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Federal Department of Foreign Affairs FDFA
Swiss Agency for Development and Cooperation SDC
Swiss Cooperation Office in Addis Ababa and Nairobi

Terms of Reference
Project evaluation

Evaluation title:

External mid-term evaluation of the Private Sector Partnership in Health (PSPH) Project 2021 – 2025

Nairobi, 08.01.2024

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Terms and Abbreviations

EPHS	Essential Package of Health Services
FMoH	Federal Ministry of Health Somalia
HoA	Horn of Africa
HSSP	Health Sector Strategic Plan
INGO	International Non-Governmental Organization
MoHD	Ministry of Health and Development Somaliland
MSD	Market System Development
NGOs	Non-Governmental Organisations
PSPH	Private Sector Partnership in Health
SDC	Swiss Agency for Development and Cooperation
SORDI	Somali Development Research and Development Institute
Swiss TPH	Swiss Tropical and Public Health Institute
UHC	Universal Health Coverage

1. Introduction

This document sets out the requirements relating to the project evaluation mandate for the first phase (2021 – 2025) of the PSPH project, the selection process and criteria.

The Terms of Reference (ToR) describe the purpose, context, objectives (including guiding indicative evaluation questions) and scope for the evaluation. They further describe the evaluation process and the expected deliverables. **The ToR will be an integral component of the contract for this evaluation mandate.**

2. Background information and context of the evaluation

Somalia has a population of approximately 16 million people and a Gross Domestic Product (GDP) per capita of US $462, making it one of the poorest countries in the world. According to official estimates, 73% of the Somali population lives on less than 2 dollar a day. The country is emerging from a long period of conflict that has brought the health infrastructure to near collapse. Somalia is transitioning toward increased stability through institutional and political reforms, and over the past decade, the Federal Ministry of Health (FMoH) has embarked on a process of health system rehabilitation with development partners, with the goal to ensure access to essential services for all. Communicable diseases, reproductive health and malnutrition constitute the largest contribution to morbidity and mortality. Maternal, infant and child mortality remain high (692 maternal death per 100'000 live births; 74 infant deaths per 1'000 live births; 117 deaths per 1'000 live births for children under 5), however, they are gradually decreasing. The proportion of birth assisted by skilled health personnel has increased from 9% (2016-17) to 32% in 2020.[1]

Overall, the healthcare system in Somalia is extremely fragile, characterized by parallel, under resourced, and fragmented systems and weak or non-existent regulatory oversight. Most public health services provided in country have been "off budget and off treasury" and regarded as humanitarian services provided by donors through implementing NGOs, UN agencies, and the Red Crescent. Estimates are that half of total health expenditure in Somalia comes from donors, with out of pocket (OOP) bearing the balance. The FMoH budget is very low, totalling only $9.35 million in 2020, this being only 2.0 percent of the total Federal budget. Per capita health expenditure is estimated at only US$ 5 – 7 per year. In 2009, Somalia developed its first Essential Package of Health Services (EPHS), and it was since revised twice. A Universal Health Care (UHC) index assessment in 2019 showed that only 25% of the Somali population have access to essential services. A current investment case for the Somalia Health sector 2022-2027 forms the basis for the Global Financing Facility's (GFF) and World Bank's support to the sector, outlining priority setting for the latest EPHS 2020 delivery across the country, and aligning to the national Health Sector Strategic Plan 2022-2026 (HSSP III). The investment case proposes five key reform priorities, led by the FMOH: financing, human resources, medicine and medical supply chains, and effective engagement of all service providers by working with non-state actors, including the private sector.

Before the collapse of the government in 1991, healthcare in Somalia was overseen by the Ministry of Health. Post 1991, private providers, both formal and informal, have replaced the former government monopoly in healthcare with homegrown drug shops, pharmacies, health centres and clinics. The private sector is currently the main provider of essential healthcare services for Somalis seeking health advice and healthcare products. As the 2020-2024 National Development Plan (NDP) states, "Informal businesses —those operating outside formal licensing and registration procedures — dominate Somalia's economy." For many Somalis, the private sector serves as their first – and sometimes only – option for accessing any healthcare. 70% of health services are estimated to be provided by the private sector. In addition, the private sector remains the principal importer and distributor of medicines, accounting for around 80% of the market. Switzerland seeks to tap into the potentials of private sector's role in the health system and has established the programme Private Sector Partnerships for

