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## EVALUATION

# Final Performance Evaluation of the Reproductive Maternal Newborn Child Health /Health Systems Strengthening Program 2008 - 2013 USAID – CAMBODIA

**July 2013**

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Dirk Horemans, Laura Slobey, Sovannarith Sok, Kristina Gryboski, Elisa Ballard and Mary Ann Evangelista.

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## **DISCLAIMER**

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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## ACRONYMS

AAD	Activity Approval Document
AIDS	Acquired Immune Deficiency Syndromes
AMTSL	Active Management of Third Stage of Labor
ANC	Antenatal Care
AOP	Annual Operational Plan
ARI	Acute Respiratory Infection
ARV	Antiretroviral
AusAID	Australian Agency for International Development
BCC	Behavior Change Communications
BEmONC	Basic Emergency Obstetrical Newborn Care
BFCI	Baby Friendly Community Initiative
BWFS	Biotech Water Filter Systems
C-DOTS	Community-Based Directly Observed Treatment Short Course
C-IMCI	Community-Integrated Management of Childhood Illness
C-MNH	Community Care of Mothers and Newborn Health
CA	Cooperative Agency
CDRI	Cambodia Development Research Institute
CA	Cooperative Agreement
CBCM	Community Based Case Management
CBD	Community Based Distribution
CBHI	Community Based Health Insurance
CC	Commune Council
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CENAT	National Center for Tuberculosis and Leprosy Control
CFH	Comedy for Health
CHBC	Community Home Based Care
CIP	Commune Investment Program
CMS	Central Medical Store
COMBI	Communication for Behavioral Impact

CPG	Clinical Practice Guidelines
CPR	Contraceptive Prevalence Rate
CRPR	Client's rights and Provider's rights
CYP	Couple Year Protection
DOTS	Directly Observed Treatment Short Course
DTK	Diarrhea Treatment Kit
EDB	Essential Drug Bureau
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetrical Newborn Care
EPI	Expanded Program on Immunization
FBD	Facility Based Delivery
FGD	Focus Group Discussion
FP	Family Planning
HBB	Helping Babies Breathe
HC	Health Centers
HCF	Health Care Financing
HCMC	Health Center Management Committee
HCPBC	Health Center Performance Based Contract
HCPC	Health Center Performance Contracting
HEF	Health Equity Fund
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HosDID	Hospital Drug Inventory Database
HSSP2	Health Sector Support Program II
IDD	Iodine Deficiency Disorder
IEC	Information Education Communication
IFFS	Iron Fortified Fish Sauce
IFSS	Iron Fortified Soy Sauce
ILSI	International Life Sciences Institute
IMCI	Integrated Management Childhood Illness
IPC	Inter Personal Counseling

IPPC	Integrated Post-Partum Care
IUD	Intra Uterine Device
IYCF	Infant Young Child Feeding
LDSC	Latter Day Saints Charity
LMIS	Logistic Management Information System
LSS	Life Saving Skills
LT	Long-term method
LT/PM	Long-term/Permanent Methods
MAM	Management of Acute Malnutrition
MBPI	Merit Based Payment Initiative
MCAT	Midwife Coordination and Alliance Team
MCH	Maternal and Child Health
MMM	Mundul Mith Chouy Mith
MOH	Ministry of Health
MOP	Ministry of Planning
MPA	Minimum Package of Activities
MSG	Mother Support Group
MSIC	Maries Stopes International Cambodia
MWRA	Married Women in Reproductive Age
NCHADS	National Center for HIV/AIDS /Dermatology and STD
NCHP	National Center for Health Promotion
NGO	Non-government Organization
NMCHC	National Maternal and Child Health Center
NNP	National Nutrition Program
NRHP	National Reproductive Health Program
NRP	Neonatal Resuscitation Program
NTP	National Tuberculosis Control Program
OCP	Oral Contraceptive Pill
OD	Operational Districts
ODDID	Operational District Drug Inventory Database
OI	Opportunistic Infection

ORS	Oral Rehydration Salts
ORT	Oral Rehydration Treatment
OVC	Orphans and Vulnerable Children
Oxfam	Oxford Committee for Famine Relief
PAC	Post Abortion Care
PHD	Provincial Health Department
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention Mother to Child Transmission
PNC	Post Natal Care
POC	Priority Operation Cost
PPH	Post-Partum Hemorrhage
PPM-DOTS	Public-Private Mix Directly Observed Treatment Short Course
PRDD	Provincial Rural Development Department
PRH	Provincial Referral Hospital
ProDID	Provincial Drug Inventory Database
PSK	Population Services Khmer
QI	Quality Improvement
RACHA	Reproductive and Child Health Alliance
RGC	Royal Government of Cambodia
RH	Referral Hospital
RH	Reproductive Health
RHAC	Reproductive Health Association of Cambodia
RTC	Regional Training Center
SAR	Semi-Annual Report
SBA	Skilled Birth Attendants
SDG	Service Delivery Grant
SfC	Saving for Change
SM	Safe Motherhood
SOA	Special Operating Agency
SSG	Self Support Group
STI	Sexually Transmitted Infection

TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Emergency Fund
USAID	United States Agency for International Development
VAC	Vitamin A Capsule
VCCT	Voluntary Confidential Counseling and Testing
VHSG	Village Health Support Group
VSC	Voluntary Surgical Contraception
WASH	Water and Sanitation/Hygiene
WFP	World Food Program
WRA	Woman of Reproductive Age

## EXECUTIVE SUMMARY

### Evaluation Purpose & Evaluation Questions

In late 2008, USAID designed and approved a five-year health program spanning the period October 2008 through September 2013.<sup>1</sup> Within this overall program, four cooperative agreements (CAs) or projects were awarded to the Reproductive and Child Health Alliance (RACHA), the Reproductive Health Association of Cambodia (RHAC), the University Research Corporation (URC) and the Population Services International (PSI) to support the specific components of the overall program. In January 2011, USAID commissioned an external mid-term evaluation of its RMNCH/HSS program, which assessed the health systems capacity development and the harmonization of implementation across the four projects and provided recommendations for project modifications and improvements.

In June 2013, USAID commissioned the final external performance evaluation of the RMNCH/HSS program in Cambodia, consisting of two primary components.

The first component is a Final Performance Evaluation of the main RMNCH and HSS projects: 1) Maternal and Child Health Program, 2) Together for Good Health, and 3) Better Health Services. The purpose of the first component was three-fold:

- Conduct a final performance evaluation of the RMNCH / HSS projects.
- Review capacity of local partners to manage for results and technically direct USAID programs in the field and at national level.
- Capture lessons learned and provide recommendations that will refine Mission investments in key activities that will be carried forward for the next five years.

