REQUEST FOR PROPOSAL (RFP)

Assessing the statues of availability, utilization and factors affecting services utilization of productive health, including HIV/AIS, Tuberculosis and Malaria (ATM) in Family Health House (FHH) in Khost and Badakhshan Provinces in Afghanistan	DATE: May 16, 2019 REFERENCE: **RFP/UNDP/AFG/2019**/0000003756 for FHH Baseline Assessment, UNDP-TB-RSSH Programme

Dear Sir / Madam:

We kindly request you to submit your Proposal for FHH Baseline Assessment, for UNDP-TB-RSSH Programme in Khost and Badakhshan Provinces in Afghanistan

Please be guided by the form attached hereto as Annex 2, in preparing your Proposal.

Proposals may be submitted on or before deadline as specified in the system (note that time zone indicated in the system is New York Time zone). In Atlas E-Tendering system

United Nations Development Programme
UNOCA Compound Jalalabad Road Kabul
UNDP/GF Procurement Unit
Procurement.af@undp.org

Your Proposal must be expressed in the English, and valid for a minimum period of 90 Days

In the course of preparing your Proposal, it shall remain your responsibility to ensure that it reaches the address above on or before the deadline. Proposals that are received by UNDP after the deadline indicated above, for whatever reason,

shall not be considered for evaluation. If you are submitting your Proposal by email, kindly ensure that they are signed and in the .pdf format, and free from any virus or corrupted files.

Services proposed shall be reviewed and evaluated based on completeness and compliance of the Proposal and responsiveness with the requirements of the RFP and all other annexes providing details of UNDP requirements.

The Proposal that complies with all of the requirements, meets all the evaluation criteria and offers the best value for money shall be selected and awarded the contract. Any offer that does not meet the requirements shall be rejected.

Any discrepancy between the unit price and the total price shall be re-computed by UNDP, and the unit price shall prevail and the total price shall be corrected. If the Service Provider does not accept the final price based on UNDP's re-computation and correction of errors, its Proposal will be rejected.

No price variation due to escalation, inflation, fluctuation in exchange rates, or any other market factors shall be accepted by UNDP after it has received the Proposal. At the time of Award of Contract or Purchase Order, UNDP reserves the right to vary (increase or decrease) the quantity of services and/or goods, by up to a maximum twenty five per cent (25%) of the total offer, without any change in the unit price or other terms and conditions.

Any Contract or Purchase Order that will be issued as a result of this RFP shall be subject to the General Terms and Conditions attached hereto. The mere act of submission of a Proposal implies that the Service Provider accepts without question the General Terms and Conditions of UNDP, herein attached as Annex 3.

Please be advised that UNDP is not bound to accept any Proposal, nor award a contract or Purchase Order, nor be responsible for any costs associated with a Service Providers preparation and submission of a Proposal, regardless of the outcome or the manner of conducting the selection process.

UNDP's vendor protest procedure is intended to afford an opportunity to appeal for persons or firms not awarded a Purchase Order or Contract in a competitive procurement process. In the event that you believe you have not been fairly treated, you can find detailed information about vendor protest procedures in the following link:
http://www.undp.org/content/undp/en/home/operations/procurement/protestandsanctions/

UNDP encourages every prospective Service Provider to prevent and avoid conflicts of interest, by disclosing to UNDP if you, or any of your affiliates or personnel, were involved in the preparation of the requirements, design, cost estimates, and other information used in this RFP.

UNDP implements a zero tolerance on fraud and other proscribed practices, and is committed to preventing, identifying and addressing all such acts and practices against UNDP, as well as third parties involved in UNDP activities. UNDP expects its Service Providers to adhere to the UN Supplier Code of Conduct found in this link : http://www.un.org/depts/ptd/pdf/conduct_english.pdf

Thank you and we look forward to receiving your Proposal.

Sincerely yours,

Mohammad Hashim Hashimi
PSM Officer UNDP/GF

Date, May 16, 2019

Section 1

Description of Requirements

Context of the Requirement	Assessing the statues of availability, utilization and factors affecting services utilization of productive health, including HIV/AIS, Tuberculosis and Malaria (ATM) in Family Health House (FHH) in Khost and Badakhshan Provinces in Afghanistan
Implementing Partner of UNDP	**UNDP, Global Fund Project, Afghanistan**
Brief Description of the Required Services[1]	Please refer to Annex 4 - TOR (Terms of Reference).
List and Description of Expected Outputs to be Delivered	Please refer to Annex-4 TOR
Person to Supervise the Work/Performance of the Service Provider	UNDP Global Fund Project – TB-RSSH Programme and GFP M & E Unit
Frequency of Reporting	Delivery based reporting as per Annex-4 TOR
Progress Reporting Requirements	N/A
Location of work	Please refer to Annex-4 TOR
Expected duration of work	Please refer to Annex-4 TOR
Target start date	Please refer to Annex-4 TOR
Latest completion date	Please refer to Annex-4 TOR
Travels Expected	Please refer to Annex-4 TOR
Deadline for submitting requests for clarifications/ questions	7 days prior to tender closing date **Note** Mandatory subject of email: RFP/UNDP/AFG/2019/0000003756 for FHH Baseline Assessment, UNDP-TB-RSSH Programme
Deadline of Submission of Proposal	Date and Time: As specified in the system (note that time zone indicated in the system is New York Time zone). **PLEASE NOTE: -** 1. Date and time visible on the main screen of event (on E-Tendering portal) will be final and prevail over any other closing time indicated elsewhere, in case they are different. Please also note that the bid closing time shown in the PDF file generated by the system is not accurate due to a technical glitch that we will resolve soon. The correct bid closing time is as indicated in the E-Tendering portal and system will not accept any bid after that time. It is the responsibility of the bidder to make sure bids are submitted within this deadline. UNDP will not accept any bid that is not submitted directly in the system. 2. Try to submit your bid a day prior or well before the closing time. Do not wait until last minute. If you face any issue submitting your bid at the last minute, UNDP may not be able to assist.

[1] *A detailed TOR may be attached if the information listed in this Annex is not sufficient to fully describe the nature of the work and other details of the requirements.*

Special Security Requirements	N/A
Facilities to be Provided by UNDP (i.e., must be excluded from Price Proposal)	N/A
Implementation Schedule indicating breakdown and timing of activities/sub-activities	☒ Required
Names and curriculum vitae of individuals who will be involved in completing the services	☒ Required- for details please refer to Annex-4 TOR
Currency of Proposal	☒ United States Dollars ☒ Local Currency For evaluation purposes, the bids submitted in other currencies will be converted to US$ using the UN Operational Exchange Rate.
Value Added Tax on Price Proposal	☒ must be inclusive of VAT
Validity Period of Proposals *(Counting for the last day of submission of quotes)*	☒ 90 days In exceptional circumstances, UNDP may request the Proposer to extend the validity of the Proposal beyond what has been initially indicated in this RFP. The Proposal shall then confirm the extension in writing, without any modification whatsoever on the Proposal.
Partial Quotes	☒ Not permitted
Performance Guarantee	N/A
Payment Terms	Please refer to Annex-4 TOR
Person(s) to review/inspect/ approve outputs/completed services and authorize the disbursement of payment	UNDP Global Fund Project – TB-RSHH Programme and GFP M&E Unit
Type of Contract to be Signed	☒ Institutional Contract
Criteria for Contract Award	☒ Lowest Price Quote among technically responsive offers ☒ Full acceptance of the UNDP Contract General Terms and Conditions (GTC). This is a mandatory criterion and cannot be deleted regardless of the nature of services required. Non-acceptance of the GTC may be grounds for the rejection of the Proposal.
Criteria for the Assessment of Proposal	A two-stage procedure is utilized in evaluating the proposals, with evaluation of the technical proposal being completed prior to any price proposal being opened and compared. Proposals that achieve above the minimum of 700 points (i.e. at least 70% of the total 1000 points) on the substantive presentation shall be reviewed for price and offeror proposing the lowest price among technically responsive offers will be recommended a contract award.