[1] Investment case for the Somali Health Sector 2022-2027; Essential Package of Health Services 2020

Health (PSPH). DT Global has won the tender process to implement PSPH. It started its mandate with a health market study which identified main challenges that hinder the private health market system to function properly. They include cross cutting constrains as well as opportunities like consumer behaviour (health seeking, health spending, awareness and knowledge of path to treatment and payment options) and human resources capacity. Constraints pertaining to healthcare finance are low insurance coverage from both public and private sectors, high mobile penetration underutilised for healthcare and inadequate benefit packages. Main challenges pertaining to service delivery networks are: access, weak regulation, and business model issues. PSPH seeks to address these constraints in order to improve access, quality of services, and provision and accountability to patients. It focuses on two healthcare sub-systems, healthcare finance and healthcare service delivery through associations and networks.

In Somalia there is limited budget for a social insurance fund nor for nationwide service delivery. Healthcare finance in resource-constrained settings is challenging, particularly when it comes to the revenue raising function, which typically is externally funded, especially for the poor. Health insurance is available, but it is very new and too expensive for most Somalis. Data from the 2020 Somalia Health and Demographic Survey (SHDS) indicates that 99.8% of all ever-married women aged 15 – 49 have no health insurance of any kind. There are only a few commercial insurers offering health insurance, who primarily serve International Non-Governmental Organizations (INGOs) and the top of the income pyramid; together they cover less than 2 percent of the population. Yet, the majority of private sector service users across Somalia can be defined as poor meaning that using private health provision can put considerable strain on the resources of vulnerable individuals and households. The Somali diaspora contribute significantly to the health sector, but information on actual volume of remittances spent on healthcare is not well documented (total remittances were estimated to be 31.4 percent of GDP in 2020).

PSPH is a market system development (MSD) mandate and runs an adaptive portfolio. Private sector partners enter and exit as their market-based interventions succeed, show no market uptake or no longer need technical assistance. It remains the only project working with the commercial private sector amongst the $173 million in donor healthcare programming in Somalia reported in 2022. The project is aligned to the health objective of the Swiss Cooperation Programme in the HoA 2022-2025, particularly its outcome 1 (improved access to better quality and affordable healthcare services).

The Somalia National Development Plan (NDP) 2020 to 2024 includes a health strategy which, while building towards improved institutional funding and capacity, will address early challenges such as inadequate access for the poor and under-served, poor regulation of non-state provision and increased professional standards and provision. PSPH is aligned with the NDP and directly addresses these early challenges through a market system development approach.

2.1. Evaluation object

PSPH is implemented by DT Global and its subcontracted partners SORDI and Swiss TPH. The overall project unit is run out of DT Global regional office, while SORDI has offices in Mogadishu and Hargeisa, leading with implementation on the ground. Swiss TPH is a technical partner on the demand-side health finance component (insurance, health savings etc.), providing assistance through consultants based both in Nairobi and Switzerland. The project is in its first phase of implementation (2021-2025), and has started with its activities mainly in the towns of Mogadishu and Hargeisa, with some outreach to businesses into rural towns such as Burao and Galkayo in late 2023.

Phase 1 has the following objectives:

PSPH follows the general objective of providing Somali citizens, including low-income population, with better access to quality and affordable health services, based on two targeted outcomes:

1. Private providers develop, test, and assess pro-poor healthcare financing mechanisms for sustainability and scalability

2. Organized private service providers deliver quality and inclusive health services across the country, including areas of difficult access

The project targets the following groups:

PSPH directly targets private providers of health services and financial solutions, such as pharmacies, clinics and health insurance companies. The project foresees to market-test 20 to 25 private sector interventions over the course of the first phase. Through its private sector partners, PSPH will support service delivery network interventions to reach up to 632,000 individual patients per year. PSPH is focused on health programming that can sustainably deliver quality and affordable health services to Somalia's economically active mass market, pushing into the vulnerable population groups who dispose of some. This mass market may reasonably count up to 70-80 percent of the population. The project will operate in Mogadishu and Galkayo in Somalia, and Hargeisa, Borama and Burao in Somaliland. It will target outreach from these main cities through intervention partners. Healthcare finance models can have broad reach beyond main population centers as they do not deliver physical products or services, and healthcare service delivery networks will reach beyond wherever there are viable opportunities for members to join. The project foresees to have 8'000 people covered by new health insurance products by 2025, and for out-of-pocket expenditure for these households to reduce to 60%. All goals and deliverables are outlined in the logframe in Annex 1 (to be shared after expression of interest).

