Scoping Review of Measurement of Equity in Service Coverage of Older People

Request for Proposals (RFP)

Bid Reference:
2019/UHC/WKC/0018

Unit Name:
HQ/HIS/WKC

Purpose of the RFP:

To characterize the ways in which equity in service coverage with respect to older people can be measured

Closing Date:

24 November 2019
The World Health Organization (WHO) is seeking offers for conducting a scoping review of metrics and measurement approaches used to assess equity in service coverage with respect to older people. Your Institution is invited to submit a proposal for the services in response to this Request for Proposals (RFP).

WHO is a public international organization, consisting of 194 Member States, and a Specialized Agency of the United Nations with the mandate to act as the directing and coordinating authority on international health work. As such, WHO is dependent on the budgetary and extra-budgetary contributions it receives for the implementation of its activities. Bidders are, therefore, requested to propose the best and most cost-effective solution to meet WHO requirements, while ensuring a high level of service.

1. Requirements

WHO requires the successful bidder to carry out a scoping review of metrics and measurement approaches used to assess equity in service coverage with respect to older people. The objective is to characterize existing research and practices in the measurement of equity in service coverage of older people, and to identify issues that need to be considered for equity-focused monitoring of UHC in the context of population ageing.

See attached detailed Terms of Reference for complete information.

The successful bidder shall be a not for profit institution operating in the field of academic research with proven expertise in the health systems research, metrics and measurement, demography, global health or other related areas.

Bidders should follow the instructions set forth below in the submission of their proposal to WHO.

2. Proposal

The proposal and all correspondence and documents relating thereto shall be prepared and submitted in the English language.

The proposal should be concisely presented and structured to include the following information:

- Information about your institution (please complete Annex 2)
- Technical proposal, including proposed methodology, time line and deliverables (no more than 5 single-spaced pages, using at least 11-point font)
- Financial proposal in US dollars, including itemized budget and justification (please complete Annex 4)
- Example of previous related work
- CVs of project personnel

Information which the bidder considers confidential, if any, should be clearly marked as such.

3. Instructions to Bidders

Bidders must follow the instructions set forth in this RFP in the submission of their proposal to WHO. A prospective bidder intending to bid, or who require any clarification on technical, contractual or commercial matters shall notify WHO via email at the following address no later than 8 November 2019 at 23:00 hours Japan standard time:

Email for submissions of intention to bid and all queries: wkc@who.int

(Please mention Bid Reference “2019/UHC/WKC/0018” in subject line)
A consolidated document of WHO's responses to all questions (including an explanation of the query but without identifying the source of enquiry) will be published on the WKC website.

From the date of issue of this RFP to the final selection, contact with WHO officials concerning the RFP process shall not be permitted, other than through the submission of queries and/or through a possible presentation or meeting called for by WHO, in accordance with the terms of this RFP.

The bidder shall submit, in writing, the complete proposal to WHO, no later than 24 November 2019 at 23:00 hours Japan standard time (“the closing date”), by email at the following email address:

    wkc@who.int

*(Please mention Bid Reference “2019/UHC/WKC/0018” in subject line)*

To be complete, a proposal shall include:

- A technical proposal, as described under part 2 above;
- A financial proposal, as described under part 2 above;
- Annex 4, budget form;
- Example of previous related work (e.g. 1-2 previously published papers on a similar topic and/or using a similar method);
- CVs of project personnel;
- Annex 2, completed and signed by a person or persons duly authorized to represent the bidder, to submit a proposal and to bind the bidder to the terms of this RFP.

Each proposal shall be marked Ref: 2019/UHC/WKC/0018.

WHO may, at its own discretion, extend the closing date for the submission of proposals by notifying all bidders thereof in writing before the above closing date and time.

Any proposal received by WHO after the closing date for submission of proposals may be rejected. Bidders are therefore advised to ensure that they have taken all steps to submit their proposals in advance of the above closing date and time.

The offer outlined in the proposal must be valid for a minimum period of 90 calendar days after the closing date. A proposal valid for a shorter period may be rejected by WHO. In exceptional circumstances, WHO may solicit the bidder’s consent to an extension of the period of validity. The request and the responses thereto shall be made in writing. Any bidder granting such an extension will not, however, be permitted to otherwise modify its proposal.

