

SPECIFIC TERMS OF REFERENCE

Support to the Disability and Rehabilitation Department of the Ministry of Public Health in Afghanistan.

FWC BENEFICIARIES 2009 LOT 8: HEALTH EuropeAid/128261/C/SER-Af/19898

1. BACKGROUND

Afghanistan has known over twenty years of war and endemic conflict. During this period of turmoil national policies undercut public and private investments in social development, creating a lack of institutional, administrative as well as technical capacities in the country's social sectors. The basic public services have collapsed.

Minimum health services were however delivered during this time, mainly through humanitarian assistance with Non Governmental Organizations (NGOs) in cooperation with Afghan health staff. And with the support of international aid, the national health system has managed to maintain coordination as illustrated by progressively improving indicators. In addition to health services, basic physical rehabilitation services were initiated and provided by NGOs.

Disability in Afghanistan. After almost 3 decades of war "disability" is a well known condition in the country, though work has been carried out in order to shift the definition of disability linked to martyrs and war victims to a larger and more comprehensive approach. Disability as a condition is constantly looked at in surveys and in routine data recording in Afghanistan. Among them the following are worth mentioning:

1. The National Disability Survey Afghanistan (NDSA)¹, carried out between April and September 2004 adopted a definition of disability based on activities and participation, concentrating on the functioning of the individual. The NDSA estimates a national prevalence rate of severe disability of 2.7%, whereby geographical distribution of persons with disability shows significant variations².
2. The 2004 qualitative survey (UNICEF, UNDP) on the perceptions of persons with disabilities found among others that improvement in attitudes of service providers towards this group is needed.
3. The National Risk and Vulnerability Assessment³ carried out in 2007 and 2008 estimate 406,000 disable in Afghanistan implying an overall disability prevalence of 1.6 percent. Among the disable some 188,000 are suffering more then one disability and the prevalence for male is higher then female 1.9/1.4.

Physical disability still constitutes the main type of disability (31.3%). However, multiple disability accounts for 15.1% of all persons with physical disability. Mental disability including epilepsy and other forms of seizures ranks second. The high level of multiple sensorial disabilities is also striking (21.4%). This is mainly due to a combination of speech and hearing impairments. Disability from birth or acquired during the first year of life represents 26.4% of total identified causes.

The Government of Afghanistan now faces the huge challenge to meet the population's basic needs such as health, water and sanitation, housing, education and employment. This proves to be even more difficult amongst the most vulnerable groups such as Persons with Disabilities (PwDs). With the exception of war disabled people, PwDs suffer from stigmatization, for instance the presence of a

¹ The NDSA was carried out by Handicap-International in collaboration with MoPH, Ministry of Martyrs and Disabled and Social affairs (MMDSA), and Central Statistics Office (CSO), in partnership with the Johns Hopkins Bloomberg School of Public Health.
<http://www.handicap-international.fr/en/around-the-world0/more-than-60-programmes-in-the/programs/afghanistan-1/actions/index.html?cHash=76b6fa6703>
[last checked 18/05/2010]

² More than half of persons with disability live in Central and Western areas. At the provincial level, highest prevalence rates are observed in Samangan (4.4%), Herat (4.1%), Kabul and Ghor (both 3.9%). In absolute figures the number of disabled is highest in Kabul and Herat province, followed by the provinces where the other main cities are located. The Southern area of the country, with lower population density has a relatively higher proportion of persons with disability. This is probably due to a combination of factors: an ongoing conflict situation, lower access to health services than anywhere else in the country, and lowest level of literacy and access to education in the country, especially for girls.

³ in <http://nrva.cso.gov.af/> [last checked 18/05/2010]

disabled person in a family not only constitutes an obstacle to marriage and subsequently normal family life for him or her, but might affect the marriage opportunities of other members in the family as well. Generally speaking, PwDs, suffer from a lack of access. This lack refers to all dimensions of life in the community: shelter, health, education and employment. More generally, it refers to participation in collective decisions, security in all its forms, the right to belong to a community, the respect of human rights. Care has not been directed towards improving the quality of life, maximizing the potential and independence of those affected. The introduction of Rehabilitation Services has yet to be appreciated, especially in the rural areas where the majority of PwD do not have the awareness of the services that may be available.

Assistance to PwD is one of the many current challenges facing the MoPH, as it must coordinate the transition from an emergency approach to a long term development effort. In other words, expanding its assistance from strictly war disabled to disabled civilians in general who in most cases are indirect victims of war (poverty, lack of primary health care etc...). The need to address the issue of disability covers the whole spectrum of actions, from prevention and awareness rising, to training and capacity building, improving the offer and access to rehabilitation services and promotion of social and economic integration.

