# Terms of reference

## 1. Background

Denmark has supported the health sector in Kenya for over 40 years with a broad range of interventions and various levels of intensity. Since the preparation of the first phase of Health Sector Programme Support in 2004, the support has comprised a closer involvement with government at different levels, lately with an important link to the devolution process in Kenya[1]. The Danish health sector support has comprised the following five overall phases[2]:

1) Health Sector Programme Support (HSPS) 2004-2006
2) Health Sector Programme Support to Kenya, HSPS Phase II (2007-2011)
3) Kenya Health Sector Programme Support. HSPS Phase III (2012-2016)
4) Thematic Programme for Health, (including Support to Universal Health Care (UHC) in the devolved system and Support for SRHR) as part of the 2016-2020 Denmark-Kenya Country programme
5) Support to Democratic Governance, Human Rights and Equitable Access to Services (including the Primary Health Care Support Programme 2021-2025 and the ACCELERATE programme) as part of the Strategic Framework Denmark-Kenya Partnership 2021-2025.

Over the years, more than DKK 1 billion has been allocated for the support, including support for a devolved health sector.

The evaluation will assess what has been achieved from the last approximately 20 years of Danish support to the health sector in Kenya. Thereby, it will be an opportunity to dive into strengths and weaknesses of one of the few remaining bilateral social sector programmes in the Danish development cooperation portfolio and assess implications of the approach to partnership and dialogue.

The five programme phases contain both commonalities and differences over time. For instance, on one hand there is found to be a continued focus on support to primary health care as well as issues related to systems strengthening and governance issues, not least in relation to the devolution process. On the other hand, modalities, scope of support and specific objectives have seen changes. Similarly, important developments have taken place in the Kenyan context, which must be considered. This includes key issues such as the growth in GDP, moving Kenya into lower middle-income status in 2014, the adoption of the new Constitution in

[1] In line with usage in Kenya, the term 'devolution' is used throughout. This does not imply a more technical distinction between devolution and decentralization.

[2] For more details about the individual programmes and engagements, please consults the list of Key Background Documents at the end of the Terms of Reference.

2010 and the process of devolution as well as more health-specific changes such as the passing of the Universal Health Care Bill in 2023 and a changing donor landscape.

The evaluation will comprise an assessment of the overall developments in the Danish health sector support to Kenya as well as specific assessments of the individual health sector programmes/phases in light of the context and the changes herein, not least the above-mentioned link to the devolution process.

A key element in the evaluation of the overall developments in the support 2004-2024 will be an assessment of the approach and modalities, including the relevance of the adjustments made, for instance in objectives, expected outcomes, ways of working and Kenyan and international partners. The overall assessment will also comprise the effects that the long-term Danish engagement since 2004 in the health sector in Kenya has contributed to, with sustainability as an important consideration. Finally, there will be an overall assessment of the relevance of sector programme support as a modality, with focus on unpacking its strengths and weaknesses.

For the individual support programmes the assessments will focus on the specific approaches and achieved results, where results will comprise health effects as well as effects on governance and capacity. These various effects will have to be considered in view of the applied modalities and partners.

## 2. Purpose and objectives

The overall purpose is to document and assess the contribution of the Danish support to the health sector in Kenya over the last 20 years, both with regards to results to which Denmark has contributed and the value added of the Danish approach and partnerships. Based on this, the evaluation should distil relevant lessons for future health sector support to Kenya as well as more broadly for working with partnerships and local ownership.

The overall objectives of the evaluation are:

- Map the development of the health sector in Kenya as well as the evolving Danish support hereto;
- Document and assess the Danish contribution to results and long-term changes in the health sector, health services and health outcomes in Kenya 2004-2023, including in the context of heath as a devolved service sector in Kenya; both at the level of the individual programme phases and looking across programme phases;

- Assess the extent to which the Danish approach to the support and partnership as well as the ability of Denmark as a donor to adapt to changing contexts and priorities have been of relevance to the health sector in Kenya in the period, and how it has influenced the performance of the support;
- Provide potential lessons learned based on the findings from the health sector support and partnership, with emphasis on lessons regarding the modality and approach, including partnerships and local ownership, and the implications hereof for Danish development cooperation in the health sector and broader.

