+TERMS OF REFERENCE

2026

ADVOCACY & TRANSITION LEARNING CONSULTANCY

MdM in Ukraine

I. BACKGROUND

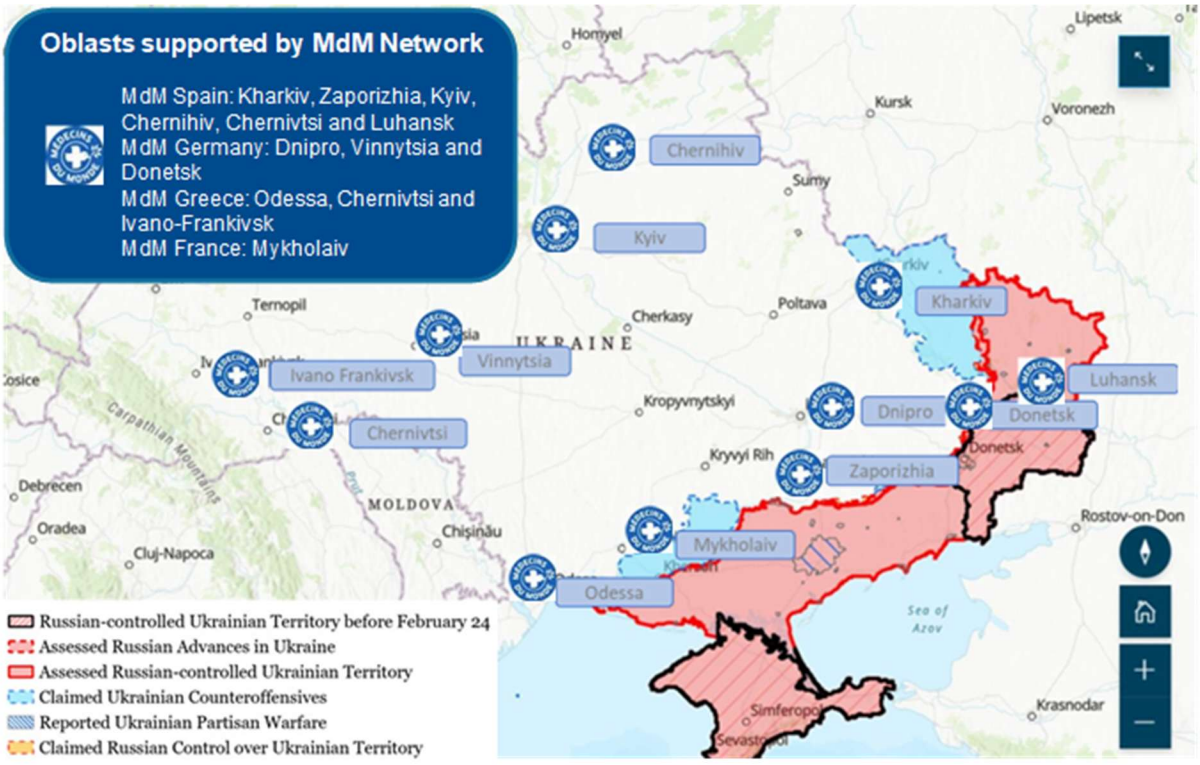
A. MDM IN UKRAINE

Médecins du Monde (Doctors of the World, MdM) is an independent international humanitarian organization founded in 1980 in France that provides medical care to vulnerable populations affected by conflict, disasters, poverty, and exclusion, while also advocating for universal access to healthcare as a fundamental human right.
Operating through a network of 17 members organizations (Chapters), MdM works both in emergency settings and on long-term health system strengthening.

In Ukraine, where it has been present since 2015 and significantly expanded its activities following the 2022 full-scale invasion, MdM operates as a coordinated international network, delivering a comprehensive humanitarian health response that includes primary healthcare through mobile medical teams, support to hospitals and local health facilities, distribution of medicines and equipment, and a strong emphasis on mental health and psychosocial support for populations affected by conflict and displacement.

The response is implemented through five operational Chapters (MdM Germany, Spain, France, Greece, Netherlands), with MdM Switzerland acting as lead for a Swiss Solidarity-funded project.