Physiotherapy has an important role to play in the prevention of disability and rehabilitation of persons living with disability and is relatively cost effective. In the BPHS the District Hospitals (DH) will be the focus for physiotherapy services to the community both via centre based services and outreach services. A minimum of 2 therapists is required per DH (male/female). Physiotherapy services at the district hospital should include services to the in-patient wards. According to the NDSA, physiotherapy service coverage of North Central and Eastern areas of Afghanistan is higher than in the Western and Southern areas in 2005. Currently there are 250 physiotherapists in the country, mainly working with NGOs, whereas the need is estimated at 400-500 physiotherapists more to achieve an acceptable scope of physiotherapy services. Training of qualified physiotherapists takes 3 years and therefore the current void can realistically not be filled in the short term. In the meantime it may be more realistic to train physiotherapy assistants, as some NGOs already do.

Current state of affairs. The MoPH developed a National Health Strategy aiming at equitable service delivery nationwide. The Strategy supports (an accelerated) the implementation of delivery of quality health services based on a Basic Package of Health Services (BPHS). Complementary to the BPHS and crucial for effectively reducing especially maternal mortality, an Essential Package of Hospital Services (EPHS) has been developed to build a referral system and to provide complementary and emergency services at a higher level of the health pyramid. The latest version of the BPHS integrates disability services into the package.

The Disability and Rehabilitation Department (DRD) was first set up in April 2006 at the Primary Health Care Directorate in MoPH. It is now under the Directorate of Curative Care in the General Directorate of Service Provision and its coordinator and technical advisors participate in all relevant internal meetings/workshops and are called in for preparations of new policy and guidelines documents. DRU has a standing Disability Task Force consisting of staff with technical and managerial expertise in the area of physical rehabilitation. When needed, the Task Force has work groups for specific tasks: (e.g. Manual of Physical Rehabilitation for BPHS Providers, or inputs to the new BPHS policy). The National Community Based Rehabilitation (CBR) coordinator based in DRU/MoPH also coordinates the National CBR Network, this network consists of CBR programme implementers and representatives of Disabled People's Organisations.

The Ministry of Labour, Social Affairs, Martyrs and Disabled (MoLSAMD) is formally mandated to provide support to PwDs. It is, however, in practice designed and structured to provide welfare payments to war-disabled and their families. The Ministry of Education (MoE) has opted for supporting inclusive education and equal access to school for children with disabilities. It created an Inclusive Education Unit, and runs the only public special school in the country for visually impaired. The Ministry of Women Affairs (MoWA) is active in the field of advocacy and advocates for the rights of disabled women.

A substantial number of other stakeholders are active in the field of rehabilitation and socio-economic integration of disabilities. Foremost is the UNDP which has since 1992 provided, directly or through NGOs, community-based rehabilitation services in several districts of the country. These include prosthetic and orthotic services, inclusive education and employment support. NGOs such as Handicap

International, the International Committee of the Red Cross, the International Assistance Mission, Sandy Galls Afghan Appeal and Serving Emergency Relief and Vocational Enterprises (SERVE) have all provided prosthetic and other services to PwD. Currently the Mine Action Coordination Centre of Afghanistan (MACCA) took over UNDP's role

The EU already supports the MoPH extensively. It contracts international and national NGOs to provide health service delivery in ten provinces. Technical Assistance (TA) to the MoPH presently aims at strengthening core units for good governance at all levels and contracts management..

This intervention plays a specific and targeted role in the overall assistance to the disability sector in the country. It provides disability-related policy advice to the MoPH to allow the development of an operational strategy to facilitate the implementation of disability services in the BPHS and EPHS, assist the MoPH in the legal definition of the physiotherapy profession and the status of the Physical Rehabilitation Centres as well as maintain on-going training to all related professionals. The TA will assist the work of the staff of the DRU and collaborate closely with a national counterparts of the Mine Action Coordination Centre of Afghanistan within the disability unit.

2. DESCRIPTION OF THE ASSIGNMENT

2.1 Global objective

To support the MoPH in its stewardship role of fostering policies and strategies for equal opportunities and full participation of children, women and men with disabilities in the process of the reconstruction of Afghanistan.

