Terms of Reference for Third Party Monitoring (TPM) of Muslim Aid Project 2026-15 SOM HLC Somalia Emergency Health Access and Resilience Initiative (SE-HARI) across health facilities in Southern Somalia

Project Title	Somalia Emergency Health Access and Resilience Initiative (SE-HARI)		
From	MEAL Department		
Subject	Terms of Reference- Third Party Monitoring for Project 2026- 15 SOM HLC Somalia Emergency Health Access and Resilience Initiative (SE-HARI) in Southern Somalia.		
ToR	March 2026		
Type of Assignment	Assessment ☐	TPM ☒	Evaluation ☐
Programme	Health ☒	Education ☐	
Donor	MA UK		
Project duration	January 2026-December 2026		
Location	Regions: Banaadir, Lower Shabelle, Lower Juba, Bakool, and Hiiran 8 Facilities: Fanoole MCH, Alanley MCH, Hudur MCH, El Ali MCH, Jamame MCH, Wanlaweyne MCH, Burdo MCH, Afgooye MCH, and MDR- TB Hospital		
Sample size	8 MNCH facilities and 1 MDR-TB hospital and sampling should be from all the targeted facilities. (Health workers, patients, mothers attending ANC, PNC, TB patients, and representatives from the government should be involved in the Third-Party Monitoring). Sampling must include all 9 facilities, with a clearly defined and statistically justified sample size per facility and per respondent group (patients, ANC/PNC mothers, TB patients, CHWs, and health staff), ensuring representation by gender, age, and disability.		
Expected completion date (Final report)	--(Third Party Monitoring Report) by end of June 2026		

1. BACKGROUND

Muslim Aid Somalia (MAS) continues implementation of its integrated emergency health and nutrition program to address critical humanitarian health needs among vulnerable populations in Banadir, Bakool, Lower Shabelle, Hiran, and Lower Juba regions. These regions are consistently affected by recurrent drought, displacement, disease outbreaks, poverty, and fragile health

infrastructure, resulting in limited access to essential primary health care, particularly for womn, children under five, persons with disabilities (PWDs), and internally displaced populations.

The 2025 Third Party Monitoring identified key gaps in service delivery including long waiting times, weak referral follow-up systems, low utilisation of complaint and feedback mechanisms, accessibility barriers for persons with disabilities, and intermittent drug stock-outs in some of the facilities. This TPM will further extend its objective to specifically assess the extent to which these gaps have been addressed in the current phase.

The overall goal of the project is to deliver high-quality, accessible, and life-saving primary healthcare emergency services, with a strong focus on maternal, newborn, and child health (MNCH), disease prevention and outbreak response, tuberculosis (TB) control, community health education, and improved WASH practices.

The 2026 phase supports 9 static health facilities (8 MNCHs and 1 MDR-TB) providing quality primary health care services targeting women and children. The services in the health facilities include treatment of common morbidities, first aid and treatment of minor injuries, treatment of communicable diseases, maternal and new-born health (including comprehensive ANC, skilled delivery services, management of intrapartum complications for mothers and new-born, timely PNC), child health services (including the treatment of malaria, pneumonia, and diarrhea), health promotion and education, and immunization services. These facilities are further supported to monitor, track, and respond adequately to the trends in morbidities and potential outbreaks of communicable diseases such as measles and AWD caused by the protracted drought using a real- time health management information system (HMIS). The intervention further prioritizes disease prevention, early detection, and epidemic preparedness and response through strengthened disease surveillance, community-based reporting, vaccination campaigns, and rapid response to outbreaks such as measles, cholera, and malaria

- Service delivery: The primary goal of the project is to deliver high-quality primary healthcare emergency services, particularly for women and children, by preventing disease outbreaks, conducting disease surveillance, strengthening immunization coverage, and improving maternal and child health services. The project will enhance healthcare accessibility, improve WASH conditions, and address rising malnutrition rates.
- Community Outreach: There is also Community Health Awareness and Outreach which the Community Health Workers (CHWs) engage the communities to educate on disease prevention, maternal health, and WASH-related illnesses through Regular community health awareness sessions on reproductive health, communicable diseases, and non- communicable diseases (NCDs).