The underlying intervention strategy and logic are as follows:

PSHP is conceptualized for implementation period of 12 years, from December 2020 to 2032, likely to be divided in 3 phases of 3-4 years. The first phase started in August 2021, after an initial planning period, and will continue to July 2025. Instead of having a fixed set of interventions, PSPH has an adaptive, diversified portfolio of market interventions addressing different systemic constraints, some of which will progress and mature, while others will die off. PSPH's portfolio approach is an iterative learning process where lessons from the successes and failures are used to inform design, adapt, scale-up and/or shut down market interventions as the markets evolve. Investments in interventions (mainly through technical assistance) are made incrementally to reduce risk of failure and successful interventions are scaled up while assistance to those that fail in the market is halted. Intervention partner organizations in the field are drawn primarily from market-based commercial private sector enterprises and professional associations that have mutual objectives with the project and the will to invest their own resources in pro-poor healthcare market development, share data, and maintain top management commitment to cooperation.

Potential intervention partners and pilot interventions come from a multitude of sources, including desk analysis and published reports, forums and roundtables, internet searches, new ideas from existing partners, referrals (networking), social media, business organizations, trade fairs and web sites. Once potential partners are identified they are selected through a screening mechanism called R-I-E-D. Interventions are screened for Relevance, Impact, Engagement, and Do-No-Harm (R-I-E-D) on a pass/fail basis. A Memorandum of Understanding (MOU) and subsequent concept note are prepared with partners who passed the screen. A

detailed action plan is created, and implementation closely monitored to adapt technical assistance to market needs and collect data for learning. The project's contributions consist of technical assistance. Support can comprise, for example, capacity building and training (e.g., corporate governance, business skills), market research (e.g., identifying consumer preferences and specific health seeking behaviours), marketing strategy and branding, test marketing, business and financial modelling (e.g., economic analysis of business models, actuarial analysis for insurance products), introduction of innovation and global best practices, networking and matchmaking (e.g. joining healthcare finance products with healthcare service providers); no supplies are given, no operational costs are paid, no subsidies used. Overall, the planning phase assessment found vast areas that can be addressed through the private sector using the MSD approach within the project's scope.

Theory of change:

IF PSPH helps commercial private sector healthcare finance and service delivery providers better identify, understand, and quantify the needs, extent, capacity, and behaviour of Somali healthcare consumers, and IF providers then gain the capacity to serve the needs of the unserved and underserved through technical assistance in a manner that is complementary to overall national health objectives, broad in scale, and economically viable for both consumers and providers, THEN private sector providers will expand and introduce innovative and affordable healthcare finance and service delivery business models to the market and strengthen a pluralistic healthcare system. THIS WILL LEAD TO better access of Somali citizens, including the most disadvantaged groups, to quality and affordable healthcare.

Current state of progress:

At the end of Year 2 of implementation, twelve market-based interventions with private sector partners were underway: two under Outcome 1 (healthcare finance) and ten under Outcome 2 (healthcare service delivery). As of end of 2023, the active portfolio has grown to 19 interventions (7 in Somalia and 12 in Somaliland), with 7 discontinued (26 total MoUs have been signed to date in Phase 1). The Somalia interventions are all based in Mogadishu, while in Somaliland, 7 are in Hargeisa and 5 are outside of Hargeisa. Project offices operate in both cities. Two of the interventions started during Year 1; one is a legacy intervention from a pilot started under SDC guidance in 2017.

2.2. Purpose and objectives

The purpose of the mid-term evaluation is to provide SDC and PSPH partners with all the required information to steer the current phase of project, elaborate the subsequent phase, and improve implementation where required in order to achieve the project's intended impact, as well as recognise current opportunities, strengths, as well as challenges and shortcomings, in the rather complex and rapid changing environment of Somalia.

