Title	Funding Code	Type of engagement	Duty Station:
WASH Cholera Rapid Response Teams Evaluation: Enumerator	SM200674	☐ Consultant ☒ Individual Contractor	Yemen

Purpose of Activity/Assignment:

Purpose

1. The purpose of the evaluation is to provide an impartial and independent assessment of cholera RRT performance in Yemen and identify key achievements, challenges, lessons learned, and practical recommendations for the upcoming phase of the program. The evaluation will systematically generate evidence on cholera RRT programming in Yemen, assessing the effectiveness of the program in achieving its stated objectives. Besides the assessment of the intended effects of the program, the evaluation also aims to identify potential unintended effects. The learning will benefit cholera response planning, as well as inform further improvement. It will also benefit UNICEF and other UN agencies, as well as MWE and MoPHP and other partners, for future program planning, coordination, and resource advocacy and allocation.

Objective

2. The objective of the independent evaluation of WASH RRTs for Cholera is to provide accountability and learning. The evaluation will provide accountability to UNICEF, local authorities, other UN agencies, donors, communities, private sector partners, and rights-holders with respect to whether UNICEF/WASH, through the implementation of its emergency WASH strategy, is fit for purpose and strategically well-positioned to respond to further outbreak of cholera and other diseases. It will also provide learning as to the relevance, effectiveness, and efficiency, as well as coverage and coordination, of cholera RRTs in Yemen and enable the identification of some best practices in cholera prevention in general and in Yemeni contexts specifically.

3. More specifically, the objectives of the evaluation are to:

   - To assess the Yemen cholera RRTs and whether the governance, structure, composition, and objectives of the RRTs were appropriate to respond to the outbreak of cholera over the period targeted by the evaluation.
   - To determine the degree to which cholera RRTs engaged stakeholders.
   - To undertake analytical (qualitative and quantitative) assessment of the progress achieved in implementing the cholera RRT program and examine programme relevance/appropriateness and performance, identifying key successes, good practices, weaknesses, and gaps / constraints that need to be addressed.
   - Examine how the programme has addressed cross-cutting issues such as gender and equity protections.

Background/Scope of Work:

Background

a. The people of Yemen are facing heightened exposure to communicable disease outbreaks and critical undernutrition driven in part by critical WASH conditions, including irregular and insufficient access to safe water, and inadequate sanitation and hygiene provisions. Over 55 percent of Yemenis have no access to an improved water source, and only 22 percent of rural and 46 percent of urban populations are connected to partially functioning public water networks. Eight percent of Yemenis are income poor and only 28 percent of poorest households have safe water access, whilst 75 percent of households report having no soap, citing cost as the main reason. Of the 3.6 million displaced persons in Yemen, over 50 percent in IDP hosting sites are in acute need of WASH assistance. Over two-thirds of Yemenis (16.76 million people) require support to meet their basic WASH needs, with 10.96 million in acute need. About half (167) of the 333 districts are in acute need of sanitation support, and in 197 districts, over 55 percent of the population has no access to an improved water source. Moreover, soaring prices and reduced purchasing power have created economic barriers for people to access safe water and personal hygiene items. Such critical water, sanitation, and personal hygiene conditions are aggravating the risk of cholera, malnutrition, and other WASH-related diseases, as well as the current risk for COVID-19 infection.

b. According to capacity and access, in 2020, the WASH Cluster is targeting 12.5 million women, men, boys, and girls, including the total people in acute need, plus a 20 percent increase for COVID-19- exacerbated and expanded needs. A minimum package of comprehensive WASH assistance is needed to protect vulnerable populations from risk of WASH-related disease and to ensure dignity and protection, including 7.6 million people living in districts at high risk of cholera (169) and critical general acute malnutrition (83); 3.2 million IDPs, including almost 1 million in and around IDP sites, plus an additional potential 1.2 million newly displaced; and 3.5 million people requiring additional COVID-19 prevention support. Water and sanitation systems require sustained support to ensure a minimum level of services and avoid collapse. In addition to water quality assurance efforts, improved hygiene behaviours are necessary to reduce WASH-related disease.

