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SPECIFIC TERMS OF REFERENCE – PART A

Mid-term Evaluation of 'Strengthening the Nigerian Health System towards Achieving Universal Health Coverage (HSS)' Programme

FWC SIEA 2018 - LOT 4 – "Human development and safety net"

EuropeAid/138778/DH/SER/multi

RFS-SIEA-2018-1159

CONTRACTING AUTHORITY: THE EUROPEAN UNION DELEGATION TO NIGERIA

1 BACKGROUND

1.1 Relevant country / region / sector background

With an estimated population of 198 million in 2018, Nigeria is the most populous country in Africa and is ranked the seventh most populous country in the world. It is a Federation of 36 states and the Federal Capital Territory (FCT), Abuja serves as the seat of government. The country operates a presidential system of government, with executive, legislative and judicial branches, and has a President that serves as both head of state and head of government. The states form the second tier of government and are further sub-divided into 774 Local Government Areas (LGAs) which constitute the third tier of government. Each state is administered by an elected Governor. However, the division of labour between the three layers of government (federal, state and local) complicates the efficiency and cost-effectiveness of the sector.

Consequently, mobilizing adequate resources for health and ensuring efficient use of those resources has remained a challenge for Nigeria. There is no framework within which resources are mobilized and allocated for health. The Nigerian social system has many challenges that affect the provision of quality and timely services to people. These include underfunding, poor stakeholder coordination, inadequate number and skills of health and education workers, poor infrastructure, limited data for planning and decision-making. This has been aggravated by inter-community and inter-ethnic conflicts and tensions and by instability caused by insurgency. Nigeria continues to have some of the worst development indicators in sub-Saharan Africa with very high infant and maternal mortality rates and levels of Global Acute Malnutrition above the emergency alert threshold especially in northern states. Over 60% of the population of Nigeria is estimated to be living below the poverty threshold of USD 1.25 per day. The country is ranked 152 out of 157 countries in the Human Capital Index (HCI) with the lowest investment in education, social protection and health, and yet one million children die in Nigeria every year from treatable and preventable diseases whilst accounting for 10% of deaths of mothers, new born and children under 5.

Furthermore, Nigeria has a young population structure wherein children aged under 15 years constitute 45% and young people (10-24 years) make up 33% of the population. Women in the reproductive age group, children under five and the elderly (at least 65 years) make up 22%, 20% and less than 5% of the population respectively. Consequently, Nigeria has a high ratio of 73.3%, which is worsened by the very high rates of youth unemployment and high total fertility rate of 5.8. More than 70% of population actually pays for health services, still Nigeria is one of the countries in the world that allocates fewer resources to health.

Nigeria runs a pluralistic health care system with public and private sectors, modern and traditional systems providing health care. Public sector healthcare is concurrently the responsibility of the three tiers of government. LGAs have responsibility for Primary Health Care (PHC) services, State Governments provide secondary level care while the Federal Government provides tertiary level care. In addition to tertiary health care provision, the Federal Ministry of Health (FMOH) leads the policy development and implementation of specific public health programmes, e.g. National AIDS and STDs Control Programme (NASCP), National Malaria Elimination Programme (NMEP), National Tuberculosis and Leprosy Control Programme (NTLCP). The Federal and State Health Ministries, Departments and Agencies (MDAs) manage the implementation of these programmes at all levels. This has resulted in the existence of multiple institutions with mandates to address different aspects of health care. However, the over 120 agencies and parastatals under the FMoH have in practice created a situation of overlapping mandates, competition over limited funding and inadequate information sharing and coordination.

Nigeria's health sector is guided by Vision 20:2020 (which proposes investments in human capital development, notably health and education, as key to sustainable development), the medium - term Economic Recovery and Growth Plan (ERGP) and the National Strategic Health Development Plan 2 (NSHDPII) which currently provides the Health Sector Medium Term roadmap to move the country towards the accomplishment of National Health Policy goals and objectives including Universal Health Coverage as well as guide national and subnational governments on the health sector priorities that recognise and identify key actions that other sectors should collaborate with, or jointly implement with the health sector in order to address the social determinants of health in the pursuit of health-related SDGs. The NSHDP 2 is a follow up to the first National Strategic Health Development Plan 1 which ended 2015 (2010-2015).

The overarching goal of the Nigerian Constitution and the National Health Act (NHAct) is to guarantee the right to health for all Nigerians. The 2016 National Health Policy provides an implementation framework to translate the provisions of the NHAct and the Sustainable Development Goals into healthy lives and wellbeing for all Nigerian citizens. Nigeria is committed to the attainment of globally agreed Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC). This commitment is reflected in the 2016 revised National Health Policy whose theme is "Promoting the Health of Nigerians to Accelerate Socio - economic Development". The tenets of Universal Health Coverage are central to the goal of National Health Policy "To strengthen Nigeria's health system, particularly the Primary Health Care sub-system, to deliver quality, effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians".

The FMoH has consequently prioritised strengthening its PHC system in order to achieve UHC. As enunciated in the NHAct and the National Health Policy (NHP), primary health care is the bedrock of Nigeria's health care delivery system. The Basic Health Care Provision Fund (BHCPF), as prescribed by the NHAct, will fund delivery of the Basic Minimum Package of Health Services including basic emergency obstetric and new-born care (BEmONC). Through the Reach Every Ward strategy (population of 10,000-20,000 per ward), FMOH aims to have at least one functional primary health centre (PHC) in each political ward with involvement of the Ward Development Committee (WDC) comprising selected community members to ensure community participation and accountability.

Key global and regional health legislation and agreements to which Nigeria is signatory the 1. Sustainable Development Goals (2015), 2. The Common African Position (CAP) on the Post 2015 Agenda (African Union 2014), 3. Abuja 2001 Declaration and Abuja+12 Declaration (2013) which committed the African Union Member States to allocate at least 15% of their annual national budgets to health, 4. Ouagadougou Declaration on Primary Health Care (2008), 5. Universal Health Coverage (UHC), 6. International Health Regulations (2005) and 7. Paris Declaration on Aid Effectiveness (2005).

The proposed interventions were consequently deemed critical in light of current global and national initiatives in health. With a renewed global push towards Universal Health Coverage (UHC) and Nigeria's more recent effort through the Presidential Summit of 10th of March, 2014, it became imperative that the country's health system be supported to deliver as needed.

Though efforts are on-going by states and by the federal government to improve financing for health and scale up financial risk protection for the populations, these are uncoordinated and are not always based on evidence. There is also an over-reliance on popular solutions for financial risk protection, as can be seen in the various attempts to establish community-based health insurance schemes (CBHI) by states in spite of evidence on challenges in its implementation and sustainability as well as the inability to expand coverage significantly with just CBHI in the move towards UHC. The Presidential Declaration on UHC identifies key strategies to move the country forward including legislation to make insurance mandatory, establishment of funds for the coverage of vulnerable populations and support to states to develop state-specific solutions for risk protection.