2.2 Specific objective(s)

The scope of the assignment includes:

- i. To increase the institutional capacity of the MoPH to define policies and formulate strategies in the field of disability and physical rehabilitation ;
- ii. To ensure the operational integration of disability issues into the BPHS and EPHS.
- iii. To contribute to the fund raising opportunities targeted to disability (BPHS, EPHS and tertiary care)

2.3 The outputs include:

The consultant will be in support of the DRD with the general task of capacity development of this department. The attitude and methodology that is expected has to be as close as possible to the definition of capacity development given by UNDP: "the process by which individuals, organization, institutions and societies develop abilities (individually and collectively) to perform functions, solve problems and set and achieve objectives". It is not expected that the consultant acts "instead of" but that acts "in support of". The results listed below may appear overambitious for the short duration of the contract. A prioritization of the deliverabilities is however possible once the contract will have started. Based on the above, among the results expected at the end of the duration of the contract are:

1. The DRD is enabled to play its guiding role in:
 - Planning for the institutionalisation and mainstreaming of disability at all levels of the health system;
 - Planning for the autonomy of the unit itself in order to become less dependant from external support;
 - Planning for resources where geographically or thematically it is more needed and/or more relevant;

- Planning for human resources for disability at short, medium and long term and facilitating formal registration of physiotherapists and orthopaedic technicians and certification as separate health professions of rehabilitation professionals.
2. The DRD is proactive in the formulation, approval and implementation of policies and strategies in line with other initiatives and national programmes. Specifically:
 - Planning for specific provisions for the EPHS
 - Following up the implementation of policies already approved
 - Planning for specific provisions for the mainstreaming of CBR
 3. The DRD is enabled to plan for capacity building (for central and provincial level) in line with existing training plans through:
 - Coordination of the existing training opportunities
 - Planning for MoPH capacity development (especially at the Provincial level)
 4. The DRD is proactive in the feedback and lessons learned are effectively institutionalised at both central and provincial levels
 5. Partnership (twinning) mechanisms are explored and developed with a western institution specialized in Disability and Rehabilitation in view of setting long term academic partnership
 6. The DRD is effectively planning over a 5 year expenditure and operational framework

2.4 Requested services, including suggested methodology

The consultant is free, in its own professional competence, to implement the methodology perceived as most appropriate. Please note that together with the documents usually requested for FWC procedures, a short *Organization and Methodology* paper would be appreciated⁴.

3. EXPERTS PROFILE

3.1 Number of requested experts per category and number of man-days per expert

One senior expert.

Estimated input days: at least 120 days

Following Art 6.2.3⁵ and taking into consideration the need of strengthening DRD, local expertise can be contracted.

3.2 Profile required (education, experience, references and category as appropriate)

This paragraph describes the expertise required in order to carry out the assignment. The team-leader (only CV requested and scored) has to have competencies on all the items listed below.

MC=Minimum Criterion marks the characteristic that need to be satisfied. Where MC is not indicated, the item is desirable (D) and its absence will not exclude the candidate

⁴ The Organization and Methodology will not be scored as such. Please note that in case two or more companies will reach the same scoring as far as CV and financial offer, the Organization and methodology may be used in order to have a better insight of the expert proposed since it is assumed that the paper is primary the input of the expert.

⁵ Framework Contractors should favourably consider calling on the **expertise available on the local market**, whenever possible and in respect of equal treatment of all experts of eligible nationality. Please note that common market prices for Afghanistan-health, for a senior expert may go as far as 3,000 €/month. Please note that this information is not binding and it is meant only to help the Companies in the preparation of the budget.

from the evaluation process. When items “desirable” are linked to specific activities described in the ToRs but are not a strong point of the CV of the expert, the Consultant can propose either subcontracting or local expertise as mentioned above.

Qualifications and skills

- 1 MC Degree in disability studies or alternatively university degree in public health or community health or alternatively author of publications on disability. The focus on disability and health will be used for scoring
- 2 MC Fluency in English
- 3 D Knowledge of Local Languages
- 4 D Strong analytical and drafting skills
- 5 D Proven ability to develop and maintain good professional relations with stakeholders, particularly counterparts and staff members⁶
- 6 MC Working experience in a post-conflict country.
- 7 D Initiative and proven ability to work with little supervision

General professional experience⁷

- 8 MC Minimum of seven years of progressive professional experience in the Field of Disability and/or Public Health. Please note that years in disability and years in general public health will be scored separately
- 9 D Knowledge and experience of institutional development, especially in the context of post-conflict, weak or failing states
- 10 D Working experience with donors, non-governmental organizations, Ministry and civil society
- 11 D Demonstrable experience in team management

Specific professional experience⁸

- 12 MC Minimum of 5 years experience in the field of policy and planning in low income countries;
- 13 D Preferably familiar with post-conflict rehabilitation and developing countries
- 14 D Prior working experience in grassroots health and disability projects
- 15 D Ability and flexibility to work under stress and understanding to address sensitive social and/or political issues
- 16 D Preferably experience in disability-sensitive programming, disability-related poverty reduction
- 17 D Preferably experience of Community Based Rehabilitation (CBR) Concept

3.3 Working language(s)

Working language will be English.

