Terms of Reference

Final Evaluation of the Outcome Health of the DGD 2017 - 2021 program in Cambodia

A.1 Context of the Evaluation

In 2016, four Belgian University NGOs (ECLOSIO (formally named ADG-Aide au Développement Gembloux), FUCID, Louvain Coopération, and ULB Coopération) have decided to join forces and strengthen their synergies through the creation of the entity "Uni4Coop" and the mutual engagement in the implementation of one common program funded by the Belgian Development Cooperation (named as DGD in this file). Within the framework of this five-year Uni4Coop program (2017-2021)[1] A Final Evaluation is planned in 2021/2022.

In Cambodia the Uni4Coop Program is implemented by two of the four Belgian University NGOs, ECLOSIO and Louvain Coopération (LC). The first step undertaken to set up the program was a context analysis that gathered inputs from all the different Belgian ANGC (Actors of Non-Governmental Cooperation) engaged in Cambodia that was ensued by a Joint Strategic Framework[2] that foreseen common strategies and objectives for each of the sectoral interventions to be supported by DGD. The Context Analysis presents an analysis of the situation of the Cambodian civil society, the decentralized authorities and the government institutions and elements for promoting circumstances of their strengthening. It led to the description of the different actors identified for intervening in the development of the sectors, including partnership, synergies and complementarities.

The Uni4Coop program in Cambodia is tackling two sectors, the Health and the Agriculture / Rural Economy; while ECLOSIO is involved in the agriculture and economic sector, LC is involved in the health sector and in the agriculture and economic sector. The Uni4Coop program is divided into Specific Objectives (SO) by country, by sector and by NGO.

This ToR aims to specify the scope of the Final Evaluation to be performed in Cambodia for the health sector with the objective of defining the impact of the programme and the evolution of the partners.

The Specific Objective (#3) as formulated in the five-year program is:

Specific Objective	Partner[3]; Synergy/collaboration
Cambodian people, especially the vulnerable groups, have access to high quality of Comprehensive Non-Communicable Diseases services (diabetes, hypertension, and mental health) through promotion, prevention, treatment and rehabilitation, contributing to a long and healthy life.	Partners: CCAMH in Kampong Cham province and Phnom Penh DMHSA in Phnom Penh and all provinces PMD in Phnom Penh and all provinces SSC in Tbong Khmum province TPO in Kampong Cham and Tbong Khmum provinces. Synergies: UCL medical students, Humanity & Inclusion, VVOB, ITM, Belgian ANGCs working in Cambodia

[1] Annex 1: Uni4Coop Program Commun Cambodge
[2] Annex 2: JSF Cambodia
[3] Annex 3: Brief description of partners

The description of the Specific Objective was formulated as "The Non-Communicable Diseases (NCD) program of LC in Cambodia will mainly address the problem of mental health in Cambodia. It will contribute to quality of health and to better access for vulnerable patients. The next 5-year program (2017-2021) will extend the actual support at all levels, including national level, provincial, operational district and community level with a comprehensive approach". The improvement of access to health care and rehabilitation services was based on the lack of ability to pay for the poorest, lack of physical access, limited knowledge about assistance schemes, some traditional beliefs and socio-cultural practices, and lack of trust in public health care facilities. In addition, education and clinical training of medical professionals for delivering high-quality, free medical care for the poor and disadvantaged in Cambodia was insufficient. The capacity of National Health Institutions remained relatively weak, compromising the implementation of evidence-based programming to address infectious diseases and other health problems in Cambodia. In particular, Non-Communicable Diseases (NCDs) represented a relatively new program area in Cambodia, the government was not able yet to address this problem effectively due to several reasons including lack of financial and human resources and the low level of education, medical knowledge and practice of medical professionals delivering these services. Although a health strategic plan on NCDs existed, diabetes & hypertension and mental health remained a low priority for the government and the implementation of these services at the level of referral hospitals (RHs) and health centers (HCs) especially in rural areas were problematic. Moreover, the supply of drugs from the central medical store for the treatment of these diseases was largely insufficient, and people weren't educated enough on disease prevention and treatment. In summary, NCDs needed an innovative approach due to their prevalence and due to the fact that these diseases were still widely neglected in Cambodia.