As noted in the mid-term review of the National Strategic Health Development Plan (NSHDP), government budgets are not based on evidence on expenditure patterns or health needs[1]. There are no systems in place for monitoring and reporting health expenditures at all levels of government, or assessing the efficiency of resource use. Although Nigeria has conducted 4 rounds of the National Health Accounts (NHA), they have so far been conducted sporadically and often are completed too late to be useful for planning. For instance, the last NHA covering the years 2006-2009 was completed in 2013. This is partly due to inadequate capacity to conduct the estimation without external support. In addition, the routine expenditure systems required to estimate the health accounts regularly are lacking in the country and need to be developed as part of the health accounts institutionalisation process. Resources are often allocated in an uncoordinated manner leading to duplication of resources on similar programmes, under-allocation to priority disease/conditions, high levels of inefficiency and wastage of resources for health. This poses a challenge to country efforts towards universal health coverage. Documentary evidence is required to guide planning and budgeting and routine expenditure reporting provides a platform for monitoring country commitments to global initiatives like the *Every Woman Every Child* initiative of the United Nations Secretary General (which includes the UN Commission on Information and Accountability and the UN Commission on Life Saving Commodities).

Specifically, for polio eradication, since the 1988 resolution in the World Health Assembly (WHA), to eradicate polio from the globe, great progress has been made with a reduction in WPV (Wild Polio Virus) cases from 350,000 in 1988 to 74 in 2015. Along with this the number of countries infected with polio declined from 125 to 2 in 2015, those being Afghanistan and Pakistan. Nigeria was removed from the polio endemic listing in 2015 having no WPVs for over 24 months. However, in August 2016, four WPVs were detected in Borno State. These cases were from areas inaccessible due to insecurity, and genetic sequencing of the virus demonstrated that circulation had been ongoing since 2011. In a letter to H.E President Buhari dated the 21 September, 2016, the Director General WHO (World Health Organisation), Dr Margaret Chan, advised that the poliovirus sequencing identified that Nigeria had not completely interrupted WPV transmission and therefore the country was returned to the list of countries with endemic WPV circulation in 2016.

In response to the detection of WPV, aggressive outbreak response immunisation campaigns were commenced covering 18 priority states in Nigeria and select areas within Republic of Niger, Chad, Cameroon and Central African Republic.

1.2 The Intervention to be evaluated[2]

Title of the Intervention to be evaluated	• Strengthening the Nigerian Health System towards Achieving Universal Health Coverage
Budget of the Intervention to be evaluated	• EUR 21,000,000
CRIS and / or OPSYS number of the Intervention to be evaluated	• FED/2017/380-043
Dates of the Intervention to be evaluated	• Start: 09/03/2017 • End: 08/08/2021

Note: ***Component 1 of the Decision 038-524 corresponding to specific objectives 1, 2 and 3 is implemented by UNICEF and not part of this evaluation.***

[1] *National Strategic Health Development Plan 2010-2015. Joint Annual Review and Mid-term review report 2014*

[2] *The term 'Action' is used throughout the report as a synonym of 'project and programme'.*

The Intervention implemented by the World Health Organisation (WHO) corresponds to specific objectives 4, 5 and 6 of the Decision 038-524 (*Support to the Health Sector in Nigeria, Phase 1)* under the first focal sector (health nutrition and resilience) of the 11th EDF EU-Nigeria National Indicative Programme (NIP), as follows:

Component 2

"Specific objective 4 - To increase and sustain herd immunity against polio virus in polio high risk states"

Component 3

"Specific objective 5 – To improve the availability and quality of health information for decision making at federal and state level

Specific objective 6 – To strengthen the health financing system at federal and state level", and will contribute to achieving the three expected results (before addendum 1) as follows:

Component 2

"Result 4 – Achieve and maintain polio free status in Nigeria by 2017

Component 3

Result 5 – Quality of Health Information and its use for decision making is strengthened, aiming to have fully operational health information systems by 2019

Result 6 – By 2019, improvement of local institutional capacity at state level to plan and prepare costed budgets and provide full narrative and financial reporting for the health sector".

The **overall objective of the Intervention** is to support the health systems strengthening efforts in Nigeria towards achieving universal health coverage and improved health outcomes through improved data analysis and information dissemination capabilities, health expenditure estimation, reduction in financial barriers to health care and to increase and sustain herd immunity against polio in polio priority states.

The specific objectives are:

- To conduct high quality Immunization Plus Days (IPDs throughout the country (nIPDs – National Immunisation Plus Days) and in polio priority states (sIPDs – Supplementary Immunisation Plus Days) (tentatively including 18 priority states of Bauchi, Borno Jigawa, Kaduna, Kano, Katsina, Kebbi, Niger, Sokoto, Yobe, Zamfara, Taraba, Adamawa, Gombe, Plateau, Nasarawa, Benue and Federal Capital Territory (FCT) as recommended by the national and international technical experts including the Expert Review Committee on Polio Eradication and Routine Immunization (ERC).
- To maintain and strengthen immunity of children against polio in 18 polio priority states in accessible areas
- Implement on-going strategies/ innovations to reach children chronically missed with polio vaccine for the duration of the grant and beyond in polio priority states
- To improve the availability and quality of health information for decision making at federal and state level (Sokoto and Anambra States)
- To strengthen the health financing system at federal and state levels (in Sokoto and Anambra States).

<u>Component 2: Polio Eradication</u>

Expected Result 4 - Maintain polio free status in non-polio infected states (Results 1, 2 and 3 to be delivered through a separate contract with UNICEF)

- **Output 4.1:** Conduct Immunisation Plus Days (IPDs) as recommended by national and international technical experts including the ERC

- **Output 4.2** Conduct supportive activities to reach children with polio vaccine in conjunction with the SIAs in polio priority states;

Component 3 Health Systems Strengthening (HSS)

Expected Result 5 **-** Quality of Health and Nutrition Information and its use for decision making is strengthened.

- **Output 5.1:** Ministry of Health supported to develop a harmonised data quality process comprising monthly, annual and a medium term in-depth verification of the entire system (indicator list, data tools and master facility list), and build the capacity of relevant programme managers at federal and state level.
- **Output 5.2:** Coordination of actors supported in health information through the relevant technical working group at national level and in the selected states.
- **Output 5.3:** Building of capacity of the Federal Ministry of Health research and statistics division and the state Monitoring and Evaluation/Health Information System (M&E/HIS) units supported on the *analysis* of health information, both from routine systems and from surveys including SMART (Standardised Monitoring and Assessment of Relief and Transitions) nutrition surveys, and the development of analysis products and policy relevant communication to inform joint sector reviews, and promote the use of health information in decision making.