## 3. Scope of work

### Evaluation period

The evaluation is expected to cover the Health Sector Programmes from 2004-2024/as far as reporting is available (with an understanding of the Danish support to health in Kenya prior to this, as background). To acquire the expected depth and solidity of analysis, the evaluation shall include both a holistic assessment of contribution to overall and long-term change as well as investigating each programme period with its distinct traits, engagements etc. This implies that each programme phase should be assessed in its own right, to be able to focus on specific results and achievements, changes in modalities and partners and the implications hereof. Further, analysis of contribution to change should also be looking across the programme phases, to be able to capture longer-term or higher-level results. While it will likely be too early to assess specific outcomes and impacts from the support from the most recent years, it will be important to assess the relevance and coherence for the more recent support, the early signs of contribution to change and the interplay between the Danish support and the current context including recent changes, to be able to provide forward-looking lessons and recommendations of relevance to a potential next phase of support to the health sector in Kenya.

### Geographical and administrative coverage

In line with the scope of the Danish support to the health sector, the evaluation will cover all districts in Kenya. A sample of districts/counties[3] will be selected for in-depth analysis. In the case selection, attention must be paid to the variation that the sample will represent, and to ensure that this allows for relevant contrasting and comparing (see more in the section on methodology below). Districts/counties that have received support over a large part of the evaluation period should be included in

[3] Districts/counties are used to both the current terminology (county) and the wording used in earlier programme phases (districts).

the sample. Further, the sample should aim to include specific districts/counties where Danish support has been targeted, such as underserved, hard-to-reach areas and selected coastal areas. Beyond "horizontal" geographical coverage, it will be important to also assess the vertical linkages between administrative and institutional levels and to ensure adequate analytical coverage ranging from local and health facility level to Council of Governors and the Ministry of Health.

## Thematic focus

All overall engagement areas of the Danish support, including the governance aspects, are to be covered. In light of the objectives of the support to the health sector, and the support to both service delivery, governance, capacity building and system strengthening, it is not expected to be possible to exclude specific result areas. It is however, expected that not everything will be covered in equal depth. Nevertheless, it is the ambition that the evaluation should shed light on contribution pathways and their interlinkages to understand the role of the Danish support in realising results and contributing to change.

As part of the inception phase, it will be important to prioritise and operationalise key contribution areas and pathways, to ensure that coverage will be relevant and sufficiently comprehensive. This shall cover both contribution to change in relation to health outcomes, access to services, capacity, systems etc., and in relation to contribution to the devolution process in Kenya with regards to the health sector. This implies that the evaluation will also need to consider support to governance and devolution when relevant to health, also when not it is not specifically a part of the health sector support. For example, Denmark provides support to the Kenya Accountable Devolution Programme III, as part of the current partnership, and this may include areas of work of relevance also to health.

When evaluating the development cooperation in the health sector and the Danish contribution to change, it is expected to not just focus on results, but also investigate what implications the approach, partnership and partnership dialogue (including with other development partners, the private sector and civil society), management and flow of funds (including flexibility of Danish funding and transaction costs), approach to capacity building (including the link to the devolution), long-term perspective and continuity versus change - have had for the cooperation and its performance. It will be important to not only address the immediate but – as far as possible – the relative strengths and weaknesses, and the likely trade-offs etc.

The areas of change, contribution pathways and core issues that the evaluation will have to address is expected to include (but not necessarily be limited to) the following:

- Service delivery, access to primary health incl. RMNCAH, as well as SRHR, GBV and gender;
- Medical supply, delivery chains, storage etc. (incl. Essential Medicines and Medical Supplies, EMMS);
- Overall health systems strengthening (such as HMIS, EMMS, M&E) and capacity building;

- Community-level work, outreach and related prevention efforts;
- Leadership and governance, especially in relation to the devolution process, including systems for financial management, as well accountability, public participation, advocacy etc.
- Collaboration and partnership with Ministry of Health, Council of Governors and National Treasury, at national level as well as County Governments and Health Facilities at decentral level; as well as collaboration and partnership with private sector actors and civil society;
- Approach management and flow of funds, including flexibility of Danish funding, handling of fungibility/counterpart funding, sustainability, transaction costs and other issues of relevance for funding and funding requirements;
- Collaboration with other DPs, donor coordination, harmonisation and division of labour etc.; as well as changes to the donor landscape and aid architecture, including increased presence of philanthropic funds in health.