The bidder may withdraw its proposal any time after the proposal’s submission and before the above-mentioned closing date, provided that written notice of the withdrawal is received by WHO at the email address indicated above, before the closing date for submission of proposals.

No proposal may be modified after its submission, unless WHO has issued an amendment to the RFP allowing such modifications.

No proposal may be withdrawn in the interval between the closing date and the expiration of the period of proposal validity specified by the bidder in the proposal (subject always to the minimum period of validity referred to above).
WHO may, at any time before the closing date, for any reason, whether on its own initiative or in response to a clarification requested by a (prospective) bidder, modify the RFP by written amendment. Amendments could, inter alia, include modification of the project scope or requirements, the project timeline expectations and/or extension of the closing date for submission.

All prospective bidders that have received the RFP will be notified in writing of all amendments to the RFP and will, where applicable, be invited to amend their proposal accordingly.

All bidders must adhere to the UN Supplier Code of Conduct, which is available on the WHO procurement website at http://www.who.int/about/finances-accountability/procurement/en/.

4. Evaluation

Before conducting the technical and financial evaluation of the proposals received, WHO will perform a preliminary examination of these proposals to determine whether they are complete, whether any computational errors have been made, whether the documents have been properly signed, and whether the proposals are generally in order. Proposals which are not in order as aforesaid may be rejected.

The evaluation panel comprising WHO staff and external experts will evaluate the technical merits of all the proposals which have passed the preliminary examination of proposals based on the following weighting:

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<th>Technical Weighting:</th>
<th>60 % of total evaluation</th>
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<tr>
<td>Financial Weighting:</td>
<td>40 % of total evaluation</td>
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The technical evaluation of the proposals will include:
• the extent to which WHO’s requirements and expectations have been satisfactorily addressed;
• the quality of the technical solution proposed;
• the experience and capacity of the institution;
• the project management plan and the qualifications and competence of the personnel proposed for the assignment; and
• the proposed timeframe for the project.

The number of points which can be obtained for each evaluation criterion is specified below and indicates the relative significance or weight of the item in the overall evaluation process. The maximum possible value for the total Technical Score is 60.

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<th>Evaluation criterion</th>
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<td>Responsiveness/Relevance to WHO’s requirements and expectations</td>
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<td>Quality of the technical solution proposed</td>
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<td>Relevant experience and capacity of the lead institution</td>
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<td>Staffing of the project</td>
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<td>Proposed timeframe for the project</td>
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Financial evaluation will be conducted by WHO staff only. The financial evaluation will be based on the following scoring system:

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<th>Evaluation criterion</th>
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<td>Budget justification is sufficient in detail.</td>
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<td>Total budget is reasonable and commensurate with the proposed scope of work (neither too high nor too low).</td>
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<td>Budget allocation across budget items (e.g. personnel, travel, supplies, etc.) is appropriate.</td>
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<tr>
<td>Taken together with the technical evaluation results, the financial proposal promises good value for money.</td>
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The maximum possible value for the total Financial Score is 40.

Please note that WHO is not bound to select any bidder and may reject all proposals. Furthermore, since a contract would be awarded in respect of the proposal which is considered most responsive to the needs of the project concerned, due consideration being given to WHO's general principles, including the principle of best value for money, WHO does not bind itself in any way to select the bidder offering the lowest price.

WHO may, at its discretion, ask any bidder for clarification of any part of its proposal. The request for clarification and the response shall be in writing. No change in price or substance of the proposal shall be sought, offered or permitted during this exchange.

NOTE: Individual contact between WHO and bidders is expressly prohibited both before and after the closing date for submission of proposals.

5. Award

WHO reserves the right to:

a) Award the contract to a bidder of its choice, even if its bid is not the lowest;
b) Award separate contracts for parts of the work, components or items, to one or more bidders of its choice, even if their bids are not the lowest;
c) Accept or reject any proposal, and to annul the solicitation process and reject all proposals at any time prior to award of contract, without thereby incurring any liability to the affected bidder or bidders and without any obligation to inform the affected bidder or bidders of the grounds for WHO's action;
d) Award the contract on the basis of the Organization’s particular objectives to a bidder whose proposal is considered to be the most responsive to the needs of the Organization and the activity concerned;
e) Not award any contract at all.

