

# Technical Assistance on Quality Indicators for Performance (QUIPs) Measurement in REBAHS

## Terms of Reference

<b>Country / Region</b>	Beirut. Lebanon
<b>Start date</b>	ASAP
<b>Author(s)</b>	Ms. Rasha Al Askar Dr Clare Shortall

# 1. INTRODUCTION

## 1.1. CONTEXT

Nearly eleven years from the start of the Syrian Crisis, Lebanon remains a fragile and conflict-affected setting (FCAS)<sup>1</sup> which has been subject to an unprecedented array of shocks dating back to the Civil War (1975–1990) and through to the more recent economic crisis. Starting in October 2019 this has quickly deteriorated into economic collapse with unprecedented political, infrastructural and economic challenges.

The Lebanese pound has lost 90% of its value, pushing more than half of the population into poverty. Unemployment rates have skyrocketed as businesses have been forced to close reducing productivity and pushing more families under the poverty line.<sup>2</sup> According to the latest World Bank Lebanon Economic Monitor (LEM), the economic and financial crisis is likely to rank in the top 10, possibly top 3, most severe crises episodes globally since the mid-nineteenth century.<sup>3</sup>

This economic collapse has threatened the very building blocks of the health system impacting on all six pillars of the health system with a cumulative effect on the primary healthcare systems ability to cope with a knock on effect on secondary healthcare. Service delivery and the quality and completeness of the Health Information System reporting is impacted by both increased needs, with more and more people turning to the primary healthcare centres to meet their needs, in an environment that only precipitates, predisposes and perpetuates poor health and wellbeing. This is coupled by increased operational costs in terms of supplies, fuel and the generators required to compensate for daily electricity outages. The system has seen a loss of human capital (human resources for health) due to pervasive brain drain. There is a markedly reduced ability to import essential drugs, medical supplies, and equipment with lack of liquidity impacting on overseas purchasing. Governance capacity has also been impacting by the PHC department at the MoPH itself not received funding.<sup>4</sup> Despite significant needs, in terms of health financing revenue the Ministry of Public Health (MoPH) budget has never exceeded 6% of the total Government Budget,<sup>5</sup> and only 5% of the MoPH budget is allocated to preventive programs and interventions.<sup>6</sup> Existing budgets allocated to the national PHC network for procurement of vaccines, chronic and essential drugs, and reproductive health supplies have at the time of writing have not been transferred or disbursed by the Ministry of Finance due to lack of available funds.<sup>4</sup> Furthermore, the primary healthcare sector has not received enough funding to develop and expand public Mental Health (MH) services along its National Plan and Non-Governmental Organisations (NGOs) offering Mental Health consultations are facing challenges in referring people with severe mental health disorders requiring more advanced treatment.<sup>4</sup>

---

1 World Bank. FY20 List of Fragile and Conflict-affected Situations  
<http://pubdocs.worldbank.org/en/179011582771134576/FCS-FY20.pdf>. Fragility is a multidimensional concept, encompassing economic, environmental, political, societal and security criteria

2 No way to run a country. A big blast should lead to big change in Lebanon. The Economist Group Limited. August 8, 2020.

3 World Bank. Lebanon Economic Monitor, Spring 2021: Lebanon Sinking (to the Top 3). Available from:  
<https://www.worldbank.org/en/country/lebanon/publication/lebanon-economic-monitor-spring-2021-lebanon-sinking-to-the-top-3>  
(accessed 20/06/2021)

4 Hamadeh, R.S., Kdouh, O., Hammoud, R. et al. Working short and working long: can primary healthcare be protected as a public good in Lebanon today?. *Confl Health* 15, 23 (2021). <https://doi.org/10.1186/s13031-021-00359-4>

5 World Bank. Lebanon economic monitor. The great capture. 2015. Washington DC: World Bank; 2015  
<http://documents.albankaldawli.org/curated/ar/397721468185952923/pdf/101022-WP-PUBLIC-disclosed-11-18-4am-DC-time-11am-Beirut-Box393257B-The-World-Bank-LEM-Fall-2015.pdf>

6 Public health: overview of the health sector. Council for Development and Reconstruction; 2013  
[http://www.cdr.gov.lb/eng/progress\\_reports/pr102013/Epub.pdf](http://www.cdr.gov.lb/eng/progress_reports/pr102013/Epub.pdf)

The primary source of health financing in Lebanon remains individual households with the private sector (also impacted by the crisis) with an increasing trend towards expensive and technological advanced curative care at the expense of preventive care and primary healthcare. The deterioration of the economic context, aggravated by a reduction in livelihood opportunities, renders the cost of primary health care unaffordable for all vulnerable populations in Lebanon.