4. LOCATION AND DURATION

4.1 Starting period

The assignment will commence in June 2010 and may run for a maximum duration of 8 months. The first phase, of approximately four weeks, will be preparation of a detailed

⁶ The difficulties of assessing this item with a score are noted. It is assumed that candidates with a profile skewed on long term missions (i.e. 6 months and above) will match easier this criteria rather than candidates with a purely short-term mission profile.

⁷ Where not specified as a minimum threshold [i.e. at least XX years of experience in ABC], the years of experience will be used for scoring.

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Implementation and Work Plan. The Implementation and Work Plan will build on existing approved MoPH planning documents and capacity building priorities. The Implementation and Work Plan will set out a staged approach to meeting the objectives of the Technical Assistance. The Implementation and Work Plan will be submitted to the Director-General, Health Services Provision for approval.

4.2 Foreseen finishing period or duration

The total duration of the contract compounds the duration of staying of the experts, the travel time and the work outside the country as well as the time elapsing from the departure of the experts till the delivery of the final technical report. See sections 4.3 for more details.

4.3 Planning including the period for notification for placement of the staff as per art 16.4 a)

What follows is a draft planning for the mission. It is intended to be a guide for the consultant as well as for the planning of the activities which will eventually lead to the output specified above. It is the responsibility of the experts, once the mission has started to re-draft the plan and re-discuss it with the Task Manager in charge at the EC delegation and the MoPH.

Please note that this is a draft and the consultant is free to i.e. change the input days of the experts. It is worth to mirror the draft planning in the *Methodology and Organization* paper (see 2.3)

Prior to the beginning of the assignment, the expert is expected to have fully familiarised with the objectives, country situation and priorities, Afghan health system, knowledge of other donors' modus operandi.

Tentative timeframe in days [1]		Activities
PROCURE -MENT PHASE	1	Publishing of request for services
	21	Deadline for receiving the proposals
	28	Feedback to companies
	40	Contract to selected company
IMPLEMENTATI ON PHASE	1	Arrival of expert in Afghanistan (travel day) [2]
	2	Briefing at EC delegation
	240	(Considering 120 input days diluted over 8 months) End of the assignment [3]
	241	Departure of experts (travel day)
	270	Consolidation of findings and preparation of final report.
	300	Final technical report delivered to EU

[1] Timeframe is given in calendar days.

[2] Travel day: 1 travel day to reach Kabul and 1 travel day at the end of assignment is calculated for each expert and the fee can be claimed. This has to be considered the maximum allowance under this contract for international travel days, notwithstanding the port of origin (and return) of the consultant. Please note that preferred routes go through Dubai and one overnight may be necessary.

[3] Please note that an indicative provision is here made to cover 6 months of work of the team leader. During the preparation of this request for services the same time span has been calculated for the support staff.

4.4 Location(s) of assignment

Kabul, Afghanistan. Possibility of travel to Provinces.

5. REPORTING

5.1 Content

Reporting refers here to official reports. The consultant is responsible for producing the following intermediate and final outputs:

Technical reports

- a. An inception report which will include an implementation plan with detail time line of the activities. The report is expected within the first 4 weeks after the arrival of the expert. The report is supposed to be consolidated with DRD.
- b. A completed draft report 4 weeks after the departure from Afghanistan.
- c. Final report to be produced maximum 8 weeks after the departure from Afghanistan. The final report will be composed of 2 parts:
 - i. An account of the contract mainly of EU pertinence
 - ii. An account for dissemination
- d. Electronic copies of the data sets collected, if any.

Financial reporting. The EC expects to receive the request for final payment no later than 2 months after the experts have left the country.

5.2 Language

The language of the reports as well as all official communications is English

5.3 Submission/comments timing

The EU expects to receive the final draft technical report 4 weeks after the departure of the consultant. The final report is expected no later than 8 weeks from the departure of the experts from the Country. In the absence of any comment from the EU project manager, notification of the final report's approval will be given within 14 calendar days from reception.

5.4 Number of report(s) copies

Final report should be provided in 5 hard copies + 5 soft copies.

6. ADMINISTRATIVE INFORMATION

6.1 Interviews if necessary indicating for which experts/position

The necessity of telephone interviews will be decided during the evaluation in consultation with MoPH.