  WASH Support and Prevention of Water-Borne Diseases: The project also aims to reduce cholera and acute watery diarrhoea by distributing WHO-approved water purification tablets to households with children under five and other vulnerable households, alongside practical demonstrations on safe water use and hygiene. Health facilities will be equipped with drinking water storage tanks to ensure safe water access for patients and caregivers.
- TB and MDR-TB Case Detection and Management: The Project continues supporting one MDR-TB facility in Banadir, providing diagnosis, treatment, follow-up, and psychosocial support in line with MoH and WHO TB protocols. The project will strengthen contact

tracing, stigma reduction, adherence support, and community awareness, while coordinating closely with the National TB Programme and WHO to improve treatment outcomes and reduce transmission.

- Infrastructure Support: Rehabilitation and Infrastructure Support through rehabilitation of all the eight health facilities with minor renovations including construction and repair of ramps, wider doorways, improved waiting areas, and privacy partitions, to ensure inclusive access for PWDs and vulnerable groups to improve service delivery to the communities.
- Capacity Building (Training): The Project further aims to enhance the knowledge and skills of health workers and Community Health Workers (CHW) in the facilities on disease prevention and control and referral to the health facilities. The training will strengthen complaints and feedback mechanisms (CFM) through staff and CHW training on safeguarding, confidentiality, and accountability; designated facility focal points; suggestion boxes; and promotion of a toll-free hotline.

MA supports the health facilities with equipment, pharmaceuticals, medical supplies, staff, and infrastructure to be able to provide preventive, diagnostic, treatment, and referral services to ensure a comprehensive package is available to all patients. In addition, MA continues to ensure global standards for infection prevention and control procedures at all service delivery sites. Data generated in health facilities are collected in MOH-approved HMIS forms, transmitted through the district, regional to the national level where MA supports the analysis and use for decision-making. All health services are provided free of charge with no discrimination by gender, age, sex, status, or ethnicity.

MA recognizes the need to sustain and further consolidate the humanitarian health assistance for IDPs and underserved rural populations and supports the Maternal Newborn and Child Health (MNCH) facilities and Multi-Drug-Resistant Tuberculosis (MDR-TB) hospital through the provision of incentive salary payments of health workers and providing running costs for the MNCH facilities and MDR-TB hospital.

The targeted facilities are listed below: -

#	Facility Name	Region	Services Provided
1.	MDR-TB Hospital	Banadir - Mogadishu	MDR-TB treatment
2.	Kismayo -Fanole	Lower Juba	MNCH
3.	Kismayo - Alanley	Lower Juba	MNCH
4.	Jamame	Lower Juba	MNCH
5.	Afgoye	Lower Shebelle	MNCH
6.	Wanlaweyn	Lower Shebelle	MNCH
7.	El- Ali	Hiran	MNCH
8.	Hudur	Bakool	MNCH
9.	Burdo	Banadir -Mogadishu	MNCH

2. PURPOSE

The Third-Party Monitoring aims to provide an independent assessment of the quality, coverage, and effectiveness of the ongoing project activities across 9 health facilities supported by Muslim Aid Somalia. It will focus on assessing service delivery, infrastructure improvements, outreach activities, and beneficiary experiences, using key indicators and means of verification from the project logframe, with particular focus on high-risk service delivery areas, referral systems, accountability mechanisms, and inclusion.
Findings from the TPM will help Muslim Aid validate implementation progress, strengthen accountability, and develop practical recommendations to further improve service delivery.

3. SPECIFIC OBJECTIVES

The Third-Party Monitoring (TPM) objectives include the following:

I. Independently verify the delivery and quality of health services across the 8 MNCH facilities and 1 MDR-TB hospital by creating a table that indicates the status of all the activities and services.
   - Evaluate the quality, availability, and accessibility of ANC, PNC, and TB services from the perspective of beneficiaries.
   - Monitor delivery, quality and timeliness of maternal and child health service in the health facilities including ANC, PNC, skilled delivery, and immunization.
   - Identify gaps, trends and variations between facilities.