	<u>Technical Proposal (70%)</u> ☒ Background/Expertise of the Firm 300 (30 %) ☒ Methodology, Its Appropriateness to the Condition and Timeliness of the Implementation Plan 400(40 %) ☒ Management Structure and Qualification of Key Personnel 300 (30 %) **<u>Financial Proposal</u>** Lowest Price Quote among technically responsive offers
UNDP will award the contract to:	☒ One and only one Service Provider
Required Documents that must be Submitted to Establish Qualification of Proposers (In "Certified True Copy" form only) .	☒ Profile – Company Profile, which should not exceed fifteen (15) pages, including printed brochures, reports of similar studies and any relevant documents; ☒ Work Experience - 5-years relevant experience; ☒ Track Record: List of all similar projects within the last 5 years - list of clients for similar services as those required by UNDP, indicating description of contract scope, contract duration, contract value, contact references; ☒ At-least three similar contracts: Provide details of previous contracts including the scope of work for at least three (03) similar project within the last 5 years along with value of the contract, duration of assignment, project owner name, address and contact details. One contract value of such previous work should be more than or equal to USD 15,000.00. ☒ Certificate of registration of the business, including Articles of Incorporation, or equivalent document if a bidder is not a corporation ☒ Structure of the team, including the names, position in the team and CVs of Key personnel; Documentation demonstrating required qualifications and requirements as mentioned in the TOR.
Annexes to this RFP	☒ Form for Submitting service provider Proposal (Section 2) ☒ Institutional contract UNDP General Conditions of Contract for Services (Section 3)2 ☒ Detailed TOR (Section 4)
Contact Person for Inquiries (Written inquiries only)[3]	Focal Person in UNDP-GFP: Supply Chain Management Office Email Address: procurement.af@undp.org Facsimile: Mandatory subject of email: RFP/UNDP/AFG/2019/0000003756 for FHH Baseline Assessment, UNDP-TB-RSSH Programme
Manner of Disseminating Supplemental Information to the RFP and responses/clarifications to queries	☒ Will be Uploaded in the system. Once uploaded, Prospective Proposers (i.e. Proposers that have accepted the bid invitation in the system) will be notified via E-Tendering generated email that changes have occurred. It is the responsibility of the Proposers to view the respective changes and clarifications in the system.

grounds for disqualification from this procurement process.
This contact person and address is officially designated by UNDP. If inquiries are sent to other person/s or address/es, even if they are UNDP staff, UNDP shall have no obligation to respond nor can UNDP confirm that the query was received.

Conditions and Procedures for electronic submission and opening, if allowed	☒ Official Address for e-submission: *[https://etendering.partneragencies.org]* ☒ Free from virus and corrupted files ☒ Format: PDF, Excel, Word ☒ Password for the financial proposal must not be provided to UNDP until it is formally requested by UNDP focal points indicated in DS No. 17. (procurement.af@undp.org) (Financial Proposal must be submitted as a separate file encrypted with a password. None of the financial proposal data is disclosed in other documents of the submission. UNDP shall request password for opening the Financial Proposal only from the Proposers who pass the Technical Evaluation as per the criteria established and disclosed in the solicitation document. The Proposer shall assume the responsibility for not encrypting the financial proposal.) ☒ Please do not put the price of your financial proposal in e-tendering price line. Instead put 1. ☒ Max. File Size per transmission: *5 MB* ☒ Virus Scanning Software to be Used prior to transmission: *Symantec/Norton/ESET NOD 32/ AVG/ Avira/ Bitdefender/ Kaspersky/ F-secure/ G Data/ Bull Guard/Avast* ☒ Time Zone to be Recognized: *local time in Kabul*
Post qualification	☒ Verification of accuracy, correctness and authenticity of the information provided by the bidder on the legal, technical and financial documents submitted; ☒ Inquiry and reference checking with Government entities with jurisdiction on the bidder, or any other entity that may have done business with the bidder; ☒ Inquiry and reference checking with other previous clients on the quality of performance on ongoing or previous contracts completed;

Summary of Technical Proposal Evaluation Forms		Score Weight	Points Obtainable
1.	Expertise of Firm / Organization	30%	300
2.	Proposed Methodology, Approach and Implementation Plan	40%	400
3.	Management Structure and Key Personnel	30%	300
	Total		**1000**

Annex 2
FORM FOR SUBMITTING SERVICE PROVIDER'S PROPOSAL[4]

(This Form must be submitted only using the Service Provider's Official Letterhead/Stationery[5])

[insert: *Location]*.
[insert: *Date]*

To: [*insert: Name and Address of UNDP focal point]*

Dear Sir/Madam:

We, the undersigned, hereby offer to render the following services to UNDP in conformity with the requirements defined in the RFP dated *[specify date]* , and all of its attachments, as well as the provisions of the UNDP General Contract Terms and Conditions:

A. **Qualifications of the Service Provider**

The Service Provider must describe and explain how and why they are the best entity that can deliver the requirements of UNDP by indicating the following: *a) Profile – describing the nature of business, field of expertise, licenses, certifications, accreditations;* *b) Business Licenses – Registration Papers, Tax Payment Certification, etc.* *c) Latest Audited Financial Statement – income statement and balance sheet to indicate Its financial stability, liquidity, credit standing, and market reputation, etc.;* *d) Track Record – list of clients for similar services as those required by UNDP, indicating description of contract scope, contract duration, contract value, contact references;* *e) Certificates and Accreditation – including Quality Certificates, Patent Registrations, Environmental Sustainability Certificates, etc.* *f) Written Self-Declaration that the company is not in the UN Security Council 1267/1989 List, UN Procurement Division List or Other UN Ineligibility List.*

B. **Proposed Methodology for the Completion of Services**

The Service Provider must describe how it will address/deliver the demands of the RFP; providing a detailed description of the essential performance characteristics, reporting conditions and quality assurance mechanisms that will be put in place, while demonstrating that the proposed methodology will be appropriate to the local conditions and context of the work.

[4] *This serves as a guide to the Service Provider in preparing the Proposal.*
[5] *Official Letterhead/Stationery must indicate contact details – addresses, email, phone and fax numbers – for verification purposes*

C. **Qualifications of Key Personnel**

If required by the RFP, the Service Provider must provide:

a) Names and qualifications of the key personnel that will perform the services indicating who is Team Leader, who are supporting, etc.;
b) CVs demonstrating qualifications must be submitted if required by the RFP; and
c) Written confirmation from each personnel that they are available for the entire duration of the contract.