The second component, a more detailed assessment of USAID's Family Planning activities, is included as part of this Final Performance Evaluation. In addition to the three USAID RMNCH/HSS activities implemented by RHAC, RACHA, and URC, the evaluation also considered specific interventions under the Support to International Family Planning Organizations (SIFPO) project, implemented in country by Marie Stopes International Cambodia (MSIC); as well as the findings of a former evaluation, conducted in October 2012, of the social marketing of family planning and child survival commodities implemented under the Social Marketing and Behavior Change Interventions for HIV/AIDS, Reproductive & Sexual Health and Child Survival (SMBCI) in Cambodia, implemented by PSI. The purpose of the second component was to:

Evaluate whether family planning goals and objectives were met by each project.

- Identify strengths and weaknesses of the various USAID-funded family planning intervention in Cambodia and identify gaps and missed opportunities that need to be addressed in future USAID-supported family planning projects.

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<sup>1</sup> Cambodia Health Program Design FY 2009-2013 Activity Approval Document, USAID/Cambodia

- Identify lessons learned and best practices that should be prioritized for scale-up to contribute to reaching the Royal Government of Cambodia's (RGC) family planning goals.

As requested by OPHE, the evaluation paid special attention to the long-term family planning vouchers implemented by MSIC and RHAC.

General aspects of HEF, CBHI, HMIS, and HIV activities were excluded from this evaluation and were not addressed due to other recent evaluations and assessments.

### **Background Country – Program- Project**

In the mid-nineties, Cambodia started to move away from a post-conflict context into an era of economic, political and social transformation. Economic growth averaged 7% a year subsequently for two decades, even during the global economic crisis, bringing the estimated GDP – per capita (PPP) to about \$2,400 in 2012<sup>2</sup>. Nevertheless Cambodia is still considered a low-income country with around 23.9%<sup>3</sup> of its population living below the poverty line.

In the health sector, Cambodia is well on course to meeting most of its health-related Millennium Development Goals (CMDGs) and National Strategic Development Plan (NSDP) indicators (see table below extracted from HSP2 MTR report). When looked at with a ten-year perspective, one can only conclude that the level of progress on NSDP/CMDG indicators achieved by Cambodia over the last decade has been nothing short of phenomenal.

The country has witnessed a significant drop in the maternal mortality ratio, from 472 per 100,000 live births in 2005 to 206 in 2010 Cambodian Demographic Health Survey 2010 (CDHS). But this is still high and remains a challenge. Births at public health facilities increased dramatically from 22% of the total in 2005 to 66.3% in 2012, while the number of deliveries in private health facilities, currently not reported, is probably significant. In both the public and private sectors, however, quality of maternal health care remains a concern. Access to emergency obstetric care is also limited, particularly in rural areas. The CDHS 2010 indicates a substantial increase in the use of modern contraception from 27% in 2005 to 35% in 2010, yet far from reaching the MDG goal of 60%. The 2010 CDHS demonstrates infant and under five mortality dropped to 45/1000 and 54/1000 live births<sup>4</sup>, respectively, but neonatal mortality remains accountable for half of the under-five deaths in Cambodia. Child malnutrition has experienced some improvement, with stunted growth having declined from 50% in 2000 to 40% in 2010. However, this rate is still 17 times what is expected in a healthy population. The HIV/AIDS prevalence rate declined from 1.6% in 2000 to an estimated 0.7% in 2009 and is projected to decline further and stabilize at 0.6% after 2010. Cambodia still remains among the countries hardest hit by the HIV/AIDS epidemic in

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<sup>2</sup> <http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD>

<sup>3</sup> <http://data.worldbank.org/country/cambodia> Survey 2009

<sup>4</sup> CDHS 2005 IMR was 66 / 1000 and <5 Mortality was 83 / 1000

the region. The prevalence of all forms of tuberculosis per 100,000 people declined from 928 in 1997 to 664 per 100,000 people in 2007 (Ministry of Planning (MOP) – 2010), but Cambodia continues to be beleaguered with one of the highest prevalence rates in the world.

These generally positive trends are the admirable result of the efforts of the RGC and other stakeholders in the health sector, particularly USAID and its implementing partners. However, to continue such rapid improvements Cambodia's health sector will need to overcome a number of critical challenges, namely poor quality of health services and access to service delivery. For nutrition, maternal and neonatal mortality, and family planning, increased efforts by the Royal Government of Cambodia and its development partners are required.

The health care system is composed of a district-based public health sector and a largely unregulated private sector. Government health facilities are generally equipped and staffed but suffer from lack of adequate funding, limited management capacity, low staff salaries and inadequate medical skill levels, which prevent them from offering quality health services to the population. In 2009, the formal private sector accounted for 70% of the reported curative treatment compared to 22% in public health facilities<sup>5</sup>. On the other hand preventive health services are almost exclusively obtained through the public sector, as are the majority of the family planning services and delivery care in rural (but not urban) areas.

In 2010, Prime Minister Hun Sen announced that the highest priority in health is to reduce maternal mortality. In response to the prime minister's appeal and with donors' support, the MOH developed the Fast Track Road Map for reducing Maternal and Newborn Mortality Initiative (FTI). The Ministry of Health developed this road map with assistance from USAID and other donors. FTI together with the Government Midwife Incentives has contributed significantly to the increasing proportion of deliveries in public health facilities.

### **USAID RMNCH/HSS Program**

USAID/Cambodia's health strategy is consistent with and supports the MOH's Strategic Health Plan through a Strategic Objective Agreement (SOAG) with the RGC, and supports the key health systems strengthening activities described in the MOH's HSP2. While USAID does not "pool" its resources under Health Sector Support Program (HSSP2), the intent of the program is to provide technical and managerial support to the MOH at several levels to help strengthen the capacity of the health system to address several major program areas described in the HSP2. The USAID program also provides valuable capacity building at the community level to expand the MOH's reach beyond the lowest level facilities and increase the accountability of the health system to the communities. It also works with the development of private service delivery, social marketing of health products and services and behavior change communication. USAID as a development partner is committed to the principles of donor harmonization and alignment of the Paris Declaration, and has been

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<sup>5</sup> Cambodian Socio-Economic Survey Analysis, Out of Pocket Expenditure, MOH 2012 based on CSES 2009.

working closely with all stakeholders, including attempting to link its activities with those of the HSSP2.

### **USAID Projects**

Implementation mechanisms for the program were narrowed down to include four integrated health projects: 1) Maternal and Child Health Program (MCHP); 2) Together for Good Health (ToGoH); 3) Better Health Services (BHS); and 4) Social Marketing and Behavior Change Interventions for HIV/AIDS, Reproductive & Sexual Health & Child Survival in Cambodia (SMBCI). USAID/Cambodia's implementing partners provide targeted technical support to improve the public health system, working in a cross-sectoral approach by engaging the public sector, private health providers, and communities.