WHO has the right to eliminate bids for technical or other reasons throughout the evaluation/selection process. WHO shall not in any way be obliged to reveal, or discuss with any bidder, how a proposal was assessed, or to provide any other information relating to the evaluation/selection process or to state the reasons for elimination to any bidder.

NOTE: WHO is acting in good faith by issuing this RFP. However, this document does not oblige WHO to contract for the performance of any work, nor for the supply of any products or services.

At any time during the evaluation/selection process, WHO reserves the right to modify the scope of the work, services and/or goods called for under this RFP. WHO shall notify the change to only those bidders who have not been officially eliminated due to technical reasons at that point in time.
WHO reserves the right at the time of award of contract to extend, reduce or otherwise revise the scope of the work, services and/or goods called for under this RFP without any change in the base price or other terms and conditions offered by the selected bidder.

WHO also reserves the right to enter into negotiations with one or more bidders of its choice, including but not limited to negotiation of the terms of the proposal(s), the price quoted in such proposal(s) and/or the deletion of certain parts of the work, components or items called for under this RFP.

Within 30 days of receipt of the contract between WHO and the successful bidder (the “Contract”), the successful bidder shall sign and date the Contract and return it to WHO according to the instructions provided at that time. If the bidder does not accept the Contract terms without changes, then WHO has the right not to proceed with the selected bidder and instead contract with another bidder of its choice. The Contract will include, without limitation, the provisions set forth in Annex 3.

Any and all of the contractor's (general and/or special) conditions of contract are hereby explicitly excluded from the Contract, i.e., regardless of whether such conditions are included in the Contractor's offer, or printed or referred to on the Contractor's letterhead, invoices and/or other material, documentation or communications.

We look forward to receiving your response to this RFP.

Annexes

1. Detailed Terms of Reference
2. Vendor Information Form
3. Contractual provisions
4. Budget form
Annex 1: Detailed Terms of Reference

Scoping Review of Measurement of Equity in Service Coverage of Older People

1. Introduction

1.1. Objective of the RFP
The objective of this RFP is to characterize the ways in which equity in service coverage can be measured in relation to older people, for the purpose of monitoring progress toward universal health coverage (UHC) in the context of population aging. Specifically, we aim to commission a scoping review of the global literature to examine how equity in service coverage of older people is conceptualized and measured in research and in national/international reporting practices, to inform country efforts to develop UHC monitoring systems that are sensitive to the demands and impacts created by population ageing. The expected outcomes of this research are two-fold: (i) a descriptive analysis of existing research and practices in the measurement of equity in service coverage of older people; and (ii) identification of issues specific to older people that need to be considered for equity-focused monitoring of UHC, including policy implications.

In the RFP, we make the distinction between (a) health system responsiveness to the needs of older people holistically (i.e. ensuring older people’s right to health), and (b) health system responsiveness to the needs of older persons by socioeconomic or other grouping among older people (e.g. reducing inequalities among older people). Both are equity issues, and both will be captured in this review. The focus of the review is not on synthesizing the evidence on the extent of inequity or inequalities that exist, but rather on the approaches taken to measure or monitor equity with respect to the older population. The goal of the research is to inform countries about UHC monitoring approaches that will capture both dimensions of equity so that progress can be assessed on both fronts – increasing health system responsiveness to older persons’ needs in the context of advancing UHC, as well as reducing inequalities among older persons.

1.2 About the WHO Centre for Health Development in Kobe, Japan (WHO Kobe Centre - WKC)
The WHO Centre for Health Development (WHO Kobe Center—WKC) was established in 1995 with the endorsement by the WHO Executive Board and the generous financial and material support of the Kobe Group. While physically located in Kobe, Japan, it is a department within the UHC and Health Systems Cluster of WHO global Headquarters (HQ) in Geneva. As such, WKC follows the institutional mandate of WHO’s General Program of Work with a global geographic scope of work. Its current research strategy for 2016-2026 is to conduct research and synthesize evidence about health systems and innovations, particularly in light of population ageing, to accelerate progress towards UHC. Under the current research plan, WKC focuses on three research themes related to UHC: service delivery, financing, and innovations; metrics and measurement; and health emergencies.

