Title	Funding Code	Type of engagement	Duty Station:
Evaluation Consultant, Community Health and Nutrition Volunteers Review		☐ Consultant ☒ Individual Contractor	Yemen

Purpose of Activity/Assignment:

Purpose

1. Since the expansion and extension of the earlier Community Based Nutrition Programme (CBNP) by MOPHP to the Community Health and Nutrition Volunteers programme which began in 2009, no in-depth review of this programme has been conducted despite the significant resources and consequent scale-up of the programme to date. Therefore, it is imperative that UNICEF take stock of the programme's achievements, best practices, gaps, challenges, opportunities, and lessons learned. The main purpose of such a review is to guide and support future scale-up and ensure improved programme effectiveness and efficiency across the various components required for a successful community-based nutrition programme.

Overall Objective

2. The objective of this review is to give UNICEF and partners a clear understanding of the extent to which the CHNV programme has met its objectives, what the strengths and weaknesses of the program are, and how to move the program forward. The review is intended to provide opportunities for learning and improve programming and ensure accountability to donors and communities served by the program.

3. In line with the existing literature on success factors for community-based nutrition programmes the specific objectives outlined below will aim to explore both programmatic – directly under the influence of the intervention - and contextual factors (Musgrove, et al, 2006) that have influenced the programme.

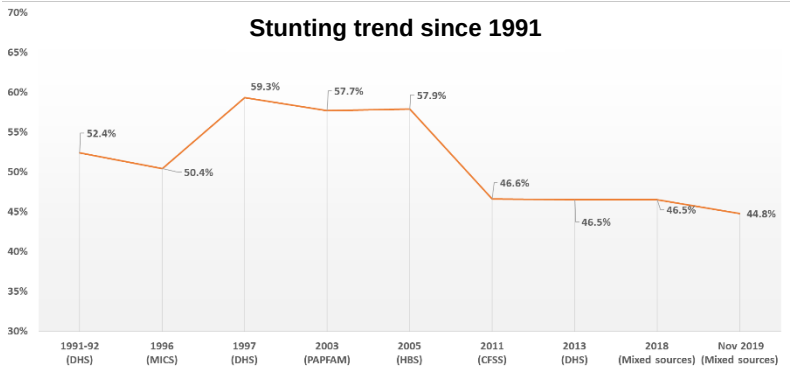
Specific Objectives

- Assess the programme's effectiveness by reviewing the programme coverage (CHNV village/district/governorate vis a vis population) coverage, targeting and programme performance (intervention coverage)
- Assess and document the evolution of the programme (design and content); capacity building, including mentoring approaches; and leadership and oversight of the programme, including linkages with other community structures
- Assess the intensity of the resources used for this programme, particularly in relation to the incentives and renumeration modalities of the programme to determine more cost-effective approaches going forward
- Review the information and reporting system (data collection, compilation, reporting, and dissemination) of the programme to ascertain the extent to which the system operates efficiently, and the reporting is used to improve interventions and services.

Background and Context

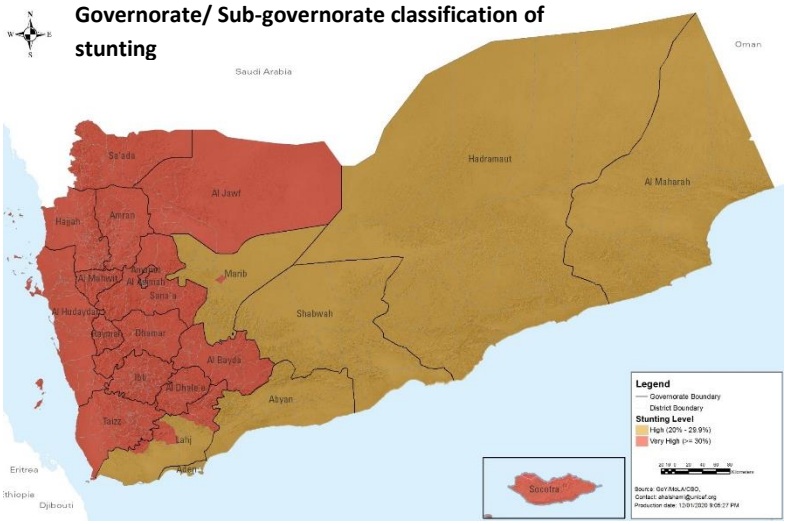
Yemen's Nutrition Situation

4. The nutrition situation



Malnutrition in Yemen exists in its different forms, chronic, acute, and multi-micronutrient deficiencies. The current prevalence of chronic malnutrition (stunting) based on different surveys done between 2017 and 2019 (mainly SMART surveys) is 44.8%, which is close to that found by DHS 2013 and CFSS 2011 and exceeds the WHO threshold of "very high prevalence". Although a reduction in stunting was reported between 2005 HBS (58%) and 2011 CFSS (46.6%), the current assessments 2018 and 2019, although not nationally representative, show stunting levels to be stagnant. However, the unfavourable circumstances due to the outbreak of war and its continuation for almost seven years with consideration to all negative consequences of conflict on economic, social, health and livelihood situation of people especially vulnerable groups, may make stunting more likely to return to upper levels. Beyond that, 17 out of the 22 governorates of Yemen, have very high stunting prevalence while 5 have 'high prevalence' based on new WHO classification of the severity of the problem[1]. There is no single governorate at medium, low, or very low stunting prevalence. The most affected governorates are Sa'ada, Rayma, Amran and Dhamar, where the stunting exceeds 60%.