The evaluation team was asked to look primarily at the first three projects, as well as at the SIFPO Project implemented by MSI Cambodia.

### **The External Environment**

The program and its projects do not work in a vacuum. They function in a changing environment that provides many constraints but also opportunities. Those constraints are related to 1) a sometimes challenging collaboration with the MOH, the main program partner; 2) the ongoing Deconcentration and Decentralization (D&D) process influencing health sector activities; 3) the fast increase in number of midwives; 4) the close collaboration with the second Health Sector Support Program, including its financial management difficulties; 5) increasing internal and cross-border migration, influencing health volunteers availability and health seeking behavior; 6) increasing economic growth and declining poverty; and 7) the growing share of health service delivery by the unregulated private for-profit sector.

### **Evaluation methods & limitations**

This performance evaluation employed a mixed-method approach relevant to this kind of evaluation. Throughout the evaluation, findings from the different methods were compared to assure consistency. Overall progress was assessed against the goals of the AAD, the program descriptions in each of the four Cooperative Agreements along with their PMPs and their annual work plans.

### **Description of Evaluation Methodology**

The evaluation team used a variety of methods for assessing and analyzing qualitative and quantitative information and data. The methods used in completing this evaluation included:

- Document Review: Prior to arriving in-country the team reviewed general background documents and reports. Review of technical reports, annual work plans, geographical coverage data, and other documents continued while in country.
- Key informant interviews: Using the guide developed during the team planning meeting, the team conducted semi-structured interviews with project staff, MOH

policy makers, and managers at PHD and OD level, other donors, health services providers, clients, and community members.

- Site visits – Seven provinces were selected for the team to visit provincial and district offices, hospitals, health centers and surrounding villages.
- Focus group discussions were convened with community health workers (VHSGs & CBDs) and clients who were users of long-term family planning method vouchers.
- Analyses of data: Quantitative methods did not involve new data collection but used existing data from the semi-annual and annual reports from the USAID partners, RHAC and RACHA annual household survey, CDHSs 2005 & 2010, MOH's up to date Health Management Information System (HMIS), existing secondary analysis and other available survey research.
- Briefing, debriefing and validation meetings: An introductory meeting was held with USAID health staff to discuss logistics and to clarify the scope of work; a second meeting with the OPHE team to present the proposed report outline and discuss the design of the evaluation; a meeting with the USAID Mission Director to receive guidance on USAID's priorities and special areas of interest; a mid-term meeting with OPHE to discuss progress and clarify issues; a final debrief with a summary of the findings and draft recommendations with both USAID and USAID implementing partners.

The evaluation team consisted of six members including three international consultants, two health specialists from USAID/Washington, and a local Khmer consultant. The team had a combination of significant RMNCH and HSS expertise, experience about the evolution of the health status of Cambodia's women and children, knowledge of USAID programming, and applied program evaluation expertise. A planning meeting was held during the evaluation team's first days in country. This time was used to clarify team members' roles and responsibilities, deliverables, development of tools and approach to the evaluation, as well as refinement of the agenda, selection of field sites and scheduling of appointments. The team also developed specific questionnaires for the various categories of stakeholders, which were used as a guide during the interviews.

Only 5 of the 10 main provinces covered by the program were visited. Two more provinces, Kandal and Takeo, were visited in order to look at MSIC activities. The selection of provinces was done by the USAID staff, purposefully. Focus group discussions (FGDs) with VHSGs, CBDs or LT/PM FP voucher users, had to be arranged by the implementing partners and the participants were informed in advance. Other users were only informed the day of the visit, and the team was able to conduct a few surprise visits. The LT/PM FP voucher users were selected randomly from the register of users of that HC.

### **Limitations of the Evaluation**

It should firstly be clarified that the evaluation did not set out to validate all the data and activities reported by the partners. The aim of the field visits was to better understand the

processes, to learn about progress, problems and recommendations from the stakeholders and beneficiaries, and to some extent confirm certain data or statements found in the implementing partner reports. The sample size of institutions visited was restricted by the time in country but did not limit the evaluation findings. The evaluation team was somewhat constrained by the breadth of technical areas to be covered in the four-week time frame.

In addition, the evaluation coincided with the national election campaign. As a result some provincial authorities were not available for meetings, and in other cases schedules needed to be rearranged. The election campaign might also have influenced available funding for community health activities.

The available datasets had different timelines. The data collection from the last RACHA and RHAC annual surveys in the project areas happened from May to July 2012. The Countrywide CDHS were from 2005 and 2010. The 2010 CDHS collected data at the second half of 2010. The methodology of the annual survey of RHAC and RACHA changed after 2010 and makes comparison with previous years impossible.

While the evaluation team did choose the geographical areas, the LT/PM FP Voucher users for the FGD and the CBDs and VHSG interviewed in those areas were identified by implementing partners. This was necessary due to the need to inform them days before the arrival of the team and required somebody on the ground for organizing that meeting. The LT/PM FP voucher users were selected randomly from the register of users of that HC. The process was verified with the team.

In some ODs the team was confronted with the presence of multiple NGOs, some of which were quite small, supporting the same HCs in the same technical domains but with slightly different interventions, sometimes complementing one another. In those places it was more difficult to attribute achievements to specific projects.

It is however the opinion of the evaluation team that none of the above limitations significantly influenced the findings of this evaluation.

## **Findings**

Comparison of the CDHS 2005 and 2010 shows that three important goals - the reduction in maternal mortality rate and in under-5 mortality rate and the increase in modern contraceptive rate - have been achieved. The maternal mortality ratio (MMR) decreased significantly from 472 per 100,000 live births in 2005 to 206 per 100,000 in 2010, a 56% reduction. The under-five mortality rate in Cambodia decreased from 83 per 1,000 live births in 2005 to 54 per 1,000 live births in 2010, a 35% reduction. Both reductions are significantly larger than the Mission's goal, set at 25%. According to the CDHS 2010, the modern contraceptive prevalence rate amongst married women was 34.9%, a proportional increase of 22% from the 27.9% CPR rate in the CDHS 2005, indicating that the CPR program goal of 35% had already been narrowly achieved in 2010.

Evidence for achieving a 20% decrease in TB prevalence, the other USAID Program Goal, is less available because of infrequent surveys due to population-based TB prevalence data

collections being very time and resource intensive. Nevertheless, available survey data shows that between 2002 and 2011 there was a reduction in the prevalence of smear-positive TB by 38% and in the prevalence of bacteriologically positive TB by 45% among persons over 15 years of age. Both reductions are very much in line with the USAID Health program goal for TB.