6.2 Language of the specific contract

The language of the specific contract is English

6.3 Other authorized items to foresee under 'Reimbursable'

Items authorized under "Reimbursable" refer to⁹:

⁹ As per Art 6.3 "Facilities to be provided by the Framework Contractor" of the global ToR: Prior to any purchase, the Framework Contractor must check whether the necessary items are not already available free of charge from the beneficiary, the EC Delegation etc. Hiring of (equipped) training facilities, meeting rooms for debriefing sessions (for workshops, seminars) etc. is authorised provided that these costs remain marginal and are foreseen in the Specific Terms of Reference

- Perdiems;
- International flights upon assignment and at the end of the consultancy. Please note that if the contract is split in subsequent different phases, each travel back and forth is eligible;
- Cost linked to in-country field missions. The costs can cover also travel and perdiems of Ministry staff deemed necessary to reach the goal of the mission;
- International travel and participation to conferences, workshops, meeting outside Afghanistan if deemed necessary to reach the goal of the mission;
- Organization of events (i.e. training, workshops, task forces) in country;
- Ancillary expenses instrumental for reaching the goal of the mission.

6.4 Others

- While calculating the budget, space has been made on the EC side to hire locally consultants/counterparts for specific tasks.
- The **Offer** expected from Framework Contractors will comprise the following:
 - * A financial offer;
 - * the CV of the senior expert
[please note that under the column “date from-date to” the minimum detail requested is MM/YYYY. If periods are given only with YYYY, the evaluators reserve the right to calculate the duration, this the weight of the experience];
 - * Statements of exclusivity and availability from.
 - * Organization and Methodology [see non binding sample]
- The Framework Contractor will be responsible for all security arrangements while the experts are in the country, being this already calculated in the experts’ fees. The EC cannot extend its security net to consultants.
- The Framework Contractor is also fully responsible for Visa arrangements of the expert coming. The EC cannot issue invitation letters to facilitate the Visa process. The administrative burden for the consultant to secure visa for experts is already calculated in the experts’ fees.
- The experts are also responsible for their own working tools and space such as laptop, printing and internet connection. The contractor must note that the European Commission can offer no computer equipment for the purposes of this assignment. Further to this, the EC cannot facilitate logistics like transportation or accommodation. Please note that some equipment has been made available to the PTF (i.e. cars and office equipment)
- The Framework Contractor must take the necessary measures to ensure the visibility of the EU. Please consult the EuropeAid website at http://europa.eu.int/comm/europeaid/visibility/index_en.htm
- All reports and data such as maps, diagrams, drawings, specifications, plans, statistics, calculations, databases, software and supporting records or materials acquired, compiled or prepared by the Contractor in the performance of the contract shall be the absolute property of the Contracting Authority. The Contractor shall, upon completion of the contract, deliver all such documents and data to the Contracting Authority. The Contractor may not retain copies of such documents and data and shall not use them for purposes unrelated to the contract without the prior written consent of the Contracting Authority. The Contractor shall not publish articles relating to the services or refer to them when carrying out any services for others, or divulge information obtained from the Contracting Authority, without the prior written consent of the Contracting Authority. Any results or rights thereon, including copyright and other intellectual or industrial property rights, obtained in performance of the Contract, shall be the absolute property of the Contracting Authority, which may use, publish, assign or transfer them as it sees fit, without

geographical or other limitation, except where intellectual or industrial property rights already exist.

- **Working week.** Experts will not be working during week-ends. Experts will mainly follow the Afghan civil servant calendar which marks as week end the day of Friday. In case a national holiday falls during the period the experts are in Afghanistan agreement needs to be asked for with the Commission. A 6 day working week has been taken into account while planning this request for services. The Afghan calendar year begins on 21 March. A couple of weeks before that the Ministry of Labour and Social Affairs announces the public holidays for the coming year. Muslim festivals* are timed according to local sightings of various phases of the moon and the dates given are approximations. As a result they can be changed at very short notice. As a basis for this tender the following has been considered:

Victory of the Russian troops	Monday 15/02/2010
Birth of the Prophet(PBUH)	Friday 26/02/2010
New Year (Nawroz)	Sunday 21/03/2010
Victory of the Islamic Revolution	Wednesday 28/04/2010
First day of Ramazan	Wednesday 11/08/2010
EID ul Fitar	Friday-Sunday 10-12/09/2010
Eid Qurban	Tuesday-Friday 16-19/11/2010
Mahram	Friday 17/12/2010

ANNEXES

Annex 1	Islamic Republic of Afghanistan - Ministry of Public Health Disability Strategy Final draft
Annex 2	Final report of the Previous TA to the Disability Unit
