TERMS OF REFERENCE

BASELINE ASSESSMENT

Content

1- Definition of Baseline study (LdB) and modalities of elaboration

1.1. Definition and objectives

In the Results Based Management (RBM) process, the Baseline, understood as the establishment of indicators of the initial situation from which we start and aim to change, reflects the basis for measuring the achievement of development objectives.

The Baseline is the first measurement of all the indicators contemplated in the design of an action, establishing the starting point or initial situation of the scenario in which a project is to be implemented. Therefore, Baseline studies are a type of applied social research aimed at obtaining the basic references of the "evaluability" of the project and thus contribute to better decision-making.

From the MfDR approach, the Baseline fulfils five complementary functions:

→ **Validate the technical feasibility of the project**, through an analysis of the project's framework of objectives and results, and an examination of the causal sequence proposed in the project to achieve them.

→ **Validate the evaluability of the intervention,** through an early review of the relevance, reliability and usefulness of the indicators proposed in the project planning matrix.

→ To carry out **a systematic study** in order to present, at the highest level of detail, the **situation prior to the start of the development intervention**, with respect to the established indicators and targets, against which progress can be measured or comparisons can be made, and to determine the baseline situation of the project's outcome and impact indicators by establishing their first value using social research techniques.

→ **To formulate more precisely the target population of the project or intervention**, which allows reformulation in order to achieve greater relevance, effectiveness, efficiency and potential sustainability.

The Project's Logical Framework Indicator Matrix will determine the indicators that are the subject of the Baseline study. The Baseline should provide information in relation to:

→ Baseline data for the indicator for the local level, in the base year.

→ Temporal reference data for the base year.

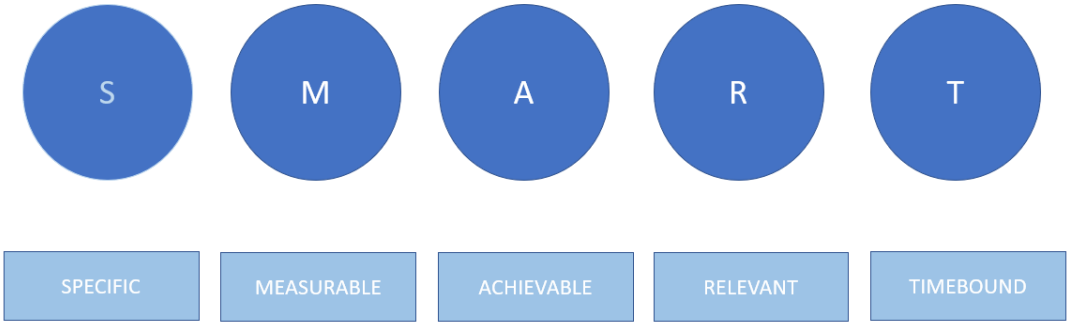
2. Content of the LDB

2.1 Objectives

These ToR are the planning document that delimits the scope and limits of the Baseline study. They are the reference instrument so that the external consultant who is going to carry out the Baseline has the basic information to be able to present a technical work proposal. From the RBM approach, the Baseline has to respond to several objectives:

1. Validate the design rationale of the project objectives and outcomes.

2. Ensure the evaluability of the project in terms of RBM, which implies reviewing the indicators in SMART terms and the sources of verification.



3. Develop the project's baseline at the time of project start-up and set operational targets.

4. Facilitate the key elements for the design of a Monitoring Plan for the project. Although we are going to delegate the management of the LdB to an external consultancy, it is the managing entity that must establish the methodological framework that it wants to guide the entire analysis process, and also define the final products to be delivered.

2.2 Background and justification

2.2.1 crisis situation motivating the intervention

Kenya hosts a large number of asylum seekers, refugees and internally displaced persons (IDPs). Factors forcing people to move and seek protection in the country include:

1. **Drought, food insecurity and funding cuts**

Kenya remains particularly vulnerable to climate variability, especially in its arid and semi-arid lands (ASALs), where livelihoods depend heavily on rain-fed agriculture and pastoralism. The country has strengthened its drought preparedness and response mechanisms through the National Drought Management Authority (NDMA), yet climate extremes continue to place significant pressure on already vulnerable communities. Women and girls are disproportionately affected, facing heightened risks of gender-based violence, reduced access to healthcare and education, and increased caregiving responsibilities during periods of environmental stress and displacement.
Food insecurity remains one of the region's most pressing humanitarian challenges. According to the latest Integrated Food Security Phase Classification (IPC) assessments, tens of millions of people across the Horn of Africa require urgent food assistance, with conflict, climate shocks, economic pressures, and displacement continuing to drive acute food insecurity. Somalia, Ethiopia, Kenya, and, more recently, Sudan remain among the countries with the highest levels of humanitarian need. Children continue to bear a disproportionate share of the crisis, with millions under the age of five suffering from acute malnutrition due to limited access to nutritious food, clean water, and essential health services.