The COVID-19 pandemic has further diverted resources leaving the health-care system overwhelmed. A total of 547,497 cases have been confirmed as of 10<sup>th</sup> July with a 7,873 associated deaths. Despite huge efforts only 12.7% of adults have received their first dose of vaccine.<sup>7</sup>

On the 4<sup>th</sup> of August, Lebanon suffered a further shock when a warehouse at the Beirut port exploded, causing widespread destruction, significant casualties and substantial damage in Eastern and Central Beirut. At least 200 people were killed, and more than 6,000 people injured. The districts of Quarantina, Bourj Hammoud, Nabaa, Rmeil, Geitawi, Mar Mikhail, Achrafieh and down-town were significantly impacted. A rapid assessment of 55 primary healthcare centres found that 37% sustained moderate-to-serious damage. Only 47% of surveyed facilities were still able to provide full routine health services at that time. Six hospitals were severely damaged while it is estimated that 2,000 doctors were unable to deliver consultations in impacted areas. This explosion put further stress on the Lebanese primary health care system, which was already under significant strain due to the sharp increase in COVID-19 cases and, more generally, by the ongoing socio-economic crisis.

In addition to this Lebanon remains host to the largest refugee population per capita in the world.<sup>8</sup> The Government of Lebanon (GoL) estimates that the country hosts 1.5 million Syrians who have fled the conflict in Syria (including 918,874 registered as refugees with UNHCR, along with 27,700 Palestinian refugees from Syria (PRS) and a pre-existing population of an estimated 180,000 Palestinian refugees from Lebanon (PRL) living in 12 camps and 156 gatherings.<sup>9</sup> With the economic and social crisis likely to deepen in the coming months, vulnerable populations in Lebanon are facing long-term marginalisation and exclusion from financial resources, leading to an overall deterioration in their health and wellbeing.

## 1.2. HISTORY OF THE PRIMARY HEALTHCARE SYSTEM IN LEBANON

The MoPH established its National PHC Network in 1996, through which it aimed to regulate and maintain quality of care and effective service delivery at PHC centres (PHCCs). This network currently comprises of 237 PHCCs; most of which are affiliated with NGOs and municipalities. It serves > 1 million people annually. Through its delivery of a comprehensive range of PHC services at reduced rates, it aims to improve access to effective, quality health care, particularly among the most vulnerable. Complementing the establishment of the network, the MoPH targets community needs through the integration of non-communicable disease management in PHC and launching of the national mental health programme. In 2009, the MoPH initiated a national primary healthcare accreditation programme, leading to the accreditation of 52 PHCCs as of June 2018. Furthermore, in 2016, the MoPH took a major step towards universal health coverage as it collaborated with the World Bank through the “Emergency primary healthcare restoration project” (EPHRP) to subsidise a benefit package delivered through 75 PHCCs, for 150,000 vulnerable Lebanese citizens; particularly those affected by the Syrian refugee crisis. The project was finalized and closed in the end of 2019. The “Lebanon health

<sup>7</sup> MoPH. COVID19 Dashboard. <https://moph.gov.lb/maps/covid19.php>

<sup>8</sup> Republic of Lebanon Ministry of Public Health Lebanon National Deployment and Vaccination Plan for COVID-19 Vaccines. Available from:

<https://www.moph.gov.lb/userfiles/files/Prevention/COVID-19%20Vaccine/Lebanon%20NDVP-%20Feb%2016%202021.pdf>