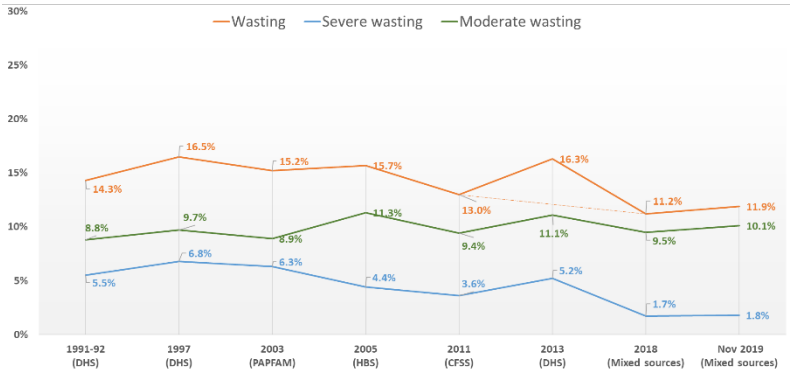
Governorate/ Sub-governorate classification of stunting



1 de Onis *etal*, doi: 10.1017/S1368980018002434. For wasting, <2·5 Very low, 2·5–<5 Low, 5–<10 Medium, 10–<15 High, and ≥ 15 Very high. For stunting, <2·5 Very low, 2·5–<10 Low, 10–< 20 Medium, 20–< 30 High, and ≥ 30% Very high.

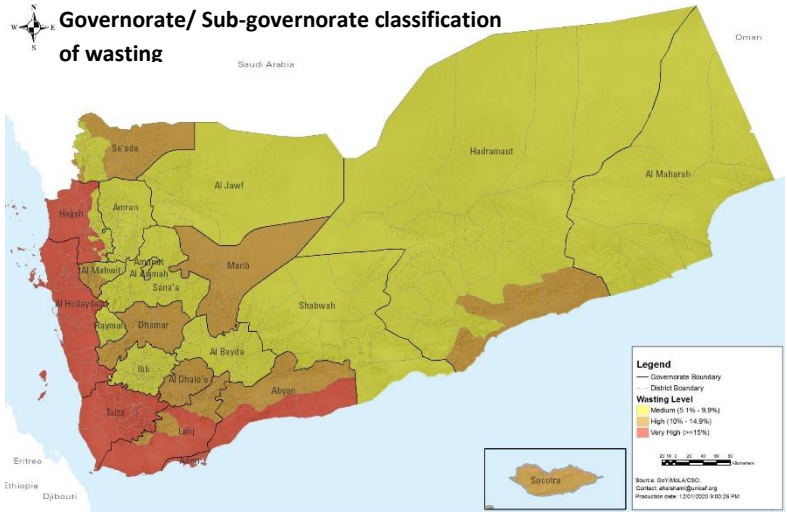
5. Acute malnutrition levels for any given time during the past 40 years or more ranged between slightly above 10% to slightly above 15% which are either 'serious or high' or 'critical or very high' using the new WHO thresholds defining the severity of the situation. The trendline shows a slight decrease in wasting level during 2011 and 2019, from 13% to 11.9%. That decrease occurred only in severe acute malnutrition (from 3.6% to 1.8%), while for moderate acute malnutrition, it has slightly increased, from 9.1% to 10.1%. The reduction in malnutrition could be partially attributed to the country-wide scale up of the CMAM programme from 599 treatment facilities (Outpatient Treatment Centres for the management of severe acute malnutrition without complications) in 2012 to 4438 facilities in 2021.

Acute malnutrition trend since



6. Four of Yemen's 22 governorates have very high wasting prevalence, 6 have high wasting prevalence, and 12 have medium wasting prevalence, based on the new WHO classification of the severity of wasting. It is worth noting that the highest prevalence is in the coastal and lowland areas, especially in the western and southwestern districts, where GAM levels exceed 20%. The WHO classification of wasting is based on weight for height criteria with no inclusion of child MUAC measurement. In Yemen, the prevalence of wasting by MUAC is 6.5% that includes 1.8% who are not identified as wasting by weight for height criteria.

