TERMS OF REFERENCE

FOR INDIVIDUAL CONTRACT

POST TITLE:	Consultant for the situation analysis for the tuberculosis services provided to returnees in four border provinces in Afghanistan
AGENCY/PROJECT NAME:	UNDP HIV, Health & Development Group
COUNTRY OF ASSIGNMENT:	Afghanistan and Home-based

1) PROJECT DESCRIPTION

This consultancy is requested by the United Nations Development Programme Regional Bureau for Asia and the Pacific (Bangkok Regional Hub) which acts as the Principal Recipient for the TB/MDR-TB interventions among Afghan refugees, returnees and mobile populations in Afghanistan, Iran and Pakistan (The Programme), funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund).

The Islamic Republic of Afghanistan has one of the highest numbers of refugees, returnees and internally displaced peoples (IDPs) in the region. In 2017, over 610,000 Afghans returned from Iran and Pakistan. 821,425 Afghans returned in 2018. Simultaneously, throughout 2018, Afghanistan has been adversely affected by severe drought, most acutely affecting Northern and Western Afghanistan and impacting the lives of more than 3 million people across the nation. Ongoing conflict has also further contributed to the country's total IDP caseload, which is estimated at 3.5 million persons, as of December 2018. The compound influx of both returnee and IDP caseloads are exacerbating the already limited capacity of host communities and placing further strain on overstretched resources and basic services, especially health services.

The top 5 provinces of destination of undocumented returnees from Pakistan were Nangarhar, Kabul, Kandahar, Kunduz and Helmand with 52% of the total returning to Nangarhar and Kabul. Undocumented returnees from Islamic Republic of Iran went primarily to Badakhshan, Badghis, Baghlan, Balkh and Bamyan. For the registered refugee returnees: 68% returned to Kabul, Nangarhar, Kunduz, Logar, and Sar-e-Pul provinces. Kabul, Nangarhar and Kunduz remain the top provinces of return since 2002[1].

Services to refugee returnees: UNHCR in coordination with the Ministry of Refugees and Repatriation (MoRR) and partners in Afghanistan manages four Encashment Centres (ECs) where it provides a cash grant to each registered refugee returnee. Besides cash grants, services include basic health care and vaccinations (delivered by Ministry of Public Health supported by WHO and UNICEF).

Services to undocumented Afghans:

[1] Source : Return to Afghanistan in 2017- IOM and UNHCR joint report

IOM continues to lead the humanitarian undocumented returnee response **at the four major border** crossings with the Islamic Republics of Iran and Pakistan through a network of IOM built and managed transit facilities. In reception centers at the borders, the Directorate for Refugees and Repatriation (DoRR) identify, screen and register all returning Afghans regardless of status. DoRR then refers vulnerable undocumented returnees to IOM, who then conduct assessments and provides immediate humanitarian post-arrival assistance in IOM Transit Centers. This includes meals, accommodation, seasonal clothes, psychosocial assistance, basic medical and tuberculosis screening, vaccinations, food and non-food items, referrals to specialised services, onward transportation for special cases including deceased persons and multi-purpose cash grants for transportation and NFIs. IOM provides Persons with Specific Needs (PSNs) with tailored protection-sensitive post arrival humanitarian assistance according to the specific needs.

Tuberculosis burden:

Amidst the displacement, mixed migration and overall population mobility within Afghanistan and in the region, increased risk and prevalence of tuberculosis (TB) is a serious public health concern. Afghanistan carries the second highest TB burden in the Eastern Mediterranean Region and TB remains one of the critical public health concerns and a focus of the national government. Pakistan has one of the highest burdens of TB in the world. It ranks fifth among 30 TB high-burden countries, and fourth among 30 high-burden multidrug-resistant TB (MDR-TB) countries. While Iran has the lowest burden of TB among these three countries, the prevalence of TB is high among undocumented Afghans living in Iran[2].

Access to health services:

Approximately 80% of the population in Afghanistan live in rural areas where it is often estimated that 30-35% cannot access a health facility within one hour by any means of transport. These populations live in extremely poor conditions that leave them more vulnerable to diseases like TB compared to the general population. TB treatment success rates are low in large cities and provinces with high population mobility and incomplete treatment outcome results for patients lost to follow-up.

In 2017, there were an estimated 67,000 people with TB in Afghanistan, of which 70% were diagnosed and treated. Almost 20,000 (33%) were missed by the health system. In Afghanistan almost 56% of people affected with TB are women with a ratio of female: male = 1.3:1. This proportion is seen uniformly across the country with some provinces, such as Kabul, Urzgan, Kandahar, Nangarhar, and Panjshir, where the gender dissemination of TB cases was almost equal. Female cases represent 63% of total MDR-TB cases notified.