## 4. Evaluation criteria and evaluation questions

The evaluation focuses on the issues mentioned above (development results; values/strengths/weaknesses in relation to the approaches/modalities; ways of working and identification of lessons learned). In relation to this, the evaluation will apply the OECD/DAC criteria: relevance, effectiveness, efficiency, coherence, impact and sustainability, to answer the evaluation questions.

Specific evaluation questions within the OECD/DAC criteria will include, but not be limited, to the following:

- **EQ1:** Map and document the development of the health sector in Kenya as well as the evolving Danish support hereto (descriptive background).

- **EQ2:** Assess the degree to which the Danish approach to the support and partnership in Kenya, including objectives, modalities and partners, and ability to adjust to changing contexts and priorities has been relevant for the needs and priorities in the Kenyan health sector and in light of the engagements of other donors (relevance and coherence).

- **EQ3:** For each of the individual health sector programme phases: Assess the achievement of results in the health sector, health services and health outcomes, including results in relation to systems, governance and capacity, also in the context of

the process of devolution, to which the Danish support has contributed. This should include an assessment of the relative importance of the Danish contribution (effectiveness and as far as possible efficiency).

- **EQ4:** Document and assess the Danish contribution to broader results and long-term changes in the health sector, health services and health outcomes in Kenya 2004-2023, achievements in relation to systems, governance and capacity when looking across programme phases. This should include assessments of potential unintended effects, sustainability issues and, as far as possible, impact (effectiveness, sustainability and impact).

- **EQ5:** Identify core elements in the Danish approach of importance to understanding the contribution to results. This should consider the approach to support and partnerships and the changes herein; including the choice of modalities, partner engagement and dialogue, ability to adapt, coherence, flexibility etc. Both positive and negative aspects should be considered (relevance and coherence as basis for effectiveness).

- **EQ6:** Provide recommendations and lessons learned based on the provided health sector support to Kenya, with a view to future health sector support in Kenya and potentially elsewhere, with a particular view of the present situation.

- **EQ7:** Provide lessons learned on the relevance of long-term programme sector support as a support modality.

During the inception phase, the evaluation questions are to be further elaborated, including a full evaluation matrix, with due consideration to the thematic issued mentioned in the section on scope.

## 5. Approach and methodology

### Overall approach

At the overall level, it is expected that the evaluation will apply a mixed-methods approach, drawing on theory-based contribution analysis (or similar) and working with a nested Theory of Change (ToC). This is expected to be relevant as the Danish support

should not be seen in isolation, but rather in relation to the expected and actual interaction and linkages with Kenyan interventions and priorities support from other development partners etc. This will be important both for assessing the role or importance of Danish support in helping bring about positive change, and for understanding the way the approach and the evolvement hereof has influenced the functioning or performance of the support. When investigating results, it will be important to not only assess against targets and indicators in the result frameworks of the programmes, but to also analyse change processes and intermediate outcomes, as well as paying attention to potential unintended effects. Process tracing is expected to be an important method, as well as mixed-methods case studies, but the evaluation should also comprise quantitative analyses of health results based on existing data, at least for part of the period (if full period is not deemed feasible, then 2012-2020 should be considered).

Below, some of the expected methodological elements are outlined.

## Nested design

It is expected that the evaluation will apply a theory-based approach, where a sufficient level of detail and specificity is needed to facilitate the nuanced analysis of the Danish contribution to results called for. It is assumed that the evaluation design will include an overarching ToC, expressing a broad understanding of the health sector support. However, at this level it is expected to mainly function as an organising framework as it is unlikely that a sector perspective ToC for the Danish support can convey the level of detail and specificity that is likely to be needed.

Within the overarching framework, more specific ToCs for each programme and phase are expected to be elaborated, with attention to degree of continuation between phases (what stays more or less the same; what changes, in context, expectations, ways of working etc.)? Depending on the specific design, it may also be relevant to develop specific "sub ToCs" that allow for zooming in on areas of importance for the Danish contribution to effects and to identify areas with enough continuity to assess longer term contribution (for instance in relation to governance or specific health results areas within RMNCAH or SRHR). This will entail to identify and operationalise relevant causal chains to follow throughout as well as to identify the different engagement and results areas that must be analysed in order to establish a picture of "credible contribution". Credible contribution further assumes an adequate understanding of relative importance of Danish support and other influencing factors.