The humanitarian response has also been severely constrained by an unprecedented funding shortfall. According to the 2026 Global Humanitarian Overview, humanitarian partners require US$33 billion to provide life-saving assistance worldwide, yet by mid-2026 only around 17–20% of the required funding had been secured, leaving a funding gap of more than 80%. As a result, UN agencies and humanitarian organizations have been forced to prioritize only the most acute needs, reducing food rations, scaling back nutrition and health programmes, limiting water and sanitation services, and suspending protection activities across several countries in the Horn of Africa. The funding crisis has significantly undermined the humanitarian response at a time when climate shocks, conflict, and displacement continue to increase the number of people requiring assistance.

2. Persisting violence in countries such as DRC, Somalia and Ethiopia

Conflict and insecurity continue to drive one of the world's largest displacement crises across the Horn of Africa and the Great Lakes region. Despite some political progress in recent years, violence remains widespread and humanitarian needs continue to grow.

In the eastern Democratic Republic of the Congo (DRC), armed violence has escalated, particularly in the provinces of North and South Kivu. Fighting involving the Armed Forces of the DRC (FARDC), the M23 armed group, the Allied Democratic Forces (ADF), Mai-Mai militias, and other non-state armed actors has resulted in repeated waves of displacement and heightened protection risks for civilians. The resurgence of M23, coupled with regional tensions and limited humanitarian access, has further aggravated an already fragile situation. At the same time, recurrent outbreaks of diseases such as cholera and mpox have placed additional pressure on affected communities and health systems.

In Ethiopia, the signing of the Pretoria Peace Agreement in November 2022 marked an important step towards ending the conflict in Tigray. However, recovery remains uneven, with millions of people still displaced or requiring humanitarian assistance. Moreover, violence has shifted to other parts of the country, particularly the Amhara and Oromia regions, where clashes involving government forces, regional militias, and armed groups continue to cause displacement, damage infrastructure, and undermine livelihoods.

Somalia also continues to experience chronic insecurity, with Al-Shabaab maintaining the capacity to carry out attacks against civilians, security forces, and public infrastructure. Although military operations have weakened the group's territorial control in some areas, insecurity remains widespread. The humanitarian situation has been further exacerbated by successive climate-related shocks, including prolonged droughts followed by devastating floods, which have intensified food insecurity and forced additional population movements.

According to the latest estimates from UNHCR and the International Organization for Migration (IOM), the Horn of Africa and Great Lakes region hosts more than 20 million internally displaced persons (IDPs), while over 6 million refugees and asylum seekers remain displaced across the region. Sudan, the DRC, Ethiopia, and Somalia continue to account for the largest displacement situations, driven by a combination of armed conflict, political instability, and climate-related disasters.

Against this backdrop, Kenya remains one of the region's principal refugee-hosting countries, providing protection to hundreds of thousands of refugees and asylum seekers, primarily from Somalia, South Sudan, the DRC, Ethiopia, and Sudan. The continued influx of displaced populations places considerable pressure on national services and host communities, reinforcing the need for sustained investment in healthcare, education, food security, livelihoods, and protection for both refugees and vulnerable local populations.