D. **Cost Breakdown per deliverable***

	Deliverables ***[list them as referred to in the RFP]***	**Percentage of Total Price** ***(Weight for payment)***	**Price** ***(Lump Sum, All Inclusive)***
1	An inception report, including the study protocol with detailed methodology and tools	20%	
2	Train the field staff, completion of data collection from the study provinces and finalized data entry template	30 %	
3	Baseline assessment final report including user-friendly summary document (3-5 pages) and slides (10-20 total) for dissemination	50 %	
	Total	100%	

**This shall be the basis of the payment tranches*

E. **Cost Breakdown by Cost Component [*This is only an Example]*:**

Description of Activity	**Remuneration per Unit of Time**	**Total Period of Engagement**	**No. of Personnel**	**Total Rate**
I. Personnel Services				
1. Services from Home Office				
a. Expertise 1				
b. Expertise 2				
2. Services from Field Offices				
a . Expertise 1				
b. Expertise 2				
3. Services from Overseas				
a. Expertise 1				
b. Expertise 2				
II. Out of Pocket Expenses				
1. Travel Costs				
2. Daily Allowance				
3. Communications				

4. Reproduction				
5. Equipment Lease				
6. Others				
III. Other Related Costs				

[Name and Signature of the Service Provider's Authorized Person]
[Designation]

[Date]

Annex- 3

General Terms and Conditions for Services

Annex 4

Terms of Reference (TOR)

Assessing the status of availability, utilization and factors affecting service utilization of reproductive health, including HIV/AIDS, Tuberculosis and Malaria (ATM) in Family Health House (FHH) in Khost and Badakshan provinces in Afghanistan.

1.0 Introduction

Despite the rapid changes that have taken place in the country over the last decade, in particular in terms of the impressive reduction of Maternal Mortality Ratio (MMR), neonatal, and child deaths, Afghanistan is still struggling to ensure basic health service are accessible and utilized by Afghan women and newborns. In response to the very high MMR, Afghanistan introduced a Basic Package of Health Services (BPHS) in 2003 with the aim to reach all Afghans through provision of basic health services through Basic Health Centres (BHC), Comprehensive Health Centres (CHC), and District Hospitals (DH), and Health Posts (HP) staffed with a female and male Community Health Workers (CHW). However, experiences of implementation of BPHS revealed that the above-mentioned health facilities could not reach all Afghans, particularly in very remote areas due to scattered location of villages. This fact led the revision of BPHS and inclusion of Health Sub-Centre (HSC), as the lower level health facility than BHC and Mobile Health Team (MHT), to expand the health services to the very remote population. However, due to the harsh and scattered geography of deep rural areas, still there are areas underserved or unserved areas called 'white areas'. Based on the evidence, around 10%[6] of the population live in very remote areas more than two hours walk from the nearest BPHS facility. The TB, HIV and malaria services are integrated into BPHS and EPHS. However, Basic health services including ATM services remain limited in hard-to-reach, rural and insecure communities. Major constraints include inadequate numbers of skilled workers and female health staff in rural areas; weak linkages between the public and private health sectors; and low levels of education, particularly for females.

1.1 Background of Family Health House (FHH) Model

The FHH model was piloted by the CBHC department of the MoPH, with technical and financial support from UNFPA, to increase access to basic RMNCAH services in white areas and bridge the gap between health posts and HSCs. FHHs are community-based health structures serving 1,500–3000 people and staffed by a trained community midwife recruited from the local population.

FHHs are sustainable community-led initiatives staffed by a community midwife nominated by residents who also bear a third of the costs. The community midwives are supported by volunteer CHWs who provide health information and conduct public awareness activities with communities, treat some basic illnesses, and refer patients to FHHs and higher-level health facilities. Whilst community midwives are

[6] Afghanistan Health Survey 2018

completing their 26-month training programme, their communities are served by a mobile health team. Once the midwives take up their posts, mobile teams are discontinued

The FHH model comprises four components: the FHH itself, one health post, two Family Health Action Groups (FHAGs), and one Community Health *Shura*

a) **Family Health House**: The FHH, or *Ashiana-e-Sehi,* is a community-based health facility established in areas that lie at least 10 kilometres from the nearest BPHS facility. It serves a population of 1,500–3,000 people and is staffed by a community midwife. The FHH provides essential RMNCAH services and establishes a referral system to higher-level health facilities, i.e. BPHS and EPHS facilities.

b) **Health Post**: Each FHH is supported by a health post staffed by one male and one female CHW, both whom have received the standard CHW training. The health post provides limited essential health services to the community, promotes standard health behaviours, particularly RMNCAH, and bridges between the community and the FHH.

c) **Family Health Action Group**: The FHAG is a group of 10–15 volunteer women of child-bearing age belonging to the local community who receive a basic orientation in promoting health messages, primarily related to RMNCAH, and encourage their communities to utilize the FHH.

d) **Community Health *Shura***: The *shura* or community group (known locally as the *Shura-e-Sehi*), comprises community leaders including religious leaders, and is formed based on MoPH's community-based health care procedures and guidelines. They have 11-15 members representing all people in the catchment areas of each FHH with 30% of their members are female or in some areas where there are lots of cultural barriers, there are spate male and female members.

1.2 Relevance of the Family Health House model

The FHH model is fully aligned with the National Health and Nutrition Policy and Strategy 2016–2020 which refers to it in the following terms: "Physical access will be improved in isolated rural areas through community health facilities, previously called family health houses". The strategy acknowledges the FHH model to be an innovative and effective intervention to deliver community-based health services, and the CBHC strategy cites it as an innovation. The National Health and Nutrition Policy action plan envisages a percentage increase in FHHs by 2020.

The model is also aligned with the RMNCAH Strategy 2017–2020 which states: "Increase the number of Family Health Houses serving remote communities.[7]"

The aim of the project is to increase access of women and children to health care services for RMNCAH, HIV, TB and malaria, reduced stigma and discrimination and promotion of health lifestyles in the community and in health facilities in underserved areas[8].
The specific objectives of the FHH projects are (as taken from FHH Concept Note):

1. To increase access (economic, physical and social) to essential RMNCAH and integrated HIV, tuberculosis (TB) and malaria services and their utilization by communities living in targeted remote areas;
2. To improve quality of health services through training and building the capacity of community

[7] FHHs concept note 2018
[8] Performance framework TBRSSH grant, MoPH 2018

midwives, community health workers (CHWs) at health posts, community groups (Community Health Shuras), Family Health Action Groups (FHAGs), and through capacity-building and management of project staff;

3. To establish a functional referral system by establishing linkages between community-based Family Health Houses (FHH) and higher-level health facilities;
4. To empower women and contribute to the elimination of gender-based violence.