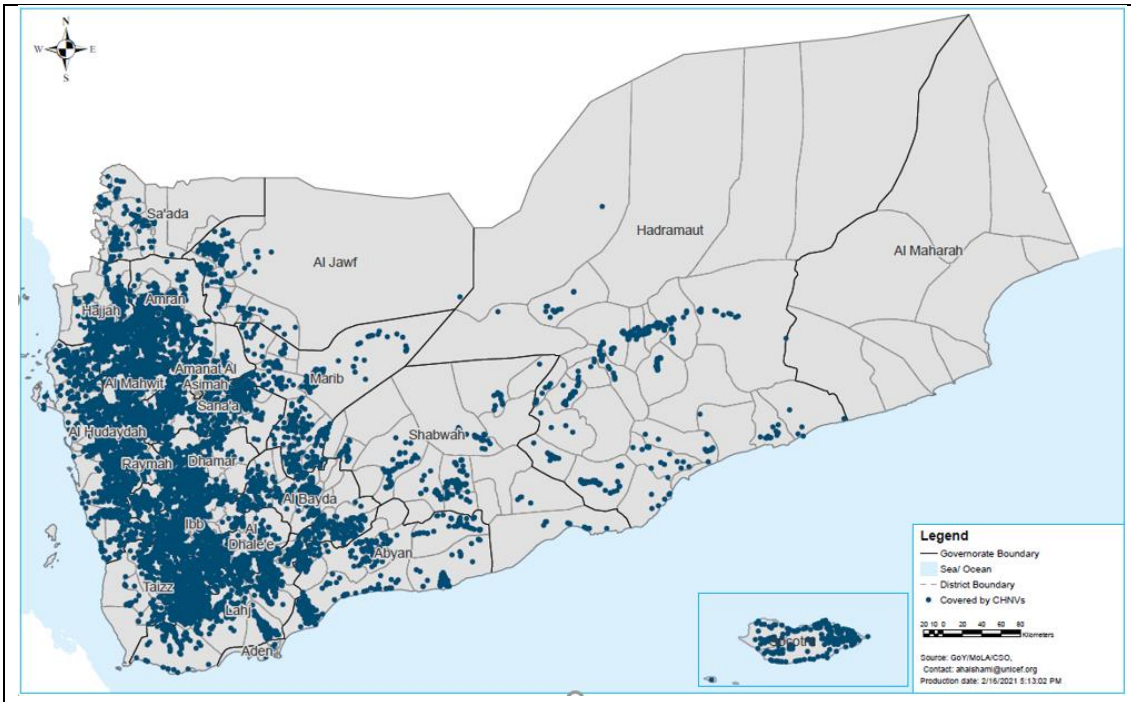
Governorate/ Sub-governorate classification of wasting



CHNV Programme Overview

7. The Community Health and Nutrition Volunteers (CHNV) program comes as an extension of the Community-based Nutrition (CBN) Program that was implemented by the Ministry of Public Health and Population (Nutrition Department) during the period 2003-2005 as part of the children's development project, in partnership with and support from UNICEF. During this period, the program was implemented in 10 districts where the number of volunteers reached 332 in 322 villages. Following the discussion of the 2006 assessment findings and after bringing the program's documents and results achieved to the attention of the Ministry's leadership, the Ministry decided to improve the program and add the health services component to the nutrition services that are provided by volunteers. Services thus included primary health care services which could be provided by the volunteer in the community through a Community Health and Nutrition Volunteers (community component) program within the Health System Strengthening program (HSS). At the same time, the Japanese International Cooperation Agency (JICA) reviewed the community-based nutrition program with community engagement and decided to provide support in this aspect. Discussion took place between MoPHP officials and JICA and it was agreed to provide support for an integrated project that would include nutrition services and health care services that can be provided by the volunteers as is the case with the community component within the Health System Strengthening (HSS) program.

8. The CHNVs program (the community component) was implemented within the HSS program from 2009 - 2010. The program targeted 35 districts, and the number of volunteers that received the training reached 918. In 2011, partnership with and support from UNICEF continued aiming at improving, managing, implementing, and scaling up the CHNV program. An evaluation of the program was conducted in 2014 and findings suggested that 80% of the volunteers continued to work. It was decided therefore to continue to expand the community network of CHNVs, and by the end of 2020, the number of trained CHNVs reached 24,648 in 243 target districts in 22 governorates.



Description of the CHNV Programme

9. The CHNV programme is one of the components of the integrated health care program aimed at mitigating health and nutritional problems in an integrated manner and at involving community in planning, implementation, and follow-up. Services are provided at the village level by volunteer women and girls from the same community and with support from community leaders. The program operates through a clear system with specific tasks at all levels.

10. This program is part of health system strengthening and draws on the previous community-based nutrition experience, the community component in the integrated child health care program, and the experiences of countries, such as Oman, Nepal, Ethiopia, Vietnam and Iran, with successful records in this field and who shared their experiences with health sector leaders and workers globally. ().