Several factors have contributed to the achievement of these goals. They are the result of an improved socio-economic environment, decreased fertility and improved quality and accessibility of preventive and curative services delivered by Hospitals, HC and community volunteers. The present (2008- 2013) and the previous (2004- 2008) USAID health programs have been working towards each of these health goals by intensively supporting public health services of government hospitals and health centers and through the activities of community volunteers. The USAID projects include an impressive number of interventions which directly target improved health outcomes.

Data from the HMIS and from the RHAC and RACHA joint annual surveys show a significant increase of health coverage and service outputs indicators in the USAID program-supported provinces since the CDHS 2010. The numbers of deliveries taking place in health facilities in 2012 had increased to 87.1% and 88.1% in the provinces supported respectively by the ToGoH and MCHP projects, while the Cesarean section rate, a proxy indicator for improved CEmONC care, increased by 51.2 % since 2009 to reach 1.6% in 2012.

The implementing partners have been successful in supporting local counterparts to implement the national nutrition program, contributing to the reduction of chronic malnutrition among children under 5 years to 40% (CDHS 2010), from 43% in 2005. They successfully equipped local counterparts to implement services for Vitamin A supplementation such that the government is now able to sustain them. Their efforts in promoting exclusive breastfeeding have contributed to the gains in newborn feeding at a large scale. Screening for anemia is done and up to 97% of women are provided 90 iron-folate tablets. At the community level, VHSG have been trained to provide nutrition messages. Nevertheless nutrition challenges in Cambodia persist due to inadequate counseling at some health centers, low community awareness, and the need for better food security linkages with agriculture.

Based on a model supported by USAID in the previous program, Community-DOTS was brought to scale by MCHP and TOGOH soon after the issuance of the National Guidelines for Community DOTS. Recently USAID has brought pediatric TB forward as a new area of focus for the National TB Program.

The USAID program has influenced the discourse on quality improvement in health in Cambodia and has been quite effective in providing guidance to the MOH on strategies to achieve this through relevant policies and innovative implementation strategies. Capacity building support has focused on improving the technical knowledge and skills of health professionals providing critical health services to target populations. USAID implementing partners have in the past five years provided numerous trainings for midwives, nurses, doctors, VHSGs, CBDs, provincial or OD staff, as well as MOH staff.

A large number of health-related community activities have been introduced by the implementing partners. The community health activities focused on the two main priority health program areas of the Health Sector Strategic Plan II (HSP-II 2008-2015): 1) Reproductive Maternal Newborn and Child Health and 2) Communicable Disease. USAID implementing partners have also explored different ways to encourage feedback and complaints by clients to hold public facilities accountable. In several areas this resulted in very active feedback and subsequently in improved functioning of the HCs.

A variety of behavioral change communication activities were carried out by all implementing partners including the development of materials. The greatest impact was achieved through the use of community volunteers or VHSGs.

USAID projects have made a significant contribution to increased utilization of family planning services in Cambodia. Between 2010 and 2012 the CPR had further increased from 37.2%<sup>6</sup> to 38.7% and from 32.1% to 46.5% in the provinces supported by the MCHP and ToGoH projects, respectively.

## **Conclusions**

Based on CDHS 2005 and 2010, as well as on more recent project household surveys, and HIS data, the evaluation team can conclude with confidence that the USAID Health Program Goals for 2013 have been achieved. Given the intensive and widespread support for interventions directly targeting those goals it is likely that the contribution of the USAID program and its projects towards the achievement of the Program Goals has been significant.

Several recommendations of the MTR have been acted upon by USAID and the implementing partners. Collaboration amongst partners has markedly improved. Project monitoring and survey systems have further improved. Some less active RHAC clinics in rural areas were closed. And to some extent, competency, qualifications issues and program knowledge of provincial and field staff have been addressed. Members of the evaluation team who had worked previously in Cambodia were impressed by the increased level of activity at the HCs and hospitals supported by the projects as well as by improvements in hygiene, equipment and the presence of utilities such as running water and electricity. The same can be said about the very active community involvement through VHSGs and CBDs.

The team noted a multitude of interesting, innovative and good practices implemented and supported by the projects. They include: support for CBDs and VHSGs, quality training with more hands-on practical approaches, creative materials for training in safe motherhood, hospital and health hygiene interventions, nutrition, FP and many more. Recommendations for Case Studies on some of these practices are included in Annex 11.

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<sup>6</sup> This is a CDHS 2010 figure as there was no comparable data from the RACHA survey for 2010

The partners have advanced D&D in the health sector through new mechanisms for community feedback and involvement, supporting innovative approaches for community-based health education and adopting best practices for maternal health interventions

While FP services have definitely improved over the past several years, much remains to be done if the country is to achieve its MDG goals for family planning by 2016. There is a critical need in Cambodia to intensify efforts to reach non-users and to motivate all women to use a modern method of FP. The MOH needs to seize opportunities to provide women with FP information and services at each point of contact with the health system and at every stage of the birth interval. USAID needs to increase its programmatic focus on RH/FP and make it clear to its partners that family planning is a high priority.

Specifically with regards to BCC, the team identified evidence of some overlap and major gaps in demand generation. Specifically there is a need for an integrated demand creation communication campaign, which focuses on the barriers to adoption of modern methods of family planning. Better coordination among partners working in the area of health communication should be encouraged.

An important strength of the program is its comprehensiveness, achieved by supporting a large number of interdependent interventions, such as assuring a good balance between demand creation and supply side support. Assuring projects' flexibility and allowing them to adapt their approaches to the changing environment has also contributed to their success.

Working with and through MOH and PHD has not become easier in recent years. In the context of low remuneration, their professional motivation seems to have suffered further from the abolition of incentives from MBPI, POC and others. With the revised USAID per diem policy it has become more difficult to involve counterparts in the important interventions.

The close collaboration with HSSP2 and JPIG has been very beneficial in general and for specific activities such as HEF. It has allowed for joint leverage on MOH, as was the case with the requirement for regular quality assessments and for keeping the HEF third party payer arrangement. Implementing partners have been advocating for transferring funding responsibilities for service delivery activities from USAID budget to HSSP2/MOH budget through AOP planning. However with the chronic delays in HSSP2 funding and eventual cuts at the OD and HC level, those activities are frequently postponed, often for several months in the beginning of the year, resulting in cancellation of some activities. Further and closer collaboration with MOH and HSSP2 donors should be encouraged.