1.3 Services provided by Family Health House model

Initially only essential RMNCAH services were provided at the FHHs. In 2017, as per the recommendation of the MoPH's Health System Strengthening Unit, tuberculosis, malaria and HIV/ AIDS were added to the list of FHH services. The FHH offers the following services to communities:

1. Antenatal care;
2. Birth planning and delivery;
3. Postnatal care;
4. Family planning/ birth spacing;
5. Outpatient services (only for integrated management of childhood illness);
6. Newborn care;
7. Health education and public awareness;
8. Referral;
9. Home visits for defaulters;
10. Nursing services (only in upgraded FHHs with a second female health worker, piloted for establishment in areas with larger catchment population);
11. FKey services in the tuberculosis programme including:
12. Key services in the tuberculosis programme including:
    - Tuberculosis case detection;
    - Referral of suspected tuberculosis cases;
    - Direct observation therapy for regular treatment;
    - Follow-up and monitoring of patients;
    - Tracing of patients' household contacts.
13. Key services in the malaria programme, including:
    - Diagnosis: Confirmation of malaria through rapid diagnostic testing; (RDT
    - Treatment: Administering ACT for P. falciparum and chloroquine for P. vivax infections;
    - Education: Use of information education and communication materials;
    - In malaria-prone white areas of Kunar, Laghman, Nuristan, Nangarhar, Khost and Paktika provinces, the FHH can distribute long-lasting insecticidal nets through antenatal care.
14. Key services in the HIV/ AIDS programme, including:
    - Counselling: Testing and counselling for HIV/ AIDS based on the National Algorithm, with three standard tests;

- Referral: Follow-up and tracing of people living with HIV who are receiving antiretroviral treatment, and referral to antiretroviral therapy services;
- Awareness: Information, education and communication, and behaviour change communication.

1.4 Criteria for selection of Family Health House model

Clear criteria have been developed for establishing a FHH, these include:

1. Population of between 1,500 to 3,000 (exceptionally 4,000)
2. Nearest health facility is more than 3 hours walk/donkey ride, or 10kms or more
3. Community participation, especially from women (including they must agree to help construct the building, agree to support and protecting security of CMW)
4. FHH to be constructed adjacent or in CMW residence
5. Must be suitable female candidate from local community available and willing to train and be deployed back in the community as a CMW.

1.5 FHH Project expected results

The project aims to deliver the following results, namely;

Impact:

1. Improved health and wellbeing of communities living in areas unserved in Khost and Badakhshan Provinces.
2. Decreased mortality and morbidity associated with RMNCAH and ATM in the catchment areas

Outcomes:

1. Enhanced community and family actions, practices and values that promote healthy lifestyles and utilization of health services
2. Increased access to and utilization of RMNACH and ATM services in the catchment areas

Outputs:

1. Established and strengthened community health shuras at FHH locations and more in adjacent villages.
2. Utilized community-based systems to mobilize resources and collective action towards construction of FHH.
3. Recruited, trained and deployed community midwives in FHHs in Khost and Badakhshan Provinces.
4. Established and operationalized 35 FHHs providing RMNCAH and ATM services including family planning services to the catchment population in Khost and Badakhshan Provinces.

The details of the performance measurement framework at impact, outcome and output level with the list of key selected indicators for FHH model is included in annex 2. This draft expected result is under partners review and the finalized version will be shared with the selected consultancy firm to be incorporated in the final baseline assessment protocol.

2.0 Rationale

The Basic Package of Health Services (BPHS) defines the reasonable population catchment area for each health facility (HF). This means that many sparsely-populated communities do not qualify to have fixed BPHS HFs. In 2008, as a response on how to address this gap the MoPH together with donors introduced Mobile Health Services. However, the Mobile Health Teams (MHTs) approach tends to be costly with intermittent and not easily sustainable services in the long-run.

In order to ensure sustainability of healthcare services, particularly provision of Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) services in the remote and hard-to-reach areas; Community Based Health Care (CBHC) Department of Ministry of Public Health, in 2009 (MoPH) and UNFPA started the Family Health House-Mobile Support Team (FHH-MST) model in Daikundi, Bamyan, and Faryab provinces and for underserved populations living in mountainous areas without access to BPHS. Later on, the three districts of Herat were added to this pilot FHH project and its activities were started in 2013. FHHs are recognized by the MoPH and other stakeholders as effective interventions to provide RMNCAH services in un(der)served areas of Afghanistan.

To increase access to essential RMNCAH and integrated TB, Malaria and HIV/AIDS services through FHH, 35 more FHHs are in process of establishment through the financial support of the Global Fund in Khost and Badakshan Provinces. The list of FHHs with population can be found in the Annex 3. Therefore, the Community Based Health Care (CBHC) department of MoPH together with UNDP are planning to undertake a baseline assessment to establish reference points to assess progress towards achieving status of intended project results at the end of project implementation.

3.0 Objectives

The overall objective is to conduct an assessment of status of intended service availability, utilization and factors affecting utilization of reproductive health, Malaria, TB and HIV services in 35 FHHs in two Provinces of Afghanistan. The specific objectives are as follows:

1. To determine the availability of services in the targeted communities prior to service delivery by FHH to compare with the end evaluation to measure an increase in availability including ATM services
2. To assess utilization and coverage of RMNCAH and ATM services in the targeted communities prior to service delivery by FHH to compare with the end evaluation to measure an increase in utilization
3. To identify factors which affect utilization of health services at FHHs in the targeted communities prior to service delivery by FHH

4.0 Study Methodology

It is envisaged that the baseline survey will employ a mix of methodological approaches (both qualitative and quantitative) as deemed necessary to respond to the baseline objectives. The methods chosen should be well documented to allow for use of the same methods in the later stages of implementation to assess programme outcomes and outputs.

The consultancy firm is expected to adopt methods that will appropriately respond to the key baseline objectives and to address indicators listed in Annex 2. These may include, but not limited to the following methods: sample surveys, desk reviews and analysis of existing data, Key informant interview, Focus Group Discussion and case studies. Approaches can be combined to improve quality of the study results. The consultancy firm is, free to recommend other appropriate methodologies that will be discussed with and approved by the FHH technical committee members.

For purposes of sample surveys, the consultancy firm is expected to determine the appropriate sample size on which to collect data based on indicators in the list of indicators (see Annex 2) and population of the FHH sites (see annex 3). Appropriate sampling techniques and data collection techniques/instruments should be applied based on the requirement of the indicators. The data collected is expected to be disaggregated by province, District, FHH sites, gender and age groups.

This is the minimum sample size for the purpose of development of financial proposal. IN the technical proposal the consultancy firm is encouraged to propose a refined sampling to ensure presentative results. The study will quantitatively measure the availability and utilization of health services including ATM services in the catchment area of each Family Health House. The numbers of people given in each village (the list in annex 3) where the FHH is located will be counted as catchment area for the corresponding FHH. The number of households in each catchment area will be calculated as the population in catchment area divided by the average household size (i.e. 7). Fifty percent of the family health houses will be randomly selected from the list of the given FHHs (in total they are 35). Then a household survey will be implemented in 30 households in the catchment area of each selected FHH. The households will be systematically (or randomly in case a household mapping and listing is applied) selected by determining the selection interval. The eligible women will be selected for interview in each household. Roughly the sample size will 30*17= 510 households.