c. The country reported over 172,000 suspected cholera/Acute Watery Diarrhoea (AWD) cases between January -15 August 2020, and over 55,000 cases of suspected dengue fever, as well as outbreaks of other diseases such as diphtheria and measles. The worst-affected governorates were Taizz, Hu daydah, and Sa'ada, out of the 22 governorates in the country. The heavy rainy storm affected a different water supply and sanitation system both in Urban and Rural areas. In Urban area around 1.5 million people will loss access to basic water and sanitation service due to the damage of the service. Increase on the number of choleras is reported in 8 governorates affected by the floods and Rainstorms: Sanaa, Ibb and Al-Hodieda Taiz, Amran, Hajah, Al Baidah (Rada'a) & Dhamar in addition the damages water supply and sanitation systems.

d. In response to cholera outbreaks in Yemen, UNICEF has worked in conjunction with health and water authorities to set up agile and mobile Rapid Response Teams (RRTs), reporting to the General Authority for Rural Water Supply Project- Emergency Unit (GARWSP- EU) under the Ministry of Water & Environment (MWE), to allow quick, flexible, and targeted control measures to be implemented in affected areas. The RRTs started work with support from UNICEF in August 2017 and aimed to target 180,000 household families (1.26 million people) per week based on their risk status for cholera transmission. To do so, RRTs deploy in communities where clusters of suspected cholera cases (20 or more at the village level) are identified.

e. The RRTs provide a considerable number of reported cholera / AWD-infected households and firewall households with cholera prevention kits. The kits are composed of chlorine for household water treatment, soap and laundry powder for handwashing, chlorinated solutions for water containers disinfection with information, education, and communication (IEC) material and adequate cholera prevention messages.

f. Despite of the efforts to scale up cholera response and integrate WASH interventions with other programs, a number of structural factors and constraints hinder efforts to implement effective cholera programming in Yemen, such as limited sectoral coordination, lack of coherence and integration of sections' cholera interventions on the ground (no or limited coordination at hub level between sections), lack of an integrated response plan and monitoring dashboard, lack of follow-up on hub response by the taskforce, no clear liaison mechanism in place (no or limited request to hubs for data analysis and response updates) and lack of epidemiological, data-driven decisions at the taskforce level.

g. While the cholera RRT program has no existing theory of change, the program has operated under the following program logic in practice: If the RRTs provide cholera prevention kits composed of chlorine, soap, laundry powder, chlorinated solutions, and informational material with cholera prevention messaging, then secondary transmission of cholera within households will be reduced. These results will be achieved provided there is coordination of different sectors and partners working on the cholera response and WASH preventive interventions, communities are receptive, and adequate funding is available, in spite of the current conflict and continue community displacement and movement and influx of refugees in Yemen.

h. There have also been several recent studies - on cholera specifically and WASH more generally – that include Yemen or focus on the country specifically in their research and evaluations. These studies include the Global Review of Water, Sanitation and Hygiene (WASH) Components in Rapid Response Mechanisms and Rapid Response Teams in Cholera Outbreak Settings (Haiti, Nigeria, South Sudan and Yemen) and the Rapid Response Team High-Level Indicative & Descriptive Assessment at Household Level. UNICEF also has third-party monitoring reports, field mission reports, previous evaluation reports, strategic documents, and standard operating procedures that may be of benefit to the evaluation team. UNICEF will make these studies and reports available at the time of the desk review.

Scope

i. The evaluation will focus on the provision of cholera prevention kits in four governorates – Sana'a, Hajjah, Aden, and Ad Dali' - from October 2018 – October 2019. Given the current constraints on collecting data in Yemen, the evaluation will focus on these governorates as individual locations and will neither compare governorates nor attempt to generalize findings from these governorates to the whole of Yemen.

Evaluability

j. The cholera RRT program in Yemen does not have a formally-articulated theory of change or monitoring framework in place, nor has it conducted a baseline assessment. However, the program has operated by a consistent informal program logic, articulated under Background above, and monitoring has been conducted weekly according to output and outcome indicators such as number of kits distributed and incidence rates, respectively. The absence of a baseline assessment limits the ability of the evaluation to determine impact, which is why evaluation questions related to impact were not included in this ToR (see Evaluation Questions, below), but UNICEF assumes that the evaluation team will identify and make use of any data that could stand in for baseline measures in considering the effectiveness and other aspects of the programme covered by the evaluation questions.