USAID implementing partners are very professional and clearly have the required capacity to manage and implement their programs and have achieved the objectives stated in their projects. They are all three well respected by MOH, by other Health Partners and by health staff and communities in the field, both for their technical capacities and for their support for service delivery. As large local NGOs, both RHAC and RACHA have become organizations well known for their expertise in the field of reproductive, maternal and child health and community level health work. They both have strong organizational capacities.

The evaluation did find a number of issues that need to be addressed in several technical domains. Based on those many findings and lessons learned, the report lists a large number of recommendations, ranging from the very detailed, to the more general, to some which require policy advocacy interventions by USAID and Health Partners colleagues. Some of these recommendations might be useful when defining or refining future USAID Program activities.

As USAID is contributing to the development of the CDHS 2015 instruments, it should make use of this opportunity to ensure the collection of important baseline data for the next program, obviously without overloading the questionnaire.

At least for the near future, NGO support will continue to play a very important role in Cambodian development in the health sector. Their support and involvement is needed for focusing on quality improvement, capacity building, working with communities and their volunteers, assisting communities to voice their health service needs or complaints, as well as for introducing and piloting innovative approaches which can then later be adopted by the system. External support for some of the present USAID-supported HSS interventions such as HEF implementation, HMIS and QA development is still required.

Finally, it should be highlighted that the USAID Health Program and its implementing partners are very much appreciated by the MOH, the other donors and the various stakeholders in the field, including the community representatives. MOH, PHDs, ODs, RH, HC and communities expressed their hope and wishes for USAID to continue supporting their institutions and communities. Several MOH authorities articulated their preference for a mix of capacity building interventions with service delivery support projects over pure capacity building support projects.

## EVALUATION PURPOSE & EVALUATION QUESTIONS

In late 2008 USAID designed and approved a five-year health program spanning the period October 2008 through September 2013.<sup>7</sup> Within this overall program, four cooperative agreements (CAs) or projects were awarded to the Reproductive and Child Health Alliance (RACHA), the Reproductive Health Association of Cambodia (RHAC), the University Research Corporation (URC) and the Population Services International (PSI) to support the specific components of the overall program. In January 2011, USAID commissioned an external mid-term evaluation of its RMNCH/HSS program, assessing health systems capacity development and the harmonization of implementation across the four projects and providing recommendations for project modifications and improvements.

In June 2013, USAID commissioned the final external performance evaluation of the RMNCH/HSS program in Cambodia, consisting of two primary components.

The first component is a Final Performance Evaluation of the main RMNCH and HSS projects: 1) Maternal and Child Health Program, 2) Together for Good Health, and 3) Better Health Services.

The **purpose of the first component** was three-fold:

- Conduct a final performance evaluation of the RMNCH / HSS projects.
- Review capacity of local partners to manage for results and technically direct USAID programs in the field and at national level.
- Capture lessons learned and provide recommendations that will refine Mission investments in key activities that will be carried forward for the next five years.

The second component, a more detailed assessment of USAID's Family Planning activities, is included as part of this Final Performance Evaluation. In addition to the three USAID RMNCH/HSS activities implemented by RHAC, RACHA, and URC, the evaluation also considered specific interventions under the Support to International Family Planning Organizations (SIFPO) project, implemented in country by Marie Stopes International Cambodia (MSIC). The social marketing of family planning and child survival commodities implemented under the Social Marketing and Behavior Change Interventions for HIV/AIDS, Reproductive & Sexual Health and Child Survival (SMBCI) in Cambodia implemented by PSI was evaluated in October 2012 and was not covered directly by this evaluation. The team did consider the contributions of the PSI program while assessing USAID's overall investment in family planning in Cambodia. The **purpose of the second component** was to:

Evaluate whether family planning goals and objectives were met by each project.

- Identify strengths and weaknesses of the various USAID-funded family planning interventions in Cambodia and identify gaps and missed opportunities that need to be addressed in future USAID-supported family planning projects.

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<sup>7</sup> Cambodia Health Program Design FY 2009-2013 Activity Approval Document, USAID/Cambodia

- Identify lessons learned and best practices that should be prioritized for scale-up to contribute to reaching the Royal Government of Cambodia's (RGC) family planning goals.

### **Key Evaluation Questions**

For Component 1, two key evaluation questions and a number of illustrative questions were defined. The illustrative questions can be found in the SOW (Annex 1). The key evaluation questions are:

Question 1: Taking into account the project changes as a result of the midterm, to what extent have the USAID-funded health projects achieved their goals and intermediate results in RMNCH and HSS as specified in the Mission's Activity Approval Document (AAD 2009 - 2013) and in the existing partner agreements, particularly.

Question 2: How well have local NGO partners managed for results and provided technical direction to their USAID-funded programs in the field and at national level?

The key evaluation questions for component 2 on Family Planning are:

Question 1: To what extent are USAID-funded family planning interventions contributing to improving the utilization and quality of services in Cambodia? How have these interventions contributed to changes in the health-seeking behavior of family planning methods of women and men?

- Community based distribution (CBD)
- Voucher schemes
- Health equity fund model
- Family planning as a part of post-abortion care
- Family planning as a part of post-partum care in hospitals

Question 2: What are the ongoing bottlenecks to family planning uptake/continuous family planning use and are the programs addressing them well (i.e. side-effecting, high drop-out rates, etc.)?

Question 3: Are the CBD agents capable of promoting behavior change for a broad mix of methods beyond oral contraceptives? What is needed to improve the CBD model?

Question 4: How are guidance, policy, and strategy helping or hindering family planning use and access? Are guidelines understood by providers and acted upon? Are policy makers supportive of family planning and what opportunities exist to exploit and influence leaders supporting family planning?

As requested by OPHE, the evaluation paid special attention to the long-term family planning vouchers implemented by MSIC and RHAC. A more detailed description of those findings and recommendations can be found in annex 6.

General aspects of HEF, CBHI, HMIS, and HIV activities were excluded from this evaluation and were not addressed due to other recent evaluations and assessments.

## BACKGROUND COUNTRY – PROGRAM- PROJECT

In the mid-nineties, Cambodia started to move away from a post-conflict context into an era of economic, political and social transformation. Economic growth averaged 7% a year subsequently for two decades, even during the global economic crisis, bringing the estimated GDP – per capita (PPP) to about \$2,400 in 2012<sup>8</sup>. Nevertheless Cambodia is still considered a low-income country with around 23.9%<sup>9</sup> of its population living below the poverty line.

In the health sector, Cambodia is well on course to meeting most of its health-related Millennium Development Goals (CMDGs) and National Strategic Development Plan (NSDP) indicators (see table below extracted from HSP2 MTR report). When looked at with a ten-year perspective, one can only conclude that the level of progress on NSDP/CMDG indicators achieved by Cambodia over the last decade has been nothing short of phenomenal.