5.0 Scope of Work of the selected consultancy firm

- Review relevant background literature related to the FHH services in Afghanistan, including but not limited to national policies and technical guidelines, previous FHH related surveys, reviews and assessments.
- Conduct desk review of relevant guidance from technical partners and peer-reviewed research on FHH and mapping to determine the appropriate methodologies for the study.
- Develop the study protocol with data collection tools and share with CBHC, EHIS, GFCU, UNDP, partners and FHH taskforce for their review and input.
- Finalize the study protocol and questionnaire by incorporating the comments from the FHH task force
- Develop, assessment work plan and detailed budget (Consultation fee, trainings, data collection, transportation, quality assurance, monitoring, analysis and other unforeseen expenditure).
- Train the selected field implementing staff (data collectors, data clerks and supervisors) on the protocol, research procedures and entire data entry and collection process
- Develop data entry template by using appropriate statistical software and perform data analysis

- Prepare a draft baseline assessment report and share with CBHC, EHIS, GFCU, UNDP, partners and FHH taskforce
- Revise and finalize the report and prepare a presentation for stakeholders' workshop
- Finalize the report and share with CBHC/MoPH and UNDP

Deliverables

- An inception report, including the study protocol with detailed methodology and Tools; (20%)
- Train the field staff, completion of data collection from the study provinces and finalize data entry templates; (30%)
- Baseline assessment report including user-friendly summary document (3-5 pages) and slides (10-20 total) for dissemination (50%)

Schedule

	Implementation steps	Timeframe
1	**An inception report** will be provided on the commencement of the assignment to UNDP/CBHC with the following attachments: • Comprehensive protocol of the study, including methodology and tools • Detailed work plan and budget of the study	Two weeks
2	Approval of the protocol by FHH steering committee, the Global Fund and the Ethics Review Board	Two weeks
3	Training of survey team (data collectors, supervisors and data clerks)	One week
4	Field implementation and completion of data collection	Three weeks
5	Data compilation, analysis and draft findings	Two weeks
4	Consensus and validation workshop. One-day workshop for presenting the results of the survey should be conducted centrally for national level stakeholders to review findings and reach consensus on recommendations.	1 day
5	Final comprehensive study report as per defined objectives. The draft report will first be shared with CBHC, EHIS, GFCU, UNDP, partners and FHH taskforce for review and comments.	4 days

6.0 Institutional Arrangement

Governance of the assessment

- FHH Baseline Assessment steering committee will be established (it will be approved by MoPH leadership under the chairmanship of GD M&EHIS)
- The evaluator will get approval of design, tools, and results from the SC
- The quality assurance of the data collection of the FHH Baseline Assessment will be done by Research Coordination and Evaluation

Reporting

The consultancy firm will report to UNDP-GF programme manager and head of CBHC and work in close collaboration with the FHH TWG.

Compliance with technical guidelines

In carrying out the services described above, the consultancy firm will comply with international guidelines (UNFPA, WHO and other technical partners) and ethics principles for public health research. The consultancy firm will ensure that MoPH and national program policies, strategies and technical guidelines are followed.

7.0 Ethical considerations and community acceptance

- FHH activities are conducted according to the ethical principles, respect of persons, informed consent, confidentiality, and access to services without discrimination or stigma, security of data and of persons, and standard quality of care. The consultancy firm is responsible to operate at all times with all persons (subjects, clients, staff, and others) according to these principles and to take all safety precautions and do no harm.

- Selected consultancy firm must obtain approval from the Ministry of Public Health Ethical Review Committee.

- For the purpose of conducting this baseline survey 'community involvement refers to working with the primary stakeholders (i.e. PHD, BPHS, health facility and community shura), and other interest groups in the design, implementation and results of the baseline assessment. This process involves the following objectives:

    i) Identify community leaders that are important to keep informed and in agreement with regarding survey activities.

    ii) Establish collaborative relationship with BPHS implementers in the study process. Use BPHS service providers for obtaining information on local conditions and better access to the communities.

    iii) Protect ethical rights, interests, physical and psychological well-being of the participants.

    iv) Control inappropriate speculations about the survey operations that might instigate community members to disrupt the survey procedure.

    v) Create high awareness among the persons involved in the research that the data collected are confidential and require safeguarding to prevent harm.

- The consultancy firm is expected to work out appropriate strategies, exercises events, their frequency and durations to ensure that the above objectives are achieved. The process to deal with the community should be transparent and fair. These efforts must ensure that:

    i) Possibilities of 'harm' in any form occurring to the participants and the survey team members is minimized to the best extent

    ii) The survey should protect the privacy of the survey participants

    iii) Communities buy-in the survey process and participate in appropriate forums / events

iv) The survey is implemented smoothly without external disruptions, particularly to the rapport between program implementers and the community

8 Authority and responsibility of UNDP, MoPH/CBHC/GFCU/EHIS, PPHD, and consultancy firm

8.1 MoPH/CBHC/GFCU/EHIS

- Provide the consultancy firm with relevant information related to the consultancy, such as exiting CBCH polies, guideline, previous similar surveys and existing survey instruments and;

- Ensure that its staff at the central, provincial and health facility levels, are available for periodic meetings/workshops as needed and for participation in the survey as needed
- Make available to the consultancy firm its physical facilities for meetings and workshops
- Review draft study protocol and provide feedback for finalization
- Facilitate and get ethical board approval on time
- Monitor and oversee all steps of implementation of the survey
- Review the inception and deliverable reports submitted by the consultancy firm and provide necessary feedback to the consultancy firm,
- Convene meetings with consultancy firm(s) to discuss and resolve issues related to the implementation process and other issues under scope of services,

8.2 Provincial Public Health Director (PPHD)

- Supervision of the implementation and data collection at the provincial level.
- Ensure effective coordination of consultancy firm with all health providers (MoPH, NGOs, Health facilities) in the Province.
- Facilitation in the movement of the consultancy firm and data collectors along other logistic issue.
- Facilitation in quality data collectors and conduction of the survey training.
- The PPHD will not seek from the consultancy firm/agency any payments, benefits, or other material resources for the PHD, their staff, or their families,

8.3 UNDP

- Process and sign contract with the consultancy firm.
- Process timely payments based on deliverables.
- Facilitate coordination with CBHC, GFCU, EHIS, FHH TWG and partners throughout the study
- Review and certify deliverables
- Ensure that survey is conducted per objectives and coordinate feedback with the Global Fund (GF) and all partners and ensure that these are addressed by the consultancy firm.
- Monitor efficient contract implementation and timely completion
- Support with related logistics as applicable

8.4 UNFPA/WHO

- Provide normative guidance on generation of strategic information
- Sharing of global guidance / documents
- Support in development/reviewing of protocol, development of questionnaire's and other tools

8.5 Consultancy firm

- Finalize methodology, tools, detailed workplan and budget with clear road map
- The consultancy firm shall be responsible for overall implementation of the study as per the TOR and provide final report within the timeline.
- Implement the assignment attaining high quality standards.