Activities include primary healthcare (PHC) delivery through Mobile Units (MUs) with integrated MHPSS and GBV services, support to health facilities through rehabilitation and equipment, and targeted health system strengthening.



B. MDM ADVOCACY IN UKRAINE

Advocacy is a core pillar of MdM, complementing its medical activities by addressing the structural and political barriers that prevent people from accessing healthcare. Beyond providing direct care, MdM actively works to influence public policies, humanitarian practices, and international attention to ensure that health is recognized and upheld as a fundamental human right. Its advocacy efforts focus on documenting and speaking out against violations such as attacks on healthcare facilities and

personnel, restrictions on access to care, and the exclusion of vulnerable groups—including displaced populations, migrants, and people living in poverty—from health systems. Through reports, campaigns, partnerships, and direct engagement with policymakers, MdM seeks not only to respond to immediate crises but also to drive long-term systemic changes in health policies and humanitarian response frameworks.

At present, advocacy is primarily driven at Chapter level, with limited alignment under a common strategic framework.
Since 2022, regular meetings of advocacy focal points have been established to coordinate efforts across Chapters. During a first period the group consisted out of focal points from MdM Germany and Spain's HQ as well as advocacy officers in-country, coordinated by the Network advocacy coordinator. Considerable data and advocacy products (as well as information through INGO networks) have been provided. However, results in data collection systems were still fragmented and there was limited harmonization across Chapters, leading to insufficient consolidation of structured, advocacy-ready evidence.

A first joint needs assessment conducted in 2025, involving all operational Chapters, represents an important step towards more coordinated and consolidated data generation. A further assessment is planned for 2026. However, despite these efforts, current data systems remain insufficiently structured and standardized to fully support evidence-based, collective advocacy at mission level.

In the first quarter of 2026, a national Advocacy Officer, contracted under MdM Germany, has been recruited in Ukraine to work mainly on healthcare legislation and policy-related issues.

Experience from other countries and multi-Chapter settings consistently demonstrates that structured advocacy coordination enhances coherence, visibility, and policy influence.

C. PRESENTATION OF THE REQUEST

The Swiss Solidarity 4 (SwS4) project:

The Swiss Solidarity funded project « *Strengthening Equitable, Sustainable Health and MHPSS Services for Conflict-Affected Populations in Zaporizhzhia and Vinnyts*ia » is implemented by MdM Spain and MdM Germany, respectively in Zaporizhia and in Vinnytsia, under the lead of MdM Switzerland as the financial partner. It is a fourth phase of a project, that started the 1st of November 2025 for 12 months, ending the 31st of Octobre 2026. The project is structured in 3 specific outcomes

1. *The conflict-affected population, especially the underserved communities of remote areas, has access to essential healthcare (PHC, SRH, GBV and MHPSS).* This is mainly provided through Mobiles Units providing PHC as well as MHPSS and GBV services, set-up of telemedicine hubs and community health promotion activities.
2. *The healthcare system's capacity to provide quality services to the conflict affected population in the target area is strengthened.* This is mainly provided through trainings of the healthcare and protection professionals, and the provision of equipment, rehabilitations of existing public health centers.
3. *The sustainability of healthcare services is ensured by local ownership, with an expected output that Local stakeholders are supported in resuming the activities set up by the project.* This is mainly provided through capacity building, progressive handover of Mobile Units, and advocacy activities.

MdM's approach relies on the phased handover of Mobile Units and integrated service delivery models to local health systems, including Primary Medical Sanitary Assistance Centers (PMSACs), social service centers, and local NGOs. It is operationalized through progressive transfer of operational and financial responsibility, capacity strengthening and co-delivery approaches, integration into national systems (NHSU and eHealth), and formalization of partnerships and monitoring mechanisms. Two main transition pathways are currently being implemented under the SwS4 project, namely the gradual handover of MUs to PMSACs in Zaporizhzhia and other regions, and the integration of MHPSS/GBV MUs services into PMSACs in Vinnytsia through co-delivery and institutionalization. These processes are

inherently context-dependent and require continuous adaptation considering security dynamics, institutional readiness, and workforce constraints.