*Expected Result 6***:** By 2019, improvement of local institutional capacity at State level to plan and prepare costed budgets and provide full narrative and financial reporting for the health sector including nutrition.

- **Output 6.1:** Government supported for monitoring of the level of coverage of risk protection schemes at various levels of the health system as well as assessing the effect of these schemes on health service use and on the cost to households of accessing healthcare.
- **Output 6.2:** Government supported to conduct annual health accounts estimation as well as other expenditure tracking processes, like public expenditure reviews, cost of treatment of malnutrition and household expenditure surveys, at regular intervals.
- **Output 6.3:** Budget processes and analysis at federal and state levels supported.

Main Activities of the intervention to be evaluated - Strengthening the Nigerian Health System towards Achieving Universal Health Coverage

Component 2: Polio

1. Planning and execution of the highest quality polio IPDs nationally and in polio priority states.
2. Implementation of special strategies/innovations to reach children chronically missed with polio vaccine in polio priority states.

Component 3: Health Systems Strengthening

3. Support the Ministry of Health to improve health information data quality through a participatory process.
4. Support for coordination of actors in health information through the relevant technical working group at national level and in the selected States.
5. Support the building of capacity within the Federal Ministry of Health Research and Statistics Division and the State Monitoring and Evaluation/Health Information System (M&E/HIS) units on the analysis of health information, both from routine systems and from surveys.
6. Support to the Government for monitoring of the level of coverage of risk protection schemes at various levels of the health system.

7. Support to the Government to conduct annual health accounts estimation as well as other expenditure tracking processes.
8. Analyse information from these processes in '5 above' alongside health outcomes data to assess efficiency of health spending

Intervention Logic

The project is anchored on the fundamental issues that hamper health sector reforms in Nigeria - **inadequate financing, poor data management and vaccine preventable disease outbreaks with potential to overwhelm an already weak health system**. It addresses the root causes of the problems (not the symptoms) through a coordinated and sector wide approach; recognising the interconnectedness of the polio eradication with a strengthened health system in the aim for Universal Health Coverage.

It seeks to support the effective implementation of key established laws (Health Act), policies (National Health Policy), plans (NSHDP2), while ensuring that institutional capacity to effectively manage the anticipated reform/change is in place, and also enabling civil society to exercise its role of watchdog on polio eradication efforts and health system strengthening. Experience with Polio eradication efforts and passage of the **National Health Act in 2014** in particular shows that a well mobilised civil society is critical to push government to initiate desired reforms and move towards increased accountability in governance. Civil society, and the public in general, also has a key role to contribute to changes in social norms and behaviour, altering the parameters of what is regarded as socially accepted/sanctioned behaviour.

The **key pillars of interventions under this project – polio eradication and health systems strengthening** – are complementary and mutually reinforcing. Persistent Wild Polio outbreak is both a cause and driver of the poor governance and performance of the health system. At the same time, a strong Nigerian health system that delivers high routine immunisation coverages confers sufficient herd immunity capable of containing outbreaks of vaccine preventable diseases including Polio as well necessity for frequent polio campaigns with attendant costs and also reduce need for incentives which could distort routine provision of essential PHC (Primary Health Care) services.

The health systems strengthening interventions target institutions within the health sector; however, its effects benefit the entire population of Nigeria, with the vulnerable and poor benefitting from the improvements in the health financing landscape.

The government's policy and strategic direction on health is defined by the **2nd National Strategic Health Development Plan** (2018 – 2022) which was adopted at the 61 NCH (National Council on Health) in 2018. The strategy foresees 5 result areas relating to (i) Enabled environment for attainment of sector outcomes; (ii) Increased utilisation of the Essential Package of Health Care Services (EPHS); (iii) Strengthened health system for delivery of EPHS; (iv) Protection from Public Health Emergencies and Risks; (v) Predictable Financing and Risk Protection

1.3 Stakeholders of the Intervention

Key stakeholders include the NPHCDA, ICC, FMoH, MFBNP, Development Partners Group on Health and Private Sector, Legislature and State Ministries of Health in Anambra and Sokoto. For polio eradication in Nigeria, the **National Primary Health Care Development Agency** (NPHCDA), which reports to the Ministry of Health, coordinates advocacy, technical guidance, and resource mobilisation at the national level. For operations, the opening of the national Emergency Operations Centre (EOC) by the Government of Nigeria in 2012 provided a venue for senior representatives from partner agencies to meet, analyse data, discuss and develop strategies to address obstacles to children receiving vaccination. The national EOC is the coordination body for all polio eradication activities in the country and the secretariat for the Presidential

Task Force on Polio Eradication (PTFoPE). The EOC is thus the operational arm of the NPHCDA for polio eradication activities.

The coordination of partner input is managed through the **Interagency Coordinating Committee** (ICC), which has been established for routine immunisation and polio eradication. The ICC is chaired by the Minister of Health and members include: the Permanent Secretary, Federal Ministry of Health, , National Primary Health Care Development Agency (NPHCDA), Association of Local Governments of Nigeria (ALGON), WHO, UNICEF (United Nations Children's Fund), European Union, Department of Foreign Affairs and Trade Canada (DFATD, now Global Affairs Canada), USAID, the World Bank, DFID (Department for International Development now Foreign and Common Wealth Office), Rotary International and other donor agencies. Along with this, various working groups with representatives from implementing partners and donor agencies provide an avenue for discussion and planning of each thematic area e.g. training, logistics etc.

The **Federal Ministry of Health (FMoH)** has about 120 agencies and parastatals under it and is primarily responsible for service delivery at tertiary care, as well as policy development. Many coordination mechanisms are led by the FMOH and its agencies which are not well replicated at state level. In addition, other federal ministries, and agencies play a role in health or that affects the health sector including the **Ministry of Finance, Budget and National Planning (MFBNP)** which signed the financing agreement for this project and oversees the National Bureau of Statistics and the National Population Commission. Others are Ministry of Environment, Ministry of Water Resources, the National Emergency Management Agency (NEMA) and the Ministry of Women Affairs.

The health sector receives support from **multilaterals like the United Nations (UN) agencies** and the World Bank and African Development Bank as well as **bilateral institutions** including the European Union, the governments of the United Kingdom, United States of America, Canada, Japan, Germany and Norway, among others. The development partners are organized through the **Development Partners Group on Health** (DPG-H), which is a forum for information sharing and collaboration on interventions across partners. It serves as a vehicle for a coherent and harmonized engagement with the government from external partners, and has often also served to improve the level of collaborative implementation among partners.