Evaluation Questions

k. The key questions for this evaluation were formulated based on the OECD-DAC criteria, as elaborated in ALNAP. The OECD-DAC criteria have been limited to relevance, effectiveness, and efficiency for this evaluation in order to focus the evaluation on a number of evaluation questions manageable and appropriate for an evaluation of this size. The humanitarian criteria of coordination and coverage have also been included. In addition, given the current context of Yemen, which faces both conflict and now COVID-19, the criteria selected have been chosen because they are the most manageable criteria that can be employed to answer the key evaluation questions – *How effective*

are the RRTs to contribute to the prevention of cholera outbreaks? Are the RRTs contributing to behaviour change or to the maintenance of existing systems? - in this context. Given the program's lack of a baseline, the impact criterion has been removed. Some humanitarian criteria – connectedness and coherence have also been removed for reasons of access to relevant data. However, cross-cutting issues of gender and equity have been integrated into the evaluation criteria. Thus, the evaluation aims to answer the following questions:

Relevance

1. To what extent have cholera RRT strategies and interventions responded to district needs and priorities? To what extent do stakeholders consider RRT the most relevant possible response to cholera outbreak, out of all possible responses?
2. To what extent has the project been aligned with the Yemen cholera response plan, wash cluster strategy, and the government's agenda, guidelines, and policies?
3. To what extent has the RRT program incorporated human rights principles and instruments, including those related to gender equality?

Efficiency

4. How systematically have funds been allocated and utilized across program strategies and activities to realize program objectives?
5. How did the provision of incentives for RRT team members facilitate and/or hinder the work of the RRTs in the cholera response?
6. How timely have the RRTs been in responding to the cholera outbreak in each governorate?

Effectiveness

7. To what extent has the project achieved its stated objective of behaviour change aimed at sharing information to address the WASH-related issues contributing to the spread of cholera and to implement protective measures?
8. To what extent has an intervention strategy, including related indicators, been developed to monitor the effectiveness of the RRT and provide adequate corrective measures?
9. How adequate, according to the standards set by programme documents, has the technical and organizational support provided for planning and implementing the cholera RRT program been?
10. To what extent has the service delivery met expected quality standards? What factors have contributed to and hampered the meeting of quality standards?

Coordination

11. How well has the coordination mechanism among the partner institutions involved in the provision of cholera RRT services functioned?
12. How well have the RRTs been integrated into broader WASH second-line and health-related work in the selected governorates?

Coverage

13. To what extent have qualified people been available and effectively mobilized to ensure appropriate cholera RRT coverage across the districts included in the evaluation?
14. Which vulnerable groups in society have faced the most difficulty accessing the services of the cholera RRTs, and why?

Budget Year:	**Requesting Section/Issuing Office:**	**Reasons why consultancy cannot be done by staff:**
2021	*Evaluation*	*External evaluation – accountability and independence*

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

<table>
<tr><td colspan="3"></td><td></td></tr>
<tr><td colspan="3">Consultant sourcing:

☒ National ☐ International ☐ Both

Consultant selection method:

☐ Competitive Selection (Roster)
☒ Competitive Selection (Advertisement/Desk Review/Interview)</td><td>Request for:
☒ New SSA

☐ Extension/ Amendment</td></tr>
<tr><td colspan="3">If Extension, Justification for extension:</td><td></td></tr>
<tr><td>Supervisor:

Sarah Capper</td><td>Start Date:

March 1, 2021</td><td>End Date:

July 31, 2021</td><td>Number of Days (working)