Within the budget of the project, a dedicated budget line is available for advocacy related activities. The project advocacy products expressed in the proposal are:

- A *Policy Brief* (4–6 pages) designed for donor dialogue, policy influence, and strategic positioning. It will support the localisation and transition narrative and present Mobile Units as a key evidence base for health system transition. It will highlight key advocacy priorities across primary health care, MHPSS, GBV, and access to services, targeting donors, policymakers, and budget holders.
- An *Advocacy Toolkit* for health authorities and health structures, designed as a practical, non-academic operational package to support the strengthening and adaptation of public health systems. It will translate evidence into actionable guidance for improving and institutionalising Mobile Unit approaches within State-led systems. The toolkit will include shared advocacy and positioning messages, simplified guidance on data use for decision-making and service planning, basic harmonisation principles for indicators and evidence, key entry points for integrating MHPSS, SRH and GBV services into primary health care and outreach systems, and practical tools such as templates, checklists, and simplified 4W mapping frameworks.

Other MdM projects:
Within the framework of other projects funded by ECHO, GMZ or GFFO, that were operationalised by MdM Spain, Germany, France and Greece, during the last years, many Mobile Medical Units have been operated, in different models.
Also, in 2025 in preparation of ECHO submission, a joint needs assessment was conducted across Dnipro, Kharkiv, Kherson, Mykolaiv, Sumy and Zaporizhia and provided a comprehensive evidence base confirming that, while primary healthcare services remain broadly functional, they are operating under sustained systemic pressure. The assessment identifies critical constraints including severe human resource shortages, weak infrastructure and transport capacity, limited referral systems, insufficient integration of MHPSS into primary healthcare, and reduced access in rural and frontline areas. It further highlights widespread unmet needs in both health and MHPSS services, low utilization driven by stigma and limited awareness, and persistent structural weaknesses in workforce capacity, supervision, and service integration. Overall, the findings indicate that the main barriers are predominantly systemic rather than individual, reinforcing the need for transition-oriented, health system strengthening, and policy-level responses.

Mobile Units models and transition strategy as key evidence
As MdM's programming in Ukraine is embedded within a structured transition framework, aimed at ensuring the sustainability of healthcare services through local ownership, **Mobile Units models and transition strategy represent a key evidence base for understanding how outreach services can be progressively institutionalized within national systems**, and under which conditions responsibilities can be sustainably transferred from humanitarian actors to public health authorities. It is a strategic operational and policy entry point for analyzing the shift from humanitarian service delivery to sustainable public health systems.

Overall, MdM works with 3 MU models:

- Full MdM Mobile Units: all staff are employed by MdM and operations are coordinated by MdM according to identified needs
- Mixed MdM-MoH (Ministry of Health) Mobile Units: staffing is shared between MdM and MoH, usually including a MoH doctor and MdM providing support in other areas (this model can be seen as a transition and capacity-building approach)
- State Mobile Units: the Mobile Unit is fully operated by the MoH, including the vehicle (MdM provides support through training, medicines, fuel and other operational inputs)

A range of strategic decisions regarding the operational running, the level and modalities of coordination with MOH services, the specific health needs they intended to address, are specific to each model. They were also conducted in areas of Ukraine that were differently affected by the conflict. Finally, all three models include a handover to MoH at the end of the project conducted by MdM, with different strategies to conduct that hand over.

A comparative analysis would help identify the enabling factors, gaps and added value of each model, as well as needs in capacity reinforcement required for a successful transition from INGO interventions to integrated state services. It would also generate evidence on the effectiveness of the current outreach models and demonstrate the added value of transferring service delivery and expertise to State MUs as a means of strengthening the national health system. Furthermore, the findings could inform the design of more effective exit and transition strategies, supporting the systematic transfer of knowledge, capacities, and operational practices to national actors. Finally, the resulting evidence and recommendations could serve both health authorities and potential donors, contributing to policy discussions on sustainable outreach service delivery and longer-term health system development in conflict-affected and recovery contexts.

In this context, MdM has a unique opportunity to assess the ability of the comparable models to contribute to resilience of the national health system in a complex context such as Ukraine through a handover of humanitarian projects to local actors (MoH as well as local NGOs).
This opportunity is also allowing MdM to build a broader understanding of health access gaps and identification of joint advocacy positioning and strategy for MdM in Ukraine.