Having outlined its causes, it is now time to describe the consequences of the crisis to which this intervention aims to respond:

A. Refugees and asylum seekers in Kenya, with a focus on Nairobi

Kenya continues to play a critical role as a refugee-hosting country in East Africa. According to the Kenya Department of Refugee Services (DRS), the country was hosting 852,388 refugees and asylum seekers as of 31 May 2026, reflecting a significant increase in recent years driven by the continued conflicts in Somalia, South Sudan, the Democratic Republic of the Congo (DRC), Ethiopia and Sudan. Approximately **49%** of refugees reside in Dadaab, **37.1%** in Kakuma and Kalobeyei, while **13.9%** live in urban areas, primarily Nairobi. Nairobi hosts Kenya's largest urban refugee population and continues to attract refugees seeking greater access to livelihoods, education and specialised services. However, many refugee households settle in informal settlements such as Eastleigh, Kasarani, Kayole and Umoja, where overcrowding, insecure housing, limited access to basic services and widespread informal employment increase their vulnerability. Although Kenya's Refugee Act (2021) has strengthened the legal framework for refugee inclusion including with the Shirika plan, urban refugees continue to face barriers in accessing healthcare, education, decent work and social protection, particularly those with limited financial resources or incomplete documentation.

B. Food insecurity, climate-related displacement and rising living costs

Climate shocks continue to undermine food security and livelihoods across Kenya. According to the Integrated Food Security Phase Classification (IPC) analysis for January–March 2026, **3.3 million people are experiencing IPC Phase 3 (Crisis)** or worse, including approximately 400,000 people facing IPC Phase 4 (Emergency) conditions. The situation is expected to deteriorate further during the 2026 lean season, with **3.7 million people** projected to require urgent humanitarian assistance.

The humanitarian situation has been further exacerbated by a severe funding crisis. Reduced contributions have forced humanitarian agencies to scale back life-saving programmes across Kenya. In refugee camps, the World Food Programme (WFP) has progressively reduced food assistance, with general food rations falling to **28% of the standard ration** because of insufficient funding. These reductions have increased household reliance on negative coping mechanisms, including reducing meal frequency, withdrawing children from school, selling productive assets and engaging in high-risk livelihood activities.

C. Vulnerabilities in Nairobi's informal settlements

The rapid expansion of Nairobi's informal settlements continues to outpace the availability of essential public services. Refugees, asylum seekers, internally displaced persons and vulnerable host communities face overlapping challenges linked to poverty, insecure livelihoods and limited access to quality healthcare, education and protection services.

Public health facilities serving informal settlements remain overstretched, with shortages of medicines, equipment and qualified health personnel limiting the availability of primary healthcare, sexual and reproductive health services, mental health support and specialised care for survivors of gender-based violence. Financial constraints, language barriers, discrimination and documentation requirements further restrict access for many refugee households.

At the same time, reductions in humanitarian funding have significantly affected the capacity of UN agencies and humanitarian organizations to deliver urban protection, health, nutrition and livelihood programmes. As assistance becomes increasingly targeted towards only the most vulnerable households, many refugees and low-income Kenyan families are left with limited access to essential services despite growing humanitarian needs.

D. Protection risks affecting women and girls

Women and girls continue to experience disproportionate protection risks associated with displacement, poverty, food insecurity and climate-related shocks. In Nairobi's informal settlements, economic hardship and insecure living conditions heighten exposure to gender-based violence (GBV), including sexual exploitation and abuse, child and forced marriage, and other forms of violence.

Although Kenya has strengthened its legal and policy framework for preventing and responding to GBV, significant barriers continue to limit access to survivor-centred services. Fear of stigma and retaliation, financial dependency, language barriers among refugee communities and reduced availability of specialised protection services contribute to the underreporting of violence and limit access to justice and comprehensive care. Continued investment in integrated health, protection and economic empowerment interventions remains essential to reduce vulnerability and strengthen the resilience of refugee and host communities alike.

CONTEXT AND IDENTIFIED NEEDS

The following humanitarian needs and their causes emerge from the information obtained in the diagnostic study phase:

1. Increase in the number of IDPs, refugees and asylum seekers as a result of the prolongation of the armed conflict in DRC and the effects of drought in arid and semi-arid areas of Kenya.

2. Increased cases of food insecurity and malnutrition due to lack of knowledge and access to adequate food, aggravated by drought and inflation.

3. Deterioration of the living conditions of the population in informal settlements due to the lack of sufficient, effective, quality and timely resources and services that guarantee access to health care for the vulnerable population.

4. Unequal impact of the crisis in terms of gender and age, resulting in the persistence of SGBV and SGBV (whose survivors do not access adequate health care in a timely manner) and of risky sexual and reproductive health practices (mainly female genital mutilation), early marriages and lack of access to education to perform household chores.