Limited access to TB prevention, diagnosis and treatment for Afghan refugees, returnees, IDPs and other migrant populations is a recognized public health concern. The living conditions and lack of access to health services and TB treatment in locations where displaced and migrant populations reside, especially in cramped informal settlements, can further compromise the health of these population groups and lead to potential exposure and transmission of TB to host communities and other mobile population

The current Tuberculosis programmes funded by the Global Fund in Afghanistan on "*scaling up innovative approaches to respond to TB challenges in Afghanistan (2018-2020)"* focus on key interventions to address the gaps in TB services. The programmes has special focus on key populations. TB services to IDPs are provided in five provinces: Kabul, Nangarhar, Herat, Kandahar, and Helmand.

[2] Total TB notifications in Iran in 2016 were 10,286 and 1,216 (13%) were notifications of non-Iranian nationals, of which 1,179 (97%) Afghan nationals.

1. Purpose of the consultancy

Complete a situation analysis for the tuberculosis services provided to returnees in four provinces. This assignment objectives are:

1. To assess the situation of the current tuberculosis services in the four provinces as detailed in Annex II.
2. To design context-based strategy and directions[3] for the tuberculosis services for returnees in the border provinces and assess the feasibility and accordingly develop guidance, approaches and activities for ACF to be implemented by IOM Afghanistan and National Tuberculosis Programme at border crossings.
3. To map out the availability, functionality, accessibility and capacity of health facilities that serve the identified priority populations of concern within the respective border sites. In this way, this assessment will contribute towards strengthening the evidence-base and information sharing on the number, location and treatment facilities available to Afghan refugees, returnees, IDPs and cross-border communities, in order to effectively find and treat TB cases among these mobile populations.
4. To provide technical guidance on the design, implementation, monitoring and evaluation of active case finding (ACF) among returnees in Afghanistan, including:
   i. selection of exact sites for ACF: ACF was originally planned to be conducted at the border provinces with Iran and Pakistan with the largest volume of border crossings namely: Nangarhar (Toor Kham), Kandahar (Spin Boldak), Herat (Islam Qalah) and Nimroz (Zarang Malik) as well as IOM reception/health facilities/transit centers;
   ii. detailed activities to be conducted at field/health facility level and deployment of diagnostic technologies and organization of supply of necessary consumables, sample transportation.
   iii. guidance note on how to undertake contact investigation, active symptom screening, finding lost-to-follow up patients, awareness rising of TB among returnees/IDPs, screening, etc.
   iv. revised/adapted/newly developed recording and reporting tools to capture and monitor ACF and to conduct routine supportive supervision.

2) SCOPE OF WORK

The assignment will be implemented in coordination with WHO office and IOM office in Afghanistan, Moreover, this assignment requires working with the Afghanistan National Tuberculosis Programme, Provincial TB Coordinators, Basic Package of Health Service implementers, UNHCR, DoRR and immigration authorities at border provinces.

IOM's Displacement Tracking Matrix (DTM) collect information on the number and location of refugees, returnees, IDPs, migrants and cross-border communities. IOM's Displacement Tracking Matrix (DTM) will be employed to evaluate the availability, access and capacity of health facilities accessible by returnees. This information will inform the assessment sampling method and recommended services.

The consultant is responsible for all deliverables listed below. The consultant is responsible for developing the assessment tools. The tools should meet the following requirements: relevant; comprehensive; evidence-based and aligned to WHO requirements and national tuberculosis guidelines.

[3] Aligned and integrated into the national health services structure.

These tools will be endorsed by technical partners and the National TB programme. **Data collection will be implemented by IOM DTM teams.**

The assignment requires visiting the health facilities in the border provinces in addition to consultations with the returnees and service providers. It is required to go for an approach which is participatory and inclusive.

The assessment will cover the following areas: service delivery; pharmaceutical and medical supplies; equipment and infrastructure; logistics; Human Resources; financing governance/ management; coordination and Information systems. It will also identify the priority areas/settlements for service provision based on: a) Access, time and distance to health facilities and b) Population density of target, at-risk populations.