- Appropriate supervision of data collection activities and assurance of data quality is the responsibility of the consultancy firm. Specific measures and dedicated personnel time should be included in the study protocols to ensure the data collected and entered is of the highest quality. The consultancy firm should develop a data entry program which allows validity checks and double-data entry facility. There must be spot checks on actual full conduct of interviews for each enumerator to prevent fabrication of interviews. This data entry and reconciliation should be completed in a timely way following the conclusion of the field work.
- Preliminary data analysis (generation of frequencies and basic data cleaning for each study and survey group) will be done by the consultancy firm. Initial descriptive analysis of the data should be available within 2 weeks of the completion of the fieldwork. In conjunction with the CBHC/GFCU/EHIS/UNDP and partners, the consultancy firm will prepare an outline and dummy tables for the final report.
- Full documentation of the datasets (process documentation, data dictionary, coding guide, study form/questionnaires for each survey group/site, etc.) should be prepared by the selected consultancy firm as part of the final product to be provided to the UNDP/MoPH. The consultancy firm will however keep the hard copies of filled questionnaires and other related material until the end of the consultancy. Electronic files should be presented in formats used by common-use software.
- The consultancy firm will have full authority on hiring, firing, posting, remuneration, and customary managerial prerogatives over staffs (enumerators, data clerks and supervisors) hired by the consultancy firm for the study.
- The consult will not provide any payments, benefits, or other material resources to the Provincial Health Director (PHD), their staff, or their families. Any resources needed by the PHD will be provided through the central MOPH and UNDP. The consultancy firm will ensure the procurement of all necessary supplies for effective conduct of the study and UNDP will support where possible.

9.0 Outline of the final report

i. Cover page (Title of the study, the date of study, recipient's name, name(s) of the consultancy firm.
ii. Preface or Acknowledgements (Optional)
iii. Table of Contents
iv. List of Acronyms
v. Lists of Charts, Tables or Figures
vi. Executive Summary [Stand-Alone, 1-3 pages, summary of report. This section may not contain any material not also found in the main part of the report]
vii. Main Part of the Report

Introduction/Background and Purpose: [Overview of the baseline study. Summaries of the development problem addressed, that is, increasing access and utilization of reproductive health services including ATM in the intervention areas and the existing on-going assistance being provided to achieve the results of the project. Additionally, the objectives of the FHH model, results, criteria for selection, rationale and etc… will be included in this section. ***Study Approach and Methods:*** [Brief summary only. Additional information, including instruments should be presented in Annexes].

Findings: [This section, organized in whatever way the team wishes, must present the basic answers to the key baseline objectives, i.e., the empirical facts and other types of evidence the baseline team

collected. This section must include the key elements of the report, that is, the assumptions and intended progress towards contributing to achievement of the results of the FHH service provision. It should include tables and graphs as necessary.

Conclusions: [This section should present the team's interpretations or judgments about its findings.

Recommendations*:* [This section should make it clear what actions should be taken as a result of the baseline study].

Annexes The report should include the following as an annex: record of meetings held with MoPH, FHH TWG, key stakeholders; data collection tools; training materials and implementation guidelines for data collectors; TOR of the consultancy and baseline indicator matrix.

10. Duration of the Work

The RFP will result contract for professional services for Three Months, starting from 20 June 2019.

11. Location of Work

The survey will be conducted in the Badakhshan and Khost provinces as described in annex 3. In addition; meeting and key informant interview with key stakeholders will be conducted in Kabul and respective provinces.

12. Qualification of Key staff of the consultancy team

12.1 Qualifications and experience for the consultancy firm

I. The firm should be registered with the Ministry of Economy or Afghanistan Investment Support Agency (AISA).

II. Similar work experience/ competencies in conducting studies with multiple components:

a) In policy analysis

b) Experience in supervising or conducting large studies (above 3 studies).

c) A demonstrated high level of professionalism and an ability to work independently and in high-pressure situations under tight deadlines;

d) Strong interpersonal and communication skills;

e) High proficiency in written and spoken English; and

f) Good understanding of the Afghan health system and local culture.

The consultancy firm should provide CV, details of previous contracts including the scope of work for at least three (03) evaluation/study/assessment assignments in the area of health and/or community services within the last 5 years along with Value of the contract, Duration of assignment, project owner name, address and contact details; Track Record: List of all similar projects within the last 5 years.

12.2 Team leader

The team leader is expected to lead the study and should have the following qualifications:

- Master Epidemiology, Infectious disease or related public health field. PhD degree will be Asset
- At least 5 years of experience in conducting evaluation studies with multiple components
- National/international with wok experience of Afghanistan

Table 1: Qualification and experience of the survey team

Designation	Qualifications	Experience	Remarks
Team leader	Master Epidemiology, Infectious disease or related public health field PhD degree will be Asset	• At least 5 years of experience in conducting evaluation/study/assessment studies with multiple components • National/international with wok experience of Afghanistan	
Field coordinators	University degree	• 3 years of experience in supervision of similar study • Work experience of the survey provinces	

Technical Evaluation Criteria and scoring sheet

Summary of Technical Proposal Evaluation Forms		Score Weight	Points Obtainable
1.	Expertise of Firm / Organization	30%	300
2.	Proposed Methodology, Approach and Implementation Plan	40%	400
3.	Management Structure and Key Personnel	30%	300
	Total		**1000**

Technical Proposal Evaluation Form 1		Points obtainable
Expertise of the Firm/Organization		
1.1	Reputation of Organization and Staff / Credibility / Reliability / Industry Standing	70
1.2	General Organizational Capability which is likely to affect implementation - Financial stability - loose consortium, holding company or one firm - age/size of the firm - strength of project management support - project financing capacity - project management controls	100
1.3	Extent to which any work would be subcontracted (subcontracting carries additional risks which may affect project implementation, but properly done it offers a chance to access specialized skills.)	30
1.4	Quality assurance procedures, warranty	30
1.5	Relevance of:	70

	- Specialized Knowledge in the proposed scope of work in the TOR - Demonstrated experience on Similar Programme / Projects - Experience on Projects in the Afghanistan - Work for UN agencies major multilateral/ or bilateral programmes	
	Subtotal	300

Technical Proposal Evaluation Form 2		Points Obtainable
Proposed Methodology, Approach and Implementation Plan		
2.1	To what degree does the proposer understand the task?	30
2.2	Have the important aspects of the scope of work been addressed in sufficient detail?	30
2.3	Are the different components of the study adequately weighted relative to one another?	40
2.4	Is the proposal based on a survey of similar project and was the findings of similar projects properly used in the preparation of the proposal?	50
2.5	Is the conceptual framework adopted appropriate for the task?	55
2.6	Is the scope of task well defined and does it correspond to the TOR?	110
2.7	Is the presentation clear and is the sequence of activities and the planning logical, realistic and promise efficient implementation to the project?	85
	Subtotal	400

Technical Proposal Evaluation Form 3				Points Obtainable
Management Structure and Key Personnel				
3.1	**Team leader**		Sub-Score	
	Master Epidemiology, Infectious disease or related public health field. PhD degree will be Asset		60	
	5 years of experience in conducting similar study		100	
	Afghan national and wok experience in Afghanistan		40	
		200		
3.3	**Field coordinators**		Sub-Score	
	University degree		30	
	3 years of experience in supervision of similar study		50	
	Working experience of the survey provinces		20	
		100		
	Subtotal	300		
Grand Total		1000		

Criteria for Selecting the Best Offer

The criteria for selection shall be combined Scoring Method, using the 70%-30% distribution for technical and financial proposals, respectively, where the minimum passing score of technical proposal is 70%.