Finally, the **private sector is a major**, but often overlooked player, in the health sector. Depending on the source document and the state, the private sector is responsible for 40-70% of health care delivery in the country. In addition, many corporations have often provided support through their budgets for Corporate Social Responsibility. However, the private sector is beginning to engage more effectively in the health sector policy processes. There are some large private sector coalitions that are playing a large role in resource mobilization, sensitization and policy engagement namely the Private Sector Health Alliance and the Health Federation of Nigeria. In 2015 alone, the private sector players have participated in the processes for the revision of the national health policy and the national health financing policy and strategy as well as directly facilitating policy dialogue on the role of the private sector in achieving universal coverage in Nigeria. Within the public sector there is also a growing realization and impetus to engage better and create an enabling environment for private sector support in health system development.

Other key stakeholders

As part of its approach to capacity development based on sustainability and institutional strengthening, the action supports respective **State Health Insurance Agencies of Sokoto and Anambra.**

The **legislature**, constituted by the National Assembly at federal level, and Houses of Assembly at state level, plays a critical role in health sector reform and health system strengthening, in terms of its law-making and deliberative functions as well as in exercising financial control and oversight of the executive

power. However, the Nigerian legislature faces significant capacity constraints in all these areas, and particularly at state level.

Civil society organisations (and other non-state actors) also play crucial roles in promoting health sector governance, reforms and system strengthening. There are also some highly specialised CSOs and CSO networks active working in the health sector. Further capacity building and institutional strengthening of many of the CSOs is needed.

Key beneficiaries

The MFBNP National Authorising Officer (NAO) of the EDF is the primary beneficiary of this evaluation.

Other beneficiaries include:

Polio Eradication (component 2)
WHO as implementing UN agency.

Inter-agency Coordinating Committee.

National Primary Health Care Development Agency (NPHCDA)

Health Systems strengthening (component 3)
Department of Planning Research and Statistics of Federal Ministry of Health

States Ministries of Health of Sokoto and Anambra as direct beneficiary agencies.

1.4 Other available information

Note: based on the evolution of travel, meetings and security restrictions, in person meetings/field trips might need to be replaced with alternative virtual means.

2 DESCRIPTION OF THE EVALUATION ASSIGNMENT

Type of evaluation	**mid-term**
Coverage	Intervention in its entirety
Geographic scope	Nigeria – With project focal states of Anambra and Sokoto for HSS component and 18 Northern States for Polio Component.
Period to be evaluated	09/03/2017 to 31/10/2020

2.1 Objectives of the evaluation

Systematic and timely evaluation of its programmes and activities is an established priority[3] of the European Commission[4]. The focus of evaluations is on the **assessment of achievements**, the **quality** and the **results**[5] of Interventions in the context of an evolving cooperation policy with an increasing emphasis on **result-oriented approaches and the contribution towards the implementation of the SDGs.** [6]

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** among: inputs and activities, and outputs, outcomes and impacts. 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, the interested stakeholders and the wider public with:

- an overall independent assessment of the past performance of the **'Strengthening the Nigerian Health System towards Achieving Universal Health Coverage' (HSS) Programme**, paying particular attention to its 'intermediate' results measured against its expected objectives; and the reasons underpinning such results;
- key lessons learned, conclusions and related recommendations in order to improve current and future Interventions.

In particular, this evaluation will serve as a useful tool in gaining a better understanding of the performance of the action, its enabling factors and those hampering proper delivery of results in order to adjust its design or implementing modalities and to inform threats and opportunities for project delivery for the remaining period of the project.

The main users of this evaluation will be EU Delegation to Nigeria and ECOWAS, the WHO, the Federal Ministry of Finance, Budget and National Planning, the Federal Ministry of Health, State Governments of the focal states (Anambra and Sokoto), key project beneficiaries and other national stakeholders, including civil society groups.

2.2 Requested services

2.2.1 Scope of the evaluation

The evaluation will assess the Intervention using the six standard DAC evaluation criteria, namely: relevance, **coherence, effectiveness**, efficiency, **sustainability** and early signs of impact. In particular, the evaluation shall give a greater focus to the following criteria - **coherence, effectiveness**, **sustainability.**

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[3] 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

[4] SEC (2007)213 "Responding to Strategic Needs: Reinforcing the use of evaluation", https://ec.europa.eu/smart-regulation/docs/com_2013_686_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

[5] 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

[6] 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

In addition, the evaluation will assess one EU specific evaluation criterion, which is:

- the **EU added value** (the extent to which the Intervention brings additional benefits to what would have resulted from Member States' interventions only);

The definition of the 6 DAC + 1 EU evaluation criteria is contained for reference in the Annex VII.

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 Intervention, its governance and monitoring.

2.2.2 Issues to be addressed

The specific 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[7] 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 issues to be addressed will become contractually binding.

The issues to be addressed will include but not limited to the following;

- **Relevance** of the action

  a) Does the intervention match the needs of national and local partners?

- **Efficiency**
  a) How cost efficient is the action to achieve the expected results?
  b) How efficient has the mapping of allocation of resources to health during the period been?
- **Coherence**

  a) How has the expected results materialised and what are the facilitating and contrasting factors?

- **Effectiveness**

  a) What has been the Staff allocation to the Action and cooperation with Ministry of Health (MoH) staff at both State and Federal levels?

  b) what Internal implementation procedures, capacity and skills, internal mechanisms for coordination are in place?

  c) What reporting relations and the performance of the management and its ability to monitor and capacity to adapt to changing conditions are in place?

  d) How effective is the programme support or not in pushing for the Health Insurance agenda in the country? (as of 2019 only 5% of the population is actually covered by Health Insurance).

- **Sustainability**
  a) What are the governing mechanisms of the Action in place and involvement of the Government including mechanisms for the Government to take over the action and continue by the end of the action?

[7] *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.*

b) how has this programme improved health services delivery in Nigeria and how is WHO ensuring the Government of Nigeria (GoN) capacity to take over the programme (sustainability, ownership, etc.)?

- **EU added value** a) What is the added value of the action in improving health services to Nigerians including those that cannot access health services due as they cannot pay?

2.3 Phases of the evaluation and required outputs

The evaluation process will be carried out in five phases:

- 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.