This RFP falls under the theme of metrics and measurement which has the following areas of focus:
- To analyse the current research landscape related to the measurement of essential health services, financial protection, care quality and equity for older populations.
- To document current country practices in measuring and monitoring UHC from the perspective of ensuring older persons’ right to health.
- To document effective approaches for research and knowledge translation to advance UHC in the context of population ageing.
- To support the development of metrics and measurement tools that enable countries to monitor UHC in the context of population ageing.

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1 The Kobe Group is composed of Hyogo Prefecture, Kobe City, Kobe Steel, Ltd., and the Kobe Chamber of Commerce and Industry.
2. Background and aims

WKC, in cooperation with other relevant units of WHO, is developing a programme of research on metrics and measurement of UHC that respond to the health system needs of an ageing population. The aim is to improve methods for quantifying progress towards UHC in the context of population ageing to advance research and to better inform policy.

Universal Health Coverage (UHC) is among the Sustainable Development Goals (SDGs) for 2030. UHC means that every person receives the quality health services they need while ensuring that the use of these services does not result in financial hardship. Currently, the global standard of reference for measuring and monitoring UHC is a framework developed by the WHO and World Bank.\(^2\) While the global monitoring framework provides an important standard of reference, it is expected that the indicators for monitoring UHC will need to be adapted to local contexts to ensure their relevance in a rapidly changing environment. As health development and population ageing progress in countries, more countries will need to adapt their measurement and monitoring of UHC so that they are relevant to the health systems challenges presented by population ageing.

One of the principles of UHC is equity, where health equity is defined as the absence of systematic, unfair and avoidable differences in health status or in the distribution of health resources. The pursuit of health equity in ageing societies is an increasing concern given global population ageing and the extraordinary diversity within this growing population group (1-3). In most countries, health systems are initially developed with a strong focus on acute care, maternal and child health-related services, and other health services that are more relevant to the earlier stages of a person’s life course, and the earlier stages of a population’s epidemiological transition. A deliberate adaptation of the health system is thus required to adequately respond to the chronic and complex needs of older people, lest they be left behind in the progress toward UHC.

Furthermore, while older people are defined by different cut-off points of chronological age which are often linked to employment and pension entitlements, this group is extremely diverse in terms of their health needs. Certain subgroups of older people characterized by their age, gender, ethnicity, health and functional status, socioeconomic status, etc. are more vulnerable or disadvantaged compared to others. However, these unfair differences would be overlooked if older people are merely treated as a homogeneous group. Thus, the measurement of equity should be explicit in UHC monitoring (4) with due attention to (i) the differences between older people and the rest of the population, and (ii) the differences among sub-populations of older people.

There are several issues that warrant consideration in studying equity in health of older people. First and foremost, the extent to which older people’s right to health is realized or ensured as compared to the rest of the population should be considered. Four criteria have been set down with regard to the right to health, or the right to achieve the highest attainable standard of health, represented by the acronym AAAQ, which stands for availability, accessibility, acceptability and quality. Thus, the equity concern from this standpoint is whether there are unfair differences in AAAQ between health services for older people and those for the rest of the population. Specific questions arise about the accessibility of health services in terms of their physical infrastructure, financial accessibility, respectful care, and avoidance of ageist biases by the provider or the system vis-à-vis older persons’ needs, capacities and preferences. Availability of care for older people is also linked to how much of their care needs are managed by informal carers, mainly women and girls, in homes. A study conducted across European countries found several interlinked barriers (e.g. cost, geography, ageism, etc.) to accessing quality healthcare among older people including those related to cost, geography and other physical barriers, and age discrimination (5).