2.2.2 Continuity project

Farmamundi and HESED have **more than 15 years of joint experience in** humanitarian action in Kenya and a **defined strategy** to achieve the reduction of the gender, age and diversity gap in health; the eradication of violence against women, adolescents, boys and girls; the access of the vulnerable population to health in a comprehensive manner and the development of public, universal and inclusive health models.

This project is a continuation of three GVA-funded interventions, one in Eastleigh and the other in Kasarani and the last one – and most recent- in both sub counties. The GVA25 Afya Zaidi project (a 12-months project) in the sub-counties of Eastleigh and Kasarani; within Nairobi County from 1st July 2026 to 30th June 2027. The project aimed to promote the right to health from a biopsychosocial approach by putting people at the center and strengthening MSVS and GBV protection and rights restitution mechanisms among the refugee, internally displaced and local populations in the informal settlements of Eastleigh and Kasarani.

Thanks to the experiences acquired in these interventions, we have learned lessons and **lessons learned** that we incorporate in a generic way in this proposal, among which we highlight the following:

1. Community engagement & ownership in the project: Early and continuous involvement of community members; including Community Health Promoters (CHPs), Community Health Committees (CHCs), local leaders, youth, and women, significantly enhances programme acceptance, trust, effectiveness, and sustainability. Strong community ownership reduces dependency on external support and contributes to longer-term impact, while continuous socialization builds shared understanding, and helps to reduce resistance to programme activities. Stakeholders' empowerment at the project onset reduces dependencies as well as increases the project outcomes.

2. Importance of government partnerships in ensuring smooth project sustainability: Strong multisectoral collaboration with county, sub-county, and facility-level government structures, each partner appreciates what they do and reduces pressure on one partner subsequently enhances programme effectiveness and sustainability and ensures continuity of services beyond the project period. Alignment with Ministry of Health (MOH) systems, tools, and reporting frameworks strengthens data credibility and promotes institutional ownership of interventions.

3. Multi-sectoral & stakeholder collaboration in ensuring the project achieves and makes a bigger impact: Partnerships across sectors; including health, education, justice, WASH, security, faith-based institutions, and NGOs, help reduce the burden on individual actors while improving the effectiveness and reach of interventions. Broad stakeholder involvement mitigates potential backlash, reinforces cultural sensitivity, and enhances social acceptability within communities. In addition, working under umbrella platforms with like-minded organizations strengthens coordination, promotes synergy, and optimizes the use of available resources.

4. Capacity building improves service delivery in health care services: Training health workers, Community Health Promoters (CHPs), teachers, police officers, and paralegals improves the quality of care, responsiveness, and accountability, and should be conducted with increased frequency to maintain effectiveness. Regular refresher trainings on emerging and trending issues are strongly recommended, particularly in light of frequent staff turnover within government systems, to ensure continuity and consistency of service provision.

5. Gender & inclusion dynamics: Male engagement is critical to reducing gender-based violence (GBV), teenage pregnancy, and household conflict, and it also reinforces the effectiveness of the community-based approach adopted in the project design. Male engagement is essential across the board, engaging the male ensures shared decision making at the household level which is key in increasing the project outcomes. Youth engagement requires interactive models; this needs to have younger people training the youth and use of youth friendly approaches to ensure effectiveness. Cultural and religious sensitivity is especially important for project success, particularly where interventions are perceived to challenge cultural norms. Working with religious leaders increases acceptance hence the need to ensure they are represented in the project design.

6. Livelihood & economic empowerment insights: Livelihood support contributes to increased household resilience; however, its sustainability is often constrained by limited access to capital and narrow skill options. Diversification of income-generating activity (IGA) skills strengthens resilience and improves overall income outcomes.

7. Health system strengthening and upgrades: Facility upgrades, availability of medical supplies, and timely infrastructure repairs are critical to maintaining service quality and effective patient care. To address these gaps, strong collaboration with partners is essential to sustain supplies and ensure continued facility functionality, particularly during periods of resource shortages.

8. Data, learning & adaptability: Data-driven decision-making strengthens accountability and improves programme quality. Regular monitoring, joint review processes, and structured feedback loops enhance programme responsiveness and allow timely adjustments. In addition, external shocks and funding limitations underscore the importance of designing programmes that are flexible, adaptive, and resilient. This speaks the need for the strengthening of the MOH tools to ensure quality data is collected for the project.