Programme Rationale

11. The following justifications reflect the significance of the program:

- The majority of children and mothers in villages do not regularly visit health facilities.
- Many health facilities are unable to provide quality health and nutritional education, counselling, follow-up, and child growth promotion services in.
- There is a small number of available health facilities compared to dispersed populations, the remoteness of facilities from villages, and rugged terrain and difficult access roads.
- The low income of most families in the countryside makes it difficult to find transportation to go to facilities providing health services.
- The program contributes to the improvement of the health of mothers and under-five children through the provision of basic health and nutrition services.
- The program contributes to the reduction of maternal and child mortality rate by improving the nutrition and health of mothers and children through direct outreach community services.

Objectives of the CHNV Programme

12. The objectives of the program are no different from the overall aim, which is to improve the health of women and children. The difference, however, is in access to community, which is facilitated by community volunteers who will work on follow-up and promotion of child growth. They will also work on promoting women's and children's access to health and nutrition services within communities, providing counselling, education, and messages that lead to enhanced health-seeking behaviours, in addition to providing referrals to health facilities when required.

13. The strategic objective of the program is to expand prevention coverage and reach mothers and children with integrated health services in areas that are far from the reach of health facilities to improve community health levels with contribution from all individuals and groups benefiting from health and nutrition services. This community involvement aims to change health and environmental behaviours for the better, as this factor will have a major positive impact in preventing all forms and levels of diseases in the short, medium, and long term.

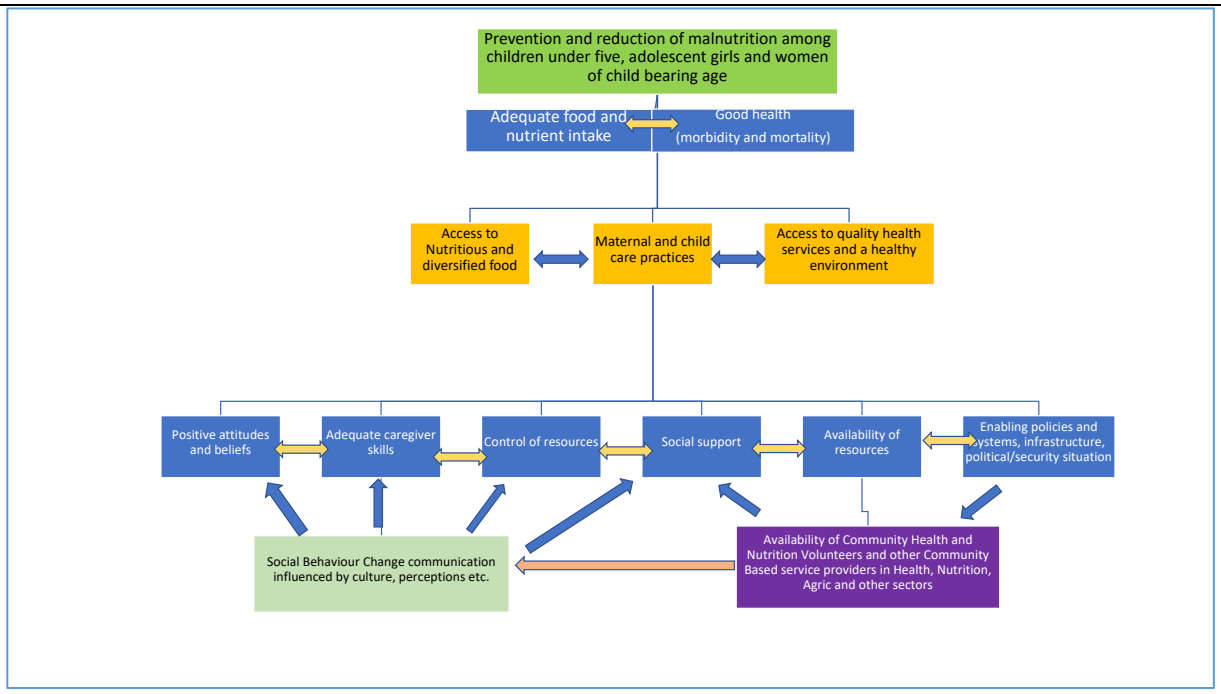
14. The essential component in these interventions is community involvement, which is primarily comprised of female volunteers who are selected from within the villages according to specific criteria and are trained to implement the program under the supervision of and cooperation with the community and those implementing the program at the central and local levels.