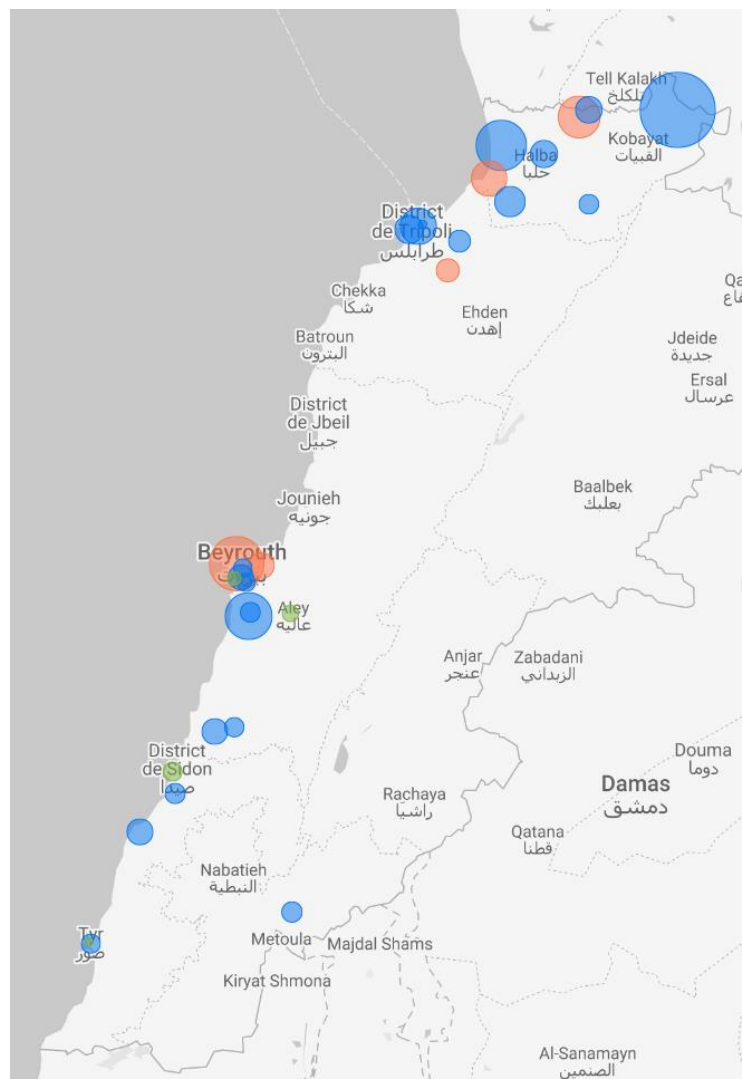
<sup>9</sup> LCRP: Lebanese Crisis Response Plan 2017-2020, updated 2019

resilience project” (LHR) financed by a loan from the World Bank aimed to implement a national roll-out of the PHC subsidization model based on the EPHRP experience. Although LHR was initially planned to rollout in 2020, this has not materialized to date.

PUI, driven by the need in Lebanon to deliver aid to people fleeing Syria whilst also strengthening the host health care system, developed the concept of the Flat Fee Model (FFM) in 2015. In 2016, both PUI and IMC further developed the model to better align with the Lebanese context and with a view to its inclusion in a prospective jointly implemented EU funded project. Subsequently, in 2018, the model was rolled out under the project “Reducing Economic Barriers to Accessing Health Services” in Lebanon (REBAHS) where it continued to evolve and adapt, and continues to form part of the “REBAHS approach” in the REBAHS II project which began in March 2020 and will end in January 2022. In the REBAHS consortium with International Medical Corps (IMC), funded by the EU Regional Trust Fund ‘Madad’, PUI has been supporting 25 Primary Health Care Centres (PHCCs) across Lebanon through the FFM. The REBAHS approach has evolved through continuous enhancement of its intervention logic to better address the health needs of the health rights holders (or “patients”) and their communities. PUI and IMC are also currently working on prevention and response to the COVID-19 pandemic, all of which has fed in to the REBAHS project’s emphasis on the integration of health security elements in its Health System Strengthening Actions.

### 1.3. MAP OF THE ZONE

PUI support PHCCs the focus will be on the PHCCs in Blue.