The country has witnessed a significant drop in the maternal mortality ratio, from 472 per 100,000 live births in 2005 to 206 in the 2010 Cambodian Demographic Health Survey (CDHS). But this is still high and remains a challenge. Births at public health facilities increased dramatically from 22% of the total in 2005 to 66.3% in 2012, while the number of deliveries in private health facilities, currently not reported, is probably significant. In both the public and private sectors, however, quality of maternal health care remains a concern. Access to emergency obstetric care is also limited, particularly in rural areas. The CDHS 2010 indicate a substantial increase in the use of modern contraception, from 27% in 2005 to 35% in 2010, yet still far from reaching the MDG goal of 60%. The 2010 CDHS demonstrates that infant and under five mortality dropped to 45/1000 and 54/1000 live births<sup>10</sup>, respectively, but neonatal mortality remains accountable for half of the under-five deaths in Cambodia. Child malnutrition has experienced some improvement, with stunted growth having declined from 50% in 2000 to 40% in 2010. However, this rate is still 17 times what is expected in a healthy population. The HIV/AIDS prevalence rate declined from 1.6% in 2000 to an estimated 0.7% in 2009 and is projected to decline further and stabilize at 0.6% after 2010. Cambodia still remains among the countries hardest hit by the HIV/AIDS epidemic in the region. The prevalence of all forms of tuberculosis per 100,000 people declined from 928 in 1997 to 664 per 100,000 people in 2007 (Ministry of Planning (MOP) – 2010), but Cambodia continues to be beleaguered with one of the highest prevalence rates in the world.

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<sup>8</sup> <http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD>

<sup>9</sup> <http://data.worldbank.org/country/cambodia> Survey 2009

<sup>10</sup> CDHS 2005 IMR was 66 / 1000 and <5 Mortality was 83 / 1000

These generally positive trends are the admirable result of the efforts of the RGC and other stakeholders of the sector, particularly USAID and its implementing partners. However, continuing such rapid improvements will become more challenging as the easier to achieve changes, the lower hanging fruits, have already been harvested. Cambodia's health sector will therefore need to overcome a number of critical challenges, namely poor quality of health services and access to service delivery. For nutrition, maternal and neonatal mortality, and family planning, more visible efforts by the Royal Government of Cambodia and its development partners are required.

Given that Cambodia is in full epidemiological transition, it has started to face the dual burden of both communicable and non-communicable diseases. The burden of non-communicable (NCD) diseases is increasing rapidly and possibly already exceeding that of communicable diseases. According to the World Health Organization (WHO), 832 deaths per 100,000 in 2004 in Cambodia were due to non-communicable diseases and only 660 to communicable diseases. It estimates that more than half (53%) of deaths in Cambodia are caused by NCDs, with cardiovascular disease the main killer causing 24% and cancers 9% of deaths<sup>11</sup>. For women the age-standardized death rates of cervical cancer and breast cancers, the most common cancers, are 16.2 and 8.0 per 100,000, respectively.

The health care system is composed of a district-based public health sector and a largely unregulated private sector. As of 2012, there were 1,024 health centers (HCs) and 83 referral hospitals (RHs) in 79 operational health districts (ODs), providing reasonable health infrastructure coverage in most of the country. Government health facilities are generally equipped and staffed but suffer from lack of adequate funding, limited management capacity, low staff salaries and inadequate medical skill levels, which prevent them from offering quality health services to the population. In 2009, the formal private sector accounted for 70% of the reported curative treatment compared to 22% in public health facilities<sup>12</sup>. On the other hand preventive health services are almost exclusively obtained through the public sector, as are the majority of the family planning services and delivery care in rural (but not urban) areas.

The Second Health Strategic Plan (HSP2) for 2008-2015 set forth an ambitious set of priorities and activities that address the current deficiencies in the health care system. The plan is structured around three health priority program areas: Reproductive, Maternal, Neonatal and Child Health; Communicable Disease Control; and Non-Communicable Diseases. It also establishes 5 sector-wide strategies to achieve those program goals. Presently MOH is in the process of producing a new HSP plan in line with the development of the next NSDP 2014-2018.

In 2010, Prime Minister Hun Sen announced that the highest priority in health is to reduce maternal mortality. In response to the prime minister's appeal and with donors' support, the

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<sup>11</sup> Age-standardized death rates from WHO Global Health Observatory; <http://apps.who.int/ghodata/?vid=100001>

<sup>12</sup> Cambodian Socio-Economic Survey Analysis, Out of Pocket Expenditure, MOH 2012 based on CSES 2009.

MOH developed the Fast Track Road Map for reducing Maternal and Newborn Mortality Initiative (FTI). The Ministry of Health developed this road map with assistance from USAID and other donors. FTI together with the Government Midwife Incentives has contributed significantly to the increasing proportion of deliveries in public health facilities.

A more extensive background description of the Cambodian health sector can be found on pages 13-15 of the SOW (annex 1).

### **USAID RMNCH/HSS Program**

USAID/Cambodia's health strategy is consistent with and supports the MOH's Strategic Health Plan through a Strategic Objective Agreement (SOAG) with the RGC, and supports the key health systems strengthening activities described in the MOH's HSP2. While USAID does not "pool" its resources under Health Sector Support Program (HSSP2), the intent of the program is to provide technical and managerial support to the MOH at several levels to help strengthen the capacity of the health system to address several major program areas described in the HSSP2. The USAID program also provides valuable capacity building at the community level to expand the MOH's reach beyond the lowest level facilities and increase the accountability of the health system to the communities. It also works with the development of private service delivery, social marketing of health products and services and behavior change communication. USAID as a development partner is committed to the principles of donor harmonization and alignment of the Paris Declaration, and has been working closely with all stakeholders, including attempting to link its activities with those of the HSSP2.

Four USAID/Cambodia Health Goals for 2015:

- Reduce maternal and under-five mortality by 25%
- Increase modern contraceptive prevalence to 33%
- Reduce prevalence of tuberculosis (TB) by 20%
- Reduce prevalence of HIV in the 20-24 age group by 10%

Four intermediate results (IRs) contributing to those targets:

IR 1: Reduce impact of HIV/AIDS, TB and other infectious disease

IR 2: Increase delivery of maternal, child and reproductive health services

IR 3: Build health systems capacity

IR 4: Change key client behaviors

### **USAID Projects**

Implementation mechanisms for the program were narrowed down to include four integrated health projects: 1) Maternal and Child Health Program (MCHP); 2) Together for Good Health

(ToGoH); 3) Better Health Services (BHS); and 4) Social Marketing and Behavior Change Interventions for HIV/AIDS, Reproductive & Sexual Health & Child Survival in Cambodia (SMBCI). USAID/Cambodia's implementing partners provide targeted technical support to improve the public health system, working in a cross-sectoral approach by engaging the public sector, private health providers, and communities.

