



Terms of reference for the recruitment of a consultant / consultants
for the final evaluation of the multi-country project financed by AFD

« Strengthening universal access to quality healthcare for patients with chronic diseases in Cambodia and Mozambique »

DSF - Cambodia & Mozambique Missions

Douleurs Sans Frontières (DSF) has received funding from the Agence Française de Développement (AFD) to implement a multi-year project aimed at **strengthening universal access to quality health care for patients living with chronic illnesses in Cambodia and Mozambique**. The project spans three years (November 2023 – October 2026). As it enters its final year, an external final evaluation is required by AFD. This evaluation is intended to support DSF and its local partners in analyzing the operational and organizational approaches implemented (intervention strategies, partnership collaborations) and to contribute to the ongoing development of interventions in both countries in line with the project's objectives.

Douleurs Sans Frontières (DSF) is a French NGO recognized as being of public interest and utility. It was founded by hospital-based physicians and specializes in physical and psychological pain management (PM) and end-of-life care. Bringing together volunteer health professionals (doctors, surgeons, nurses, psychiatrists, psychologists) and project management staff, DSF's mission is to support local partners in developing integrated and context-adapted systems of care. With nearly 30 years of experience in several countries and recognized as a key actor in pain management and palliative care, DSF has developed a holistic, patient-centered approach, emphasizing ethics and quality of care through compassionate reception, multidisciplinary collaboration, communication with patients and their families, and coordination among health services to ensure a more coherent and adapted continuum of care.

1. Description of the project to be evaluated

1.1 Context

In May 2019, the World Health Organization (WHO) released the new edition of the International Classification of Diseases (ICD-11), which officially recognizes chronic pain as a health condition in its own right, requiring access to quality treatments tailored to each clinical situation. This institutional recognition is part of a broader effort to ensure access to essential health care, particularly in low and middle income countries (LMICs), and contributes to the achievement of the Sustainable Development Goals (SDGs), especially SDG 3 (Good Health and Well-Being) and SDG 10 (Reduced Inequalities).

According to the Worldwide Hospice Palliative Care Alliance (WHPCA), an estimated 40 million people require palliative care (PC) each year, 78% of whom live in LMICs where these services are often limited or entirely unavailable. Globally, only 14% of those in need of PC currently receive it (WHO, 2016). These needs continue to grow due to population aging and the rise in chronic diseases such as HIV/AIDS, cancer, tuberculosis, and cardiovascular conditions. In this context, PM and PC remain insufficiently integrated into health systems, particularly in Africa and Southeast Asia.

Douleurs Sans Frontières (DSF), NGO specialized in the management of severe health-related suffering (SHS), especially that caused by HIV/AIDS and cancer, promotes a humanized approach to care and is committed to improving access to integrated, person-centered, and high-quality health services that are adapted to local contexts. DSF works in close collaboration with health structures and communities by strengthening the capacities of healthcare professionals, supporting adherence to care and treatment, and developing palliative care services, including home-based care.

In **Cambodia**, the country has undergone an epidemiological transition in recent years, marked by a significant increase in non-communicable diseases (NCDs), which have become a major public health challenge. In 2018, NCDs accounted for 64% of all deaths (nearly 60,000 people), with one in four deaths (23%) occurring prematurely before the age of 70 due to one of the four main NCDs. Despite this, the health system continues to face major limitations: fragile infrastructure, a shortage of trained staff, limited equipment, and restricted access to essential medicines. Given the country's limited resources, the Ministry of Health promotes cost-effective interventions focused on risk factor prevention, early diagnosis, and care delivery at the primary and community health levels.

In **Mozambique**, according to the 2021 INSIDA survey, approximately 2.1 million people are living with HIV (PLHIV), with a prevalence rate of 12.5% among adults aged 15–49 (15% among women and 9.5% among men). The provinces of Maputo (15.5%) and Sofala (13.2%) have the highest rates. In a context of structural poverty, many PLHIV face chronic food insecurity, exacerbated by the impacts of climate change on subsistence agriculture. Malnutrition is a major barrier to adherence to antiretroviral treatment (ART), leading to serious complications in the absence of continuous care. Furthermore, the advanced stages of HIV/AIDS, combined with rising rates of cancer and other opportunistic diseases, underscore the growing need for PM and PC in the country—needs that remain largely unmet, as such services are still in an embryonic stage.