Key Pillars of the Programme

15. The CHNV programme is structured around eight key pillars:

- The program is in line with the recommendations of international conferences on health, which affirm that health and nutritional care is the primary entry point for all citizens to reach a certain level of health that allows them to lead a socially and economically productive life, which is a major social goal for governments. They also affirm that governments have a responsibility toward the health of their people, and this responsibility can only be fulfilled by taking complete health and social measures. At the same time, people have a right and a duty to participate, as individuals and groups, in the planning and implementation of their health and nutrition services, and that full community participation is essential for the improvement of primary health care and the overall health of people.
- The program system is in line with the State's directions in terms of the health sector reform policy, as it enhances community participation. Community participation is considered one of the most important elements in the provision of health care services, and which is emphasized by the health sector reform policy and project.
- The program is based on the integration of health and nutritional services at the district level, and coordination and cooperation at other levels, and has a clear regulatory framework at all levels that can be monitored, supervised, evaluated, and corrected and which can receive feedback.
- National strategies such as the poverty reduction strategy, as well as health strategies such as the health sector reform strategy, consider community participation and involvement in development and health programs a necessity to ensure the sustainability of and continued viability of these programs.
- The program reaches villages far from district centres and health facilities with health and nutrition services. This is in full consistency with the international principles established in the work plans of the Millennium and/or the Sustainable Development Goals, and which stipulate that health and development plans should take into consideration reaching the poor and the vulnerable in local communities in the hardest to reach areas.
- Integration in providing primary health care services means reduction of expenses in health services, especially costs associated with provision of treatments.
- Information reported by villages can be used at the community level (village) and district level as an excellent tool and a useful guide in analysing community problems and identifying their basic needs in a reliable and methodological manner. With regard to the health system, this information can substitute for expensive nutrition surveys in the future.
- The program relies on community volunteers. Continuous training and supervision are aimed at building capacities in community health and nutrition which will be beneficial for future generations. The presence of such capacities will over a sustained period lead to healthy practices and behaviours.

CHNV Programme Theory of Change



Budget Year:	**Requesting Section/Issuing Office:**	**Reasons why consultancy cannot be done by staff:**
2022	*Evaluation*	*Need for external, independent evaluation*

Included in Annual/Rolling Workplan*:* ☒ Yes ☐ No, please justify:

Consultant sourcing:	**Request for:**
☒ National ☐ International ☐ Both	☒ New SSA ☐ Extension/ Amendment
Consultant selection method: ☒ Competitive Selection (Roster) ☒ Competitive Selection (Advertisement/Desk Review/Interview)	
If Extension, Justification for extension:	

Supervisor:	**Start Date:**	**End Date:**	**Number of Days (working)**
Sarah Capper	March 15, 2022	August 15, 2022	50

TERMS OF REFERENCE FOR INDIVIDUAL CONSULTANTS AND CONTRACTORS

Work Assignment Overview

Scope

16. The proposed review will assess both programmatic and contextual factors that have driven the programme and/or have limited the programme's effectiveness or efficiency, in the period from January 2019 to present. This will look at the whole of Yemen using a desk review. The review will also address gender- and geography-related vulnerabilities.

Evaluability

17. The CHNV programme has a theory of change and results framework that link inputs, process, outputs, outcome, and impact. These resources are available above in this document. The Ministry and other partners developed a unified reporting tool and mechanism in 2013-2014 to track scale-up efforts nationally, and that tool was revised in 2018-2019 and adopted by the Nutrition Cluster and ministries. Data flows monthly directly from the CHNVs to each health facility's administrators, who send the data to the district-level health offices. From the district level, the data then goes to governorate-level health offices and then, finally, to the MoPHP. The government and partners conduct monthly review meetings and supportive supervision is designed to take place regularly. The reporting data is available from both the Ministry and the Nutrition Cluster. The programme lacks a baseline assessment; however, there was a review of the earlier Community-Based Nutrition Programme in 2006.

Evaluative Review Questions

Relevance/Appropriateness

a. How aligned is the CHNV programme design with the needs of the affected population?[2] How aligned is it with the existing national nutrition strategy?

Coverage

b. To what extent has there been a focus on ensuring that programme services are equitable and accessible for disabled children and caregivers, and for all individuals of all genders, geographic regions, and abilities? In which ways were they inaccessible or inequitable, and why?
c. What factors enabled and hindered performance of the programme across different geographical areas?

Coherence

d. To what extent has the CHNV programme adopted a multisectoral approach, linking CHNV interventions with other complementary community-based interventions that address malnutrition (both within the health sector and beyond), including the WASH, education, social protection, food security and agriculture sectors? What are the missed opportunities and what can be done differently?

Efficiency

e. How timely is the information and reporting system of the CHNV programme in collecting, compiling, reporting, and disseminating data? What factors limit reporting and what are the solutions?
f. How cost-effective is the CHNV programme, particularly in relation to the role the allowances and overall renumeration modality at different levels play in the programme's work?