3) EXPECTED OUTPUTS AND DELIVERABLES

a. Inception report detailing the assessment methodology, including criteria for the selection of sites to be assessed, and the study protocol and tools. (Expected up to 7 working days)

b. A TB situation analysis and health facility mapping report which review the current services, gaps and opportunities to strengthen services in returnees' settings and ensure that diagnosis is offered, and that treatment is initiated as soon as possible. The report will specify the interventions and activities that need to be implemented which could be *additional human resource, training of health workers dealing with returnees and IDPs, procurement of laboratory equipment and consumables, digital X-ray equipment etc*. (Expected up to 20 total working days- 10 working days for data collection, 10 working days for report writing)

c. Facilitate a national workshop to review and validate the assignment deliverables involving all the relevant stakeholders such as NTP staff, field health care workers, NGOs dealing with returnees and IDPs, international technical agencies and others. (Expected up to 5 working days)

d. Develop a guidance document/SOPs and an operational plan on how to undertake contact investigation, active symptom screening, tracing lost-to-follow up patients, awareness rising of TB among returnees/IDPs, screening and Isoniazid prevention therapy (IPT) for people living with HIV (PLHIV) as well as how to organize supply of necessary equipment and consumables, sample transportation, incentives for engaged community workers. The guidance document/SOPs should include revised/adapted/newly developed recording and reporting tools to capture and monitor ACF and procedures to conduct routine supportive supervision. (Expected up to 8 working days)

4) INSTITUTIONAL ARRANGEMENTS

The Consultant shall report to the Team Leader for the Asia and the Pacific Health team in UNDP Bangkok Regional Hub. The work will be facilitated by with the UNDP Health Implementation support team in close coordination with the WHO Regional Office for the Eastern Mediterranean (EMRO) and the Stop TB partnership

5) DURATION OF ASSIGNMENT, DUTY STATION AND EXPECTED PLACES OF TRAVEL

The duration of the assignment is for 40 working days with an expected start date of 5 June until 30 August 2019.

The duty station is Kabul, Afghanistan for a total of 25 working days and home-based for 15 working days. There is expected travel within Afghanistan.

(i) In the event of authorized travel, payment of travel costs including tickets, lodging and terminal expenses should be agreed upon, between the respective business unit and the Individual Consultant, prior to travel and will be reimbursed by UNDP.

The fare will always be "most direct, most economical" and any difference in price with the preferred route will be paid for by the expert.

Travel costs shall be reimbursed at actual but not exceeding the quotation from UNDP approved travel agent.

6) DEGREE OF EXPERTISE AND QUALIFICATIONS

Education:

- A post-graduate degree on public health, medicine, or equivalent.

Experience:

- At least 10-year experience working with TB programmes in developing countries,
- Experience with projects undertaken with government and/or academic institutions of similar nature and magnitude in a country setting and/or internationally, and
- Preferably, experience in working for TB programme in refugee/migratory settings,

Skills/Technical skills and knowledge:

- Expertise in situation and gap analysis in the Health Sector.
- Sound knowledge of organization, processes and challenges in Tuberculosis disease management.

Language

- Fluent in English

Competencies

- Proven experience in conducting health systems assessment, Tuberculosis Programme Review, and/or program monitoring and evaluation;
- Preferable experience in assessment of coordination, referral and communication systems for TB/communicable diseases
- Excellent organizational, communication, interpersonal and writing skills.

7) REQUIRED DOCUMENTS

Interested individual consultants must submit the following documents/information to demonstrate their qualifications. Please group them into **one (1) single PDF document** as the application only allows to upload maximum one document:

- **Letter of Confirmation of Interest and Availability** using the template provided in Annex III. Note: National consultants must quote prices in Thai Baht.
- **Personal CV,** indicating all past experience from similar projects, as well as the contact details (email and telephone number) of the Candidate and at least three (3) professional references.
- **Financial Proposal** that indicates the all-inclusive fixed total contract price supported by a breakdown of costs, as per template provided. IF an Offeror is employed by an organization/company/institution, and he/she expects his/her employer to charge a management fee in the process of releasing him/her to UNDP under Reimbursable Loan Agreement (RLA), the Offeror must indicate at this point, and ensure that all such costs are duly incorporated in the financial proposal submitted to UNDP.

Incomplete proposals may not be considered. Shortlisted applicant will be requested to submit a technical and financial proposals. Applicants will be evaluated based on a cumulative analysis method that combines the results of technical and financial evaluation results.

8) CRITERIA FOR SELECTION OF THE BEST OFFER

Applicants will be evaluated based on the following methodology. The award of the contract shall be made to the individual consultant whose offer has been evaluated and determined as a) responsive/compliant/acceptable; and b) having received the highest score out of set of weighted technical criteria (70%). and financial criteria (30%). Financial score shall be computed as a ratio of the proposal being evaluated and the lowest priced proposal received by UNDP for the assignment.

Technical Criteria for Evaluation (Maximum 70 points)

- Criteria 1 Eg. Relevance of Education – Max 10 points
- Criteria 2 Eg. Relevance of work experience - Max 20 points
- Criteria 3 Eg. Relevance of knowledge of key technical areas – Max 40 points

Only candidates obtaining a minimum of 49 points (70% of the total technical points) would be considered for the Financial Evaluation.