In both countries, disease diagnosis often occurs late, therapeutic options are limited, access to analgesics and opioids is restricted, and technical competencies in PM and PC are underdeveloped. Moreover, the psychosocial dimension of care is frequently overlooked, despite being essential to the well-being of patients and their families. It is therefore urgent to strengthen training, research, and advocacy in PM and PC to promote their effective integration into national health policies.

1.2 *Project summary*

This project aims to build upon the actions initiated by DSF in Cambodia and Mozambique during Phase I, particularly in terms of the recognition and development of PM and PC within the national health systems (NHS) of both countries. It seeks to strengthen the capacities of institutional and civil society partners, improve access to care, and enhance the quality of patient management, with the ultimate goal of integrating these services into the NHS. The project provides health care tailored to the needs of patients

experiencing serious illness and/or those in the terminal phase, both in hospital settings and through home-based care.

The program is structured in three phases, each with specific objectives aimed at gradually ensuring the long-term integration of PM and PC into national health strategies. This will be achieved by empowering local stakeholders—both public health institutions and civil society organizations—and supporting the nationwide scale-up and ownership of these services.

1.3 Geographical areas of action

Cambodia: Provinces of Phnom Penh, Kandal, Kampong Cham, Prey Veng, Kampong Speu, Kampong Chhnang, Pursat, Battambang, Takeo, Tboung Khmum, Sihanoukville, Kampot.

Mozambique: Province - city of Maputo.

1.4 Main partners

In Cambodia:

Ministry of Health (MoH) and Hospitals: Calmette, Luang Me, National Pediatric Hospital, Kossamak, and Japan Heart. These institutions play a key role in supporting DSF in the development of a Cambodian model for palliative care.

CCCA – Cambodia Catholic Community Association

DSF has collaborated with CCCA for several years. CCCA provides home-based patient care with DSF's support. A mutual referral system between DSF and CCCA is in place, with both organizations coordinating patient follow-up based on geographic location and the family's financial and social situation. Capacity-building activities and experience-sharing are ongoing, with the goal of expanding the partnership to other provinces.

Louvain Coopération

Louvain Coopération au Développement is a Belgian university-based NGO affiliated with the Catholic University of Louvain. It connects DSF with local partners to help establish palliative care services at the community level. Louvain Coopération is also a co-funder of the project.

In Mozambique:

Network of Pain and Palliative Care Units (UDSP and CdD):

These multidisciplinary units include trained or experienced professionals in pain management and palliative care. Their mission is to relieve pain and improve the quality of life of patients living with chronic pain due to HIV/AIDS or other chronic illnesses. Services include medical and psychological consultations as well as continuous nursing support. In this second phase of the project, new services will be introduced, including Intra-Hospital Mobile Palliative Care Units (UMIH).

Local Health Authorities:

These include Provincial Health Services (SPS-DPS) and District Health and Social Affairs Services (SDSMAS). DSF works with them to optimize intervention strategies and enhance the impact on health service access for the greatest number of people in the targeted provinces. These authorities are responsible for the supervision, monitoring, and evaluation of the Integrated Home-Based Care system and community-level activities.

Health partners (local NGOs and associations):

DSF collaborates with several community-based organizations (CBOs) and civil society organizations (CSOs) for activity implementation. These partners are involved in various roles, including patient referrals, complementary care, and joint awareness-raising efforts. Some have benefited from training in good governance and/or health-related topics (palliative care, pain management, psychosocial support):

- VGV – Visão Global para a Vida: A CSO founded in 2004 focused on community health (home-based care, HIV/SRH awareness, etc.).
- ALCC – Associação de Luta Contra o Câncer: A CSO created in 2001, specializing in cancer awareness, advocacy, and patient support.
- CMA: A CSO working to improve the health of highly vulnerable children and adolescents, especially

1.5 Target groups/beneficiaries

The project aims to reach the following direct beneficiaries:

- **10,000 patients** living with chronic illnesses and/or at the end of life, and their family caregivers (including **5,900 receiving home-based care**);
- **7,540 individuals and families** sensitized to HIV/AIDS, tuberculosis, pain, and palliative care, and aware of their serological status;
- **5,450 women** reached with awareness activities on female cancers;
- **400 healthcare professionals** trained or sensitized;
- **600 students** sensitized and trained;
- **95 local partners/community agents** trained.

In total, the project will benefit approximately **20,000 direct beneficiaries**.

Indirect beneficiaries: Users of the national health systems (NHS) in both **Mozambique and Cambodia**.

1.6 OSpecific Objectives and Expected Results

Specific Objective 1:Strengthen integrated home-based care to improve the quality of life of patients.