Existing studies tend to focus on disease-specific measures and overlook the need for a service planning approach based on a comprehensive assessment of the health status and functional level of the older people to coordinate a broader range of services, including health and social care, that older people often require compared to younger

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people. There are various age-specific conditions, such as frailty, falls, hearing or vision loss, or dementia that the health system needs to deliver. Many older people also have one or more chronic conditions that typically require a great deal of self-care, day-to-day management and behavioural modification. As such, the health care component is only one part of a health system success in terms of whether patients can be proactive in identifying and exercising problem solving and self-management for chronic conditions (6). Studies on equity in access to care among people tend to focus on specific types of conditions and services, from prevention (i.e. cancer screening) (7) to medication treatment for a specific disease (8), use of home care services (9,10) or community health services (11). UHC monitoring systems that are in line with this approach of focusing on services that are directed at certain illnesses and conditions would fail to capture the need for a more comprehensive approach to deliver integrated people-centred care for all older people, regardless of their socioeconomic or other characteristics. It would also overlook the need for a mix of health and social services and effective care management at the boundary of health and social services, i.e., long-term care, to ensure a continuum of care for older people (5).

Furthermore, typical health systems measures, such as hospital admissions and length of stay, do not adequately capture health service coverage or quality of care for older people. High-income countries are increasingly using facility-based data to generate monitoring systems that more accurately reflect coverage, utilization and quality among older adults, including availability and use of medical homes, and reduced re-admissions, emergency department visits and admissions to intensive care (12,13). The extent to which these data exist or can be measured in low- and middle-income countries is not well known.

All these issues must also be considered from the perspective of equity within the older population. It is well recognized that inequalities or disparities in healthcare access, utilization and outcomes exist by age, gender, race/ethnicity, socioeconomic status, geography and other social stratifiers (14). A recent review of evidence from European countries found that these socially determined inequalities in health outcomes and access to health services indeed affect the older population (3). However, a common measurement practice that constrains our understanding of equity in health among older persons is to aggregate older people into one very broad age group for analysis (e.g. 50 or 60 years old and above). This hinders the identification of vulnerable or disadvantaged groups within the older population. The AAAQ of health services and other measures of health system performance would need to be disaggregated by relevant social stratifiers to identify such inequities. Given the preponderance of women in older age groups, gender needs to be systematically included through qualitative analysis as a significant determinant of older women’s health in and of itself, and not just as a stratifier of quantitative data (15).

While there is a considerable amount of literature on socioeconomic inequalities in health among older persons, it has not yet been comprehensively reviewed from the perspective of the kinds of metrics and measurement approaches that are used, and their utility for country monitoring and policy development for UHC. At least one systematic review has been recently conducted which characterised research approaches to identifying age-related inequalities in the receipt of public health and healthcare interventions with a focus on older people (16). This review found 49 relevant studies, most of which were published after 2010. The review found that most studies did not sufficiently address differential need in relation to age-related differences observed in receipt of healthcare, nor did they adequately consider potential confounders such as patient preference or sources of clinically warranted variation, thus making it difficult or impossible to judge whether the observed differences are unfair, and thus inequitable. This review, however, was limited to research on populations from countries in the Organisation for Economic Co-operation and Development (OECD) and papers published in English up to July 2014. It is plausible that there has been a surge of literature on this topic since 2014, given that the first WHO world report on ageing and health (2) was published in 2015, the first global strategy and action plan on ageing and health was adopted in 2016, and the Sustainable Development Goals, which includes the goal to ensure healthy lives and promote well-being for all at all ages, was adopted in 2015. In order to inform country efforts in equity-focused monitoring of UHC progress in the context of population ageing, it would be useful to take stock of recent literature, globally, to assess the extent of applications of existing definitions, concepts and measurement approaches of equity in health service coverage to the older population group, both in research and in practice.
References


3. Work to be Performed

3.1 Research questions

This research is exploratory in nature and does not entail hypothesis testing or confirmatory analysis. The main research question is:

**How should equity in service coverage be measured for the purpose of monitoring UHC progress in the context of population ageing, considering the diverse and complex needs and capacities of older people, their right to health, and the imperative to ensure that needed health services are available, accessible, acceptable, and high quality for all people at all ages?**

This question requires that the research address two types of inequities: (i) older people versus the rest of the population, and (ii) sub-populations within older people that are likely to be more disadvantaged. With regard to these two types of inequities, we are interested in understanding how they have been measured in research or in
practice in various country contexts, and what it means for UHC monitoring especially as countries undergo demographic and epidemiological transitions. It is envisioned that the research findings will provide the basis for a policy brief about equity-focused UHC monitoring to ensure that there are no unfair differences in health services access for older people compared to the rest of the population, or between subgroups of older people.