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*
Inception Phase	• Initial document/data collection • Background analysis • Inception interview • 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 Contracting Authority and the Reference Group* via **remote conference** • Inception Note • Slide presentation of the Inception Note • Theory of Change Remote meeting to present the inception note.
Desk Phase	• In-depth document analysis (focused on the issues to be addressed) • Interviews • Identification of information gaps and of hypotheses to be tested in the field phase • Methodological design of the Field Phase	

Phases of the evaluation	Key activities	Outputs and *meetings*
Field Phase	• Gathering of primary evidence with the use of the most appropriate techniques • Data collection and analysis	• *Initial meetings at country level with* all stakeholders and beneficiaries of the project. • Slide Presentation of key findings of the field phase • *Face-to-face debriefing with the* EUD and stakeholders. *Note: based on the evolution of travel, meetings and security restrictions, in person meetings/field trips might need to be replaced with alternative virtual means*
Synthesis phase	• Final analysis of findings (with focus on the Issues to be addressed) • Formulation of the overall assessment, conclusions and recommendations • Reporting	• Draft Final Report • Executive Summary according to the standard template published in the EVAL module • Final Report
Dissemination Phase	• Organisation of the final presentation seminar	• *Final presentation seminar* *Note: based on the evolution of travel, meetings and security restrictions, in person meetings/field trips might need to be replaced with alternative virtual means*

2.3.2 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 session in Abuja between the EU Delegation, the WHO, the National Authorising Officer and the evaluators via remote conference. The meeting aims 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 the Health sector in Nigeria, the evaluation team, in consultation with the Evaluation Manager, will reconstruct or as necessary construct, the Intervention Logic of the Intervention to be evaluated.

Furthermore, based on the Intervention Logic, the evaluators will develop a narrative explanation of the logic of the Intervention that describes how change is expected to happen within the Intervention, 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 impact), and articulates the assumptions that must hold for the Intervention 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[8], which will be included in the Inception Report. 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 evaluation team will then, present in Abuja the **Inception Note** to the EUD (*Note: based on the evolution of travel, meetings and security restrictions, in person meetings/field trips might need to be replaced with alternative virtual means*).

2.3.3 Desk Phase

This phase is when the document analysis takes place. The analysis should include a brief synthesis of the existing literature relevant to the Intervention including but not limited to, the National Strategic Health Development Plan 2, revised National Health Policy and National Health Act.

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

Selected phone interviews with the programme management, the relevant EU services in Abuja, Nigeria and key partners in Nigeria may be conducted during this phase to support the analysis of secondary sources.

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.

2.3.4 Field Phase

The Field Phase starts after the desk phase and 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.

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[8] 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,

In the first days of the field phase, the evaluation team shall hold a briefing meeting with the programme management, and other relevant stakeholders.

During the field phase, the evaluation team shall ensure adequate contact and consultation with, and involvement of the different stakeholders; with the relevant government authorities and agencies. 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 EU Delegation, the WHO and the National Authorising Officer.

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

2.3.5 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 Abuja the **Draft Final Report** to the EUD to discuss the draft findings, conclusions and recommendations. One day of presence is required of – as minimum – evaluation team leader. (*Note: based on the evolution of travel, meetings and security restrictions, in person meetings/field trips might need to be replaced with alternative virtual means*).

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.

2.3.6 Dissemination phase

Final debriefing meeting with the Contracting Authority and the Reference Group as well as key stakeholders with submission of complete reports to the EUD will be organised during the final presentation to the EUD.

2.4 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 (if applicable) the communication action messages, materials and management structures.

Considering the current global covid crisis and the many restrictions on travels, the following elements of methodological design are expected from the contractors, namely at least:

- a methodology adaptive to travel restriction,
- a methodology adapted to covid: Ethical protocol, adapted evaluation methodology to avoid spreading / exposing to the virus, online tools, (on guidance for the methodological adaptation may refer to: https://europa.eu/capacity4dev/devco-ess and https://www.betterevaluation.org/en/theme/MandE_technology_insecure_settings

2.5 Management and Steering of the evaluation

2.5.1 At the EU level

The evaluation is managed by Programme 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 Delegation, the WHO and National Authorising Officer.

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 Intervention.
- 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.

2.5.2 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.

3 LOGISTICS AND TIMING

Please refer to Part B of the Terms of Reference.

3.1 Planning, including the period for notification for placement of the staff[9]

As part of the technical offer, the framework contractor must fill in the timetable in the Annex IV (to be finalized 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.

4 REQUIREMENTS

Please refer to Part B of the Terms of Reference.

5 REPORTS

For the list of reports, please refer to Part B of the Terms of Reference.

5.1 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.

5.2 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 5 paper copies and in electronic version at no extra cost.

5.3 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.

[9] *As per art 16.4 a) of the General Conditions of the Framework Contract SIEA*

6 MONITORING AND EVALUATION

6.1 Content of reporting

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 Intervention is required (to be attached as Annex).

6.2 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. The revised reports addressing the comments shall be submitted within 10 calendar days from the date of receipt of the comments. 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.

6.3 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.

7 PRACTICAL INFORMATION

Please address any request for clarification and other communication to the following address(es):

delegation-nigeria-cris-fwc-offers@eeas.europa.eu; copy anthony.ayeke@eeas.europa.eu

ANNEXES TO TOR - PART A

ANNEX I: SPECIFIC TECHNICAL EVALUATION CRITERIA

SPECIFIC TECHNICAL EVALUATION CRITERIA

Request for Services n. RFS-SIEA-2018-1159

FWC SIEA 2018 - LOT 4 – "Human development and safety net"

EuropeAid/138778/DH/SER/multi

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[10].

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***

2. TECHNICAL THRESHOLD

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

[10] *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*

ANNEX II: INFORMATION THAT WILL BE PROVIDED TO THE EVALUATION TEAM

- Legal texts and political commitments pertaining to the Intervention(s) to be evaluated
- Country Strategy Paper Nigeria and Indicative Programmes (and equivalent) for the periods covered
- Relevant national / sector policies and plans from National and Local partners and other donors
- Intervention identification studies
- Intervention feasibility / formulation studies
- Intervention financing agreement and addenda
- Intervention's quarterly and annual progress reports, and technical reports
- Relevant documentation from National/Local partners and other donors
- Guidance for Gender sensitive evaluations
- Calendar and minutes of all the meeting of the Steering Committee of the Intervention(s)
- Any other relevant document

Note: The evaluation team has to identify and obtain any other document worth analysing, through independent research and during interviews with relevant informed parties and stakeholders of the Intervention.

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 Intervention, 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 Intervention, 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 Intervention. 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 Intervention in the framework of the cycle under way, or to prepare the design of a new Intervention 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 Intervention 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[11]		
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)				

[11] *Add one column per each evaluator*

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.