Annex 1. Performance measurement framework (Logical framework)

Title: Improving access to and utilization of reproductive health (RH) and ATM services in un(der)served communities and promoting women's empowerment
Afghanistan — Badakhshan and Khost Provinces

EXPECTED RESULTS[1]	INDICATORS[2]	BASELINE DATA	TARGETS[3]	DATA SOURCES	DATA COLLECTION METHODS	FREQUENCY	RESPONSIBILITY
Impact							
1.1 Improve the health and wellbeing of communities living in under-served areas in Badakhshan and Khost	1. Poverty incidence in catchment area of FHH (sex-disaggregated)	Not available	TBD	National survey	Desk review	2018 and 2020	MoPH
1.2 Decreased mortality and morbidity associated with RMNCAH and ATM in the catchment areas	1. Maternal mortality ratio, per 100,000 population	Not available	TBD	National survey	Desk review	2018 and 2020	MoPH
	2. Neonatal mortality rate	22 AHS 2018	17	National survey	Desk review	2018 and 2020	MoPH
	3. Under 5 mortality rate	55 AHS 2018	42	National survey	Desk review		
Outcome							
2.1 Enhanced community and family actions, practices and values that promote healthy lifestyles and utilization of health services including ATM services	1. Modern contraceptive prevalence rate	17.4 AHS 2018	TBC with baseline data	National survey	Desk review	2018 and 2020	MoPH
	2. Percentage of deliveries conducted by skilled birth attendants	58.8 AHS 2018	TBC with baseline data	National survey	Desk review	2018 and 2020	MoPH
	3. # of communities where women participate regularly in community health shuras	0	100% by 2019	Administrative report	PHD reporting	Once	SRs, CBHC, PHD

EXPECTED RESULTS[1]	INDICATORS[2]	BASELINE DATA	TARGETS[3]	DATA SOURCES	DATA COLLECTION METHODS	FREQUENCY	RESPONSIBILITY
	4.# of FHAG that facilitate FHAP	0	35 male and 35 female CHW by 2019	Project records and supervision reports	Administrative report	Once	SRs, CBHC, PHD
	5. Coverage of FHH catchment area population with Family Health Action Plans	0	70 Family Health Action Groups by 2020	Project records and supervision reports	Administrative report	Once	SRs, CBHC, PHD
	6. Proportion of population that slept under an insecticide-treated net the previous night (Disaggregation- pregnant women and children)	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
	7. Proportion of women who have a correct knowledge about HIV transmission	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
	8. Proportion of women who have a correct knowledge about TB transmission	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
2.2 Increased access to and utilization of RMNACH and ATM services in the catchment areas	1.% of pregnant women receiving at least one antenatal checkups in catchment area	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
	2.% of pregnant women receiving 4+ antenatal checkup in catchment area	TBC with baseline date	% by 2019	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
	3.% of institutional deliveries	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
	4. Proportion of women who have attended PNC -1	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP

EXPECTED RESULTS[1]	INDICATORS[2]	BASELINE DATA	TARGETS[3]	DATA SOURCES	DATA COLLECTION METHODS	FREQUENCY	RESPONSIBILITY
	5. Proportion of women who have attended PNC -3	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	
	6. % of couples in reproductive age receiving at least one modern contraceptive method	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
	7. Immunization coverage by antigen (BCG, measles, Penta/DPT3)	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
	8. Morbidity of Under five year Children (Diarrhea and ARI)	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
	9. Percent of cases of diarrhea treated with ORS or recommended home fluids	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
	10. Prevalence of Low Birth Weight (LBW)	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
	11. Access to health care within two hours	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
Output							
1. Established and strengthened community health shuras at FHH locations and more in adjacent villages.	1.# of Health Shura functional	0	35 shuras established 2019	Shura meeting minutes and supervision reports	Analyses of records	Quarterly	SRs, CBHC, PHD
	2. Community commitments confirmed to support the CMW upon their return and to build a FHH	0	35 shuras established by 2019	Shura meeting minutes and supervision reports	Analyses of records	Quarterly	SRs, CBHC, PHD
2. Utilized community based systems to mobilize resources and collective action	1. Community action/contributions (ashar), community funds	0	35 communities by 2019	Cash and records book	Verification of cash and records books	Quarterly	SRs

EXPECTED RESULTS[1]	INDICATORS[2]	BASELINE DATA	TARGETS[3]	DATA SOURCES	DATA COLLECTION METHODS	FREQUENCY	RESPONSIBILITY
towards construction of FHH.	2. # of FHHs constructed/renovated	0	35 communities by 2019	Administrative report	PHD reporting	Once	SRs, CBHC, PHD
3. Recruited, trained and deployed community midwives in FHHs in Khost and Badakhshan Provinces.	1. # of CMWs trained	0	35 by 2019	Test report	Document verification	At graduation	SRs
	2. # of CMWs deployed	0	35 by 2019	Administrative report	PHD reporting	Once	SRs, CBHC, PHD
4. Established and operationalized 35 FHHs providing RMNCAH and ATM services including family planning services to a population of 126,00 (Badakhshan - 39,00 & Khost 87,000)	1. Mapping of all FHHs completed	0	35 by 2019	Administrative report	PHD reporting	Once	SRs, CBHC, PHD
	2.# of FHH locations confirmed	0	35 by 2019	Administrative report	PHD reporting	Once	SRs, CBHC, PHD
	3. Referral facility identified (CHC/CHC+/DH/PH)	0	35 by 2019	Administrative report	PHD reporting	Once	SRs, CBHC, PHD
	4. Number of FHH maintaining full registry of the population in their catchment area	0	35 by 2020	FHH reporting	Survey	Annually in 2019 and 2020	SRs, CBHC, PHD
	5. % of catchment area population covered by up to date Family Health Plan	0	35 by 2020	FHH reporting	Survey	Annually in 2019 and 2020	SRs, CBHC, PHD
	6. Number of FHH catchment areas with health referral funds	0	35 by 2020	SRs reporting	Survey	Annually in 2019 and 2020	SRs, CBHC, PHD
	7. Number of FHHs functional	0	35 by 2019	Administrative report	PHD reporting	Once	SRs, CBHC, PHD
	8. Numbers of participants (m/f) to health education sessions provided by FHH in target population	0	TBD	FHH quarterly reporting	SR report	Quarterly	SRs, CBHC, PHD

EXPECTED RESULTS[1]	INDICATORS[2]	BASELINE DATA	TARGETS[3]	DATA SOURCES	DATA COLLECTION METHODS	FREQUENCY	RESPONSIBILITY
	9. Number of people receiving services through Family Health Houses (FHHs) (sex desegregated)	0	TBD	FHH quarterly reporting	SR report	Quarterly	SRs, CBHC, PHD
	10. Number of sick newborn referred (sex desegregated)	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	2018 and 2020	MoPH and UNDP
	11. Clients satisfied with the quality of service provided by FHHs	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	Once	MoPH and UNDP
	12. Number of presumptive TB cases referred	TBC with baseline date	TBC with baseline data	Baseline study; endline survey	Survey	Once	MoPH and UNDP

Annex 2 Baseline Indicator Matrix

This baseline indicator matrix and overall PMF for FHH project are currently under review and be finalized version will be shared with the selected consultancy firm to be incorporated in the final assessment protocol and tools.