## Differentiated methodological approach

In light of the timeframe and the broadness of support, the evaluation is expected to ensure adequate methodological differentiation adapted to the individual programme phases and thematic areas (depending on objectives, approach, changes in partners etc). The inception report shall contain a suggested detailed methodological approach for all EQs.

It is envisaged that the evaluation of the first two health sector programmes will mainly be based on document reviews and key informant interviews, while the last three programmes will be evaluated in more depth applying a mixed-methods approach including case studies/district level studies, qualitative as well as quantitative analysis, process tracing etc.

## Establishing an overview and placing Danish support in the relevant context

To gain the needed understanding of both the context, policies and interventions on the Kenyan side of the partnership as well the evolvement of Danish support, a solid overview will need to be established as point of departure for the analysis. This is expected to include an overview of the Kenyan context and important changes over time, including but not necessarily limited to health policies and strategies, budgets, broader political economy, approach to cooperation partner-donor coordination, changes in constitution etc., as well as an overview of the Danish support and relevant changes in policies, strategies, budgets, modalities, partnerships with various actors (including CSOs/NGOs and the private sector), coordination etc. To be able to place the Danish support in the relevant context and understand the role and relative importance hereof, it will also be important to include information regarding the support from other donors, both in relation to amounts, focus areas and approaches (for instance in relation to donor coordination and division of labour).

## Case studies and case selection

The evaluation is expected to include case studies to be able to gain depth of analysis in selected areas and as a tool for comparison, as relevant. Cases should be selected to allow for exploration of whether and how Danish support has contributed to different types of results at different levels. This implies that some case studies may be geographically defined (certain districts/counties and sub-counties), while some may be thematic or vertical, and others may be organisational (it should be noted that these types of cases are not necessarily mutually exclusive). The case studies are expected to emphasise the support and results for the last 10 years, but to allow for a long-term analysis and understanding of the linkages and contributions between support periods, it will be a priority to include thematic areas and district/county cases, where Danish support has been present

earlier as well. The geographical and socio-economic issues indicated above should be considered when deciding on which geographical areas of focus on. Further, the case selection should be seen in conjuncture with the nested, theory-based design outlined below, so that it is clear which areas of continuous work (across phases of support), phase-specific results, horizontal and vertical linkages and contribution pathways, the case studies cover.

The tender should include a preliminary outline of the selection process, as well as any key criteria suggested as point of departure. The inception report shall present a full analytical overview of suggested case criteria, case selection and the coverage this implies, and reflect this both in relation to the nested ToR and the evaluation matrix.

It is expected that the evaluation will include an inception visit and a minimum four week visit during the main phase of the evaluation. The team leader shall participate full time in both the inception visit and the main mission to Kenya.

## Data collection methods

In line with the call for a differentiated and mixed methodological approach, the evaluation is expected to draw on a wide range of data and data collections methods. This is expected to include:

- Literature study regarding experiences with sector programme support, both in health and more broadly including capacity building and devolution/decentralisation, and both from Kenya and other countries as relevant;
- Extensive document review, for context and development in Kenya, the Danish support as well as core information regarding support from other donors, existing evaluations, reviews, research and "grey literature" of relevance to the specific issue of the health sector in Kenya, as well as for the issue of devolution/decentralisation and related reforms;
- Drawing on existing quantitative data sets; please note that efforts to gain access to data/data bases in Kenya may be required by the team (with support from MFA of Denmark);
- Stakeholder and key informant interviews, including:
    - Stakeholders and partners in Kenya at all levels; incl. Ministry of Health, National Treasury, Council of Governors, County Governments and local level actors, Health Facility staff (including both current and former, as far as relevant);
    - Ministry of Foreign affairs staff, Embassy of Denmark in Kenya (local and posted staff), Technical advisors (current and former);
    - Other Development partners, including like-minded bilateral donors, multilaterals and CSO partners, philanthropic funds active in health in Kenya etc.;
    - Beneficiaries;

- Independent researchers.