Intervention (Project/Programme) evaluation – Quality Assessment Grid Final Report				
Evaluation data				
Evaluation title				
Evaluation managed by			**Type of evaluation**	
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/OPSYS # 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**	

2. 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**	

3. 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**	

4. 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**	

5. 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 Intervention's exit strategy, post-Intervention sustainability or for adjusting Intervention's design or plans

Strengths	Weaknesses	Score
Contractor's comments	**Contractor's comments**	

6. 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)

	Intervention logic	Indicators	Baselines (incl. reference year)	Targets (incl. reference year)	Status as at 31 December 2017	Sources and means of verification	Assumptions
Overall objective: Impact	• Improved resource allocation to national health priorities	• % of government expenditure on health *	TBD	15%		Expenditure reviews	Data from the reviews and assessments will be used as recommended to improve planning
	• Reduction in financial barriers to health care access	• Proportion of Nigerians covered by any risk-pooling mechanisms*	TBD	30%		Living standards surveys, household expenditure reviews	
	• Data from health management information systems used for policy and planning	• Percentage of Federal and State plans and strategies that are based on routine HMIS data to improve coverage and quality of high impact interventions*	TBD	80%		Joint review processes	
	• Achieve and maintain polio free status in Nigeria	• No indigenous poliovirus cases ((WPV/cVDPV) in the country from AFP or environmental samples during and after the grant period	0 WPV and CVDPV	0 WPV and CVDPV	0 WPV and CVDPV	AFP data base	Planned SIAs implemented as scheduled. Security conditions are good enough to implement PEI activities

Specific objective(s): Outcome(s)	• Improved availability of health expenditure data for policy and planning	• Number of policy briefs on financing developed in support of review and planning processes	0 (2015)	4 (2018)		Review reports	There will be political will to make recommended reforms
	• Improved availability of information on health service use and health outcomes	• Number of bulletins and health statistics briefs developed from HMIS data	0 (2015)	3 (2018) (at least one per year for annual reviews)		Administrative reports	
	• Reduce the proportion of missed children	• Proportion of LGAs with < 5% missed children in all SIAs	88%	ALL LGAs <5% missed children	95%	IPD data bases	Improved access in security compromised areas.
	• Increased and sustained herd immunity against poliovirus in polio high risk states	• Proportion of LGAs in high risk states that have achieved >90% LQAS in three consecutive SIAs	86%	90%	82%	LQAS data base	Improved access in security compromised areas.
		• Proportion of LGAs that have achieved 80% coverage for IPV	42%	80% of LGAs	82%	DVD-MT data	
Outputs	• Data on health expenditures routinely collected and reported	• Number of health accounts estimations conducted	3 (2015)	6 (2018; cumulative)		Health accounts reports	No delays or interruptions to planned timelines for activities due to

	• Quality of data assessed regularly, at least once per year, using internationally agreed data quality criteria	• Number of planned data quality assessments conducted using internationally agreed quality criteria such as the Data Quality Assessment Framework (DQAF)	0 (2015)	3 (2018) (at least one per year)		Reports of DQA assessments	political/security factors.
	• Highest quality polio SIA activities, including micro-planning, implementation of activities and supervision	• Proportion of high risk settlements that are supervised by Management support team during SIAs	TBD	80%	84%	IPD data base	Timely prioritization of risk LGAs done

HSS (Health Systems Strengthening) COMPONENT

	Intervention logic	Indicators	Baselines (incl. reference year)	Targets (incl. reference year)	Status as at 31 December 2017	Status as at 31 December 2018	Status as at 31 December 2019	Status as at 31 December 2020	Sources and means of verification	Assumptions
Overall objective	• Improved resource allocation to	• % of government	TBD	15% (by 2020)					Expenditure reviews	Data from assessments, reviews and

	national health priorities	expenditure on health *								studies will be used as recommended to improve planning
	• Reduction in financial barriers to health care access	• Proportion of Nigerians covered by any risk-pooling mechanisms*		30% (By 2020)					Living standards surveys, household expenditure reviews	
	• Improved capacity for tracking and reporting on UHC	• Federal and State MoH able to generate UHC Service Coverage index	NA	50% by 2020 (At least each State should have 50% of data on UHC SCI					National Health Observatory	
	• Data from health management information systems used for policy and planning	• Percentage of Federal and State plans and strategies that are based on routine HMIS data to improve coverage and quality of high impact interventions*	TBD	100% by 2020 (All key State Plans and Strategies based on HMIS data)		100% achieved Anambra and Sokoto SSHDP II, Anambra and Sokoto State M&E Operational Plan for 2018 and 2019 and the Federal level M&E Operational Plan			Joint review processes	

						2019 are all based on HMIS data				
Specific objective(s): Outcome(s)	• Improved availability of health expenditure data for policy and planning	• Number of policy briefs on financing developed in support of review and planning processes	0 (2015)	4 by 2020 (At least 1 per year)					Review reports	There will be political will to make recommended reforms
	• Improved availability of information on health service use and health outcomes	• Number of bulletins and health statistics briefs developed from HMIS data	0 (2015)	4 by 2020 (at least one per year from annual reviews)	0	6 health information products developed and disseminated			Administrative reports	
Outputs	• Data on health expenditures routinely collected and reported	• Number of health accounts estimations conducted	3 (2015)	6 by 2020; (cumulative)					Health accounts reports	No delays or interruptions to planned timelines for activities due to political/security factors.
	• Quality of data assessed regularly, at least once per year, using internationally	• Number of planned data quality assessments conducted using internationally	0 (2015)	3 (2020) (at least one round of DQA per year)	0	4 rounds of DQA were carried out in Anambra and Sokoto State			Reports of DQA assessments	

	agreed data quality criteria	agreed quality criteria such as the Data Quality Assessment Framework (DQAF)								

HSS Milestone Matrix

	Health Information Management System						
Outcome	**Indicator/Milestone**	**Baseline 2017**			**Target 2018**	**Target 2019**	**Target 2020**
		Anambra	**Sokoto**	**Federal**			
1. Agreed Policy and Strategy for HIS operational in the State	HIS Policy and Strategy in place	0	0	1 (but outdated and needs review and update)		1	3
	HIS costed operational Plan developed	0	0	0	2 (achieved)	3	3
1. Effective routine (HMIS) data management structure, plan and process in the state according to the	Number of facilities reporting	665	770		At least 900 HF reporting in Anambra and 800 in Sokoto State (725 health facilities report in Anambra; 825 reports in Sokoto)	At least 950 HF reporting routinely in Anambra, 830 in Sokoto	At least 1000 HF reporting routinely in Anambra, 830 in Sokoto

national HIS Policy or SOP							
2. Health Data Governance Platforms for functional	Number of resolutions made by the HDGC based on submission by the HDCC	0	0	0	At least 1 (2 achieved)	At least 1	At least 1
	Number of HDCC meetings that held	0	1	0	4 (6 achieved)	At least 6 (2 per State) 10 achieved	At least 6
3. HIS Platforms for coordination and management of LG HIS operational in the States	Number Integrated Health Data Management Team meeting	0	0		At least 8 per State (20 achieved)	At least 8 per State	At least 4 per State
4. Effective institutional and human capacity for data analysis, dissemination in State and LG levels	Number of staff trained on HMIS/DHIS2	25	30		100 (0)	300	1000
	Number of health Bulletins circulated per annum	0	0		4 (6 achieved)	4	6
5. Institutional reporting of hospital deaths through the DHIS2	Number of Health facilities reporting hospital deaths routinely on the DHIS	0	0		20	30	50