The objective of the mid-term evaluation is to assess the effectiveness of the intervention logic, methodology and first results of the project's first phase, and provide an analysis of gaps and weaknesses, strengths and opportunities, and link the findings to current policies.

The mid-term evaluation will inform the second phase of the project in terms of intervention logic, operational improvements and stakeholders (other than businesses) to be involved, and provide recommendations on the way forward. Both mid-term recommendations to be implemented in the current phase, as well as long-term recommendations for the design of the next phase are expected.

The project evaluation should be guided by the OECD/DAC Criteria (i.e. relevance, coherence, effectiveness, efficiency, impact and sustainability; Annex 2), according to the questions below under 3.4. The focus on and the exclusion of questions under each criteria should be explicitly stated in the bid of the consultant and in the final evaluation report. Annex 2 will be a mandatory deliverable together with the final evaluation report.

2.3. Scope

The breadth and depth of the evaluation will be informed by the indicative evaluation questions that the evaluation seeks to answer (see chapter below). The evaluation will assess the implementation of the project activities, with specific focus on the following:

1) The intervention logic and underlying current and future assumptions in relation to various stakeholders (rules and regulations, and support functions related to the health market; market buy-in, risk of cartels) and the target population (mass market, urban and rural areas).

2) Operational strengths, opportunities, gaps and weaknesses (geographic expansion, human capacity, political environment); as well as an understanding of the needs of the participating businesses (including beyond technical assistance).

3) An understanding of the perspective of health authorities towards collaborating with the private sector on EPHS delivery and specialised services, insurance coverage, challenges and sequencing of initial steps towards this goal.

The retrospective scope of the evaluation is limited to the first 3 years of phase 1, from August 2021 to July 2024, however the focus is clearly forward looking, carving out key recommendations on operational, market and political aspects going forward. The geographical scope includes both Somalia and Somaliland, with a focus on Mogadishu and Hargeisa, and some interventions in the town of Borama.

Indicative evaluation questions / key focus area

During the inception phase, the evaluator, in consultation with the SDC, should further refine and prioritise the questions that are structured according to the OECD DAC criteria. The bidder is expected to address this within the technical bid.

Relevance	• To what extent are the activities and outputs consistent with the intended results? • Are the achieved results consistent with the needs of the target groups, including women and girls? • To what extent is the MSD approach, as it has been implemented in the PSPH so far, appropriate to achieve the intended outcomes? Is the intervention logic valid? • What have been draw backs and benefits of the MSD approach? • What gaps have been identified by the recipients of technical assistance / businesses, for example when trying to launch their product in the market? What part of the technical assistance has been the most helpful? • How can unmet demands (ex. financial de-risking, more/closer assistance) be addressed, either by the PSPH and/or by other initiatives, including existing funds?

	• To what extent do the objectives of the intervention respond and align to the priorities and policies of the national and subnational level line ministries?
Coherence	• Is the approach taken by PSPH sufficient in order to mobilize the private sector to further contribute to UHC and EPHS delivery? • Does the government (MoH/MoHD) take up opportunities to capitalize on PSPH and its output, to guide the private sector in its role to provide access health services rapidly in Somalia?
Effectiveness	• Which major factors have influenced the achievement or non-achievement of the expected results? • What are the root causes of the challenges identified, and what could be done differently to address these? • To what extent is the current project and implementation set-up suitable for efficient and effective services delivery and achievements of project outcomes (for example capacity and number of intervention managers, remote supervision, accessibility to sites)?
Efficiency	• To what extent is the project and its components implemented efficiently, with regard to cost, timeliness, human resources? Are resources allocated efficiently in terms of target population vs operational costs? • Which alternative approaches might have led to similar results at lower costs? • In the view of the MoH/MoHD, is private health services delivery giving them/the donor value for money in order to achieve UHC for their population? • How efficient is service delivery currently in the private sector (cost vs benefit), and how can for example overuse of diagnostics/treatments be regulated? Can private sector self-regulation contribute to overall health system regulation? Is self-regulation taking place among current programme participants?
Impact	• Is there market-buy in to be observed? • Can the free market play its role in UHC delivery when not guided, or would a defined package of services for those business receiving technical assistance be more targeted? • What are the chances of the rural and the low-income populations benefiting in the long term, and what are possible dynamics around consumer decisions and products in terms of their social, political and institutional environment? • Which unexpected and unintended positive and negative (side) effects have occurred and how can these be addressed?
Sustainability	• Which major factors might enhance or hinder the buy-in from government (political or financial commitment, change in legislation framework)? • Are there additional stakeholders (political, economic, social agents and institutions) to be involved, based on their power, influence, dependencies, interest and capacities?