Effectiveness

g. To what extent has the CHNV programme reached its targets? What roles has the programme planning (programme design including service delivery package, geographical targeting, training content, leadership/coordination, monitoring and supervision) and overall programme implementation contributed to the programme's results?
h. What role have the social behaviour change and communications and advocacy elements played in the programme's results, and how well have these elements engaged local leaders and influencers? How well have these elements supported the programme's goals? What are the missed opportunities and recommendations?

Connectedness/Sustainability

i. How committed have donors been to continued financing of the CHNV programme over the last two years? How viable is the programme without donor funding?

Stakeholders

18. The following stakeholders have been identified for this evaluation:

- MoPHP
- Nutrition Cluster
- UNICEF Yemen Country Office
- WFP Yemen

- WHO Yemen
- Other key NGO implementing partners in Yemen including national and international NGOs
- Governorate and District level health authorities in Yemen
- Local and district-level health workers at health facilities and mobile teams in Yemen Community health workers and volunteers in Yemen
- UNICEF Middle East and North Africa Regional Office
- Community leaders and structures

Methodology

19. Given the nature of the program, data availability, and the current context of COVID-19, this review will make use of existing data and will only collect new qualitative data from UNICEF and partner staff, not from governorate- or district-level staff, CHNVs themselves, or service users. There are CHNV data available; however, there are gaps in the available data. There is no existing baseline study. Data from early stages of the program may be used to attempt to reconstruct one, but the consultant team should anticipate that existing data will not be adequate to constitute a true baseline.

20. Because this evaluation will only collect data from UNICEF and partners, the evaluation team should anticipate working with gaps in data and mitigating the effects of incomplete data. The evaluation methodology will be based on the evaluation framework outlined in the inception report. The selected consultant team will be requested to refine and submit the final detailed methodology for review by UNICEF at Country Office, Regional Office and NY Headquarters level at the inception phase. UNICEF anticipates that the methodology will include a thorough desk review, given that no additional data will be collected from CHNVs, HWs, or local authorities.

Inception

21. The evaluation manager will organize a briefing for the consultant team within one day of the signing of the evaluative review contract. By the time of the briefing, the consultant team will receive all documents required for the writing of the inception report. After the briefing, the consultant team will have one week to develop the inception report, which should include an elaborated methodology as well as a workplan with timeline and data collection instruments. Requests for additional documents and data should also be begun at this time. After the submission of the inception report, UNICEF will have one week to provide feedback and obtain ethical clearance. The consultant team will then have one additional week to revise and submit the final inception report, including the instruments for data collection from UNICEF and partner staff.

Desk Review

22. The desk review for the CHNV review should be extensive given the inability to collect much additional data in the current circumstances. The desk review should include a review of CHNV program records and related data at the national, governorate, district, facility and CHNV levels (based on availability). Program managers will provide data that are readily available from various sources, some of which may be in Arabic and may require translation for consultants who do not read Arabic. In addition, the desk review is expected to include secondary data and documents when available.

Data Collection

23. After the final methodology and data collection instruments are finalized at the inception stage, the consultant will collect data from UNICEF and its partners using an interview format. The interviews will be a combination of face-to-face and remote, if possible; data collection methodology will be elaborated at inception. Data collection itself will consist primarily of interviews conducted remotely or face-to-face with key informants to include MoPHP officials; UNICEF, WFP, and WHO staff; Nutrition cluster partners; and donor representatives. Data collection from ministry officials may also be possible. When possible, existing quantitative data should be disaggregated by gender and geographical location; variables will be

[2] UNICEF Yemen is aware of the limitations of asking this question, as well as questions b and h, without direct access for the evaluation consultant to affected population, service users, and local leaders and influencers. It is hoped that this desk review can give UNICEF preliminary information on these questions and upon which UNICEF can build at a later point in time when it is more possible to access these groups.

finalized at the time of the inception report. Additional information at facility or community levels, if necessary, will be collected through programme monitoring visits by UNICEF staff or Facilitators.

Data Analysis and Reporting

24. Given the sensitive context of Yemen, the consultancy team should pay special attention to data quality control. The consultant team, working together with UNICEF, will exercise data quality control mechanisms intended to preserve the integrity and confidentiality of the data. Quality control measures should be outlined in the inception report and should cover confidential handling and storage of the review's data, as well as culturally-sensitive and ethical data collection (according to UNEG standards) and ethical evaluator conduct. In addition, the consultant should record the interviews if possible and submit them to UNICEF with the final report. The consultant team should store the recordings and coded data securely and keep them for 90 days after the submission of the final report. After 90 days, the data should be deleted.

25. Data analysis should be guided by the evaluative review questions, and the final report should be structured around each of the overarching evaluation criteria – relevance/appropriateness, coverage, coherence, efficiency, effectiveness, connectedness/sustainability – instead of individually by question. Analysis should focus existing quantitative data on descriptive statistics, as there is no baseline, and qualitative data should be mined for patterns. Data should be triangulated across sources. In addition, evidence of unintended consequences should be highlighted. Throughout the analysis, whenever possible, existing data should be disaggregated by the variables agreed in the inception report.