The research question may be addressed through a combination of more specific questions, which may include but are not limited to:

- How is equity in service coverage (including the boundary between health and social care, i.e., long-term care) conceptualized and measured in relation to older people?
- How is the vulnerability or disadvantage of older people in terms of service coverage, relative to the rest of the population, measured?
- What measurement approaches are used to assess progress toward realizing all older people’s right to health?
- How can the availability, accessibility, acceptability and quality of services be assessed in a way that is relevant to all people, including older people?
- Which services are considered essential to meet the complex needs of older people, and therefore, have been the focus of research or country monitoring?
- How is health system performance in comprehensive service planning (integrated people-centred care vs. disease management) measured?
- How is the extent to which patients are actively part of their own care and, as such, part of the system of service delivery for UHC captured?
- How is the extent to which family caregivers satisfy the care needs of older people and, as such, are also part of the system for service delivery for UHC measured?
- What measurement approaches are taken to identify subgroups of older people who may be more disadvantaged/vulnerable in terms of health service coverage? Which social stratifiers (e.g. gender, discrete age groups, wealth/income/consumption, health/functional status, ethnicity, rural vs urban residence, informal sector vs formal sector work history, education) and dependent variables (e.g. health care access, utilization, outcomes, etc.) are typically examined?
- What is the judgment of unfairness or inequity based on?
- Which of the identified metrics and measurements have relatively greater relevance for policies to ensure that there are no unfair differences in health service coverage for older people compared to the rest of the population, or between subgroups of older people?
- Are the data needed to support the measurement of the identified metrics typically available in low- and middle-income countries?

3.2 Methods
An evidence synthesis based on a scoping review is the preferred method for this study. An attempt should be made to not only look at English literature nor just PubMed. For instance, Global Index Medicus should be searched, especially to capture studies from low- and middle-income countries. The researchers should also have the language capacity to deal with at least one other UN official language. A search should also be done for grey literature as there may be some evidence that is classified as “grey” but still be very strong evidence for a synthesis.

The bidder should describe the details of their review method in the proposal, including specific guiding questions, timeframe, data sources, search keywords, inclusion/exclusion criteria, appraisal method, and method for evidence synthesis (e.g. quantification or categorization of data, qualitative summary, etc.). The successful bidder is expected to refine the review method in discussion with WKC before commencing the work as well as throughout the review process. It is expected that the parameters for the review will need to be revised through an iterative process based on the results of initial searches.
3.3 Reporting/Deliverables
The successful bidder will be expected to produce the following set of deliverables:

1. For research outputs: Research protocol, technical paper, policy brief
2. For public communication/dissemination: 2 research briefs (on research overview and on final outcomes)
3. For project monitoring: Interim progress report, final project report, financial report

The technical paper is the main research output, and this should be prepared in the format of a journal manuscript with the expectation that it will be submitted as a joint publication with WKC to a peer-review Open Access journal upon completion of the research. The paper should be used as the basis for a policy brief designed for WHO Member States. The research briefs will be part of WKC’s communication/social media products aimed at disseminating research to the public. The interim and final project reports should be completed using a report template provided by WKC. It is a project monitoring tool that covers key aspects of project implementation, including achievement of milestones, any expected delays, modification of research protocol, budget implementation, personnel change, etc.

3.4 Consultation and review process
The quality and timeliness of activities and deliverables will be closely monitored by the WKC in accordance with the WHO Kobe Centre’s Research Quality Assurance Plan. Each deliverable will be reviewed by the WKC responsible officer. The research protocol and technical paper may also be peer-reviewed by other WHO technical staff and external experts, as necessary and appropriate. The successful bidder is expected to comply with the review process and requirements and respond to comments provided by WHO on the deliverables. All deliverables must be deemed satisfactory by WHO in the end.

3.5 Budget and timeline
The requested budget must be sufficiently justified and commensurate with the scope of work proposed. Value for money will be one of the criteria for the financial evaluation of the proposal. The expected total duration for the project is for a maximum of 12 months between January and December 2020.