9. Psychosocial & mental health: Psychosocial and mental health support is essential for improving overall well-being and resilience among rights holding populations. Training community health workers, counselors, and other frontline staff enhances their capacity to identify and address mental health needs. Integrating mental health services into existing community and health structures ensures accessibility and sustainability, while promoting community awareness, reducing stigma, and fostering supportive networks.

2.3 Scope of the LDB

2.3.1 Temporary Scope

The project will be developed over a period of 12 months, starting on July 1rst 2026 and ending on June 30th 2027. This timeframe will allow for the full implementation of the planned activities, as well as the monitoring and evaluation of the results and impact generated. It is foreseen that the baseline starting the project will have a duration of six weeks

2.3.2 Geographical Scope

The geographical area of intervention will focus on Nairobi County, specifically Kamukunji and Kasarani sub-counties, where FM and HESED have had a sustained collaboration for over 15 years. This region has been selected as the area of intervention due to the identified need in the areas of health and rights protection, as well as the presence of existing infrastructure and community networks that can facilitate effective implementation of the project.

2.4 Identification of the subject population

The target group with direct rights, obligations and responsibilities is made up of a **total of 27,316 people (18,159 women and children under 5 years of age),** distributed as follows:

ROLE	Men	Women	Under 5 minors	Total
BENEFICIARIES	8.328	14.419	4.072	26.819
OBLIGATION BEARERS	36	39	-	75
DUTY BEARES	96	133	-	229
TOTAL	**8.460**	**14.591**	**4.072**	**27.123**

RIGHTSHOLDERS

Rights holders actively participate in the design of the intervention, ensuring that their needs, challenges, capabilities, and priorities in health—including sexual and reproductive health (SRH), maternal and child health (MCH), and mental health and psychosocial support (MHPSS)—are taken into account, as well as in the prevention and response to sexual and gender-based violence (SGBV). Their participation and commitment will be maintained throughout the entire project cycle, empowering them as key actors in exercising and demanding their rights.

Specifically, the rights-holding population participates in care services and distributions aimed at improving community health through a biopsychosocial approach. This includes their involvement in community dialogues and awareness-raising sessions on health, sexual and reproductive rights (SRR), and the prevention of sexual and gender-based violence (SGBV). Survivors of SGBV will actively participate in the

comprehensive care pathway, accessing mental health services, legal support, and economic empowerment, as well as advocacy spaces to promote a life free from violence.

In addition, the participation of vulnerable refugees—especially young people outside the formal education system—will be encouraged through tailored kits and educational programs in public schools. Their involvement is also planned in participatory and accountability forums, as well as in monitoring and follow-up

processes. In this way, the project aims to ensure its relevance, ownership, and sustainability by gathering their opinions and suggestions to improve the quality of the intervention.

Activity Code	*Rights Holders (Activity)*	*Men*	*Women*	*Children Under 5*	*Total*
A1.1	Strengthening and upgrading the Kasarani Sub-County Public Health Centre	2,320	4,048	1,680	8,048
A1.2	Strengthening the capacity of public health facilities in Eastleigh Sub-County	1,750	3,200	1,050	6,000
A1.2	Strengthening the capacity of public health facilities in Kasarani Sub-County	1,750	3,200	1,050	6,000
A2.2	Community dialogues to promote participation and informed decision-making on health and sexual and gender-based violence (SGBV)	64	96	0	160
A2.3.1	Group sessions with vulnerable youth to facilitate comprehensive access to health services	192	288	0	480
A2.3.2	Distribution of WASH kits tailored to the specific and gender-related needs of vulnerable youth outside the formal education system in Eastleigh and Kasarani	500	0	0	500
A2.3.2	Distribution of nutrition kits tailored to the specific gender-related needs of vulnerable households and youth outside the formal education system in Eastleigh and Kasarani	58	100	42	200
A2.3.2	Distribution of nutrition kits tailored to the specific gender-related needs of vulnerable children under 5 in Eastleigh and Kasarani	0	0	250	250
A2.3.2	Distribution of dignity kits for vulnerable girls outside the formal education system in Eastleigh and Kasarani	0	1,500	0	1,500
A2.3.2	Distribution of dignity kits for vulnerable boys outside the formal education system in Eastleigh and Kasarani	600	0	0	600
A2.4.2	Distribution of hygiene and dignity kits tailored to the specific needs of female students in public schools in Eastleigh and Kasarani	0	1,500	0	1,500
A2.4.2	Distribution of hygiene and dignity kits tailored to the specific needs of boys	1,000	0	0	1,000
A3.1	Psychosocial support for vulnerable refugees and survivors of sexual and gender-based violence	250	0	0	250
A3.2.1	Provision of legal accompaniment services for survivors of sexual and gender-based violence	40	0	0	40
A3.2.2	Delivery of mobile legal clinics	35	85	0	120
A3.3	Development of an economic empowerment programme for refugee women survivors of sexual and gender-based violence	0	50	0	50
A4.1.2	Establishment of monitoring, consultation and reflection committees with rights holders	3	3	0	6
A4.1.2	Establishment of monitoring, consultation and reflection committees with rights holders	23	22	0	45