II. Verify the functionality and effectiveness of the referral system, by using a triangulation methodology that includes facility records, referral registers, and beneficiary follow-up interviews, including:
   - Issuance and use of referral slips
   - Referral tracking mechanisms at facility and CHW level
   - Percentage of referred patients who complete treatment
   - Follow-up processes conducted by CHWs
   - Barriers to referral completion, including transport, cost, and access constraint

III. Verification of the staff seconded to the project and effective utilization of supplies provided to health facilities by identifying gaps or deviations in service provision across health facilities.
   - On site verification on the end use of resources (medical supplies, pharmaceuticals, facility running costs, general facility expenses)
   - Assess whether staffing numbers and competencies are aligned with service delivery needs.

IV. Verify availability and management of essential drugs and vaccines, including identification of stock-outs, stock management practices, and supply chain challenges affecting service delivery.

V. Assess the coordination with other health actors and complementarity with other health programme.

VI. Evaluate the quality of health services from the beneficiary perspective, including satisfaction, perceived quality of care and key barriers/enablers to access
   - Collect qualitative feedback from mothers and TB patients on their experience,

satisfaction, and barriers to accessing services.

- Collect qualitative and quantitative data from beneficiaries on the quality i.e. (effectiveness, safety, timeliness, efficiency, patient centered, accessibility and continuity of care) and satisfaction of service delivery in all the targeted facilities.

VII. Verify the progress on the project's indicators that are part of the Logframe. Include all indicators.

- Compare actual service delivery with programme targets (e.g., ANC visits, PNC check-ups, TB treatment completion rates) and verify reported data against primary source documents (HMIS registers, facility records, and patient records).
- Identify gaps, trends and variations between the health facilities. and variations between facilities.

VIII. Measure patient waiting time and assess the effectiveness of queue management systems in reducing waiting time, including average consultation waiting time and patient flow processes at facility level.

IX. Verify the status and quality of rehabilitation works at supported health facilities.

- Number/percentage of health facilities rehabilitated as per project standards
- Number of ramps constructed in the targeted health facilities
- Assess the quality of repairs and construction works of the ramps, wider doorways, improved waiting areas, and privacy partitions

X. Assess the functionality and effectiveness of community-based outreach and health promotion activities, including CHW engagement.

XI. Monitor and assess awareness, accessibility, utilization, effectiveness and use of feedback and CRM and determine:

- % of beneficiaries aware of CFM
- % of beneficiaries using CFM
- Timeliness and quality of response
- Beneficiary trust in the system
- Percentage of facility-level complaints and feedback documented and resolved
- Determine the appropriateness and functionality of the Focal persons appointed for CFM

XII. Identify key implementation successes, gaps, and areas for improvement, and provide actionable recommendations for programme improvement.

XIII. Verify the extent to which corrective actions from the 2025 Third Party Monitoring findings have been implemented and are effective. This should include, but not be limited to:

- Accessibility improvements for PWDs (e.g., presence, quality, and usability of ramps, widened doorways, and priority access mechanisms)
- Reduction in patient waiting times and effectiveness of queue management systems (including measurement of actual waiting time and patient flow processes)
- Availability and presence of female health staff, particularly in MNCH services
- Functionality of referral systems, including:
    - Issuance of referral slips
    - Referral tracking mechanisms
    - % of referred patients completing treatment
    - Follow-up by CHWs
- Availability and appropriateness of IEC materials (including relevance, visibility,

and beneficiary understanding)
- Availability of vaccines and essential drugs, including verification of stock-outs and mitigation measures
- Functionality and utilization of Complaint and Feedback Mechanisms (CFM), including:
    - Awareness vs actual usage
    - Accessibility of channels
    - Timeliness of response
    - Beneficiary trust
- Coordination with Ministry of Health and other stakeholders, including joint supervision and reporting mechanisms

4. SCOPE OF WORK

The scope of Third-Party Monitoring (TPM) is to conduct independent monitoring that can observe, verify, and monitor the activities and services provided by the health programme during the project. It should focus on monitoring activities, and outputs. The TPM should cover the following areas:

- Activity verification
- Output monitoring
- Data Quality and Reporting Accuracy
- Beneficiary Feedback and Satisfaction
- Referral system verification
- Waiting time assessment and patient flow analysis
- Drug and vaccine availability verification
- Inclusion and accessibility verification (PWDs, gender, vulnerable groups)
- Complaint and Feedback Mechanism (CFM) functionality assessment
- Recommendations and Real-Time Learning

5. PROPOSED METHODOLOGY

We encourage the use of a triangulation methodology for the TPM that can verify and validate data by cross-checking it through multiple sources, methods, or perspectives. By document review, direct observation with checklist, beneficiaries' interviews, implementing partner's reports, community feedback mechanism. This helps ensure that findings are credible, accurate, and not based on a single, potentially biased, input.

A fundamental component of the contractor's approach will be a desk review of all pertinent project materials, including the project proposal, budget, the Monitoring, Evaluation, Accountability, and Learning (MEAL) framework, previous TPM reports, work plans, sub-award agreements with implementing partners, and Memorandums of Understanding (MOUs) with local authorities. This review will serve as the foundation for developing a targeted data collection strategy that aligns with the project's key performance indicators and reporting requirements. The contractor is expected to synthesize this information into an initial finding report, highlighting gaps, opportunities, and potential challenges in project implementation.

The data collection methodology must be grounded in robust scientific principles, ensuring the reliability and validity of the findings. The consultant is required to define a well-justified sampling strategy, specifying the minimum sample size based on statistical power calculations, response rate projections, and demographic considerations. The choice of sampling methods, whether probability-based (such as stratified or cluster sampling) or non-probability-based (such as purposive or quota sampling), must be clearly rationalized within the proposal. Sampling should ensure adequate representativeness across facility catchments, with attention to gender, age, and disability and follow the Muslim Aid minimum sample size criteria:

Muslim Aid Sample Size

Category	Requirement / Details
Margin of Error	5%
Confidence Level	90%
Response Distribution	50% male / 50% female, with a 10% variance
Locations	All 9 locations
Disability Inclusion	At least 10% of the total sample must include persons with disabilities
External Evaluations	Sample size based on total number of **direct beneficiaries reached**
Services and Products	Must be disaggregated in evaluation findings. Examples:
- Health	Nutrition, immunizations, MNCHS services, medicine distribution, medical referrals, WASH services, Training to health workers, etc.

The methodology must include direct observation of service delivery, patient flow tracking for waiting time measurement, verification of referral completion, and spot checks of drug and vaccine availability.

A combination of quantitative and qualitative data collection tools should be employed to capture both measurable outcomes and nuanced contextual insights. Quantitative methodologies should include structured surveys administered via mobile data collection platforms, ensuring efficiency and minimizing data entry errors. Household surveys should be designed with clear targeting criteria, covering key beneficiary groups. In parallel, qualitative approaches should encompass key informant interviews (KIIs) with community leaders and institutional stakeholders, focus group discussions (FGDs) to explore collective perspectives, and field observations to contextualize findings within the project environment.

The proposal should detail the number of FGDs, participant selection criteria, and facilitation techniques to enhance data credibility. Where appropriate, case studies may also be incorporated to provide deeper insights into the project's beneficiary experience on individual beneficiaries. A clear and actionable implementation plan must be outlined, detailing the sequencing of field activities, recruitment of enumerators, and quality control mechanisms.

The consultant will be responsible for selecting and training field teams, ensuring they are well-versed in survey administration, ethical research principles, and data quality assurance. The training program should encompass not only technical aspects, such as the correct use of digital data collection tools, but also ethical considerations, including informed consent procedures and safeguarding protocols. All data collection must adhere to safeguarding principles and ethical standards, particularly when engaging vulnerable groups such as women, children, and TB patients.

To enhance data integrity, the consultant must implement a comprehensive data management and analysis plan. This plan should detail the use of a secure, mobile-based data collection platform (e.g., Kobo Toolbox or ODK) to facilitate real-time data entry and minimize transcription errors.