The Theory of Change visioned that people living with NCDs (diabetes & hypertension, mental health conditions) have access to high quality of care services provided by village health volunteers (community level) and caregivers (first level) concerning promotion, preventive and curative care. In addition, service providers would have changed their misconceptions on treatment for NCDs and would have adopted positive attitudes to continuous care. Moreover, gender and environmental issues that were cross-cutting themes of the program would have been addressed.

The target groups distributed by partners are:

Partners	Direct Target groups	Indirect Target groups
CCAMH TPO SSC PMD and DMHSA	2 725 patients 3000 patients 225 patients 24 patients	16 350 patients 18 000 patients 900 parents and family members 708 patients
Total number of participating populations	5 974 persons (direct) + 35 958 persons (indirect)	

The intervention strategy included:

- Development of research, studies and assessments with presentation and implementation of the recommendations.

- Database set up (patient's records, health performance indicators, and active screening to identify the presence or absence of risk factors) and training support on database management for PMD and DMHSA
- Meetings and lobbying with PMD & DPHI to integrate more relevant data on NCD into the HMIS system.
- Medical staff training, mentoring and coaching, and follow up support (in referral hospitals and health centers)
- Health education, psycho awareness raising/campaigns, and field work among villages and families in the communities.
- Training of village volunteers, volunteers for children development, community social workers and commune council for women and children
- Set up of self-help groups for mental health and parenting groups targeting small scale farmers and rural families affected by increasing costs of NCDs.

The strengthening of LC's partners institutional and operational capabilities would have allowed them to fully accomplish their function of intermediaries with an emphasis on integrating local health centers and district hospitals, and on the involvement of community volunteers in networks of care with the aim to make patients and doctors collaborate in the care delivery system. An additional important contribution by CCAMH and SSC was the provision of services dedicated to children, adolescents and women affected by different forms of violence.

Changes in the Cambodian health context have led to some adaptations in the objectives and activities identified in the inception of the program.

The Covid-19 situation affected some project activities at the community level. Community Social Workers (CSW) were not allowed to work with the volunteers (VHSGs) directly in the communities, instead clients were seen at health centers and referral hospitals. However, many of the CSW who were located near the target villages continued to visit their clients. In the same way, the CCAMH team continued their outreach activities while adopting preventive measures; and TPO opened 5 hotlines for psychological support and online counseling service on their Facebook page. This situation has had a big impact in the modalities of implementation of a community-based care and the monitoring of the project and has influenced the achievement of some of the results.

A financial incentive system was introduced to support staff working in mental health service delivery to motivate them and improve their work performance. In the fourth year of the program this system was cut since the number of patients for mental health services increased, which generated an increase in the hospital revenue through the user fee system.

In 2020, the DMHSA requested LC to switch the support for the development of a database system to the development of a pilot project on community mental health that was identified as a new national priority. The contribution of LC to the pilot project is to support the creation of a Standard Operating Procedure (SOP) for Community Mental Health (CMH) including the organization of consultative meetings with relevant stakeholders to gather inputs and make sure that it is applicable, acceptable and in line with Cambodian context.

However, the Preventive Medicine Department (PMD) of the Ministry of Health decided to improve the existing database system. After an assessment carried on in 2019, the new database system adding the health management of diabetes and hypertension was developed in 2020 by Louvain Cooperation and the Institute of Technology of Cambodia.

At the organizational level, in February 2020 LC hired a psychologist to work as Health Technical Assistant to do monitoring, follow up and provide technical advisory support to local partners. In November 2020 the country director resigned, and the Program Manager was nominated to take the position.