	• To what extent can the businesses benefiting from technical assistance adjust their strategies to changing conditions? (Do they have sufficient financial and technical capacity, if not what would be needed)? • Is the underlying assumption (Theory of change) still valid, have there been changes in framework conditions (supporting and regulation functions) in the last 3 years? Would anything need to change, and if yes what would need to change for the MSD approach to lead to sustainable impact? • Does the underlying assumption, that private sector health services are less exposed to security risk in relation to terrorism, intra-clan violence and political conflict, hold true?

3. Evaluation process and methods

3.1. Evaluation methodology

This is an external evaluation, whereby the evaluation team can comprise of different experts, but is coordinated by the lead consultant. A mix of qualitative and quantitative methods is expected to characterise this evaluation.

The lead consultant will propose an adequate methodology; however, the minimum criteria defined below have to be met:

- Coverage of both main project locations in Somalia, and one rural location (Mogadishu, Hargeisa, Borama);
- Desk review: all project documents such as the project proposal, market system assessment, annual reports, and budget, will be reviewed against the results framework (logframe). Documents shaping the wider external environment, such as policies and strategies employed by national (FMOH) and sub-national bodies (MOHD) will be reviewed;
- Field work: field visits to the project sites and businesses will be conducted. Data collection methods might include key informant interviews, focus group discussions, and field-level observations, including at the service level where this applies (at least Private Hospital Network Caafinet).

3.2. Roles and responsibilities of the evaluator(s)

The evaluation will be conducted by a team composed of a lead consultant, accompanied by one or more additional consultants. The team should have relevant expertise and experience in the Somali context, MSD and private health sector business operations, as well as in the health sector in general.

The lead consultant

The lead consultant has the overall responsibility for the evaluation and to lead the evaluation team (communication to all parties, including SDC), to subcontract and coordinate the other consultants and their contributions. The lead consultant will be responsible for organizing and financing the logistics, leading the design and development of study tools, methodologies, and approaches; conducting literature reviews; coordinating key informant interviews and focus group discussions; ensuring quality control by developing mechanisms and tools for this purpose; and ensuring that timelines for research delivery are met. The lead consultant will report to the Swiss Cooperation Office in the Embassy of Switzerland in Nairobi.

The other consultants

One or several additional consultants (profiles to be assessed for each sub-topic) will support the main consultant in the field study part on the ground and, if needed, provide logistical support. It will be the responsibility of the lead consultant to recruit and subcontract the additional consultants and to supervise their work.

SDC office in Nairobi

The programme officer managing the PSPH project from the Embassy of Switzerland in Nairobi will be responsible for coordinating the operational management of the mid-term evaluation. She will follow up contractual and evaluation processes and ensure the timeliness and quality of the deliverables. She will provide all the required documentation (as indicated in the annexe) and support letters for the evaluators.

PSPH partners

PSPH partners, led by DT Global, will facilitate the mid-term evaluation by providing all project documentation required, logistically supporting the evaluation team in the field work by facilitating the coordination of key informants, focus group discussants, local officials (as available) etc, and coordinating the participants of the focus group discussions and key informants during the process of data collection.

3.3. Evaluation process and timeframe

The following work plan provides suggested dates, responsibilities and resources needed for the various activities of the evaluation process. This work plan will be adapted by the evaluation team, in consultation with the SDC, during the inception phase.