Throughout the project, the contractor will be responsible for generating high-quality analytical reports, including periodic progress reports and a final comprehensive report. The final report should present a synthesis of key findings, integrating both quantitative trends and qualitative insights. It should offer practical, evidence-based recommendations to inform decision-making and future programming. The language of reporting should be clear and precise, ensuring that findings are accessible to both technical and non-technical audiences.

6. THIRD PARTY MONITORING TEAM

The TPM shall be conducted by an external consultant or evaluation team, selected through competitive proposal submission process. The following are minimum requirements for the team/consultant to be considered for conducting the assignment.

- At least a master's degree in project management, Statistics, or any other related fields
- Minimum of 5 years' relevant professional experience in conducting evaluations and TPM for Health programs.
- Strong experience in Project Monitoring and Evaluation in Somalia.
- Strong knowledge and /or demonstrated experience in designing and conducting similar Monitoring and Evaluation activities in insecure contexts.
- Exceptional knowledge of the context, especially in Somalia
- Strong Knowledge of Core Humanitarian Standards
- Strong analytical skills and ability to clearly synthesize and present findings.
- Excellent communication and report writing skills.

7. AWARD CRITERIA

The following award criteria will be used during the evaluation of the proposals: -

Description	Possible Score
Compliance with Consultancy requirement - Provision of required information C documents; responsiveness to TOR's	10
Consultant Experience - Qualifications and general experience of the firm/team - Proven specific experience in performing similar assignments especially in Somalia in the past three years with reputable organizations.	25 15
Adequacy of Work Plan C Methodology - Methodology and techniques to be applied well stipulated - Clear description of tasks in their Scope of Work	30 10
Bidder's Price Quotation (MK)	10

Total Score	**100**

8. TIMELINE FOR OUTPUT AND DELIVERABLES

The following specific deliverables are expected:

1. An Inception report produced no later than **June 18, 2026.**
2. Data sets (SPSS, Excel) – for all collected data (quantitative and qualitative). Qualitative data should be transcribed for future use by Muslim Aid Country programme. The data sets should be in an appropriate format (SPSS, Excel, and Word) and will be submitted together with the final TPM report on **June 18, 2026.**
3. A draft TPM report produced by no later than **July 25,2026.**
    a. Maximum 25 pages including images and testimonies.
    b. 2 cases studies- as annexes (1 Health facility, 1 MDR-TB Hospital)
4. A Final TPM report including country case studies and recommendations for Country Programme for future use of Programme design and/or alternative solutions to achieve the same objectives produced by **July 30, 2026**.
5. PowerPoint presentation, summarizing the key findings from the TPM submitted together with the final TPM report on **August 2026.**

9. MA Somalia Responsibilities

The MA Somalia will be responsible for the following:

- Ensure overall coordination and facilitation of the TPM assignment.
- Approve the inception report
- Provide technical input into the development of monitoring tools, verification methodologies, and data collection approach.
- Provide consultants with literature review materials/necessary documentation.
- Link consultants to relevant stakeholders
- Reviewing analysis of the data collected prior to the documentation of the final report
- Review draft report
- Approve and signoff final report draft

10. Ownership of Research Data/Findings

All data collected and report findings for this study shall remain the property of the MA Somalia.

11. ADMINISTRATIVE/LOGISTICAL SUPPORT

Budget: The lead evaluator should submit to Muslim Aid forecast of the budget including their consultancy fees. All other costs for the evaluations – transport, flights and in-country accommodation must be included in the consultancy fees. Currency used in the budget should be US Dollars.

12. SCHEDULE OF PAYMENT

The following payments will be made to the consultant using and agreed mode of payment.

- Before Commencement: 20%
- After First draft: 30%
- After Final Report is approved by Muslim Aid (including HQ): 50% Applications deadline and mode of submission

All Proposal (including proposal, CV, budget, evidence of experience) must be submitted via email Somaliarecruitment@muslimaid.com

All interested applicants are requested to submit their proposal no later than May 4th,2026