A4.2.2	Self-care workshops to strengthen HESED staff coping capacities and stress management skills	8	12	0	20
A4.3.2	Awareness-raising forum on FGM and other forms of sexual and gender-based violence among the refugee population	25	25	0	50
TOTAL		8,328	14,419	4,072	26,819

BONDHOLDERS

The project will strengthen the capacities of duty-bearers (health care workers, community health promoters, teachers, and local authorities) using a biopsychosocial and gender-sensitive approach to ensure access to comprehensive, high-quality health services (SRH, MCH, MH) and eradicate sexual and gender-based violence (SGBV) in Eastleigh and Kasarani. They will be trained in identifying, caring for, and referring survivors of VAWG, including FGM, with a special focus on mental health and self-care.

Their participation is crucial for shared responsibility and peacebuilding. Their involvement will be promoted in forums for redress, accountability, and guarantees against the recurrence of VAWG, in collaboration with survivors participating in the comprehensive care pathway. Local authorities will be represented on the project's Coordination and Monitoring Committee, promoting participation and accountability (PyRdC) among all stakeholders. Additionally, efforts will be made to encourage the application of the skills acquired in psychosocial care and the exercise of the rights of urban refugees.

	Men	**Women**	**Total**
Establishment of monitoring, consultation, and reflection committees with the population holding DD, RR, and OO (A4.1.2)	23	22	45
Training for Public Officials on the VSyVbG and the Rights and Protection of Refugees (A4.2.3)	8	12	20
Advocacy Forum on the Situation of FGM and Other Forms of GBV (A4.3.2)	5	5	10
TOTAL	36	39	**75**

RESPONSIBILITY HOLDERS

The selected key stakeholders (healthcare workers, community health promoters, and gender advocates) are community leaders with legitimacy and influence within the refugee communities of Eastleigh and Kasarani. Their shared cultural background with the target population ensures the relevance, acceptability, and ownership of the project's activities. These key actors will facilitate access to health services, identify and refer cases of sexual and gender-based violence (SGBV), and lead awareness campaigns on available services, sexual and reproductive health (SRH), and mental health.

The capacities of health care staff at public health centers, community health promoters (CHPs), and gender advocates will be strengthened by training them in comprehensive responses to SGBV (including FGM), SRH, MCH, nutrition, and mental health. Healthcare staff will also receive training in self-care and stress management. This training will be applied to the comprehensive care of the refugee population and health promotion, especially among young people. Key stakeholders will also actively participate in participation and accountability mechanisms (PyRdC) and project monitoring, contributing to the project's sustainability.

RESPONSIBILITY HOLDERS	Men	Women	Total
Training for healthcare personnel on protocols for the management, storage, and prescribing of medications, and the management of health data (A1.2.2)	12	18	30
Training for healthcare personnel on protocols for prevention, response, referral, and mitigation of the risk of sexual and gender-based violence (A1.3.1)	12	18	30
Self-Care Workshops for Healthcare Staff at Public Health Centers (A1.3.2)	12	18	30
Training for CHPs to strengthen their capacity to provide a comprehensive response to the challenges faced by refugees and the most vulnerable populations in the areas of violence against women and girls, sexual and reproductive health, maternal and child health, nutrition, and mental health (A2.1.1)	8	12	20
Self-Care Workshops for CHP (A2.1.2)	16	24	40
Teacher Training on the Biopsychosocial Approach to Health and Sexual and Reproductive Health in the Classroom (A2.4.1)	5	7	12
Establishment of monitoring, consultation, and reflection committees with the population holding DD, RR, and OO (A4.1.2)	3	4	7
Training on mental health and protection for the local partner organization, with a focus on psychosocial care for the refugee population (A4.2.1)	8	12	20
Advocacy Forum on the Situation of FGM and Other Forms of GBV Among the Refugee Population (A4.3.2)	20	20	40
TOTAL			