Activity	Date	Responsibilities
Kick-off meeting with evaluation team	24.04.2024	SDC; Consultant/s
Consultations with stakeholders, partners, desk study, etc.	TBC	Consultant/s
Preparation of the Inception Report: evaluation objectives and questions, evaluation design, methodology	TBC	Consultant/s
Draft Inception Report	10.05.2024	Consultant/s
Feedback on the Inception Report by SDC and implementing partners	17.05.2024	SDC
Submission of Final Inception Report	24.05.2024	Consultant/s
Logistical and administrative preparation for data collection, evaluation workshops, field visits, etc.	TBC	Consultant/s
Field mission (indicative timeframe) with data collection, interviews, evaluation workshops, etc. (including debriefing at the sites individually)	1.06.-30.06.2024	Consultant/s
Data analysis and preparation of Draft Evaluation Report	TBC	Consultant/s
Draft Evaluation Report	28.07.2024	Consultant/s
Online validation meeting with SDC and implementing partners	08.08.2024	Consultants
Feedback on the Draft Evaluation Report by the evaluation team and implementing partners	12.08.2024	SDC
Final Evaluation Report	26.08.2024	Consultant/s
SDC Management Response	09.09.2024	SDC
Dissemination of the Final Evaluation Report	11.09.2024	SDC

Timeframe to be discussed with consultant(s), but the work will be **limited to 35 working days for all consultants cumulatively**, and will be undertaken over a timeline of approximately four months.

4. Deliverables

The following deliverables will be submitted by the evaluator(s):

- Inception Report (maximum 10 pages)
- Draft Evaluation Report
- Hybrid validation meeting to discuss first findings
- Final Evaluation Report (25 pages including 2 pages executive summary, excluding annexes)
- The SDC's Assessment Grid of the DAC Criteria (tool 7) must be completed by the evaluator(s) and attached to the final evaluation report
- List of interviewed persons; minutes of meetings; slides used for debriefing; videos; leaflets; case studies; etc. to be annexed

5. Reference Documents

After signing the contract, the evaluation manager (SDC) will share the following documents with the evaluator(s) for the evaluator's first desk review:

- PSPH Project document for phase 1;
- Credit Proposal for PSPH phase 1;
- Annual project reports;
- Market system assessment
- Online access to Intervention dashboard
- Swiss Cooperation Programme Horn of Africa, 2022–2025

6. Competency profile of the evaluators

The evaluators are expected to bring along the following evaluation and thematic expertise and experience.

Essential qualities are:

- Thematic expertise on MSD preferably in health and/or thin markets (outside of traditional MSD sectors like agriculture); or at least private sector development background;
- Prior experience of evaluation for MSD approaches;
- Master Degree in economy or public health, or a related relevant field;
- Extensive experience working on and/or assessing projects in fragile contexts; familiarity with adaptive programming;
- Good understanding of the Somali health sector and challenges in Somalia;
- Knowledge of the specific political economy, social structure and business culture in Somalia and Somaliland;
- Be able to work and steer as an individual or a team, incorporate team members that are acquainted with the local context of project implementation;
- Documented experience in the management of an evaluation team comparable in size, composition and scope;
- Strong M&E background with experience in evaluating long-term projects;
- Be well acquainted with cross-cutting or transversal themes such as conflict-sensitive programme management, gender, LNOB and governance (application of gender and governance sensitive evaluation methodologies);
- Strong analytical and editorial skills in English language, ability to synthesise and write intelligibly for different audiences;
- Ability to apply the DAC/OECD[2] evaluation standards;
- Knowledge of the local language and ability to go to the implementation locations within the consultant team;
- Ability to move and conduct studies in highly fragile contexts

Desired qualities are:

- Substantial working experience in Somalia; or at least in a fragile context in Sub-Saharan Africa
- Knowledge of the Swiss Development Cooperation system;
- Prior experience of evaluation for MSD approaches in health;

2 https://www.oecd.org/development/evaluation/qualitystandards.pdf

7. Reporting

The lead consultant will report to the responsible Programme Officer of the Embassy of Switzerland in Nairobi for the entire duration of the assignment.

8. Suitability and award criteria

No.	Suitability criteria
SC1	Evaluators must be independent of the FDFA and, in particular, the SDC and not have been involved in activities covered by this evaluation.
SC2	Experience with evaluating the MSD approach (Lead evaluator)
SC3	Documented experience in conducting evaluations and in the management of an evaluation team (Lead evaluator)
SC4	Knowledge of the local language and ability to go to the implementation locations (within the consultant team)
SC5	Good understanding of the Somali health sector and challenges in Somalia (within the consultation team)

Award criteria	Weighting
Understanding of the TOR	10%
Proposed Approach (Methodology, Organization, Team composition)	20%
Knowledge and competency of personnel (thematic and evaluation procedures)	15%
Experience of personnel	15%
Knowledge of the Somali health sector and political context of Somalia	10%
Financial offer (budget) for consultancy service offered	30%

9. Application procedure

Expression of interest have to be submitted to the Swiss Representation in Nairobi by email to corinne.corradi@eda.admin.ch by 18 January 2024, 23:00 hrs EAT.