Following the previously mentioned changes, the components to take into particular attention for the development of this evaluation are:

1) The actions taken for the establishment and strengthening of a comprehensive community based mental health, diabetes & hypertension care and support; the description of this model; the efficiency of the cross-referral system from community workers (Village Health Support Groups, volunteers for child development, and community social workers) to local health facilities and, the impact of awareness campaigns in the referral process.
2) The impact on performance and the challenges originated from the cut of the financial incentive to health staff working in mental health service delivery. This assessment is planned to be conducted in the last year of the program.
3) The level of the utilization, management, data analysis and reporting of the improved database (PMD) to validate the Theory of Change assumption "when governmental authorities will have good sanitary databases concerning non communicable diseases (NCDS) they will be more able to choose the good strategies to fight against these diseases in the Cambodian context". This particular point will also guide strategies of healthcare technology for the new program (tracking systems of patients records for an integrated collaborative care model, and mobile Apps for healthcare in diabetes and hypertension).

A.2 Objectives, Scope and Use of the evaluation:

A.2.1 Objective:

Accountability:
The DGD requires that all CAD criteria be evaluated, with particular emphasis on effectiveness, **impact, sustainability, relevance, and efficiency** without forgetting the contribution to JSF[4]

Learning:
Analyze the impact of the planned partnership relationships and participatory implementation of this program.
Propose recommendations and suggestions for improvement (preparation of the second phase of the 2022-2026 strategic framework) regarding partnership relationships.

A.2.2 Main Users:

The final evaluation is a duty of accountability to the DGD, the main donor.
The underlying objective is to reflect on partnership relations, the partners of this program will be the privileged users.
UNI4COOP and JSF: conclusions and lessons learned will be shared with other ACNGs.
The results will also be shared with other cooperation actors and the general public.

[4] Joint Strategic Framework (JSF), which objective is to define and justify the vision and common priorities in a country or around a subject.

A.2.3 Period concerned by the review:

The evaluation will cover the entire duration of the project from 2017 to 2021 with particular attention to the three last years in which the biggest adaptations have taken place.

A.3 Type of Evaluation

This is an external end-of-program evaluation to be carried out in all areas covered by the project.

A.4 Global approach

The DGD requires that all CAD criteria are analyzed, with the possibility of emphasizing on specific ones.

Formulation of Questions for the Evaluation

CAD criteria and evaluation question	Comments
Efficiency To what extent are inputs managed in a cost-efficient way? Given the changes in the Cambodian health context and the effects of the Covid-19 situation (explained above), the reassignment of the main human and material resources have been perceived as relevant by partners? What could have been the alternative allocation strategies? How efficient is the current project structure/project management to ensure the project is well monitored and achieving the expected results? What is the capacity of the programme to address emerging priorities? **Accountability and Learning**	The input/output ratio: the means used provide the best “cost/benefit” ratio to achieve the predefined outputs. For the costs, reference is made to the budget as approved by the DGD. No need to carry out a detailed analysis of each expenditure, but to analyze the reallocation of resources with questions like "what if we had to do it again"? Would we use the same allocation strategy? Proposed approach: Semi-structured interviews with partners involved in the program.
Effectiveness To what extent has the SO been achieved? How well have we achieved the results, are they of good quality? The quality refers to meeting the needs of the participating populations. Does the intervention work, for whom and under what circumstances? How and why does it work or not? What are the key internal and external factors (both positive and negative,	Title of the SO: Cambodian people, especially the vulnerable groups, have access to high quality of Comprehensive Non-Communicable Diseases services (diabetes, hypertension and mental health) through promotion, prevention, treatment and rehabilitation. The major indicator to keep track of our progress during this 5-year program was the **total number of new patients** diagnosed with mental health problems. By the end of the 4th year, 597 new cases (68% women) received mental health consultation in any of the 6 health centers and 2 referral hospitals managed by the program. The expected number of contact rate of MH new cases (cumulative) by