3.6 Compliance with WHO’s Framework for Engagement with Non-State Actors
Prior to contracting, the successful bidder may be required to submit additional information and documents regarding the signatory entity in order to be compliant with WHO’s Framework for Engagement with Non-State Actors (FENSA). These include a disclosure of involvement with tobacco and arms industries; proof of the legal status/registration; composition of the decision-making body (such as the Board, Council, Assembly); main sources of funding including current funding received by the PI (lists of donors and sponsors); and the constitution/statutes/by-laws and affiliation (subsidiaries or branches) for the signatory entity.

3.7 Place of work
The project should be carried out and managed from within the home institution of the PI in collaboration with any necessary international or local partners.

4. Technical requirements
- Proven experience with conducting systematic reviews, scoping reviews, rapid reviews, and other types of literature reviews in a related area.
- Content expertise related to health systems research, metrics and measurement, demography, global health or other related areas.
- Demonstrable capacity and expertise of the research team and base institution to execute the work in a timely manner.
- Ability to review and appraise literature published in English and in at least one other UN official language (i.e. Arabic, Chinese, French, Russian or Spanish).
- Collaborations among two or more research institutions encouraged.
## Annex 2: Vendor Information Form

### Company Information to be provided by the Vendor submitting the proposal

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| **Organization structure** (include description of those parts of your organization that would be involved in the performance of the work)  |
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<th><strong>Relevant experience</strong> (how could your expertise contribute to WHO's needs for the purpose of this RFP) – Please attach reference and contact details</th>
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<th><strong>Staffing information</strong></th>
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* [http://www.who.int/about/finances-accountability/procurement/en/](http://www.who.int/about/finances-accountability/procurement/en/)

Within 30 days of receipt of the contract between WHO and the successful bidder (the “Contract”), the successful bidder shall sign and date the Contract and return it to WHO according to the instructions provided at that time. If the bidder does not accept the Contract terms without changes, then WHO has the right not to proceed with the selected bidder and instead contract with another bidder of its choice. The Contract will include, without limitation, the provisions set forth below (with the successful bidder referred to below as the “Contractor”):

1. **Compliance with WHO Codes and Policies.** By entering into the Contract, the Contractor acknowledges that it has read, and hereby accepts and agrees to comply with, the WHO Policies (as defined below).

   In connection with the foregoing, the Contractor shall take appropriate measures to prevent and respond to any violations of the standards of conduct, as described in the WHO Policies, by its employees and any other persons engaged by the Contractor to perform any services under the Contract.

   Without limiting the foregoing, the Contractor shall promptly report to WHO, in accordance with the terms of the applicable WHO Policies, any actual or suspected violations of any WHO Policies of which the Contractor becomes aware.

   For purposes of the Contract, the term “WHO Policies” means collectively: (i) the WHO Code of Ethics and Professional Conduct; (ii) the WHO Policy on Sexual Exploitation and Abuse Prevention and Response; (iii) the WHO Code of Conduct for responsible Research; (iv) the WHO Policy on Whistleblowing and Protection Against Retaliation; and (v) the UN Supplier Code of Conduct, in each case, as amended from time to time and which are publicly available on the WHO website at the following links: http://www.who.int/about/finances-accountability/procurement/en/ for the UN Supplier Code of Conduct and at http://www.who.int/about/ethics/en/ for the other WHO Policies.

2. **Zero tolerance for sexual exploitation and abuse.** WHO has zero tolerance towards sexual exploitation and abuse. In this regard, and without limiting any other provisions contained herein:

   (i) each legal entity Contractor warrants that it will: (i) take all reasonable and appropriate measures to prevent sexual exploitation or abuse as described in the WHO Policy on Sexual Exploitation and Abuse Prevention and Response by any of its employees and any other persons engaged by it to perform any services under the Contract; and (ii) promptly report to WHO and respond to, in accordance with the terms of the Policy, any actual or suspected violations of the Policy of which the contractor becomes aware; and

   (ii) each individual Contractor warrants that he/she will (i) not engage in any conduct that would constitute sexual exploitation or abuse as described in the WHO Policy on Sexual Exploitation and Abuse Prevention and Response; and (ii) promptly report to WHO, in accordance with the terms of the Policy, any actual or suspected violations of the Policy of which the Contractor becomes aware.