- **Result 1.1:** The capacities of CSOs and community actors in delivering integrated health services are strengthened.
- **Result 1.2:** Patient and caregiver support is improved through the establishment of support groups, psychological and psychosocial assistance, and economic support.

Outcome indicators:

- I1: 14,300 integrated home care (IHC) visits conducted by community agents, local partners, and DSF.
- I2: 1,070 people participated in support groups, and 2,720 individuals received psychosocial support (PSS).

Key activities:

- Strengthening the organizational and technical capacities of partner CSOs/CBOs in delivering IHC to ensure proper care for patients and their families.
- Creation and reinforcement of accessible support groups for patients and their families.
- Provision of economic support and/or PSS to caregivers and patient groups.

Activity monitoring indicators:

- At least 5,900 patients and caregivers receive IHC services.
- 274 support group sessions implemented.
- 11,150 PSS consultations delivered.

Specific Objective 2: Support the development of a network of specialized pain management and palliative care services to improve access to quality health services for users of the health system.

- **Result 2.1:** The network of specialized pain/PC services is expanded and strengthened.
- **Result 2.2:** Continuity of care between health structures and patients' homes is ensured.

Outcome indicators:

- 14,600 consultations related to pain or PC delivered in specialized units.
- 150 healthcare professionals and 15 trainers/lecturers trained in PM, PC, and PSS.
- 675 technical support visits conducted by DSF.

Key activities:

- Strengthening the technical and organizational capacities of partner health facilities and establishing specialized PM and PC services in inpatient, outpatient, and teleconsultation formats.
- Establishment of a referral system to ensure the connection between health facilities and home-based care.

Activity monitoring indicators:

- 3,800 patients will have accessed specialized PM and PC services.
- 7,340 teleconsultations conducted.

Specific Objective 3: Promote access to PM and PC at the national level.

- **Result 3.1:** Target communities, students, and health professionals are sensitized to the importance of PM and PC.
- **Result 3.2:** Women in targeted areas have access to information on female cancers and are referred to appropriate care services.
- **Result 3.3:** Institutional partners recognize the importance of integrating PM and PC into the NHS for patients with chronic diseases, including access to opioids as a component of quality service provision.

Outcome indicators:

- 7,540 people sensitized.
- 910 healthcare professionals and students trained in PM/PC/PSS.
- 5,450 women reached with awareness on female cancers.
- 6 national or provincial health policies/strategies/action plans incorporate PM and/or PC.

- In Mozambique: 1 national palliative care policy updated, and 2 national health plans (PEES and PEN VI) revised.
- In Cambodia: 2 strategies and 1 action plan for PC validated.

Key activities:

- Communication and awareness-raising activities.
- Advocacy actions to promote IHC, PM, and PC.
- Design, capitalization, and cross-country sharing of technical documents.

Activity monitoring indicators:

- Awareness and communication campaigns on PC and cross-cutting issues implemented by DSF and/or local partners.
- 5,150 young women under 25 reached with messaging on HPV vaccination and cervical cancer screening.

2. Content of evaluation work

2.1 Drawing up an overall assessment of the project under evaluation

The objective of the final evaluation is to analyze the achievement of the program's objectives and to identify the mechanisms of effectiveness in relation to the contexts of deployment, using criteria of transferability and sustainability. It will also aim to identify areas for improvement and provide strategic guidance for a potential third phase of the project.

More specifically, the evaluation will:

- Review the activities implemented, the results achieved, and the progress made over the implementation period;
- Assess the relevance of the actions carried out in relation to the needs of the beneficiaries, the local context, and national health strategies, particularly with regard to HIV/AIDS and cancer;
- Identify challenges and constraints encountered during the planning, implementation, and monitoring phases, including the use and effectiveness of operational management tools;
- Analyze the strengths and weaknesses of the intervention strategies and explore necessary adjustments through concrete and actionable recommendations;
- Examine the sustainability strategy put in place and evaluate the extent to which the actions, results, and capacities developed are likely to be sustained by local actors and systems;
- Analyze how cross-cutting issues such as gender, human rights, and climate/environmental concerns have been integrated into the overall implementation of the project;
- Evaluate the processes, partnerships, work modalities, strategic approaches, and adaptations that took place during the project;
- Evaluate the relationship between Douleurs sans Frontières and its partners, especially NGOs and associations, and the capacity building of partners (institutional, operational) through the project
- Examine the changes to which the project has contributed, including both intended and unintended outcomes;
- Review the synergies created and the transversal approach supporting integrated health development between Cambodia and Mozambique;
- Identify internal and external constraints that may have impacted the expected results;

- Highlight key functions and innovations of the program and assess their potential for replication or transfer in other contexts.