26. The final report should be shared with UNICEF, as well as other stakeholders, as a draft for comments. The draft report should be organized around these criteria and should be comprehensive and provide detailed and specific results and conclusions, as well as clear recommendations. During inception phase, UNICEF and the consultant will discuss options for various formats for presenting preliminary findings at the beginning of the report drafting phase of the evaluation.

Ethical Considerations

27. Ethical issues and considerations as per the UNEG and UNICEF ethical standards for evaluation should be adhered to. This includes explicit reference to the obligations of evaluators (independence, impartiality, credibility, conflicts of interest, accountability); ethical safeguards for participants appropriate for the issues described (respect for dignity and diversity, right to self-determination, fair representation, compliance with codes for vulnerable groups, confidentiality, and avoidance of harm); and if the consultant plans to interview children, the UNICEF procedures for 'Ethical Research Involving Children' should be explicitly referred to. The consultant will also integrate gender and human rights considerations into the evaluation, in both the evaluation questions and in the conduct of the evaluation.

Limitations

28. As noted in the evaluability section above, the CHNV programme lacks some aspects of ideal evaluability. The lack of a baseline assessment prevents some components of robust evaluation and is one reason that this exercise is intended as a lighter evaluative review.

29. Given the current security situation in Yemen and restrictions in access, as well as COVID-19, the review will rely on remote data collection to reach a wider geographical scope and to avoid challenges raised by inaccessibility of certain areas due to road conditions and conflict. Selection of samples may rely on convenient and purposive sampling rather than randomized methods. Alternative methods may also be used. However, the consultant team will have to provide the justifications and framework for the sample selection methods to be used.

30. Visits to Yemen by international team members will not be possible; international consultants who wish to apply should plan to conduct the evaluation remotely with support from local consultants.

31. In addition to the access restrictions listed above, given the humanitarian situation of Yemen and the onset of COVID-19, the consultant team should remain cognizant that the programmatic staff dealing with this evaluative review will continue to face heavy workloads and will not be as available to respond to questions as in many other contexts globally under different circumstances. Communication should flow strictly through the Evaluation Specialist so as to limit further overloading already-overburdened programmatic staff; the consultant team should be aware that tight and early coordination with the Evaluation Specialist is necessary when questions for program staff arise, and that responses could take a longer-than-average time under the current circumstances.

32. As a result of the constraints listed above, this evaluative review will not attempt to cover impact, and will focus on the objectives listed in the Purpose and Objectives section.

Governance

33. The review will be funded and managed by UNICEF Yemen, with technical consultation with the UNICEF regional office. The Evaluation Specialist will supervise the consultant. Stakeholders will provide the consultant access to data and information and facilitate remote data collection via the Evaluation Specialist. The Evaluation Specialist and consultant will hold biweekly calls to facilitate the review and address any challenges that arise. The review may require clearance by an ethical board via the UNICEF MENA Regional Office.

Payment

34. All interested consultants are requested to include in their submission detailed costs including:

- Daily rate including hours per day
- Additional expenses (interpretation and translation, costs for training data collectors, etc.) to be agreed prior to commencing project
- The consultant would be required to use their own computers, printers, photocopier etc.

35. The contract will be awarded on a best value-for-money basis. Payment is contingent on approval by the Evaluation Specialist and will be made in three instalments:

- 25 percent after the inception report
- 35 percent after the presentation of preliminary findings
- 40 percent on completion of all deliverables and final report to the satisfaction of UNICEF.

Location

36. The work will be home-based, though the national consultant should be based in Yemen.

ICT Considerations and Data Security

37. The evaluation team will require access to some of the UNICEF internal databases and documents. Where UNICEF engages third parties to conduct monitoring on its behalf, they are obliged to implement appropriate data security measures. UNICEF data, including intellectual property rights, are the exclusive property of UNICEF and the evaluation team has a limited, nonexclusive permission to access and use the data. As provided in the contract, the data will be used solely for the purpose of performing its obligations under the contract. The evaluation team has no other rights under the contract, whether express or implied, to any UNICEF data or its context. To maintain the integrity of stored data, data should be protected from physical damage as well as from tampering, loss, or theft by limiting access to the data.

38. Data stored on paper, such as on data collection tools should be kept in a safe, secure location away from public access, e.g., a locked filing cabinet. Confidentiality and anonymity should be assured by replacing names and other personal information with encoded identifiers.

39. All data collected by the evaluation consultant at UNICEF's request is the sole property of UNICEF. The consultant will hand over all reports and raw data to UNICEF upon satisfactory completion of the evaluation. In terms of disposal, the evaluation data will be retained for a minimum of 3 months after UNICEF approval of the evaluation report and raw datasets. Paper documents will be shredded, and digitally stored information destroyed or securely overwritten. The consultant will be expected to provide UNICEF with a letter confirming that the data has been disposed appropriately. All evaluation data will be stored centrally in one database by the Evaluation section.