## 2. TECHNICAL ASSISTANCE REQUESTED

PUI has just started the 4<sup>th</sup> year of intervention of “Reducing Economic Barriers to Accessing Health Services” (REBAHS) in Lebanon a consortium with IMC (25 PHCCs for PUI and 41 PHCCs for IMC)

In this context, PUI is looking for technical expertise to develop Quality, Outcome<sup>10</sup> and Key Performance Indicators<sup>11</sup> for REBAHS and to assess REBAHS PHCC performance against said indicators as part of an assessment of the quality of care delivered within REBAHS as a way of measuring performance for Health System Improvement. This should be complementary but not overlap with the endline evaluation that will be carried out at the end of the project.

### 2.1. OBJECTIVES OF THE MISSION

The general objective of this short-term mission is to support the REBAHS Consortium in assessing the quality of care implemented under the REBAHS project in accordance with MoPH standards as is delivered in supported PHCCs in Lebanon. It should also feed into the main evaluation in terms of its assessment and identification of best practices, challenges, lessons, knowledge and experiences gained through implementation however the focus will be on Quality of care as an in-depth technical service evaluation. Primarily, it should make clear and practical recommendations to inform the implementation and development in an ever-changing context.

More specifically, the short-term mission objectives will include:

- To review current and identify additional Quality, Outcome and Performance indicators for REBAHS across a range of domains including the full range of quality dimensions including accessibility, workload, outcomes, timeliness, satisfaction, safety and people-centeredness.
- To assess REBAHS PHCCs performance against these Indicators at an in-depth level. Drawing on the concepts of equity, fairness and the values and principles inherent to the concept of UHC.

Health systems even at primary healthcare level are complex entities with many different stakeholders including patients, various types of health-care providers, payers, purchaser organizations (IMC/PUI in this setting), regulators, government and the broader population. These stakeholders are linked by a series of accountability relationships. Accountability has two broad elements for PUI: the rendering of an account (provision of information) and the consequent holding to account (sanctions or rewards for the accountable party). The fundamental role of performance measurement is therefore to help hold the various agents to account by enabling stakeholders to make informed decisions. The key issue for this TOR is how data sources can be designed and exploited to satisfy the demands of different users (often using data from the same sources in

---

<sup>10</sup> Outcomes for the purpose of this TOR are defined as valued health care outputs, such as quality-adjusted life years, patient-reported outcome measures or some other measure of health gain. The World Health Organization defines an outcome measure as a “change in the health of an individual, group of people, or population that is attributable to an intervention or series of interventions.” Outcome measures (mortality, readmission, patient experience, etc.) are the quality and cost targets healthcare organizations are trying to improve.

<sup>11</sup> For the purposes of this TOR performance measurement is seen as seeking to monitor, evaluate and communicate the extent to which various aspects of the health system meet key objectives. These objectives tend to be: • health conferred on citizens by the health system • responsiveness to individual needs and preferences of patients • financial protection offered by the health system • productivity of utilization of health resources.

different forms) within the health systems' capacity to provide and analyse data. For an evidence-based assessment of the quality of services, it is understood that there is a need to understand how services compare with quality standards and that outcome monitoring based on qualitative techniques, cannot always be identified in advance but instead should follow a qualitative study design and be based on the stakeholders' perceptions and objective observations.<sup>12</sup>

## 4. METHODOLOGY

The expert(s) will have to propose their own methodology. However, the proposed methodology should include the following steps at the minimum:

### **Result 1.1 REBAHS Quality, Outcome and Performance Indicators are developed**

- Desk work to review existing documentation, and data including an initial framing meeting with PUI, IMC and the MoPH.
- Develop a clear conceptual framework and a clear vision of the purpose of the performance-measurement system. Establishing PUI/IMC specific objectives which are to be addressed by REBAHS and should be aligned with the accountability relationships inherent in the health system.
- Review current key performance indicators ensuring any quality assessment measure adheres to certain key attributes. These include a clear definition and purpose, their acceptability to assessors and those being assessed, needs assessment, clinical feasibility and relevance, sensitivity to change,<sup>13</sup> potential for improvement, discrimination/variance, technical feasibility and reliability of data extraction, an understanding of how they will be implemented and validity (including evidence base and addressing unintended consequences).<sup>14</sup> If measures are not 100% under the direct control of those being assessed (attribution or controllability) then the expert(s) should be able to employ risk adjustment techniques e.g. propensity scores or instrumental variables when evaluating the relationship between the PHCCs being assessed and the REBAHS Quality, Outcome and Performance Indicators.<sup>15</sup>
- Propose new indicators which should have a combination of **structural/process** and **outcome/proxy outcome** technical indicators as indicated with a view to ensuring that they address quality of care. These new Quality, Outcome and Performance indicators, should be accompanied by a careful consideration of the sources of random and systematic error in measurement and sampling with recommendations on institutionalised data collection procedures that maximize the reliability and accuracy of the data (both primary and secondary) used for the quality assessment. Some indicators are envisaged as being part of an in-depth service evaluation but it is expected that some indicators will be identified for regular monitoring. Indicators could include:
  - Individual level:

<sup>12</sup> Diana M, Yeager V, Hotchkiss D (2017) Health Systems Strengthening – A Compendium of Indicators.

<sup>13</sup> Understood in this TOR as “responsiveness” the extent to which an indicator is able to detect changes over time in respondents' health.

<sup>14</sup> Campbell, SM. Braspenning, J. Hutchinson, A. Marshall, MN (2002). ‘Research methods used in developing and applying quality indicators in primary care. Quality and Safety in Health Care, 11(4): 358–364.

<sup>15</sup> For the purposes of this TOR it is understood that proper statistical treatment of performance indicators is essential if appropriate policy inferences are to be drawn, given the large degree of random variation present in most performance indicators



- Access/Equity<sup>16</sup> – these could include: total utilisation rate, specific utilisation rate, share of total utilisation rate for prevention
  - Percent of patients' visits seeking care with an ICD-10 code categorized as NCD who have had the entire MoPH package of care
  - Percent of patients' visits seeking care with an ICD-10 code categorized as ANC who have had the entire MoPH package of care
- Equity and Cost – e.g. average total payment per patient
- Effectiveness of care – covering both clinical effectiveness and interpersonal care
  - Clinical care and Disease Management - effectiveness of care outcome measures are expected to evaluate across two main domains: 1. compliance with MoPH care guidelines and 2. Achieved outcomes. These could for example include but do not necessarily have to if the requirements above are not met:
    - Generic Measures if felt appropriate
    - Disease-specific measures such as
      - % of cases of defined tracer condition with diagnosis & treatment according to guidelines (PUI audit tool)
      - % of patients with diabetes whose last measured HbA1C is < 9 %
      - Malnutrition screening for children under 5 at Health Facility level
      - Hospitalization rates, cost and length of stay by refugee population sub-group among REBAHS facility users and other refugees. (these can be patient reported or linked to UNHCR data if possible)
      - Adverse maternal and neonatal health outcomes (C-section, NICU stay, etc. (can be patient reported ))
    - Patient-reported outcome measures (PROMs) that look at symptom burden, functional impact and health-related quality of life
    - Clinical Process Indicators - those based on actions or structures for which there is an evidence base for their association with health system outcomes. Examples of useful process measures could include appropriate prescribing, regular blood pressure monitoring for hypertension or glucose monitoring for diabetic patients. The draft process indicators and the literature review described should be referred to an expert panel that votes on which indicators should be included.
  - Person Centeredness / satisfaction /Responsiveness of Health System<sup>17</sup>. Measures should look at the way individuals are treated and the environment in which they are treated during health system interactions. Responsiveness should focus on issues of patient dignity

<sup>16</sup> Equity is defined in this TOR as the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically or geographically. Measures of extent to which there is equity in health, access to health care, responsiveness and financing are considered to include: Utilization measures, Rates of access, Use-needs ratios, Spending thresholds, and disaggregated health outcome measures

<sup>17</sup> Responsiveness for the purpose of this TOR relates to individual welfare enhancement through better interactions with the health system. Responsiveness has two main aspects: respect of persons and people-centred orientation. The first incorporates issues such as dignity, autonomy and confidentiality, while the latter relates to prompt attention, quality of basic amenities, choice of care provider and access to social support networks during care. It is not only the average level of responsiveness at facility level that is important, but issues of distribution with regard to different socio-economic and demographic groups as well.