INDIRECT TARGET GROUP

	Men	Women	Children under 5 years of age	Total
Kasarani	263.539	268.003	80.256	611.798
Kamukunji	136.037	138.341	39.915	314.293
TOTAL	399.576	406.344	120.171	**926.091**

The indirect target group consists of 926,021 people (406,344 women, 399,576 men, and 120,171 children under 5). These individuals are considered potential users of primary health care services, which will have been improved in terms of quality, responsiveness, and the number of trained staff. Similarly, they are considered potential recipients of messages related to health promotion and a life free from violence.

3. Targets, outcomes and indicators formulated.

The overall objective of the contract is to provide the project "F*or a Safe Life: Health and Comprehensive Protection in Nariobi's Informal Settlements.* with an baseline (LdB) that improves its monitoring and facilitates the in-process assessment of the achievements in its specific thematic areas, according to the evaluation criteria defined in its formulation.

Consequently, the Baseline study- (Linera de base-LdB) report should focus on:

a) Show evidence that characterises the target population at the start of the intervention.
b) Analyse the dynamics of the context and, in particular, those external factors that would affect the achievement of project results for subsequent monitoring.
c) Redefine the standards associated with each of the indicators proposed to be achieved by the intervention.
d) Determine the baseline situation of the project's outcome and impact indicators, by establishing their first value using social research techniques.
e) Organise a database according to information needs.
f) Design the instrument for measuring and monitoring the evolution of the Baseline indicators.
g) To constitute an input for a possible reformulation of the project according to the data collected.

To see the objectives, results and indicators of the formulated project see logframe attached.

4. Methodological approach.

The process of designing the LdB will include the coordination of actions in consultation with the different direct and indirect project stakeholders in order to identify the logic of the work on the ground. In this sense, it is proposed to consider the following methodological steps:

- ***Identification and consultation***: with project staff (HESED and FARMAMUNDI) and local partners in order to identify the application in practice of the implementation mechanisms and to obtain suggestions relevant to the design of the Baseline methodology.

- ***Documentary review***: review of reference documentation, including the planning matrix, operational plans, databases, monitoring system and other reference documents of the intervention logic and methodology.

- ***Methodological design***: Establish the baseline sample, methodology and tools based on interviews with key contacts, aligning project results, targets and indicators. The tools should facilitate the collection of gender-disaggregated data for analysis and presentation in the final report.

- ***Data collection:*** application of the instruments designed, incorporating the suggestions received in the first stages of the development of the process, including the validation of the method for constructing the indicators, taking into account the local context, the quality and formality of the data sources, as well as the capacity to replicate the methodology for obtaining the information.

- ***Data analysis***: presenting the results in the form of indicators, with their respective analysis of the usefulness for monitoring the implementation of project activities, as well as the analysis of the quality of the baseline, and the overall usefulness for contextualising the problem of access to and rational use of quality medicines in Kenyan society.

- ***Report preparation***: presenting the information in a user-friendly way in order to obtain detailed information to be able to replicate the elaboration of the indicators for monitoring during implementation, but also for use when comparing with a final external evaluation.

5. Deliverables

5.1 Documentation to be submitted in order to participate in the procurement process

In order to be considered for the elaboration of the LdB we propose, a methodological proposal must be submitted in addition to the curriculum of the whole team that opts for the contract. This is the basic planning instrument for the preparation of the LdB, and its main purpose is to establish the technical, methodological, instrumental, temporal and human and material resources elements with which the fieldwork and the presentation of the report will be carried out.

Thus, the person applying for the recruitment process shall submit the following documents:

1. **Technical and methodological proposal,** with the following minimum content:
   → Objectives of the baseline.
   → Scope (temporal, geographical, etc.)
   → Typology and quantification of the estimated beneficiary population.
   → Formulated objectives, results and indicators.
   → Methodology to be used.