II. OBJECTIVES

A. GENERAL OBJECTIVE OF THE CONSULTANCY

The overall objective of the consultancy is to strengthen evidence-based and coordinated advocacy of MdM Chapters in Ukraine by generating an analysis of humanitarian needs and response models and health system resilience, capitalising on operational experiences to inform sustainable service delivery and local ownership.

Within this framework, the consultancy will provide a comparative study of Mobile Units (MUs) models as a key entry point for understanding the transition to resilient national health system after humanitarian response, contributing to donor and health authorities dialogue on sustainability and local ownership, while also informing broader strategic reflection on advocacy coordination across MdM in Ukraine. In addition, the consultancy will support the development of an evidence-based advocacy agenda by designing and guiding a targeted needs assessment on primary healthcare and protection-related needs, providing an updated understanding of priority gaps affecting conflict-affected populations.

B. SPECIFIC OBJECTIVES

The consultant(s) will work on two advocacy streams: (1) the NGO health intervention through Mobile Units performance, transition and sustainability agenda as a concrete advocacy case study, and the (2) broader advocacy strategy and coordination across MdM Ukraine.

Specific Objective 1 – Comparative study of the MU models that generates evidence and strategic recommendations on operational transitions and health system resilience

Provide a shared analytical basis on Mobile Units as a key entry point for understanding the transition from NGO humanitarian service delivery to nationally owned sustainable health services. Through a comparative analysis of the three MU models implemented by MdM in Ukraine, the consultancy will assess key operational performance indicators but also efficiency, sustainability, quality of service delivery, and the conditions required for transferability, institutionalisation, and public ownership.
Particular attention should be given to understanding the comparative added value of MdM-supported and hybrid models in terms of geographical coverage, responsiveness to health emergencies, continuity of care, integration of specialised services, technical expertise, and operational capacities.
The analysis should identify potential gaps that may emerge during transition to fully State-operated Mobile Units and assess their implications for equitable access to quality healthcare, particularly in hard-to-reach and conflict-affected areas.
The study should generate evidence to support dialogue with health authorities, donors, and other

stakeholders on sustainable outreach service delivery, health system strengthening, and transition pathways from humanitarian assistance to nationally owned public health services. It should identify practical measures through which State Mobile Units can progressively incorporate successful elements of MdM-supported models, while informing realistic transition and exit strategies for humanitarian actors. The study should ultimately contribute to the development of evidence-based recommendations and advocacy messages to support policy discussions on outreach services, health system resilience, and local ownership in Ukraine.

Proposed research question for the study:

Identifying key enablers that support health system performance and resilience in health intervention conducted by NGO's: Review of 3 models of mobile health units in the Ukrainian context (key enablers might include: the model of MU, the target populations, project objectives, practical implementation; the MoH resources and contribution; the existing local health system, the partnership and articulations between these actors, as well as broader contextual political, economic, social and humanitarian context related factors)

To answer this question, the focus is put on two practical dimensions:

- The ability of each model to be successfully handed over to MoH or relevant local actors
- The contribution of each model to the performance and resilience of the national health system at the time of the study

The conclusion will highlight the key enablers (internal and contextual) that can be replicated

Specific questions:

- What is the level of alignment of the projects with the various national and local health policies and strategies? The entry point of the 6 building blocks of a health system can be used as reference for the fields to cover.
- What was the integration within the local health facilities with regard to continuum of care, the clinical management procedure, the protocols used, perception of the population, etc., during the project?
- Identify potential dimensions of quality of care (effectiveness, safety, people centeredness, timeliness, equity, integrated, efficiency) documented in the project that led to changes/improvement replicated in the national health system. This can be through formal trainings, experience sharing, tools and protocol sharing, etc.
- What was the level of participation of the MOH and local health actors during the different phases of the project (using a standardised participation scale).
- What were the models of transition, pathways planned, and their actual implementation?
- What are the systemic constraints and opportunities observed, and lessons learned related to outreach service delivery, transition, and health system integration.
- What is the alignment of the three operational strategic models with reference frameworks in the fields of emergency development nexus, health system resilience.
- What are the comparative strengths, limitations, and enabling factors associated with each Mobile Unit model in terms of sustainability and institutionalisation?
- How do the three models compare in terms of service coverage, emergency response capacity, multidisciplinary service provision, continuity of care, and access for vulnerable and hard-to-reach populations?
- What specialised services and professional profiles (including MHPSS, SRH and GBV-related services) are available under each model, and what service gaps may emerge through transition to fully State-operated Mobile Units?
- What institutional, operational, financial, governance, and human resource capacities are required to support successful transition and strengthening of State Mobile Units?
- How have partnerships, coordination mechanisms, training approaches, equipment provision, technical support, and budgetary investments contributed to transition processes and local ownership?