(respectful treatment and communication), autonomy (involvement in decisions), confidentiality of personal information, choice of healthcare provider, prompt attention (convenient travel and short waiting times), access to family and community supports and quality of basic amenities.<sup>18</sup> Possible measure could include:

- Patient-reported experience measures (PREMs) this can focus on specific areas for patient satisfaction e.g. Demand satisfied with modern methods of family planning among women 15–49 years who are married or in a union (%)
- Responsiveness Survey at Facility Level<sup>28</sup>
- GPAQ-R2<sup>19</sup>
- Workload - ratio of personnel to patients disaggregated and assessment of number of staff to workload for Midwives as per appropriate assessment tool e.g. WISN<sup>20</sup>
- Timeliness - Timeliness of care outcome measures assess patient access to care. Should focus on four main domains - staffing patterns, registration, triage assessment by the registered nurse, and early access to a qualified medical provide
- Safety - Patient safety indicators (PSI)<sup>21</sup> here are defined as measures that intend to identify, monitor and evaluate unintended events or hazardous conditions in healthcare delivery, (rather than events that are related to the patient's disease), which led or could have led to unintended health consequences for the patient they can be broken down into four main areas:
  - Leadership – culture of safety and quality
  - Clinical - three subdomains: overall organizational structures e.g. Management of urgent requests for assistance, treatment protocols e.g. myocardial infarction.
  - Patient safety procedures e.g. detection of patient safety incidents, Safety mechanisms and procedures for blood sample collection and processes for safe prescription
- System and Organisation Performance  
Medical records and information, information for patients, education and training, practice management, medicines management.
- Population level
  - Equity of access - equity is a key element of quality especially where resources are distributed unevenly across population groups. Given the relationship between responsiveness and equity, equity in responsiveness and equity in access, it is possible to use measures of responsiveness inequalities by different social groups (stratified according to need, e.g. proxied by income) to anticipate inequities in access.

<sup>18</sup> Smith, P., Mossialos, M., Papanicolas, I. and Leatherman, S. (eds) (2010), Performance Measurement for Health System Improvement: Experiences, Challenges and Prospects, Cambridge: Cambridge University Press

<sup>19</sup> Roland, M., Roberts, M., Rhenius, V. et al. GPAQ-R: development and psychometric properties of a version of the General Practice Assessment Questionnaire for use for revalidation by general practitioners in the UK. BMC Fam Pract 14, 160 (2013). <https://doi.org/10.1186/1471-2296-14-160>

<sup>20</sup>This is a method is based on a health worker's workload, with activity (time) standards applied for each workload component. The method: 1) determines how many health workers of a particular type are required to cope with the workload of a given health facility; 2) assesses the workload pressure of the health workers in that facility. [https://www.who.int/hrh/resources/WISN\\_Eng\\_UsersManual.pdf](https://www.who.int/hrh/resources/WISN_Eng_UsersManual.pdf)

<sup>21</sup> Eva Frigola-Capell, Clara Pareja-Rossell, Montse Gens-Barber, Glòria Oliva-Oliva, Fernando Alava-Cano, Michel Wensing & Josep Davins-Miralles (2015) Quality indicators for patient safety in primary care. A review and Delphi-survey by the LINNEAUS collaboration on patient safety in primary care, European Journal of General Practice, 21:sup1, 31-34, <https://doi.org/10.3109/13814788.2015.1043730>



- Efficiency<sup>22</sup> - Efficiency is an important marker of quality of care for populations as inefficient care (e.g. prescribing expensive but ineffective drugs) may have opportunity costs for the care that can be provided to other patients.
  - Prescription of generic medicines
  - Number of antibiotic prescriptions for patients aged 16–65 per 100 patients