Evaluation Process of the Proposal

40. Consultants are requested to submit CVs and a financial proposal. Assessment will be done based on the CVs according to academic background and work experience, and then financial proposals of qualified, pre-selected finalists will be evaluated for competitiveness.

Unsatisfactory Performance

41. In case of unsatisfactory performance, the payment will be withheld until quality deliverables are submitted. If the selected consultant is unable to complete the assignment, the contract will be terminated by notification letter sent 14 days prior to the termination date. In the meantime, UNICEF will initiate another selection process to identify appropriate candidate.

Conditions and Administrative Issues

42. The consultant will work on their own computer(s) and use their own office resources and materials in the execution of this assignment. The contractor's fee shall therefore be inclusive of all office administrative costs.

43. Granting access to UNICEF ICT resources for consultants/non-staff is considered as 'exception,' and therefore shall only be granted upon authorization by the head of the office on justification/need basis. This includes creation of a UNICEF email address, as well as access to ICT equipment such as laptops and mobile devices.

44. All persons engaged under a UNICEF service contract, either directly through an individual contract, or indirectly through an institutional contract, shall be subject to the UN Supplier Code of Conduct: https://www.ungm.org/Public/CodeOfConduct

45. Please also see UNICEF's Standard Terms and Conditions attached.

Tasks/Milestone:	Deliverables/Outputs:	Timeline	Estimate Budget
Desk research and planning phase • Participate in evaluation kick-off meeting • Conduce preliminary desk review • Write and submit inception report including instruments, in English and Arabic • Receive ethical clearance and UNICEF comments on draft inception report • Revise and submit final inception report including instruments, in English and Arabic	Inception report[3],with evaluation instruments, in English and Arabic	6 weeks	25%
Data collection, analysis, and drafting phase • Review existing documentation and collect data • Analyse data • Draft and translate report • Submit draft report	Draft report,[4] in English and Arabic	11 weeks	35%
Reporting phase • Receive comments from UNICEF on draft report • Revise and submit final report (including translation and copyediting) The report will follow the UNICEF guidelines and be cognizant of relevant UNICEF and UNEG guidelines for evaluation.	Final report in English and Arabic with comments matrix	3 weeks	40%

[3] In case the report is not accepted after a quality assurance check, an additional commenting process might be necessary.

[4] In case the report is not accepted after a quality assurance check, an additional commenting process might be necessary.

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Estimated Consultancy fee			
Travel International (if applicable)			
Travel Local (please include travel plan)			
DSA (if applicable)			
Printing, communications, and translation costs			
Total estimated consultancy costs[i]			

Minimum Qualifications required:

☐ Bachelors ☒ Masters ☐ PhD ☐ Other

Enter Disciplines: Evaluation, development studies, economics, social science, nutrition, public health, etc.

Knowledge/Expertise/Skills required:

- Relevant master's degree (evaluation, development studies economics, social science, nutrition, public health, etc.), PhD preferred
- Minimum of 10 years of experience in leading evaluation teams in the UN system and in politically-sensitive and crisis-affected environments
- Experience in analysing nutrition programming
- Experience integrating gender, equity, and human rights into evaluations using social science methodologies
- Experience working in humanitarian contexts and familiarity/ background with nutrition and public health in these contexts
- Good understanding of statistical analysis
- Proven ability to produce high-quality reports for a policy audience
- Strong interpersonal skills and ability to work with senior officials
- Understanding of the various contexts of Yemen, especially as related to nutrition
- Fluency in Arabic and full working proficiency in English

Administrative details:

Visa assistance required: ☐

Transportation arranged by the office: ☐

☒ Home Based ☐ Office Based:

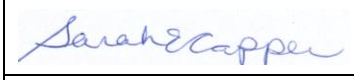
If office based, seating arrangement identified: ☐

IT and Communication equipment required: ☐

Internet access required: ☐

Request Authorised by Section Head

Sarah Capper, Evaluation Specialist 06.02.2022



Request Verified by HR:

Approval of Chief of Operations (if Operations):

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Approval of Deputy Representative (if Programme)

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Representative (in case of single sourcing/or if not listed in Annual Workplan)

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[i] Costs indicated are estimated. Final rate shall follow the “best value for money” principle, i.e., achieving the desired outcome at the lowest possible fee. Consultants will be asked to stipulate all-inclusive fees, including lump sum travel and subsistence costs, as applicable.

Payment of professional fees will be based on submission of agreed deliverables. UNICEF reserves the right to withhold payment in case the deliverables submitted are not up to the required standard or in case of delays in submitting the deliverables on the part of the consultant