## 6. Outputs

The following outputs are envisaged:

- An Inception Report, including a suggested outline for the main report, a review of the evaluation questions (EQs) in an evaluation matrix, including the elaborated sub-questions needed to cover the scope, and a detailed outline of the evaluation methodology and work programme (not exceeding 20 pages plus annexes);
- A Synthesis Note presenting the findings of the literature study (emerging picture regarding experience with sector programme support), together with the Inception Report (not exceeding 10 pages plus annexes);
- Short field trip reports (maximum 5 pages for each field trip, inception and the main visit(s));
- A Preliminary Findings Paper (maximum 15 pages);
- A draft Evaluation Report including Executive Summary (not exceeding 40 pages plus annexes);
- A final Evaluation Report including Executive Summary (not exceeding 40 pages plus annexes).

The final approved Evaluation Report will also serve as the Completion Report, cf. Section 1.01 of the Agreement.

## 7. Timing and reporting

A tentative schedule for the evaluation is as follows:

| **Activity** | **Date/period** | **Responsible** |
|---|---|---|
| Contract signed | Fall 2024 | LEARNING and ET |
| Inception phase | November 2024 – February 2025 | ET |

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|---|---|---|
| Draft Inception Report and Synthesis Note for discussion with ERG | February 2025 | ET and ERG |
| Main evaluation phase, including case studies | March -May 2025 | ET |
| Preliminary Findings Paper for comments from ERG | June 2025 | ET and ERG |
| Workshop on emerging findings in Kenya | August/September 2025 | ET and LEARNING |
| Draft Evaluation Report, possible discussion with ERG | September 2025 | ET and ERG |
| Final Evaluation Report | October 2025 | ET |
| Launch of Evaluation Report with possible seminar in Denmark and/or Kenya | November/December 2025 | LEARNING |

## 8. Team composition

Evaluation Team (ET, the Consultant)

The ET must consist of a core team of four consultants:

- Team Leader, senior specialist on evaluation of health policy and health sector programme support;
- Specialist on evaluation of support for institutional development;

- Specialist on evaluation of primary health care support;
- Specialist on evaluation of public financial management.

In addition, the ET must include up to four national consultants covering the following areas of expertise:

- Specialist on health policy and the health sector in Kenya;
- Specialist on institutional development with the social sectors in Kenya;
- Specialist on primary health care in Kenya;
- Specialist on public financial management in Kenya.

## 9. Management

Evaluation management (LEARNING, the Client)

The evaluation will be managed by the Evaluation, Learning and Quality (LEARNING) Department in the Danish Ministry of Foreign Affairs (MFA). LEARNING will:

- Provide feedback to the ET;
- Comment on the draft Inception Report, field trip reports, Preliminary Findings Paper, and the draft Evaluation Report as well as approve the final Evaluation Report;
- Organize and participate in meetings of the ERG;
- Facilitate possible workshop(s) after the completion of the evaluation in Kenya and Copenhagen;

Evaluation Team (ET, the Consultant)

The ET will carry out the Assignment based on the Agreement and will:

- Prepare and carry out the evaluation according to Appendix 1 Scope of Services, the approved Inception Report, the OECD-DAC Evaluation Quality Standards[4] and the Danida Evaluation Guidelines[5];

[4] https://www.oecd-ilibrary.org/development/dac-quality-standards-for-development-evaluation_9789264083905-en

[5] https://um.dk/en/-/media/websites/umen/danida/results/evaluation-of-development-assistance/relevant-documents/evaluation-guidelines-2024.ashx

- Be responsible to the management for the findings, conclusions and recommendations of the evaluation;
- Ensure that quality assurance is carried out and documented throughout the evaluation process (as described in the tender);
- Report to LEARNING regularly about progress of the evaluation;
- Organise and coordinate meetings and studies, and other key events, including debriefing sessions and/or validation workshops.

The Team Leader is responsible for the organisation, quality assurance and reporting of the work of the team. The Team Leader will participate in meetings of the ERG and a final workshop in Copenhagen and in Kenya.

The ET shall coordinate and communicate (as relevant) with the Client's consultant on the joint evaluation of support to multi-donor trust funds to maximise value and avoid duplication of effort.