Indicators	Definition	Data sources	Remarks
Maternal Health			
Percentage of institutional deliveries	Number of deliveries occurring in health facilities in period of time*100/number of deliveries in same period of time	Baseline survey	
% of deliveries conducted by skilled birth attendants	Number of deliveries assisted by SBA in period of time * 100/estimated number of deliveries in same period	Baseline survey	
% of pregnant women receiving at least one antenatal checkup in catchment area	Number of women attended at least 1 ANC visit, related to pregnancy to an SBA, during pregnancy in a specified period of time*100/estimated number of pregnancies during the same time period	Baseline survey	

% of pregnant women receiving 4+ antenatal checkup in catchment area	Number of women attended at least 4 ANC visits, related to pregnancy to an SBA, during pregnancy in a specified period of time * 100/estimated number of pregnancies during the same time period	Baseline survey	
Proportion of women who have postpartum contact with a health provider after delivery	Number of women who attended at least 1 PNC visits in a specified period of time * 100/estimated number of deliveries during the same period of time	Baseline survey	
Proportion of women who have attended PNC -3	Number of women who attended at least 3 PNC visits in a specified period of time * 100/estimated number of deliveries during the same period of time	Baseline survey	
Newborn Health			
Proportion of newborns breast-fed within one hour after birth	Number of newborn breastfed within one hour after birth * 100/total number of births	Baseline survey	
Proportion of newborns receiving basic neonatal care (sex desegregated)	Number of newborns receiving basic neonatal care* 100/total neonates sick	Baseline survey	
Prevalence of Low Birth Weight (LBW)	Percentage of newborns < 2500 gm*100/total newborns	Baseline survey	
Number of sick newborn referred (sex desegregated)	Number of sick newborn referred by FHHS	Routine report	
Birth Spacing and Family Planning			
Modern contraceptive prevalence rate	The percentage of all women of reproductive age who are using (or whose partner is using) at least one modern method of contraception at a point in time	Baseline survey	
Child Health			
% of women reported their children had diarrhea within two weeks prior to the survey	Number of women reported their children had diarrhea within the past two weeks prior to the survey * 100/total respondents	Baseline survey	
Percent of cases of diarrhea treated with ORS or recommended home fluids	Number of cases of diarrhea treated with ORS/RHL * 100/total cases of diarrhea	Baseline survey	
% of women reported their children had ARI within two weeks prior to the survey	Number of women reported their children had diarrhea within the past two weeks prior to the survey * 100/total respondents	Baseline survey	
Percentage of children under five years of age with suspected pneumonia taken to a health facility	Percentage of children under five years of age with suspected pneumonia (cough and difficult breathing NOT due to a problem in the chest, and a blocked nose) in the two weeks preceding taken to an appropriate health facility or provider.	Baseline survey	
% of children <6 months who are breastfed exclusively	Number of children 0–6 months old who are exclusively breastfed/total number of children 0–6 months old	Baseline survey	

Immunization			
Immunization coverage by antigen (BCG, measles, penta 3)	Number of children 12-24 months vaccinated for BCG, measles and DPT3*100/total children 12-24 months	Baseline survey	
Women of child bearing age (15-49 years) received TT2	Number of women 15-49 years vaccinated for TT2*100/total women 15-49 years	Baseline survey	
HIV/AIDS, Malaria and Tuberculosis			
Proportion of population that slept under an insecticide-treated net the previous night (Disaggregation- pregnant women and children)	Numerator: # of individuals who slept under an ITN the previous night Denominator: Total number of individuals who spent the previous night in surveyed households	Baseline survey	
% of women who have a correct knowledge about HIV transmission	Number of respondents who have correct knowledge of HIV transmission*100/total respondents	Baseline survey	
% of women tested for HIV and know their results	Number who were tested for HIV and know their results*100/total respondents	Baseline survey	
% of women who have a correct knowledge about TB transmission	Number of respondents who have correct knowledge of TB transmission*100/total respondents	Baseline survey	
Number of presumptive TB cases referred (sex desegregated)	Number of presumptive TB cases referred by FHHS	Routine report	
Access to health care within two hours	The walking distance to the public health facilities in hours.	Baseline survey	

Annex 3. List of FHH sites in Khost and Badakhshan provinces

No	FHH Name	District Name	Population	Distance from HF	HH Size	HF Name	Remarks
	Badakhshan Province						
1	Khawhan	Khawhan	1800	35 km	257	Khawhan	
2	shahre safa	Daryem	5550	20 km	793	shahre safa	
3	khordakan	shah-re Buzurg	2300	30km	329	khordakan	
4	Ziraki	Ragistan	1500	18km	214	Ziraki	
5	kishim	kishim	2200	10km	314	kishim	
6	Tagab	Tagab	2100	10km	300	Tagab	
7	Hafizmughul	Argo	4300	35km	614	Hafizmughul	
8	Langar	Faizabad	1300	10km	186	Langar	
9	Eshkashim	Eshkashim	3000	10km	429	Eshkashim	
10	Wakhan	Wakhan	1650	25km	236	Wakhan	
11	Zibak	Zibak	1500	15km	214	Zibak	
12	Jamarch	Maimai	1560	15km	223	Jamarch	
13	Nusai	Nusai	2000	25km	286	Nusai	
14	shukai	shukai	2297	17km	328	shukai	
15	shugnan	shugnan	1576	30km	214	shugnan	
16	Baharak	Baharak	3500	10km	500	Baharak	
17	khash	khash	2000	11km	286	khash	
Subtotal		17	40,133		5733		
	Khost Province						
1	Habash Khial	Center Matoon	6000	10 km	857	Khost PH	
2	Ayob Khial	Center Lakan	6000	10 km	857	Lakan CHC	
3	Shamal Piran	Center Shamal	4500	11 km	643	Gharshin BHC	
4	Laghori Kotki	Tani Dragai	3500	10 km	500	Dragai CHC	
5	Dermalaka	Tani Dragai	2000	11 km	286	Dragai CHC	
6	Egdan Wal	Gurbez	3000	11 km	429	Gurbez CHC	
7	Dagona	Ismail Khial/Mandozai	4500	10 km	643	Mandozai CHC	
8	Hasanzai	Ismail Khial/Mandozai	4500	11 km	643	Mandozai CHC	
9	Sahra Kaly	Alishir	3000	10 km	429	Alishir CHC	
10	Spenki Bori	Alishir	3500	10 km	500	Alishir CHC	
11	Mali Pashow	Sabari	2500	10 km	357	Kholbisat CHC	
12	Gulnam Kaly	Sabari	12000	10 km	1714	Kholbisat CHC	
13	Totak	Baak	4500	10 km	643	Baak CHC	
14	Wakilan Kaly	Baak	11000	10 km	1571	Baak CHC	
15	Sperawoni	Musakhial	2000	10 km	286	Zoor Kot CHC	
16	Tapia	MusaKhial	3000	11 km	429	Zoor Kot CHC	
17	Khojrim Kaly	Nadar Sha Kot	7000	10 km	1000	Shambawoot BHC	

18	Satiwan	Jajimidan	4390	10 km	627	Jajimidan CHC	
Subtotal		18	86,890		12,413		
Grand Total		35	127,023		18,146		