9) CONSULTANT PRESENCE REQUIRED ON DUTY STATION/UNDP PREMISES

NONE PARTIAL INTERMITTENT FULL TIME

10) PAYMENT TERMS

The Consultant must send a financial proposal based on the lump sum amount.

The total amount quoted shall be all-inclusive and include all costs components required to perform the deliverables identified in the TOR, including professional fee, travel costs, living allowance (if any work is to be done outside the IC's duty station) and any other applicable cost to be incurred by the IC in completing the assignment. The contract price will be fixed out-put based price regardless of extension of the herein specified duration. Payments will be done upon completion of the deliverables/outputs and as per below percentages:

Deliverables/Outputs	Payment
First payment of 15% shall be made upon successful receipt of an inception report detailing the assessment methodology, including criteria for the selection of sites to be assessed, and the study protocol and tools. – 7 working days (home based)	Payment of 15%
Second payment of 35% shall be made upon the successful receipt of a TB situation analysis and health facility mapping report which review the current services, gaps and opportunities to strengthen services in returnees' settings and ensure that diagnosis is offered, and that treatment is initiated as soon as possible. 20 working days (Afghanistan)	Payment of 35%
Third payment of 15% shall be made upon the successful facilitation a national workshop to review and validate the assignment deliverables involving all the relevant stakeholders such as NTP staff, field health care workers, NGOs dealing with returnees and IDPs, international technical agencies and others. 5 working days (Afghanistan)	Payment of 15%
Fourth payment of 35% shall be made upon the successful receipt of a guidance document/SOPs and an operational plan on how to undertake contact investigation, active symptom screening, tracing lost-to-follow up patients, awareness rising of TB among returnees/IDPs, screening and Isoniazid prevention therapy (IPT) for people living with HIV (PLHIV) as well as how to organize supply of necessary equipment and consumables, sample transportation, incentives for engaged community workers. 8 working days (home based)	Payment of 35%

In general, UNDP shall not accept travel costs exceeding those of an economy class ticket. Should the IC wish to travel on a higher class, he/she should do so using their own resources.

In the event of unforeseeable travel not anticipated in this TOR, payment of travel costs including tickets, lodging and terminal expenses should be agreed upon between the respective business unit and the Individual Consultant, prior to travel and will be reimbursed.

Travel costs shall be reimbursed at actual but not exceeding the quotation from UNDP approved travel agent. The provided living allowance will not be exceeding UNDP DSA rates. Repatriation travel cost from home to duty station in Bangkok and return shall not be covered by UNDP.

11) ANNEXES TO THE TOR

ANNEX 1- INDIVIDUAL CONSULTANT GENERAL TERMS AND CONDITIONS is provided here:
http://www.undp.org/content/dam/undp/documents/procurement/documents/IC%20-%20General%20Conditions.pdf

ANNEX 2 – IDENTIFIED FOUR PROVINCES

1. For this activity, four target provinces have been identified:
    a. Kandahar

DTM 2018 estimates that there is a total of 181,511 IDPs in Kandahar, of which 150,394 (83%) are displaced due to conflict. Simultaneously, DTM estimates that there are 76,388 returnees in Kandahar. A primary area of high mobility would be Kandahar City and surrounding peri-urban settlements, which host large numbers of returnees, IDPs and migrant populations. As of December 2018, 16,559 Afghan migrants have been recorded to have moved or fled abroad from Kandahar.

Spin Boldak is another target area of concern in Kandahar, as it is a border district and serves as a major point of entry between Afghanistan and Pakistan. The assessment of Spin Boldak is crucial as it has a large cross-border community and a porous, open border with need of improved IHR health security measures in place. The monitoring of the Spin Boldak – Chaman crossing is also important for this programme as it borders Pakistan's highest-risk district with the greatest prevalence of MDR-TB cases.

Through prior Flow Monitoring activities conducted between 19 April to 28 June 2018, DTM counted 789,940 outflowing migrants (border crossing events) travelling from Afghanistan to Pakistan, and 1,003,443 inflowing migrants travelling from Pakistan to Afghanistan through the Spin Boldak – Chaman border. Significantly, these figures translate into an average daily outflow of 13,389 migrants and inflow of 16,724 migrants per day, whereby the primary reason for travel to Pakistan is to access health services.