expected and unexpected) that have influenced the project achievements? Are there any vulnerable groups left behind by the approaches and methodologies used? **Accountability**	year 5 was 3100, the achievement of this indicator has been challenged in year 4 and 5 by the Covid-19 situation and the shortage of community social workers and volunteers due to the restrictions imposed by the government. In addition, the survey about changes in community members' attitude toward mentally ill patients was not completed in 2020 and delayed until 2021; we couldn't identify potential improvements for self-referrals. Proposed approach: The evaluator is asked to corroborate the level or not of achievement of these results on the basis of the documents provided and on a survey among a sample of participating populations and community health workers (social workers, nurses and community volunteers).
Impact: What difference have we made in building trust within and across communities for mental health services? What changes have we contributed to the management of the public health system? What were the roles played by LC in the improvement of the public health system at a district level? What were those by the partners and at the community level? **Accountability and Learning**	The programme was intended to lead to an improvement of the management of the public health system (at district level) with the implementation of a patient-driven approach for mental health services. Besides, it was planned to change the perception of the community about the public health system, increasing their trust in general and even their use of other services. On this same line, it was also identified the improvement of the acceptance of mental health, both at the family level and the professional sector. Proposed approach: Semi-structured interviews with all categories of parties' stakeholders involved in the development of patient-driven approach for mental health services, their knowledge about this approach and about the need to ensure patients monitoring systems, supervision and evaluation. More structured interviews with members of the DMHSA, PMD, OD, PHD, referral centers, and health centers on the tools designed in this program. An analysis of the tools.
Sustainability Do the partners, health care workers and community staff have the required capacities to take control of the intervention and to continue the results? (Knowledge transfer/capacity strengthening/technical sustainability) In what measure will the partners be	The project aimed at strengthening the public health system by both technical and financial support. Trained primary healthcare workers (nurses and physicians working at RH and HC) would be able to offer accessible, good quality and culturally relevant mental health services to the community. Plus, they received a monetary incentive related to their performance. We would like to understand the challenges faced by mental health

able to continue with the implementation of activities and/or support to health staff and social workers after the end of the programme? Have the conditions for local ownership been met and will they remain so after the intervention has ended? (Social sustainability) Which external factors influence the sustainability of the project achievements/changes (e.g., capacity, resources, environment, social, political, gender roles relation, etc.)? What long-term changes (positive or negative) are likely to take place as a result of the project? What is the evidence? **Accountability and Learning**	providers in their training and practice, what additional support they need to sustain their work, and how the cut of financial incentives has affected their performance and motivation. An analysis of the partnership with the OD, provincial and national counterparts to ensure stakeholder buy-in for the various activities and accountability for the outcomes of the project. The strengthening of the health system was also intended by the improvement of the healthcare database on NCDs for efficient healthcare implementations. We want to understand the particular challenges that this database encountered, and what is preventing this database from reaching its full potential.
Relevance How has the programme contributed to the quality of Health and better access for all vulnerable patients? (JSG 2) What was the perceived relevance that partners and local authorities have had on the implementation activities while running the program? What are the resulting social responses from the population to MH patients and caregivers in rural communities? Are the programme's objectives and activities meeting partners' priorities and participating populations needs? **Accountability**	Focus on the involvement of Village Health Support Groups, the work of community social workers, the activities among the villages and communities, the efforts to make patients and doctors collaborate in the health care process, and the emphasis on integrating local health centers and district hospitals.
Contribution to Results In what level has the programme contributed to achieve the following results? Which factors were crucial for the achievements? Which factors were inhibiting to reach the expected results? **Accountability**	Result 1: NCD policy, guideline development and advocacy both at national and sub-national level are promoted and strengthened. Result 4: Community based MH, DM, HTN care and support to protect and promote healthy diet and MH well-being of the Cambodian population is established and strengthened What are the related challenges and lessons learnt of a more comprehensive community approach for MH? Result 5: The capacity of partner organizations to improve management and technical skills as well as to ensure their sustainability is strengthened.