Limitations:

- Heterogeneity of the projects and the context that might lead to limitations in the ability to have comparable data.
- Limited possibility for primary data collection and necessity to rely on secondary data, not

initially collected for the purpose of that study (definitions of indicators, available variables, quality and completeness of databases, etc.).
- The relatively short period since project completion limits the ability to assess the long-term sustainability of outcomes.

Specific Objective 2 - Inform broader strategic reflection on advocacy coordination and positioning across MdM chapters in Ukraine

Provide an evidence-based analysis of advocacy practices, coordination mechanisms, priorities, capacities, and data systems across MdM Chapters operating in Ukraine. This objective also aims to ensure that advocacy priorities are grounded in an updated analysis of humanitarian and recovery needs related to primary healthcare and protection covering the frontline. To this end, the consultancy will design and technically guide a targeted needs assessment, whose findings will inform the identification and prioritisation of advocacy themes and recommendations. The objective is to identify opportunities to strengthen strategic alignment, coherence of messaging, evidence generation, and collective positioning, while assessing the added value, feasibility, and potential functions of a joint Advocacy Coordination mechanism at mission level.

This objective will include:
- Mapping existing advocacy practices, coordination structures, roles, and capacities across MdM Chapters;
- Analysing the broader advocacy landscape in Ukraine, including key stakeholders, thematic priorities, and MdM's positioning within the humanitarian, health, protection and recovery sectors;
- Assessing existing advocacy-related data systems and evidence-generation processes, identifying gaps in data collection, harmonisation, and use for policy influence and donor engagement;
- Identifying opportunities to strengthen strategic alignment, coordination, and collective advocacy approaches across Chapters.
- Designing the methodology, data collection tools and analytical framework for a targeted needs assessment on primary healthcare and protection-related needs
- Providing technical guidance to MdM teams during data collection, ensuring methodological consistency and quality assurance.
- Analysing the results of the needs assessment and identifying key humanitarian and health system priorities that should inform MdM's advocacy positioning and strategy.

C. METHODOLOGY

The consultancy will adopt a qualitative, quantitative, participatory, and policy-oriented approach structured around three phases: data collection, analysis, and production of deliverables – for both specific objectives.

I. Data collection phase:

The consultancy can use following sources of information (list not exclusive):

A) Literature review

B) Secondary data collection and analysis
- National and regional/local health policies and strategies
- MdM projects documentation: needs assessments, proposals, logframes, reports, SOP's, clinical guidelines, existing MoUs, medical supply chain and stock management tools, team training tools, transitions strategies.
- Other internal documents: job descriptions, thematic reference framework, institutional and country strategies.
- Datas and datas systems across MdM Chapters.
- Clinical data (anonymised): extract and analyse specific project indicators.
- International frameworks in terms of performance and resilience of health system.

- Advocacy materials and minutes of advocacy coordination meetings across Chapters.

B) Primary data collection and analysis:

- Key stakeholder interview: internal with MdM Chapter teams and external stakeholders (actors who are coordinating MUs, MoH actors at national, regional, local level, etc.).
- Field visits where feasible, depending on access and security conditions.
- Primary data collection tools to be developed by consultant according to each specific objective.

II. **Analysis phase:**
- Comparative analysis of operational models.
- Analysis and interpretation of the primary data collected through the needs assessment, identifying priority health and protection needs, service gaps, barriers to access and operational challenges relevant for advocacy.
- Identification of gaps, opportunities, and strategic entry points for advocacy coordination and health system transition.
- Synthesis of advocacy findings across Chapters and thematic areas.

III. **Co-production and validation phase:**
- Comparative study report.
- Iterative development of key deliverables (policy brief and advocacy toolkit) based on findings of the MU comparative study.
- Facilitation of internal multi-Chapter workshops to validate findings, refine recommendations based on feedback, and ensure alignment across Chapters.
- Integration of feedback from workshops into final deliverables.