6. Improved quality or routine health data	Number of health facilities visited for Data Quality Reviews	NA	NA		At least 120 (102 achieved)	120	120
7. Improved capacity of LGA and health facility staff on data management	Number of health facilities visited for ISS	NA	NA		100 (102 achieved)	120	120
8. SMOH with functional linked dashboard for data analysis	Dashboard functional at State levels	0	0.5	0	2	2	2
9. State Master Facility List and updated database of health facilities available	Availability of updated Master facility list/database; update through physical mapping of facilities and completion of provided checklist	0	0	0	2 (2 achieved)	2 (2 achieved)	2
	Health Facility registry for continuous update of MFL functional	0	0	0	2 (0)	2 (2 achieved)	2
10. Effective framework for data analysis, dissemination and use	Availability of SOP/TOR for the DOC desk officers	0	0	0	2 (2 achieved)	2 (2 achieved)	2
	Number of HIS officers and stakeholders trained in data analysis	21	33		50 (113 achieved)	100	100

	Number of health facilities with standard template for data analysis	0	0		100 (60 achieved)	200	300
11. Guidance developed for more effective use of technology for data management and improved health services	National Digital Health Policy developed	0	0	0			1
	Updated National Digital Health Strategy developed	0	0	1 (but outdated)			1
12.Institutionalizatio n of ICD standards	Governance Structure for ICD standards adoption and coordination developed	0	0	0			1
	Capacity building for ICD implementation	0	0	0			At least 100 health workers trained
13. Operational Research Conducted to improve planning and policy making	OR on barriers to access to health services conducted in Sokoto State		0				1
	OR on effective private sector engagement conducted in Anambra State	0					1
14. Institutional Health Research	Situation analysis of the country research for	0	0	0			1

System Capacity development	health system capacity conducted						
	National Research For Health System Strategy Developed	0	0	0			1
	Publications from the National Research System capacity development	0	0	0			At least 3 publications

Human Resources for Health Information System						
Outcome	**Outcome indicator**	**Baseline 2017**		**Target 2018**	**Target 2019**	**Target 2020**
		Anambra	**Sokoto**			
1) HRH policy, Strategy and Operational plans and guidelines in place	HRH Policy and Strategy in place	0	0	1	1	1
2) HRH division fully functional with ICT equipment, furniture and fittings in place	Equipment procured, installed and commissioned	0	0	2 (achieved)		
3) A reliable web based database -Human	Web based functional HRH Registry at SMOH	0	0	1	1(2 achieved)	1

Resources for Health Registry functional	Number of senior government staff trained on the use of HRH Registry for HRH management	0	0	30	30	40
4) HRH management decision making, policy making and funding based on output from the HRHIS	Number of HRH management decisions based on data on Registry	0	0	1	1	1

Healthcare Financing					
Outcome	**Outcome Indicator**	**Baseline 2017**	**Target 2018**	**Target 2019**	**Target 2020**
1) Approved HCF policy, Strategy operational in the States	HCF Policy and Strategy in place	0	2 (achieved)	2	2
2) HCF activities are coordinated by the HCF unit in MOH	HCF Units are established and functioning	1	2 (achieved)	2	2
3) Strengthened and integrated health financing coordination platforms	Number of coordination meetings held by HCF TWG	0	At least 4 (achieved)	At least 4	At least 4
4) HCF Baseline studies and core analytics reports produced	Number of studies conducted	0	5 (achieved)	At least 2	At least 3
5) Health Personnel trained on HF and Management	Number of health personnel trained	0	100 (110, achieved)	100	50

6) Annual health accounts reports produced	Annual health accounts reports in place	1	3 (achieved)	3	3
7) Annual Budget and outcomes analysis conducted	Annual Budget and outcomes analysis produced	0	0	2	2
8) Investment Case for health developed and used for resource mobilization	Number of States with Investment Case for health	0	2 (achieved)	2	2
9) Processes for data transfer and upload to the health accounts software from government financial management information systems automated	Number of States with functional automated financial management system	0	2 (achieved)	2	2
10) Operations research on health financial risk protection conducted	Report of operations research available to inform policy and practice	0	0	1	2
11) State level scorecards based on health expenditure and health service information to inform state level annual reviews developed	Health financing scorecard in place	0	1 (achieved)	1	2

ANNEX VII: THE EVALUATION CRITERIA

The definition and the number of the DAC evaluation criteria has changed following the release (10 December 2019) of the document "Evaluation Criteria: Adapted Definitions and Principles for Use" (DCD/DAC(2019)58/FINAL).

The evaluators will ensure that their analysis will respect the new definitions of these criteria and their explanatory notes. Reference and guidance documents are being developed and can be found here: https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

Unless otherwise specified in the chapter 2.2.1, the evaluation will assess the Intervention using the six standard DAC evaluation criteria and the EU added value, which is a specific EU evaluation criterion. Their definitions are reported below:

DAC CRITERIA

- **Relevance**: the "extent to which the intervention objectives and design respond to beneficiaries', global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change."
- **Coherence**: the "compatibility of the intervention with other interventions in a country, sector or institution."
- **Effectiveness**: the "extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups."
- **Efficiency**: the "extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way."
- **Impact**: the "extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects."
- **Sustainability**: the "extent to which the net benefits of the intervention continue or are likely to continue."

EU-SPECIFIC CRITERION

EU added value: the extent to which the Intervention brings additional benefits to what would have resulted from Member States' interventions only in the partner country. It directly stems from the principle of subsidiarity defined in the Article 5 of the Treaty on European Union (https://www.europarl.europa.eu/factsheets/en/sheet/7/the-principle-of-subsidiarity).

TERMS OF REFERENCE – PART B

BACKGROUND INFORMATION

1. Benefitting Zone

Nigeria

2. Contracting authority

The European Union, represented by the European Commission, B-1049 Brussels, Belgium.