At the end of the evaluation, the following elements are expected through the deliverables:

- A comprehensive assessment of the activities carried out and the results achieved;
- A valuation of the changes and impacts (planned and unplanned) brought about by the program;
- A set of lessons learned, including those that may be relevant for replication or transfer in the other country of intervention;
- Practical and strategic recommendations to guide the consolidation and sustainability of achievements, especially in preparation for a third phase of the project;
- An identification of good practices, innovations, resources, and skills developed and acquired by DSF and its partners throughout the program;
- An analysis of institutional learning and capacity building of local partners and civil society organizations (CSOs), including recommendations for the transfer of activities and responsibilities.

For information: cross-cutting / gender issues are described in the AFD methodological guide. This guide is available on their website or can be provided on request to the selected consultant(s).

3. Organization of the assessment

3.1 Evaluation procedure

Phase 1: Evaluation Framing and Exploratory Phase

The evaluation will begin with an exploratory phase including:

- A preparatory meeting for the evaluation at DSF headquarters.
- A documentary analysis, based on documents provided by DSF (project documents, reports provided to AFD, evaluation reports, workshop reports, etc.)

DSF will provide all the documentation necessary to understand the project in its various forms (project proposal, interim reports, list of stakeholders, etc.). This step should provide the consultant(s) with a precise and detailed knowledge of the project, its evolution and its context.

Interviews can be conducted with DSF headquarters with the General Coordinator, the Program Directors of each country, and if necessary remotely with the project coordinators, the remote country directors.

During this preparatory phase, the consultant(s) will produce a detailed framework note outlining the evaluation's objectives, methodology (particularly fieldwork activities), target stakeholders and engagement methods, as well as the data collection and analysis tools to be used.

This framework note will be submitted for validation by the Evaluation Steering Committee. If necessary, the consultant(s) will revise the note accordingly. The Steering Committee should be kept informed of any modifications throughout the process.

In parallel, the project teams will notify all relevant stakeholders—particularly the beneficiaries—that an evaluation will take place in their respective countries during a specified period.

The framework note will be reviewed and validated during a scoping meeting bringing together the Steering Committee and the consultant(s). This meeting, to be held either at DSF headquarters in Paris or remotely, will serve to finalize any remaining adjustments prior to the start of fieldwork.

Phase 2: Field mission for data collection:

This phase will be marked by a survey and individual and/or group interviews in the field in Cambodia and Mozambique. As the evaluation can be the occasion for a participatory review of the program, DSF would like to see it conducted in such a way as to include time for collective exchanges involving different categories of stakeholders. Indeed, group time can be conducive to joint learning and the identification of areas for improvement. This approach could also help strengthen the ownership of the actions by the stakeholders. DSF is open to any proposal for work along these lines.

However, the consultant(s) is/are encouraged to adopt a mixed quantitative and qualitative approach in order to produce a more detailed analysis of the issues raised by the implementation of the project. The main beneficiaries of the project to be taken into account (caregivers, patients, students) will have to be interviewed during the survey in order to produce an analysis capable of integrating the experiences, the benefits brought by the interventions as well as the possible unmet or unexpressed needs.

Among the people involved in the project, the following may be consulted

1. In Phnom Penh, Cambodia (not exhaustive):

- a. Project teams from DSF and partner organizations
- b. The relevant branches of the Department of Health, the Technical Working Palliative Care (TWG-PC) coordinated by the Department of Preventive Medicine
- c. The officials of the University Of Health Sciences Of Phnom Penh
- d. The managers and Heads of Departments of the partner hospitals of Phnom Penh and provinces
- e. Individuals in the program and their families

2. In Mozambique (not exhaustive):

- a. DSF project teams and partners.
- b. Health officials following the project (DPS, SPS, SDSMAS).
- c. The managers and heads of departments of the partner hospitals.
- d. Individuals served in the program and their families.

However, in order to limit travel, a sampling of the places to be visited is possible. This could be done, if necessary, with the partner organizations. For travel in the regions, the consultant(s) can be accompanied by the DSF project teams, who will remain available throughout the mission to facilitate the work. These trips could be made with the project's vehicles.

In each country of action, the country coordination team will be present to accompany and facilitate the work of the consultant(s). The contacts of the coordination team will be communicated to the consultant(s) so that they can also exchange information in order to best prepare their mission. The DSF coordination team will be responsible for informing, organizing meetings and/or seeking input from program partners at all stages of the evaluation process.