The methodology will remain flexible and iterative, adapting to operational realities, security constraints, and stakeholder availability.

Limitations:
- Heterogeneity of the projects and the context that might lead to limitations in the ability to have comparable data.
- Limited possibility for primary data collection and necessity to rely on secondary data, not initially collected for the purpose of that study (definitions of indicators, available variables, quality and completeness of databases…).
- Project and transition phases still ongoing, consequently limited distance and overview to measure long term sustainability.

D. DELIVERABLES

The consultant(s) will be expected to produce:

I. **Inception note** – 1 consolidated or 2 (1 per outcome): outlining the refined methodology and analytical framework, workplan and timeline, stakeholder mapping and consultation plan, final scope confirmation (MU comparative study as well as broader advocacy strategy)

Under Specific Objective 1:

II. **Study Report** – a consolidated analytical report

This report will include:
- A comparative analysis of the three Mobile Unit models implemented by MdM in Ukraine (Full MdM, Mixed MdM-MoH, and State-operated), focusing on efficiency, sustainability, quality of service delivery, and conditions for transferability and public ownership, including the identification of elements that are most effectively transferable to State systems or hybrid models;

- An analysis of MU transition pathways and their contribution to SwS IV project Outcome 3 on local ownership and health system sustainability, with a specific focus on transition logic, sequencing, and enabling conditions for successful handover from humanitarian to public service delivery;
- Identification of key systemic constraints, opportunities, and lessons learned related to outreach service delivery, transition, and health system integration.
- A structured reflection on transition and exit strategies, including principles, steps, and operational considerations that could inform a replicable "transition approach" or framework for gradual handover of Mobile Units to public authorities or hybrid arrangements.
- A practical transition framework and set of recommendations outlining key success factors, minimum conditions, and capacity requirements for the transfer of outreach services from humanitarian actors to national health authorities, with potential applicability across MdM contexts.

The report will explicitly highlight the added value of different models (humanitarian-led, mixed, and State-operated) in strengthening service delivery and health system resilience, while outlining practical recommendations for improving State Mobile Units through integration of proven operational, clinical, and coordination practices derived from MdM experience.

III. **Restitution document** to be addressed to stakeholders and participants to the study

This document based on the study report should extract key points for advocacy purpose, at central level and regional level. This report would serve advocacy strategic decision-making, as well as donor and health authority engagement on sustainable outreach service delivery and transition pathways.

The restitution document will serve several purposes:
- Providing health authorities with actionable lessons learned from MdM-supported models to strengthen, adapt, and improve their health services including outreach services.
- Demonstrating to donors the relevance and added-value of MdM's interventions, including the rationale for continued support to State MUs and/or hybrid transition models.
- Providing MdM's chapters in Ukraine relevant data for evidenced-based advocacy.

➔ Together, these products ensure that the analytical findings are operationalised both for external policy influence (donors and strategic stakeholders) and for direct uptake by health authorities and service delivery structures to support sustainable localisation and transition of outreach services.

<u>Under Specific Objective 2:</u>

IV. **Advocacy prioritization and strategic recommendations report** - a strategic document translating research findings into actionable advocacy priorities and recommendations for MdM in Ukraine.

This report will include:
- A consolidated needs assessment report presenting the findings of the targeted assessment on primary healthcare and protection-related needs and informed by a structured review and synthesis of existing evidence, including the 2025 multi-oblast needs assessment and its analysis ensuring continuity and comparability of findings across time;
- Mapping and analysis of advocacy-related data systems, information flows, and key gaps affecting evidence generation and advocacy efforts across MdM Chapters;
- Mapping and analysis of advocacy practices, priorities, capacities, and coordination mechanisms across MdM Chapters;
- Assessment of current levels of strategic alignment, coherence of messaging, and collective positioning across Chapters;
- Identification and prioritization of key advocacy opportunities at national and sub-national levels;
- Strategic recommendations to strengthen evidence use, advocacy planning, coordination, and collective influence across MdM Chapters;

- Initial recommendations regarding the feasibility, added value, and potential scope of a joint Advocacy Coordination function at mission level;
- Proposed advocacy priorities, key messages, target audiences, and engagement pathways for donors, health authorities, and other relevant stakeholders.