Based on DTM's Flow Monitoring Registry tool, 97% of all migrants crossing the Spin Boldak – Chaman border travel for the following top four reasons:

Spin Boldak – Chaman crossing	Outflow: Spin Boldak to Chaman		Inflow: Spin Boldak to Chaman	
Top four reasons for travelling	Health services	37%	Travelling home	70%
	Travelling home	27%	Travelling to the market	14%
	Travelling to the market	17%	Visiting family	8%
	Visiting family	16%	Return (voluntary or spontaneous)	4%

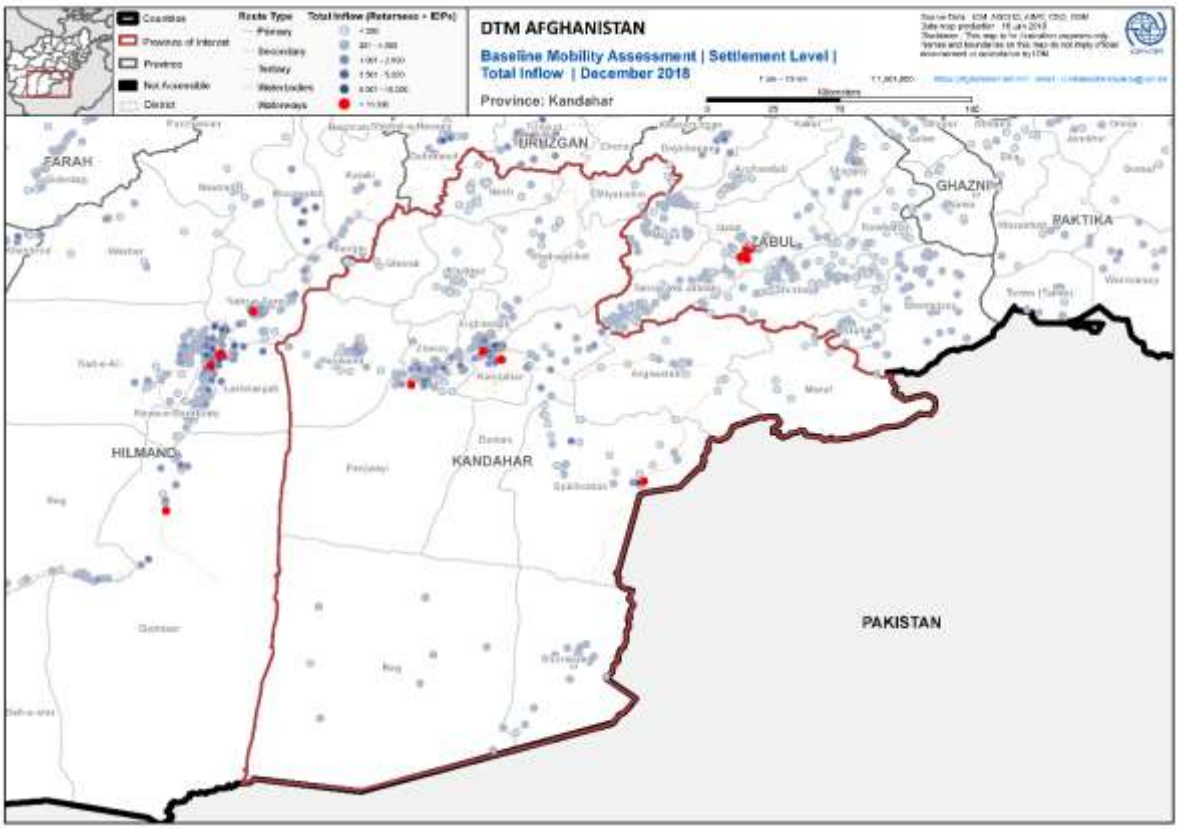

Figure 1: Total inflow (returnees + IDPs) in Kandahar as of December 2018

b. Nangarhar

Due to on-going conflict, Nangarhar recorded the second highest number of IDPs in DTM's latest, December 2018 round of Baseline Mobility Assessments, with a staggering 302,730 IDPs displaced by conflict. 30,946 out-migrants have also moved or fled abroad from Nangarhar. Despite the insecurity, the province has observed 495,833 returnees between 2012 and 2018.

One priority location of concern is Torkham, which is the second busiest border crossings between Afghanistan and Pakistan. Despite tighter visa and customs controls, Torkham receives a high volume of traffic, due to its connection to Peshawar and Kabul. Another key area of concern is densely populated Jalalabad, which is a popular destination for return and displaced populations, due to its role as a leading, urban centre for social and economic activities, relative security, and its proximity with the Torkham border.

Through Flow Monitoring of the Torkham – Bab-i-Pakistan border crossing from 12 May to 28 June 2018, DTM recorded an outflow of 269,568 migrants travelling from Afghanistan to Pakistan and an inflow of 296,022 migrants travelling from Pakistan to Afghanistan. On average, this results in a daily outflow of 6,728 migrants and inflow of 6,127 migrants each day.