Remark:
As a cross-cutting criteria, the evaluation is also expected to identify Key Areas of Success and Critical Areas for Improvement. Therefore, in addition to the key questions mentioned above, the following questions should also guide the assessment of each of the above criteria:

- Which factors were crucial for the achievements?
- Which factors were inhibiting to reach the expected results?

A.5 Desired method and tools

Some approaches are offered in the comment column opposite to each evaluation question. The assessor is of course free to suggest other approaches in her/his technical offer. An outline scoping report, drawn up at the end of the documentary phase, will determine, by mutual agreement, the evaluation methods and tools that will be used during the field phase and their justification. The evaluation should involve a representation of key partners and participating populations at different levels. LC encourages the use of innovative methods of data collection and stakeholder consultation, which may include remote data collection methods.

A.6 Skills required

It is envisaged that the assignment is carried out by an evaluation expert or team with profound knowledge of the health sector and extensive proven experience in Cambodia.
It is to be expected that international travel will remain restricted in 2021, beginning of 2022. Therefore, any proposal by an evaluation expert who is not based in Cambodia, must include one in-country expert (as co-evaluator) to conduct (as a minimum) the field-phase. In case the in-country evaluator is not a native Khmer speaker, the project team must also include an experienced translator. Evaluation experts based in Cambodia can also decide to include one or more co-evaluators/assistants in their proposal. In any case, the evaluation expert or team should be able to work independently in the sense that LC cannot assist with translations during interviews or with the translations of relevant documents.

The proposed consultant or team of consultants should meet the following requirements:

- Solid experience with the evaluation of international development/donor-funded projects, both midterm and final evaluations
- Team leader has developed a minimum of 3 evaluations or other relevant studies in the past 5 years, preferably in Cambodia
- Knowledgeable on the government health system and the related challenges in Cambodia
- Knowledgeable on the specific local context in Cambodia (including the current political, economic, social, cultural, technological, legal and ethical developments and restraints and their effects in the public health sectors)
- Experience with the evaluation of capacity development interventions in the health sector
- Excellent written and spoken command of English, notion of Khmer language is an asset
- Sensitivity to the themes of gender and environment

A.7 Budget

The maximum budget available is 12.500 US Dollars or 10.700 Euros (including taxes).
These amounts cover all the costs related to the evaluation (fees, international and local transportation, accommodation and per diem, visa, organization of workshops ...), with the following exceptions:
• The program will make one vehicle available for major trips during the field visits but not for the travel within Phnom Penh.

A.8 Modalities of the Expertise:

A.8.1 Content of the Technical Offer

Proposals must provide the following:

- An understanding note of the ToRs, as well as how the context and the evaluation questions were understood in relation to the theory of change;
- A constructive feedback of the methodological approach envisaged to answer the questions and objectives set out in these ToRs. The recommendations may relate to the tools for collecting information, the profile of involved persons, etc.
- An indicative timetable of the mission as well as an estimate of the costs in terms of person/day.
- A presentation of the expert(s) highlighting the aspects particularly relevant to the intended evaluation.
- The profile of the expert (s) (max 3 pages per CV), references, and
- A financial offer including the detailed budget in euros including tax of the service

Ethical principles: autonomy and confidentiality, neutrality of the evaluation team, validity and reliability of information.

A.8.2. Documents to review

For drafting the offer:
Annex 1: Uni4Coop Program Commun Cambodge
Annex 2: JSF Cambodia
Annex 3: Brief description of partners

After selection:
After selection, the project will make the following documents available to the retained consultant (s):
• The project document.
• Technical reports.
• Partnership management and evaluation tools developed as part of the project and previous projects.
• The expert may ask to consult any document she/he deems useful (partnerships agreements, reports, list of groups and participating populations, etc.)

A.8.3. Modalities for carrying out the field mission

Support by the expert will be done remotely (head office) and face-to-face (Cambodia). The expert will be in contact with the steering committee and with the coordination team in Phnom Penh.