The design and implementation of the Baseline should take into account the following methodological considerations:

- Define the scope in order to elaborate a consistent matrix between the logical framework and the Project Baseline, which allows corroborating the data obtained in the diagnosis.
- Identify the different sources of information, both primary and secondary, in order to develop instruments and participatory methods for its collection, as well as to triangulate the information in order to have a greater rigor in the collection of information.
- Provide updated information about the project intervention territory, its main actors and beneficiary population.
- Tools and actors involved depending on the tool.

Techniques for data collection should be considered:

- Documentary analysis.
- Direct observation: systematic and planned observation of the reality in which the action is planned to be carried out.
- In-depth interviews
- Semi-structured and open-ended interview.
- Consultation process: focus groups and key informants.
- Work plan.
- Budget.
- Team profile.

2. **Curriculum Vitae** of the persons who will carry out the Baseline (LdB) survey, with information that allows verifying compliance with the experience and training requirements set out in this Guide.

5.2 Deliverables of the contracted team for the development of the LDB

The Baseline Survey (LdB) report shall contain at least the following sections:

- → Cover page (including project title, NGDO, report completion date, funders).
- → Executive summary.
- → Brief presentation of the work team. If internal to the entity, position held and profile.
- → Description and objectives of the consultancy service.
- → Scope of the consultancy
- → Work plan.
- → Activities carried out and techniques used in the data collection stage.
- → Information processing and analysis.
- → Conditions to the work carried out.
- → Baseline results.
- → Review of the project planning matrix (objectives and results) and its evaluability (indicators).
- → The database generated for the development of the study.
- → Conclusions.
- → Recommendations.
- → Annexes.

The presentation of the final report will be carried out following the guidelines established in the "*Guia de gestion de justificación de proyectos*" 2025 shared with the signature of the contract.

6. Proposed work plan

Activity	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
Identification and consultation	x					
Documentary review	x					
Methodological design	x					
Data collection		x	x			
Data analysis				x		
Report preparation					x	x

7. Budget and payments

a. Payment

The consulting team, natural or legal person, will receive a payment appropriate to the offer submitted. The total amount to be paid in KESH and it will be paid in KESH by HESED-Africa. Any taxes that may affect the contracting will be the responsibility of the consultant person or team, as well as any subcontracting expenses, materials and supplies, travel, accommodation and per diem necessary for the preparation of the final report foreseen; including all expenses for the deliverables and the payment transfer commissions in the country.

b. Terms of payment

- 40% Upon signature of the contract, after the delivery of the final methodological design.
- 35% Upon submission of the final draft report for review

- 25%on completion of the contracted service, after the delivery of the final versions of the documents set out in point 5.2 of this document.

  Payment fee will be subjected to 5%vwithholding tax

8. Selection criteria

The person or persons who make up the technical team of consultants must meet a series of requirements:

- Demonstrable experience in the design and elaboration of baseline, mid-term and/or impact studies of development projects (at least 5 studies elaborated, of which 3 must be related to the country of intervention and/or in the sector of action).

- One member of the consultancy team or the consultant must have specific training in methodologies and application of social research techniques.

- As far as possible, the inclusion of professionals from the country where the intervention takes place and gender balance will be promoted.

FM-HESED undertake to review them and adjust to the offer that best suits them.

9. Deadline and form of submission of proposals

The deadline for the submission of applications by interested persons or evaluation entities is **July 20th.**

Technical and Financial Proposals should be sent to the e-mail addresses hesedafrica@gmail.org and ahe3@farmamundi.org indicating in the subject line "***Technical baseline bid-..."*** followed by the name of the consultant or professional responsible for the bid.

The **deadline for the award will end on July 27th, 2026**, after which there will be interviews for the shortlisted consultants. Only those who make it to the shortlist will be contacted.

The total duration of the baseline process, excluding the phase of dissemination of its results, shall not exceed **2 months from the date of signature of the corresponding contract**.

However, the provision of the service will not end until the Baseline Report is accepted by the . According to it, the LdB report may be refused for the following reasons:

- Low technical quality.
- Non-compliance with the commitments made in the ToR and/or in the methodological proposal.
- The criteria established in the present TORs and in the aforementioned Guide for the Monitoring and Evaluation of Projects Financed by the donor in the Field of Development Cooperation have not been followed.

Once the final LdB report has been approved, its use will be monitored by the entity in the presentation of the six-monthly monitoring reports and in the elaboration of the ToR and/or the methodological proposal for the final evaluation of the project.