The role of the field teams is exclusively to facilitate the consultant(s) in the implementation of the evaluation, meetings, and logistical and administrative facilitation.

Before conducting the analysis, the consultant(s) is/are asked to present in detail the methodology that will be used (see Deliverables below).

3.2 Skills required to carry out the assessment

The evaluation can be led by one international . with field missions in both countries of intervention or, the evaluation team can consist of one international consultant (mission leader) and one consultant per country of intervention, preferably with experience of working together on development program evaluations.

It is also possible to propose individual consultants for each country of intervention (Cambodia and Mozambique). However, it is necessary for DSF and AFD to maintain the "multi-country" dimension throughout the final evaluation of this project. To this end, the two evaluators will be asked to exchange and synthesize the country evaluations in order to draw joint conclusions and recommendations on the issues to be addressed in the "multi-country" strategy.

The expected skills that will be valued during the selection process are:

- Demonstrated experience in the health sector, including public health systems strengthening, community health approaches, and non-communicable disease and chronic disease control strategies (including HIV/AIDS).
- Significant experience in project and program evaluation.
- Experience in facilitating group workshops.
- Ideally, the consultant (or one of the consultants) should have a good knowledge of Cambodia or at least of the Southeast Asian region and Mozambique (or the other consultant, if applicable).
- Fluency in English for the consultant(s). French and ideally knowledge of Khmer and /or Portuguese would be greatly appreciated.
- A sensitivity to gender issues, particularly in the area of health, will be valued.

3.3 Evaluation time

This schedule may be adjusted during the course of the study in consultation with the consultant(s) selected for the study, while respecting the dates for submission of the first summary elements and the preliminary report.

Elements	Dates
Launch of the consultancy tender	20th October 2025
Deadline to respond to the call for tenders	9th November at midnight
AMI relaunch if necessary	
Analysis of the offers	10th-17th November 2025
Selection of consultants	17th-24th November 2025
Consultant(s) contact and contracting	5th December 2025
Study methodological scoping note meeting	10th December 2025

Finalization of methodological scoping note for the evaluation (evaluation methodology)	20th December 2025
Field missions and data collection in Cambodia and Mozambique	Month of January 2026
Submission of the first summaries of the evaluation and recommendations	Week of 16th February 2026
Delivery of the intermediate report	Week of 2 nd March 2026
Restitution of the intermediate report	Week of 16th March 2026
Final report	End of March 2026
Restitution of the final report	
Extended final restitution at the headquarters (Paris) or remotely	By Mid-April 2026 (Flexible)

3.4 Documents to be submitted by consultants

Consultants invited to bid should provide the following:

- **A technical bid including:**
 - A note explaining the terms of reference and presenting the methodology used;
 - The consultant's references and experience;
 - The provisional timetable for intervention;
- **A financial bid** including the overall budget (before and after tax) and detailed prices (fees, per diems, transport, etc.).

For information: maximum available budget of **20,000 Euros**.

4. Expected Deliverables

- **A methodological scoping note** prior to the data collection phase and presentation of the methodology (techniques and tools) proposed by the consultant(s) must be made to the steering committee at the beginning of the evaluation.
 - **A document of the first elements of the synthesis of the evaluation report**, to be delivered to the evaluation Steering Committee **imperatively by the first week of February 2026, followed by a restitution.**
 - **A intermediate report** must be **delivered** by mid-February.
 - **Writing of a final report** with restitution at the end of February.
- Regular communication between the consultant(s) and the evaluation steering committee should be maintained throughout the evaluation process.
- The findings of this evaluation will be shared with AFD by DSF.

Renditions:

- **Meeting of the scoping note** and then of a **methodological scoping note** validated by DSF;

- **Feedback at the end of the mission in Cambodia to the local DSF teams;**
- **Feedback at the end of the mission in Mozambique to the local DSF teams;**
- **Meeting to present the first synthesis elements of the cluster evaluation report;**
- **Debriefing in France of the mission,** by videoconference with DSF headquarters;
- **Restitution of the intermediate report;**
- **Final report to the DSF steering committee and its partners,** based on the final report.

5. Tender procedure

Candidates (structures or independent individuals) interested in bidding for this evaluation should send their application by email to: recrutement@douleurs.org with “Consultance Evaluation KH_MOZ” in the subject line.

The deadline for submission of tender documents is November 9, 2025 at 12:00 pm (Paris time).