40</td></tr>
</table>

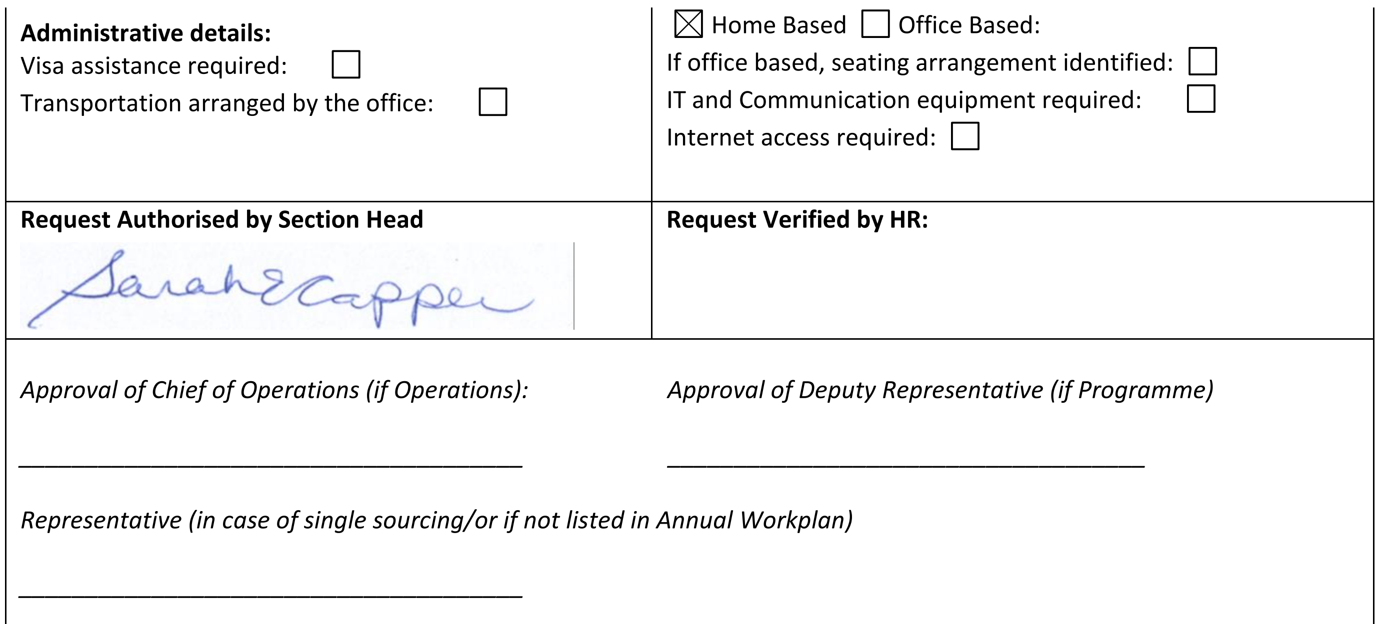
TERMS OF REFERENCE FOR INDIVIDUAL CONSULTANTS AND CONTRACTORS

Work Assignment Overview

Each Enumerator will work with a team that includes a team leader/evaluation specialist, a technical specialist, a data analyst, a data collection team manager, and other enumerators. The Enumerator will collect data via focus groups and interviews, online and, if circumstances allow, in person. They will also enter data and perform data quality checks under the supervision of the Data Collection Team Manager. In addition, they will debrief the Data Collection Team Manager at regular intervals on the progress of the data collection and note any challenges faced so that any necessary adjustments to the data collection methods can be made in a timely manner. The enumerator will be contracted directly through UNICEF but will report to the Data Collection Team Manager for all technical matters.

Tasks/Milestone:	Deliverables/Outputs:	Timeline	Estimate Budget
1. Preparatory and inception phase • Reviews data collection tools and methods • Contributes to answers to questions from the ethical clearance process if required • Contributes to responses to issues raised by the Steering Committee and the ethical clearance process	N/A	6 weeks	35%
2. Data collection, preliminary findings, and drafting phase • Attends enumerator orientation/training • Collects qualitative data collection • Enters data and performs data quality assurance checks according to the guidance of the Data Collection Team Manager • Submits raw data and datasets to Data Collection Team Manager	• Raw data and datasets • Inputs on the preliminary findings • Inputs on the draft evaluation report	12 weeks	65%
3. Completion phase • N/A	• N/A	2 weeks	N/A
Estimated Consultancy fee			
Travel International (if applicable)			
Travel Local (please include travel plan)			
DSA (if applicable)			
Total estimated consultancy costs[i]			

Minimum Qualifications required:	**Knowledge/Expertise/Skills required:**
☒ Bachelors ☐ Masters ☐ PhD ☐ Other Enter Disciplines: Public health, water engineering, social sciences, statistics, data management, or related field	• Relevant degree in public health, water engineering, social sciences, statistics, data management, or related field • Experience in collecting qualitative data • Experience in working in humanitarian settings • Strong interpersonal skills • Cultural sensitivity • Fluency in Arabic



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	**Request Verified by HR:**
Approval of Chief of Operations (if Operations): _______________________________________ *Representative (in case of single sourcing/or if not listed in Annual Workplan)* _______________________________________	*Approval of Deputy Representative (if Programme)* _______________________________________

[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