The evaluator will provide:

- A framework meeting in Cambodia, following which, she/he will draft a scoping note in case the mission outline needs to be reviewed on the basis of the knowledge of the documentation that will be given to her/him, and the first exchanges conducted both in Belgium and in the field.
- Restitution meetings with the local team and partners of LC.
- A debriefing at the end of the field mission, organized with the main actors and in particular with the local team of LC.
- A post-submission meeting of the interim report organized with the steering committee. It allows for adjustments before the final report is submitted.
- A discussion meeting following the submission of the final report. This provides a better understanding of the nature of the recommendations.
- A post-evaluation meeting when the managerial response has been formulated on the basis of the final evaluation report, the location of which will be agreed on time.

The Louvain Cooperation operational team based in the intervention country will be available to facilitate the smooth running of the evaluation (contacts, general information, logistical assistance, etc.).

A.9. Selection and contractual arrangements

A.9.1 Selection Method

Application must include the following:

Interested applicants are requested to prepare technical and financial proposals in English and submit to Dr Thann Khem tkhem@louvaincooperation.org and Giuliana Zegarra gzegarra@louvaincooperation.org

-The technical proposal includes detailed evaluation methodology, tentative work plan, deliverables and CV of the consultant team that shows capabilities and past experiences relevant to the evaluation.
-The financial proposal needs to include all costs (consultant fee, transportation cost …etc.) required for conducting the evaluation.
-Previous similar assessment/evaluation report

The assessment of the proposals will follow:

Criteria	Score
Profile of the expert(s)	**50**
- Qualifications, experience and skills	25
- Experience of the thematic to be evaluated	15
- Knowledge of the local context	10
Technical and methodological offer	**30**

- Presentation of the problem and understanding of the subject	15
- Proposed methodological approach	15
Financial offer	**20**
- Price of the service	10
- Realism of costs in relation to the proposed methodology	10
Total	**100**

A.9.2 Contractual Modalities

The payment of fees will be made in three instalments: 40 % upon signature of the contract, 30 % upon submission of the interim report and 30 % upon approval of the final report.

These arrangements may be reviewed if necessary.

The per diem will be paid at the start of the mission on the basis of a declaration of claim (debt). Other costs will be paid on the basis of the submission of the appropriate supporting documents.

Other specific arrangements are also feasible.

A.9.3 Expected Deliverables:

- **A summary document for accountability** of +/- three pages for the general public, members of Uni4Coop and LC, participating populations, this document shows the main conclusions and recommendations related to the evaluation questions, with illustrations (diagrams, photos, graphics, drawings, etc.) and at least one beneficiary's testimonial.
- **A presentation of restitution** (PowerPoint format).
- **A complete report** containing:
  1. Summary of key findings and recommendations.
  2. Objective, scope of the evaluation and context.
  3. Definition of the main concepts used.
  4. Methodological approach and its justification, and the challenges encountered.
  5. Assessment of the understanding of the logic of intervention/theory of change.
  6. Findings (with reference to sources) and results of the evaluation based on the ToRs and above lead questions.
  7. Conclusions addressing the evaluation questions. Any underlying analysis will be explicitly formulated.
  8. Concrete and operational reasoned recommendations, to be implemented in the continuation of the program or in future interventions and in relation to the evaluation questions.

9. Appendices: Anonymous raw data.

Documents will be written in English and sent in electronic and paper format for the final version of the report.

A.9.4 Provisional timetable:

Process	Deadline
Publication of the call for offers	November the 1st, 2021
Deadline for supplementary questions (only by email)	November 10, 2021
Submission of offers Assessment and selection of the evaluator	November 22, 2021 December 6, 2021
Information of the selected evaluator Signature and beginning of the contract Scooping note and discussion	December 7, 2021 December 10, 2021 December 15, 2021
Field mission	Mid-December 2021 to January 2022
Briefing workshop	February 11, 2022
Submission of the interim report	February 18, 2022
Submission of the final report	March 11, 2022
Management Response Meeting	March 25, 2022