## **Result 1.2 REBAHS PHCCs performance is evaluated against the Quality, Outcome and Performance Indicators**

- After the Quality, Outcome and Performance indicators have been agreed by the REBAHS consortium the consultant should develop a service evaluation plan to assess these at each of the REBAHS support PHCCs
- The methodology must be participatory, inclusive of beneficiaries and project stakeholders in the capturing of learnings and analysis of results. The learning and evaluation process should ensure adequate reflection on progress against the indicators to enable adaptive management.
- Statistical Analysis - The expert(s) should be able to employ the necessary statistical technical to ensure the causality behind observed measures is attributed to the correct sources in order to inform policy, improve service delivery and ensure accountability. They should employ risk adjustment techniques when evaluating the relationship between agents under assessment and the quality indicators. For instance, providers' locus of control may vary substantially between different practice contexts and for different patient subgroups within a given context. Factors that influence a provider's ability to direct their actions/inactions within their practice environment should be accounted for in health-care performance measurement. These factors are possible confounders to be included in the risk adjustment process.

## **Result 1.3 Recommendations for Service Improvement are made**

- The Consultant(s) should give technical recommendations based on their service evaluation on areas for service improvement

---

<sup>22</sup> Efficacy, for the purpose of this TOR, considers the use of health-care resources and whether there is scope for better utilization. Productivity and efficiency are interlinked but distinct with former being a measure of the ratio of output to input while the latter incorporates the concept of what level of production might be technically feasible.

## 5. EXPECTED DELIVERABLES

To be shared with PUI and IMC at each stage

**1. Inception report** - two weeks after the signing of the contract and should include:

- Detailed description of assessment design
- Draft list of possible interviews
- Defined methodological approach to the assessment
- Clearly outlined work plan including timelines and strategies for each phase of the assessment.
- An analytical framework that includes assessment questions, potential quality, outcome and performance indicators, and the related data collection method(s).

**2. Interim Project report** including agreed the quality, outcome and performance indicators - Four weeks after the signing of the contract

**3. Advanced draft Assessment Report** - twelve weeks after the signing of the contract - To include an analysis of all REBAHS PHCCs performance against the agreed quality, outcome and performance indicators and recommendations for project institutionalization and modifications to the theory of change for the programme.

**4. Facilitation of consultation/validation session** organized with key stakeholders of the project to include a summary of key findings and recommendations fourteen weeks after the signing of the contract.

**5. Final Assessment Report** sixteen weeks after the signing of the contract. This report should describe the assessment and put forward the experts' findings, recommendations and lessons learned.

## 6. BUDGET AND ADMINISTRATIVE

The maximum budget for the 3 months consultancy shall not exceed **45.000 EUR**, all included.

The consultant is responsible to contract its own insurance, pay its flight ticket, per diem and housing.

## 7. TIMELINE

	Month 1	Month 2	Month 3
Result 1.1 and 1.2			
Result 1.3			
Finalize Assessment Report			

## 8. EXPERIENCE/QUALIFICATIONS OF THE CONSULTANT(S)

The consultant/consultancy firm should have personnel with the following qualifications and experience:

Required:

- Advanced university degree (Masters) in the field of health sciences, patient safety, medication safety, public health or health systems and services
- Knowledge of the Lebanese Health System;
- Significant experience in Health Policy and Financing;
- Experience working with International NGOs ;
- Excellent English oral, report writing and presentation skills;
- Strong critical analysis skills and attention to detail;
- Cultural sensitivity and gender sensitivity/awareness.

## 9. APPLICATIONS

*Interested consultancy firms should submit in English:*

✓ *A technical offer with:*

- *Understanding of the Terms of Reference (ToR): development of key points and formulation of key questions, which the offer proposes to respond to*
- *The methodology and tools proposed for the evaluation*
- *The timetable showing the details for the completion of each of the evaluation phases. The proposed schedule should include time for briefing and debriefing on the mission and as much as possible at the headquarters.*

✓ *A financial offer including a budget with detailed sections (fees, other costs)*

✓ *An updated CV*

✓ *An example of similar consultancies*

✓ *References*

*Consultancy Firms should send all of this documentation in electronic format to:*

[lmasse@premiere-urgence.org](mailto:lmasse@premiere-urgence.org)

Cc: [cshortall@premiere-urgence.org](mailto:cshortall@premiere-urgence.org) ; [gassaf@premiere-urgence.org](mailto:gassaf@premiere-urgence.org)

*The deadline for the submission of applications will be the **15<sup>th</sup> August 2021 6pm Paris time***