The evaluation team was asked to look primarily at the first three projects, as well as at the SIFPO Project implemented by MSI Cambodia.

The **SIFPO** Project, implemented by Marie Stopes International (MSI), and funded annually by USAID/Cambodia, began in 2011. This Project aims to increase access to the full range of family planning (FP) methods with particular attention to long-acting and permanent methods (LT/PM), which have historically been inaccessible in rural areas of Cambodia. Under the SIFPO project, MSIC supports public health facilities in two provinces and pilots effective means of integrating FP into HIV prevention and treatment services.

The USAID **Maternal and Child Health Program (MCHP)** (2008-2013) project is implemented by the infectious disease and HIV/AIDS services in 19 districts of five provinces (Siem Reap, Pursat, Banteay Meanchey, Prey Veng and Koh Kong). The project helps to strengthen MOH managerial and technical capacity by assisting provincial and district-level management teams, and by helping to translate MOH technical policy and program priorities into effective interventions in the field. Specific interventions include technical assistance and capacity building to healthcare providers on emergency obstetric care (EmONC), life-saving skills (LSS), post-abortion care (PAC), baby friendly community initiative (BFCI), integrated management of childhood illnesses (IMCI), Vitamin A distribution, management of acute malnutrition (MAM), directly observed treatment (DOT) and Community DOT for the treatment of TB. A major focus area is the provision of support for community-based health activities, including community-based distribution of family planning methods. The project also supports capacity building for Village Health Support Groups (VHSGs), Health Center Management Committees (HCMCs), and Commune Councils (CCs).

Through the current 5-year USAID-funded project, **Together for Good Health (ToGoH)**, the Reproductive Health Association of Cambodia (RHAC) provides technical and managerial support to the MOH to strengthen access to and quality of reproductive health, family planning, maternal, newborn, and child health services and assistance to reduce the transmission of HIV/AIDS. The Project works primarily at the OD and health center level in five provinces (Battambang, Kampong Speu, Kampong Cham, Pailin, and Preah Sihanouk). Support includes building the capacity of health providers to deliver quality RMNCH services, provision of health education to communities through existing health system structures, and promoting demand for quality services. Specific to family planning, the Project supports the MOH community-based distribution of family planning commodities and pilots a voucher scheme for family planning in public health centers. In addition to supporting public sector counterparts, RHAC operates 15 clinics in 12 ODs. The 15 RHAC clinics, located in the 9 provinces of Phnom Penh, Kampong Speu, Kampong Cham, Battambang, Pailin, Preah, Takeo, Siem Reap and Svay Rieng, offer a comprehensive package of quality reproductive health services for women of reproductive age and provide special services to the nation's large and growing youth

population.

**The Better Health Services (BHS) project**, carried out by the University Research Corporation (URC), began implementation in Cambodia in late 2008, building on the lessons learned from USAID's first Health Systems Strengthening Project. The project focuses on developing capacity of the public health system at the national provincial and district health offices to improve the quality of health care services; increasing the uniformity and scale-up of innovative health care financing schemes; and improving referral systems between health centers and hospitals. At referral hospitals, the program emphasizes the improvement and integration of clinical and managerial capacity in RMNCH, HIV/AIDS, TB and infection control. In health financing, BHS provides technical and financial support to the MOH to implement health financing schemes, especially health equity funds and community-based health insurance to increase access by the poor to quality public health services.

The **Social Marketing and Behavior Change Interventions for HIV/AIDS, Reproductive & Sexual Health, and Child Survival in Cambodia (SMBCI)** began in 2007 with support from USAID and DfID. Population Services International (PSI) works with the private sector to increase the availability of health and family planning products, improving the quality of services provided by private health care providers, while simultaneously educating the public about the availability, safety and efficacy of family planning methods. PSI is in the process of transferring full responsibility for management of the project over to the local social marketing entity PSK, established in 2012.

**A midterm review of the USAID RMNCH/HSS program** was conducted in March 2011. The MTR concluded that the overall program was on track to achieving its objectives. The evaluation identified a number of challenges along with recommendations. Based on the results, the MCH and HSS teams within USAID's OPHE prioritized areas for improvement and narrowed down and adapted the evaluation team's recommendations. This evaluation looks at the full performance of the portfolio over the last five years, while taking into consideration the results of the midterm evaluation.

## **EVALUATION METHODS & LIMITATIONS**

The team employed a mixed-method evaluation approach relevant to this kind of performance evaluation. Throughout the evaluation, findings from the different methods were compared to assure consistency.

Overall progress was assessed against the goals of the AAD, the program descriptions in each of the four Cooperative Agreements along with their PMPs and their annual work plans.

### **Description of Evaluation Methodology**

The evaluation team used a variety of methods for assessing and analyzing qualitative and quantitative information and data. The methods used in completing this evaluation included:

- **Document Review:** Prior to arriving in-country the team reviewed general background

documents and reports. A list of key documents is contained in Annex 4. Review of technical reports, annual work plans, geographical coverage data, and other documents from USAID, implementing partners, MOH and other donors continued while in country.

- Key informant interviews: Using the guide developed during the team planning meeting, the team conducted semi-structured interviews with project staff, MOH policy makers, and managers at PHD and OD level, other donors, health services providers, clients, and community members.
- Site visits – Seven provinces were selected for the team to visit provincial and district offices, hospitals, health centers and surrounding villages.
- Focus group discussions were convened with community health workers (VHSGs & CBDs) and clients who were users of long-term family planning method vouchers.
- Analyses of data: Quantitative methods did not involve new data collection but used existing data from the semi-annual and annual reports from the USAID partners, RHAC and RACHA annual household survey, CDHSs 2005 & 2010, MOH's up to date Health Management Information System (HMIS), existing secondary analysis and other available survey research.
- Briefing, debriefing and validation meetings: An introductory meeting was held with USAID health staff to discuss logistics and to clarify the scope of work; a second meeting with the OPHE team to present the proposed report outline and discuss the design of the evaluation; a meeting with the USAID Mission Director to receive guidance on USAID's priorities and special areas of interest; a mid-term meeting with OPHE to discuss progress and clarify issues; a final debrief with a summary of the findings and draft recommendations with both USAID and USAID implementing partners.

A three-day planning meeting was held during the evaluation team's first two days in country. This time was used to clarify team members' roles and responsibilities, deliverables, development of tools and approach to the evaluation, as well as refinement of the agenda, selection of field sites and scheduling of appointments. The team also developed specific questionnaires for the various categories of stakeholders, which were used as a guide during the interviews. The questionnaires can be found in Annex 3.