In addition to the ET, the Assignment shall be supported by a technical QA expert (see Section B) to ensure that the Team Leader receives timely and substantial QA input to draft evaluation outputs.

Evaluation Reference Group (ERG)

An ERG will be established and chaired by LEARNING. The mandate of the ERG is to provide advisory support and inputs to the evaluation, e.g. through comments to draft reports. The ERG will work with direct meetings, e-mail communication and/or videoconferencing.

The main tasks of the ERG are to:

- Comment on the draft Inception Report, draft Preliminary Findings Paper, short field trip reports and the draft Evaluation Report to ensure that the evaluation is based on factual knowledge about Danish management of development cooperation.

Other key stakeholders may be consulted at strategic points in time of the evaluation either through mail correspondence or through participation in stakeholder meetings/workshops.

## 10. Budget

The total budget for the Services is a maximum of DKK 3.5 million net of VAT. The budget shall include all fees and reimbursable expenses required for the provision of the Services and completion of the Assignment, including surveys, field trips, participation in ERGs and a final workshop in Copenhagen and in Kenya.

It is the responsibility of the Consultant to ensure that the products and outputs specified above, and all other tasks specified (by the Client or the Consultant) are performed within the framework of the tender and the Contract Price in Appendix 3.

A designated technical QA expert shall be assigned, with time set aside for technical/analytical QA, both in budget and in work plan.

The cost of internal quality assurance management must be included in the Consultant's overhead.

LEARNING will cover the expenditures incurred for preparing the final Evaluation Report for publication.

## 11. Security

If the Client and the Consultant agree that close protection is required during the Assignment, the Consultant shall use the security company provided by the Ministry of Foreign Affairs, regardless of whether staff from the Ministry of Foreign Affairs participates in the missions in an area of conflict or an area with high security risks. The Consultant hence accepts and agrees to use the security company used for close protection by the Ministry of Foreign Affairs and accepts and agrees that this security company will carry out protection to the full satisfaction of the Consultant, as indicated in Section 19.03 of the Agreement. The Client will determine a fixed budget for the expenses to be paid to the security company, but the Client will reimburse the actual expenses to be paid to the security company. The Consultant shall in a timely manner keep the Client informed in case the expense exceeds the budgeted amount.

## 12. Eligibility

The OECD-DAC evaluation principles of independence of the ET will be applied. In situations where conflict of interest occurs, candidates may be excluded from participation, if their participation may question the independence and impartiality of the evaluation. In other words, any firm or individual consultant whose independence and impartiality may be questioned will be excluded from participation in the tender.

Tenderers are obliged to carefully consider issues of eligibility for individual consultants and inform the Client of any potential issues

relating to a possible conflict of interest.[6]

## 13. Requirement for home office support

The Consultant's home office shall provide the following, to be covered by the Consultant's overhead:

- General home office administration and professional back-up;
- Quality assurance (QA) in accordance with the quality management and quality assurance system described in the tender.

LEARNING may request documentation for the QA undertaken in the process.

## 14. Key Background Documents

- Ministry of Foreign Affairs of Denmark, 2004. Programme Document for Danish Health Sector Programme Support to Kenya, Phase I (2004-2006).

- Ministry of Foreign Affairs of Denmark, 2006. Health Sector Programme Support to Kenya. Phase II (2007-2011). Programme Document.
- Ministry of Foreign Affairs of Denmark, 2011. Kenya Health Sector Programme Support. HSPS Phase III (2012-2016). Programme Document.

- Ministry of Foreign Affairs of Denmark, 2015. Kenya Country Programme 2016-2020.

- Ministry of Foreign Affairs of Denmark (2020). Strategic Framework Denmark-Kenya Partnership 2021-2025.

- Ministry of foreign affairs of Denmark (2020). Development Engagement Document. Primary Health Care (PHC) Support Program: Improved primary health care with focus on reproductive, maternal, new-born, child and adolescent health. 2021-2025.

- Ministry of Foreign Affairs of Denmark (2024). Denmark-Kenya Bilateral Programme Midterm Review 2021-2025.

[6] See: Danida Evaluation Guidelines, April 2024, Chapter 6 and Annex 1.