97% of all migrants crossing the Torkham – Bab-i-Pakistan border travelled for the following top four reasons:

Torkham – Bab-i-Pakistan crossing	Outflow: Torkham to Bab-i-Pakistan		Inflow: Bab-i-Pakistan to Torkham	
Top four reasons for travelling	Health services	31%	Travelling home	69%
	Travelling home	25%	Event (Social/Public/Religious)	8%
	Event (Social/Public/Religious)	11%	Travelling to the market	7%
	Visiting family	10%	Tourism	7%

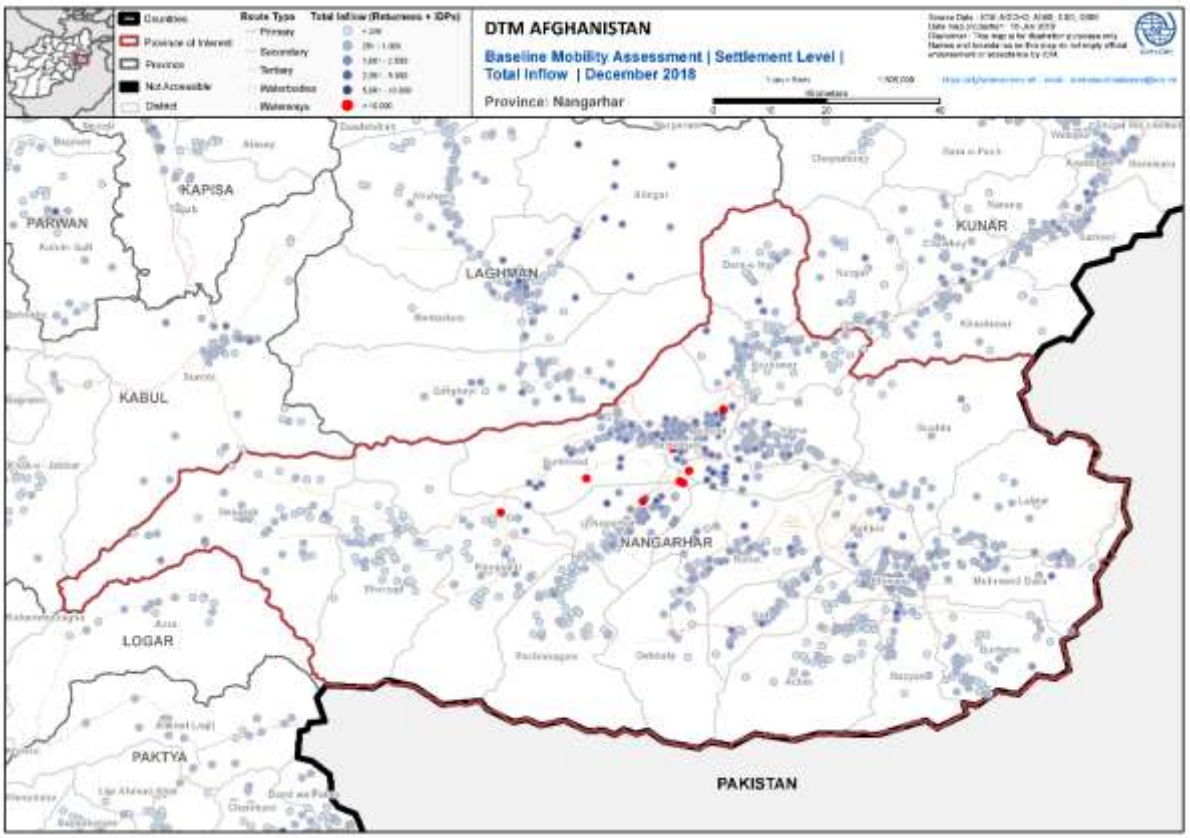

Figure 2: Total inflow (returnees + IDPs) in Nangarhar as of December 2018

c. Nimroz

According to DTM's Baseline Mobility Assessment, a total of 72,808 IDPs can be found in Nimroz, whereby the majority, comprising of 65,324 individuals (90%) were displaced to this province due to conflict. The number of IDPs exceed the number of returnees and out-migrants which stand at 39,643 and 21,462 respectively.

Nimroz is a province of concern as it receives the largest number of deportees in Afghanistan, many of whom would have spent more than eight hours in prison and more than eight hours en route in public transportation. The lack of sanitation and exposure to diseases that deportees face both in prisons and on buses renders them as an at-risk population, while also placing their host communities in Nimroz at risk. Although the main economic activity in Nimroz is agriculture, the drought has severely impacted crop production, resulting in internal displacement within the same province, to other provinces, as well as forcing migrants to seek employment in neighbouring countries like Iran. As a result, there is also a large labour migrant population returning from poor

living conditions and overcrowded accommodation in Iran back to Afghanistan. Access to health facilities for these mobile populations and continuation of treatment for TB-infected migrants is crucial.