3. Contract language

English

LOCATION AND DURATION

4. Location

- **Monitoring and Evaluation Expert 1::**
    - Normal place of posting of the specific assignment: Normal place of posting of the specific assignment: Abuja, FCT Nigeria.
    - Mission(s) outside the normal place of posting and duration(s): Mission(s) outside the normal place(s) of posting and duration(s): field visits in Anambra, Sokoto and at least any other 2 northern high risk States for Polio (16 working days)
- **Public Health Specialist; Evaluation Team Leader:**
    - Normal place of posting of the specific assignment: Normal place of posting of the specific assignment: Abuja, FCT Nigeria
    - Mission(s) outside the normal place of posting and duration(s): Mission(s) outside the normal place(s) of posting and duration(s): field visits in Anambra, Sokoto and at least any other 2 northern high risk States for Polio (16 working days)

5. Start date and period of implementation

The indicative start date is 01/02/2021 and the period of implementation of the contract will be 70 days from this date (indicative end date: 12/04/2021).

REQUIREMENTS

6. Expertise

For this assignment, one individual expert must be proposed for each position.

The expertise required for the implementation of the specific contract is detailed below.

- **Monitoring and Evaluation Expert 1::**

- General description of the position: A university graduate with demonstrable experience in M&E in donor supported Health Sector programmes
- Expert category: Cat. I (>12 years of experience)
- Qualifications and skills required: 1. At least a Master Degree (Academic level) in Public Health, Sociology or Health Finance or relevant, directly related discipline, or equivalent; 2. Minimum 12 years of experience with organisational and institutional development and efficiency, and project/programme management and/or implementation of activities at international level (worked in at least two countries) some of which should have been acquired in a developing country. SKILLS: • ICT Proficiency • Expertise in problem analysis, stakeholders' analysis and preparation of Log frames; • Knowledge/Experience in Nigeria and/or West Africa or similar countries is an advantage.
- General professional experience: 3. Demonstrable Experience in leading missions for project evaluations.
- Specific professional experience: 4. Specific expertise in designing technical assistance, capacity development and training programs. 5. Minimum of 4 years' experience with EDF programming procedures will be an asset; 6. Demonstrated ability to innovate, integrate, synthesize and communicate complex concepts and ideas verbally and in writing.
- Language skills: Full working knowledge of English, as well as excellent field research report writing and communication skills.
- Minimum number of working days: **35** days
- Additional information: Minimum number of working days on mission = 16

- **Public Health Specialist; Evaluation Team Leader:**
  - General description of the position: A medical professional with demonstrable experience managing programme evaluations
  - Expert category: Cat. I (>12 years of experience)
  - Qualifications and skills required: 1. Master’s degree in Medicine or related fields, Health Financing/Economics, Public Health, Social Sciences or Economics. 2. At least 12 years’ experience and technical expertise in Health Financing, Public Health, Health Systems, Public Finance Management, health policy and strategy development, Strategic planning, monitoring and evaluating health systems SKILLS: • Experience with capacity development projects as per guidance provided by the "EU backbone strategy" (http://ec.europa.eu/development/icenter/repository/backbone_strategy_technical_cooperation_en.pdf) and the "Guidelines on "Making technical cooperation more effective"" (http://ec.europa.eu/europeaid/how/ensure-aid-effectiveness/documents/guidelines_on_tc_finale_en.pdf). • Familiarity with international standards and methods regarding health financing and health reforms • Familiarity with contractual and tender procedures; • Minimum of 3 years' experience with EDF programming procedures will be an asset; • Proven field research and report writing skills; • Creative ability to identify practical solutions to overcome challenges to time-critical projects; • Excellent interpersonal skills to relate to counterparts on all

levels of hierarchy; • IT literate, very good data-processing knowledge, and of office automation software; • Experience in communication, negotiation and dialogue at high level.

- General professional experience: 3. Professional experience in a developing country(ies) and demonstrable knowledge of the political economy of health including health insurance 4. Professional experience in leading missions for project evaluations demonstrated by leadership of at least 3 missions.
- Specific professional experience: 5. Demonstrated ability to analyse political contexts, interact, and negotiate effectively with multiple interests at the political level. 6. Demonstrated ability to provide sound methodological and technical advice and guidance to government and multiple stakeholders and partners
- Language skills: proficient in English Language
- Minimum number of working days: **35** days
- Additional information: Minimum number of working days on mission = 16

7. Incidental expenditure

No incidental expenditure provided for in this contract.

8. Lump sums

No lump sums provided for in this contract.

9. Expenditure verification

No expenditure verification report is required.

10. Other details

No other details provided for in this contract.

REPORTS AND DELIVERABLES

11. Reports and deliverables requirements

Title	Content	Language	Submission timing or deadline
Inception Note at end of inception phase	Analysis of risks related to the evaluation methodology and mitigation measures • Intervention logic • Stakeholder map • Methodology for the evaluation, incl.: 1. Evaluation Matrix: Issues to	English	Within 2 Week(s) After the project start

Title	Content	Language	Submission timing or deadline
	be addressed, with judgement criteria and indicators, and data analysis and collection methods 2. Consultation strategy 3. Field visit approach • Analysis of risks related to the evaluation methodology and mitigation measures • Work plan		
Intermediary Report at end of field phase	Key preliminary findings (combining desk and field ones) • Activities conducted during the field phase • Difficulties encountered during the field phase and mitigation measures adopted • Key preliminary findings (combining desk and field ones)	English	Within 8 Week(s) After the project start
Draft final report	• Cf. detailed structure in Annex III	English	Within 9 Week(s) After the project start
Draft Executive Summary – by using the EVAL online template	• Cf. detailed structure in Annex III	English	Within 10 Week(s) After the project start
Final report	The final report has to demonstrate a solid understanding of the context, the sector and the methodology of evaluation: • Same specifications as of the Draft Final Report, incorporating any comments received from the concerned parties on the draft report that have been accepted. The structure, format and level of detail of	English	Within 12 Week(s) After the project start

Title	Content	Language	Submission timing or deadline
	the three final reports will be agreed with the EU Delegation during the briefing at the beginning of the assignment. As a minimum, the final reports must include the following: i. Executive Summary ii. Introduction / Background iii. Project outline and management iv. Objectives v. Methodology vi. Analysis vii. Findings viii. Lessons Learned ix. Recommendations x. Relevant Annexes, e.g. a. List of people interviewed b. List of acronyms c. Evaluation work plan and TORs d. Key reference documents The recommendations must be duly justified. The final report have to be submitted 2 weeks after having received comments to the Draft Final Report.		
Executive Summary – by using the EVAL online template	• Same specifications as for the Draft Executive Summary, incorporating any comments received from the concerned parties on the draft report that have been accepted Apart from their submission - preferably via the EVAL Module-, the approved version of the Final Report will	English	Within 12 Week(s) After the project start

Title	Content	Language	Submission timing or deadline
	be also provided in 5 paper copies and in electronic version at no extra cost. 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		