Technical and financial proposals have to be submitted to the Swiss representation in Nairobi by email to corinne.corradi@eda.admin.ch 23:00 hrs local time (EAT) on 23 February 2024. Subject title “PSPH Evaluation Proposal”

The technical proposal should not exceed 15 pages and should outline the service provider’s:

I. Understanding of the assignment;
II. Approach to and methodology for the assignment;
III. Team composition. CVs (max 3 pages per person including two references and documents/reports proving relevant experience) and division of responsibilities between team members; A sworn statement as to the absence of any conflict of interest of each team member. In the case a group of consultants, Embassy of Switzerland will only engage with one point of contact or person for contractual and obligation for the deliverables.
IV. **Letter of Confirmation** of interest and availability (for all team members) stating the Point of contact (PoC) of the proposed team.

V. Draft evaluation work plan;
VI. Draft report outline;
VII. Financial proposal, including costs for logistics, insurance coverage and security, including for subcontractors

The financial proposal should follow the template provided in the reference documents and should clearly outline the total budget in USD including all taxes (WHT, VAT etc.) and incorporating a detailed budget break-down (daily fees rate per consultant, living expenses, travel, etc.)

Timeline

Deadline	Activity
08.01.2024	Share the request to Expression of Interest (EOI) and the TORs to the bidders
18.01.2024	Expression of Interest and questions by email to corinne.corradi@eda.admin.ch
24.01.2024	Sharing of the questions and answers with all the interested bidders.
28.01.2024	Re-confirm Expression of Interest by email to corinne.corradi@eda.admin.ch
29.01.2024	Sharing the reference documents (see Annex below) of the TOR to the interested bidders
23.02.2024	Deadline for submitting the offer
05.03.-08.03 2024	Interviews with selected bidders
15.03.2024	Awarding of contract and notice to unsuccessful bidders
27.03.2024	Contract issued

10. Contracting

The contract will be awarded by SDC evaluation team and contract signed with the Swiss representation in Nairobi following an analysis of technical and financial proposals received in response to these terms of reference. The tenderer has no right for appeal under this procedure.

The winning bidder shall be required to submit the following administrative information to be verified and validated before the contract is awarded.

i. Corporate person/company
- Certificate of registration/Incorporation of the company.
- Latest Tax Compliance Certificate of the company
- Copies of academic certificates of proposed consultant(s).

ii. For natural persons/individuals/freelancers
- Latest Tax Compliance Certificate.
- Copies of academic certificates of the consultant(s).

Compliance with local law on taxation

a) Withholding tax (WHT)

Taxes, charges and social security contributions will be applicable in conformity with local legislation. The Embassy is obligated to deduct and submit Withholding Tax (WHT) to the Kenyan Revenue Authority (KRA). WHT is a percentage of the earnings and will vary depending on the country of origin of the consultant.

i. For non-residents, the Embassy will respect existing “double taxation agreements (DTA)”. The maximum WHT rate of 20% (subject to change depending on legislation) for non-residents, will be deducted.
ii. For residents, the maximum WHT is 5% for this type of consultancy.

More information on the applicable tax rates can be found here: https://www.kra.go.ke/en/helping-tax-payers/faqs/more-about-withholding-tax.

b) Value Added Tax (VAT)

The Embassy is exempt from VAT. The service is subject to VAT according to the local law, the resident corporate person will within 30 days reimburse the VAT amount to the Embassy as soon as the exemption certificate is availed by the Embassy.

The legal status of the consultant in the country of engagement

The consultant must have valid a work permit or equivalent authorization before travelling, which allows such a person to live and work in the respective country.

11. Annex

1) Project Logframe
2) Assessment Grid for the DAC Criteria
3) Template for financial proposal
4) Switzerland’s International Cooperation Strategy 2021-2024
5) Regional Cooperation Programme Horn of Africa 2022-2025