Through prior Flow Monitoring activities conducted between 7 February to 12 September 2018, DTM counted 90,425 outflowing migrants travelling from Afghanistan to Iran, and 458,933 inflowing migrants travelling from Iran to Afghanistan through the Zaranj – Milak border. This means that the average daily movements of inflows from Iran to Afghanistan (1530 migrants) is roughly five times the number of outflows (301 migrants).

Based on DTM's Flow Monitoring Registry tool, 97% of all migrants crossing Zaranj – Milak border travel for the following top four reasons:

Zaranj – Milak crossing	Outflow: Zaranj to Milak		Inflow: Milak to Zaranj	
Top four reasons for travelling	Travelling to the market	82%	Deportation	57%
	Economic migration (< 6 months)	5%	Travelling to the market	23%
	Family visit	4%	Return (voluntary/spontaneous)	11%
	Economic migration (> 6 months)	4%	Travelling home	4%

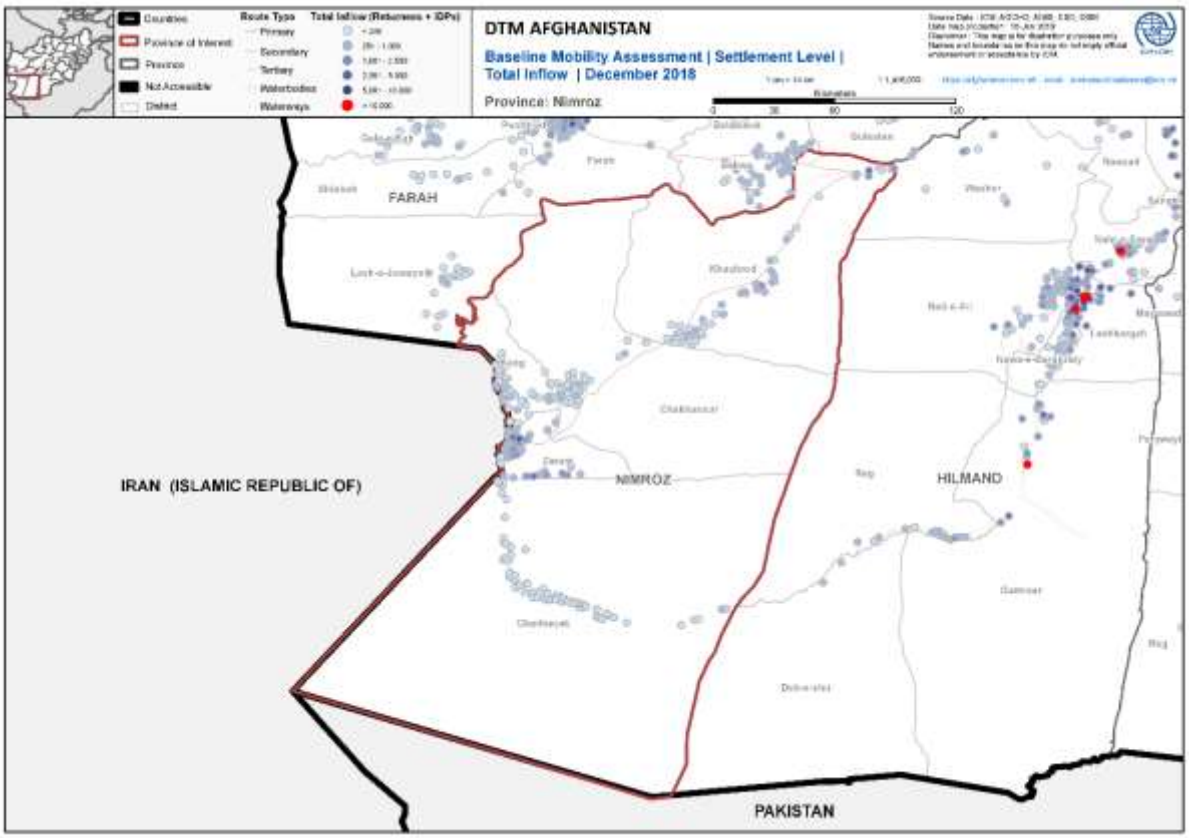

Figure 3: Total inflow (returnees + IDPs) in Nimroz as of December 2018

d. Herat

Herat holds the highest number of IDPs in Afghanistan with a total of 544,500 IDPs as of December 2018. Based on DTM's estimations, Herat is the largest recipient of IDPs displaced by conflict at 349,320 IDPs, making up 64% of the province's total IDP caseload. While the total

number of returnees between 2012 to 2018 is 91,806, the rate of return has reduced significantly from 31,078 returnees between 2012 to 2015, to only 6,134 returnees in 2018. Additionally, 136,511 out-migrants have fled Herat in the last seven years.