V. **Multi-chapter workshop** - one facilitated workshop will be conducted, structured in two thematic sessions with differentiated audiences:

- **Session 1 (MdM Spain & MdM Germany) -** Validation of findings and shared framing of Mobile Units transition analysis, focusing on implementation experience and field-level lessons.
  - *Support used:* PowerPoint presentation summarising key findings and shared framing on Mobile Medical Units and OMT transition analysis, including implementation lessons learned. This presentation will be designed as a replicable facilitation tool, enabling each operational Chapter to use it for internal dissemination and contextual workshops.

- **Session 2 (All MdM Chapters in Ukraine) -** Strategic discussion on advocacy priorities, data use, and coordination mechanisms, including reflection on broader advocacy alignment and coordination options across Chapters.
  - *Support used:* One consolidated synthesis note, capturing: key agreements and divergences, operational and strategic insights, implications for advocacy coordination and transition pathways, agreed next steps across Chapters

IV. STUDY PLANNING AND IMPLEMENTATION

A. COMPOSITION OF THE TEAM

The mission will be carried out by:

- **One-several consultants or firm,** with the following expertise and experience:
  - Public health with expertise in the area of health system management;
  - Quantitative data analysis (epidemiology and biostatistics);
  - Strong knowledge of humanitarian action and sector;
  - Advocacy expertise;
  - Multi-actor coordination;
  - Knowledge and prior experience in Ukraine;

The consultant(s) will work in close collaboration with:

- **Technical and operational teams of MdM-Germany and MdM-Spain** in Ukraine (including health staff, coordination staff, MEAL, and advocacy focal points) providing technical expertise and support, contextual knowledge and field-based insights
- **MdM-Germany and MdM-Spain HQ technical referents (Health Referent and Advocacy Referent)**, providing technical guidance
- **SwS4 Project Coordinator in Ukraine (Kyiv)**, ensuring overall coordination of the process, facilitating communication across Chapters, and supporting methodological coherence and alignment of outputs.

B. STEERING COMMITTEE

A steering committee, led by the SwS4 Project Coordinator, will be composed of:

- For **Specific Objective 1**: MdM Spain and Germany HQ Health Referent; in-country Medical Coordinators of MdM Spain and MdM Germany; as well as General Coordinators.
- For **Specific Objective 2**: Advocacy focal points from MdM Spain, MdM Germany, MdM France, MdM Greece and MdM Netherlands, as well as MdM Switzerland in Ukraine, will provide strategic oversight to the consultancy.

The Steering Committee will be responsible for their respective objective of the following:

- Validation of the methodological approach and analytical framework;
- Provision of strategic guidance throughout the process;
- Review and validation of key deliverables;
- Contribution to the definition of advocacy priorities and key messages;
- Validation of the design and outcomes of multi-Chapter workshops.

The SwS4 Project Coordinator will ensure overall coordination of the process, facilitate communication between chapters involved, and support methodological coherence and alignment of outputs.

C. CHRONOGRAM

The assignment should take place between 01/08/2026 and 15/10/2026:

- **Preparation phase** (literature review and briefings): between 01/08/2026 and 15/08/2026
- **Field visit** (data collection and analysis): between 15/08/2026 and 30/09/2026
- **Multi-Chapter facilitation**: between 01/09/2026 and 30/09/2026
- **Reporting and finalization phase**: between 30/09/2029 and 15/10/2026

The indicative timetable is subject to change at any time depending on changes in the context. The adjustments to the timetable should be communicated and agreed to between the parties.

D. BUDGET

Costs related to travels to and within Ukraine, (flights, train, accommodation, refreshments, etc.) should be included in the budget proposed and paid directly by the consultant.

E. KEY DOCUMENTS

The following documents will be available:

- Need assessment (ECHO HIP), 2025;
- Analysis of the ECHO needs assessment conducted by ISGlobal, 2026;
- Swiss Solidarity (Phase 3 & 4) Project Proposal, logframe, reports;
- ECHO project Proposal, intermediary and final report;
- MdM Advocacy booklet;

F. APPLICATION

All applicants should include in the proposal:

- Technical proposition, including methodology for both specific objectives and timeframe suggested;
- Financial proposition;
- Profiles of the consultant(s);
- Motivation letter;