3. **Tobacco/Arms Related Disclosure Statement.** The Contractor may be required to disclose relationships it may have with the tobacco and/or arms industry through completion of the WHO Tobacco/Arms Disclosure Statement. In the event WHO requires completion of this Statement, the Contractor undertakes not to permit work on the Contract to commence, until WHO has assessed the disclosed information and confirmed to the Contractor in writing that the work can commence.
4. **Anti-Terrorism and UN Sanctions; Fraud and Corruption.** The Contractor warrants for the entire duration of the Contract that:

   i. it is not and will not be involved in, or associated with, any person or entity associated with terrorism, as designated by any UN Security Council sanctions regime, that it will not make any payment or provide any other support to any such person or entity and that it will not enter into any employment or subcontracting relationship with any such person or entity;

   ii. it shall not engage in any illegal, corrupt, fraudulent, collusive or coercive practices (including bribery, theft and other misuse of funds) in connection with the execution of the Contract; and

   iii. the Contractor shall take all necessary precautions to prevent the financing of terrorism and/or any illegal corrupt, fraudulent, collusive or coercive practices (including bribery, theft and other misuse of funds) in connection with the execution of the Contract.

Any payments used by the Contractor for the promotion of any terrorist activity or any illegal, corrupt, fraudulent, collusive or coercive practice shall be repaid to WHO without delay.

5. **Breach of essential terms.** The Contractor acknowledges and agrees that each of the provisions of paragraphs 1, 2, 3 and 4 above constitutes an essential term of the Contract, and that in case of breach of any of these provisions, WHO may, in its sole discretion, decide to:

   i. terminate the Contract, and/or any other contract concluded by WHO with the Contractor, immediately upon written notice to the Contractor, without any liability for termination charges or any other liability of any kind; and/or

   ii. exclude the Contractor from participating in any ongoing or future tenders and/or entering into any future contractual or collaborative relationships with WHO.

WHO shall be entitled to report any violation of such provisions to WHO’s governing bodies, other UN agencies, and/or donors.

6. **Use of WHO Name and Emblem.** Without WHO’s prior written approval, the Contractor shall not, in any statement or material of an advertising or promotional nature, refer to the Contract or the Contractor’s relationship with WHO, or otherwise use the name (or any abbreviation thereof) and/or emblem of the World Health Organization.

7. **Assurances regarding procurement.** If the option for payment of a maximum amount applies, to the extent the Contractor is required to purchase any goods and/or services in connection with its performance of the Contract, the Contractor shall ensure that such goods and/or services shall be procured in accordance with the principle of best value for money. "Best value for money" means the responsive offer that is the best combination of technical specifications, quality and price.

8. **Audit.** WHO may request a financial and operational review or audit of the work performed under the Contract, to be conducted by WHO and/or parties authorized by WHO, and the Contractor undertakes to facilitate such review or audit. This review or audit may be carried out at any time during the implementation of the work performed under the Contract, or within five years of completion of the work. In order to facilitate such financial and operational review or audit, the Contractor shall keep accurate and systematic accounts and records in respect of the work performed under the Contract.
The Contractor shall make available, without restriction, to WHO and/or parties authorized by WHO:

i. the Contractor’s books, records and systems (including all relevant financial and operational information) relating to the Contract; and

ii. reasonable access to the Contractor’s premises and personnel.

The Contractor shall provide satisfactory explanations to all queries arising in connection with the aforementioned audit and access rights.

WHO may request the Contractor to provide complementary information about the work performed under the Contract that is reasonably available, including the findings and results of an audit (internal or external) conducted by the Contractor and related to the work performed under the Contract.

9. **Publication of Contract.** Subject to considerations of confidentiality, WHO may acknowledge the existence of the Contract to the public and publish and/or otherwise publicly disclose the Contractor’s name and country of incorporation, general information with respect to the work described herein and the Contract value. Such disclosure will be made in accordance with WHO’s Information Disclosure Policy and shall be consistent with the terms of the Contract.