Herat is a target area of concern as it is one of Afghanistan's largest cities, due to the substantial displacement caseload it is hosting and as it serves as a key border province with Iran. The Islam Qala – Taybad border is a major gateway that connects Afghanistan and Iran with many Afghan migrants travelling to Iran for employment purposes.

Based on DTM's Flow Monitoring conducted from 21 February to 30 September 2018, 464,487 outflowing migrants were travelling from Afghanistan to Iran primarily for economic migration. Conversely, 723,302 inflowing migrants were travelling from Iran to Afghanistan along the Islam Qala – Taybad border during the same period, where for the main reasons for travel were to return or to travel home. The average daily movement for outflowing migrants is 1,733 and 2,699 for inflowing migrants.

DTM's Flow Monitoring Registry tool further records the top four reasons that 97% of all migrants had for crossing the Islam Qala – Taybad border:

Islam Qala – Taybad crossing	Outflow: Islam Qala to Taybad		Inflow: Taybad to Islam Qala	
Top four reasons for travelling	Economic migration (> 6 months)	21%	Return (voluntary/spontaneous)	28%
	Economic migration (< 6 months)	21%	Travelling home	22%
	Family visit	16%	Deportation	22%
	Event (Social/Public/Religious)	14%	Economic migration (> 6 months)	17%

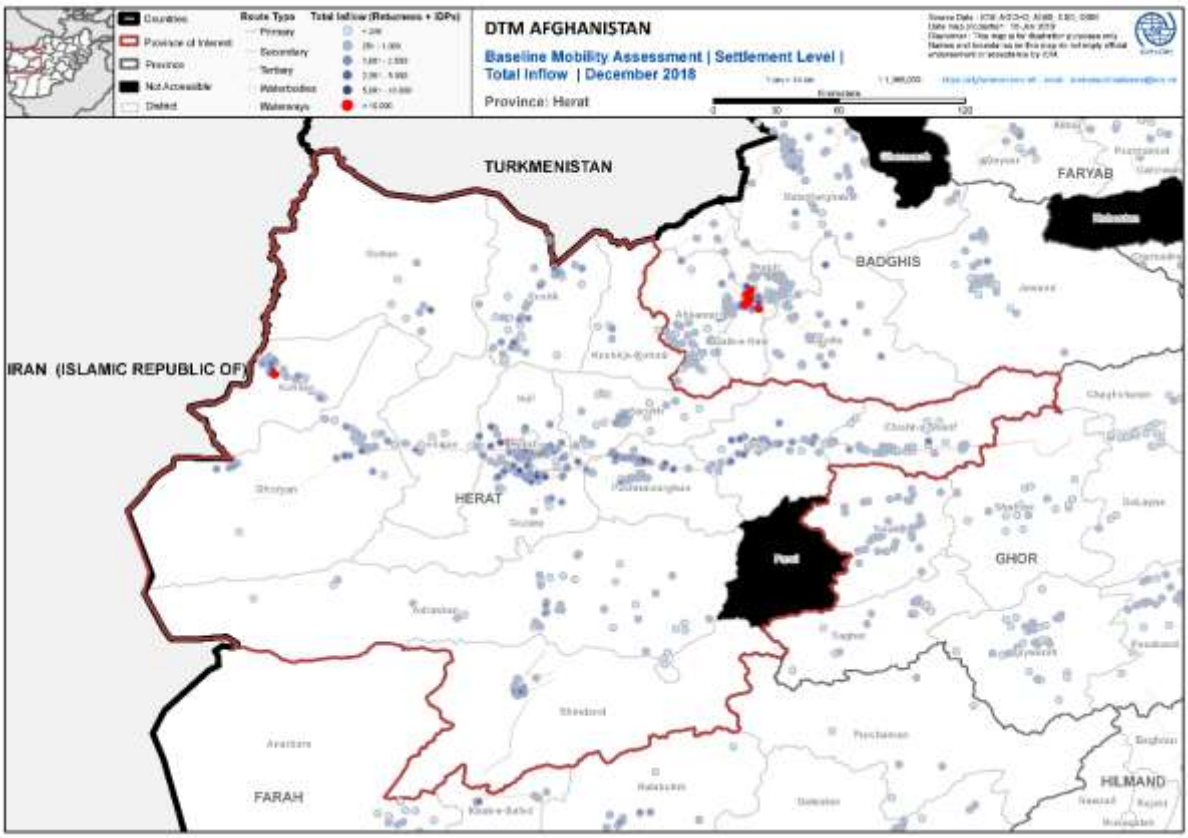

Figure 4: T