MoH [↑](#footnote-ref-11)
11. Zambia Health Profile, WHO [↑](#footnote-ref-12)
12. The responsibility for primary health care was in 2015 transferred from the Ministry of Community Development, Mother and Child Health to the Ministry of Health. [↑](#footnote-ref-13)
13. The responsibility for primary health care was in 2015 transferred from the Ministry of Community Development, Mother and Child Health to the Ministry of Health [↑](#footnote-ref-14)
14. Support for improvement of the Health Information Systems is addressed by other EU interventions than the HSS Programme [↑](#footnote-ref-15)
15. COM(2013) 686 final “Strengthening the foundations of Smart Regulation – improving evaluation” - <http://ec.europa.eu/smart-regulation/docs/com_2013_686_en.pdf>; EU Financial regulation (art 27); Regulation (EC) No 1905/200; Regulation (EC) No 1889/2006; Regulation (EC) No 1638/2006; Regulation (EC) No 1717/2006; Council Regulation (EC) No 215/2008 [↑](#footnote-ref-16)
16. SEC (2007)213 "Responding to Strategic Needs: Reinforcing the use of evaluation", <http://ec.europa.eu/smart-regulation/evaluation/docs/eval_comm_sec_2007_213_en.pdf> ; SWD (2015)111 “Better Regulation Guidelines”, <http://ec.europa.eu/smart-regulation/guidelines/docs/swd_br_guidelines_en.pdf> ; COM(2017) 651 final ‘Completing the Better Regulation Agenda: Better solutions for better results’, <https://ec.europa.eu/info/sites/info/files/completing-the-better-regulation-agenda-better-solutions-for-better-results_en.pdf> [↑](#footnote-ref-17)
17. Reference is made to the entire results chain, covering outputs, outcomes and impacts. Cfr. Regulation (EU) No 236/2014 “Laying down common rules and procedures for the implementation of the Union's instruments for financing external action” - https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/pdf/financial\_assistance/ipa/2014/236-2014\_cir.pdf. [↑](#footnote-ref-18)
18. The New European Consensus on Development 'Our World, Our Dignity, Our Future', Official Journal 30th of June 2017. http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=OJ:C:2017:210:TOC [↑](#footnote-ref-19)
19. The Evaluation Manager is the staff of the Contracting Authority managing the evaluation contract. In most cases this person will be the Operational manager of the Action(s) under evaluation. [↑](#footnote-ref-20)
20. The Evaluation Matrix is a tool to structure the evaluation analysis (by defining judgement criteria and indicators for each evaluation question). It helps also to consider the most appropriate and feasible data collection method for each of the questions, [↑](#footnote-ref-21)
21. Please note that a draft of the brochure should be approved by the Contracting Authority prior to printing the 3000 copies. [↑](#footnote-ref-22)
22. Measured from the deadline for submission of offers. [↑](#footnote-ref-23)
23. As per art 16.4 a) of the General Conditions of the Framework Contract SIEA [↑](#footnote-ref-24)
24. For more details about the 80/20 rule, please see the PRAG, chapter 3.3.10.5 - <https://ec.europa.eu/europeaid/funding/about-funding-and-procedures/procedures-and-practical-guide-prag_en> [↑](#footnote-ref-25)
25. Add one column per each evaluator [↑](#footnote-ref-26)
26. The responsibility for primary health care was in 2015 transferred from the Ministry of Community Development, Mother and Child Health to the Ministry of Health [↑](#footnote-ref-27)
27. The responsibility for primary health care was in 2015 transferred from the Ministry of Community Development, Mother and Child Health to the Ministry of Health [↑](#footnote-ref-28)
28. Support for improvement of the Health Information Systems is addressed by other EU interventions than the HSS Programme [↑](#footnote-ref-29)