Only 5 of the 10 main provinces covered by the program were visited. Two more provinces, Kandal and Takeo, were visited in order to look at MSIC activities. The selection of provinces was done by the USAID staff, purposefully. Three so-called "old" provinces, Battambang, Bantay Meanchey and Siem Reap, where the partners had worked for many years; and two "newer" provinces, Prey Veng and Kampong Cham, were selected. Selection of institutions to be visited was done by the evaluation team, also purposefully, trying to have a mix of more urban or easier to reach and more remote institutions. Focus group discussions (FGDs) with VHSGs, CBDs or LT/PM FP voucher users had to be arranged by the implementing partners and the participants were informed in advance. Other users were only informed the day of the visit, and the team was able to conduct a few surprise visits. The LT/PM FP voucher users were selected randomly from the register of users of that HC.

The evaluation team, divided into two sub-teams, were able to visit 40 institutions or organizations, and meet with 272 individuals. Annex 4 list the persons met and the institutions visited.

### **Limitations of the Evaluation**

It should firstly be clarified that the evaluation did not set out to validate all the data and activities reported by the partners. The aim of the field visits was to better understand the processes, to learn about progress, problems and recommendations from the stakeholders and beneficiaries, and to some extent confirm certain data or statements found in the implementing partner reports. The sample size of institutions visited was restricted by the time in country but did not limit the evaluation findings.

The evaluation team was somewhat constrained by the breadth of technical areas to be covered in the four-week time frame. In addition, while the SOW called for a six-person team, with two USAID/W experts, one responsible for MCH and nutrition and the other for M&E, unfortunately they were unable to fully participate due to health concerns and early departures. While the evaluation team was not able to explore all areas of work as thoroughly as desired, the team does feel confident about its findings and recommendations.

In addition, the evaluation coincided with the national election campaign. As a result some provincial authorities were not available for meetings, in other cases schedules needed to be rearranged. The election campaign might also have influenced available funding for community health activities.

The available datasets had different timelines. The data collection from the last RACHA and RHAC annual surveys in the project areas happened from May to July 2012. The Countrywide CDHS were from 2005 and 2010. The 2010 CDHS collected data at the second half of 2010. The methodology of the annual survey of RHAC and RACHA changed after 2010 and makes comparison with previous years impossible.

While the evaluation team did choose the geographical areas, the LT/PM FP Voucher users for the FGD and the CBDs and VHSG interviewed in those areas were identified by implementing partners. This was necessary due to the need to inform them days before the arrival of the team and required somebody on the ground for organizing that meeting. The LT/PM FP voucher users were selected randomly from the register of users of that HC. The process was verified with the team.

In some ODs the team was confronted with the presence of multiple NGOs, some of which were quite small, supporting the same HCs in the same technical domains but with slightly different interventions, sometimes complementing one another. In those places it was more difficult to attribute achievements to specific projects.

Limitations specific to assessing the contribution of the Program and its projects in achieving the Program Goals are specified in more detail in a section specific allocated to this subject.

It is however the opinion of the evaluation team that none of the above limitations significantly influenced the findings of this evaluation.

## THE EXTERNAL ENVIRONMENT

The program and its projects do not work in a vacuum. They function in a changing environment that provides many constraints but also opportunities.

In recent years collaboration with the MOH, the main program partner, has become more challenging, at least at central and PHD office level due to transparency issues, limited motivation and changes in per diem policies. This has been exacerbated further with cancellation of previously existing incentive schemes, such as Merit Based Payment Initiative (MBPI) and Priority Operational Cost (POC). Most interviewed government counterparts insisted on the need to continue funding service delivery activities and were not interested in a pure capacity building support.

Contribution of the health sector to Deconcentration and Decentralization (D&D) remains complicated, as MOH itself is not yet clear on the future changes. Outside the MOH, support by political authorities for Family Planning (FP) is not very strong, with isolated reports of resistance in some provinces. This does not immediately influence FP fieldwork, but does complicate FP policy advocacy work to some extent.

The increasing number of midwives through recruitment of freshly graduated midwives is very positive for the health sector, but forces the projects to revise their practical training activities. The number of primary and secondary midwives increased by 313 and 605 in 2011 and 2012, respectively.

The close collaboration with HSSP2 and Joint Partnership Arrangement Development Partners Interface Group (JPIG) has been very beneficial in general and for specific activities such as Health Equity funds (HEF). It has allowed for joint influence on MOH, as was the case with requirements for regular quality assessments or for keeping the HEF third party payer arrangement. Implementing partners have been advocating for transferring funding responsibilities for service delivery activities from USAID budget to HSSP2/MOH budget through Annual Operational Plan (AOP) planning. However, with the chronic delays in HSSP2 funding, those activities are frequently postponed, often for several months, resulting in cancellation of some activities.

In several Operational Districts (OD) a multitude of big and small NGOs are supporting the OD, HCs and communities, often in the same technical fields. This results in a multi-dimensional jigsaw puzzle of support. For the most part, this is well coordinated and functions without overlap. But it certainly complicates daily work and monitoring, and requires intensive planning and coordination efforts from ODs, HC and NGOs themselves. In one HC in Sangkae OD, eight NGOs (KOFIH, CYCD, SCC, PFD, RDA, RHAC, MSI and Medicam) were working with commune volunteers on RMNCH.

An important and seemingly increasing internal and cross-border migration results in high turnover rates among VHSGs, CBDs and Youth Peer educators. As a result, implementing partners need to select and train their replacements frequently. This migration also impacts health-seeking behavior and compliance of clients for family planning, ANC, PNC, nutrition and

STI.

The continuous economic growth seems to have resulted in an important decline in people living under the poverty line. This will contribute to better living standards and should by itself influence health outcome indicators by 2015. Higher income, continuing perception of poor quality of the public sector and aggressive marketing by private providers (often involved in dual practice) contribute to the further increase in utilization of the formal private sector health facilities. Secondary analysis of the Cambodian Socio Economic Survey 2010 on out-of-pocket spending (MOH, December 2012) shows that 70% of the populations seeks care in the formal private sector. Under the influence of the pharmaceutical sector and because of sales profits, doctors have been very aggressive in promoting and prescribing non-essential drugs. This behavior could also influence choices of breastfeeding over baby formula or family planning choices, certainly in urban areas.

## **CONTRIBUTION OF PROJECTS AND PROGRAM TO THE USAID PROGRAM GOALS**

The four USAID Program Cambodia-Specific Health Goals by end 2015 are:

- Reduce maternal and under-5 mortality by 25%.
- Increase modern contraceptive prevalence to at least 33%.
- Reduce TB prevalence by 20%.
- Reduce HIV prevalence in the 20-24 age group by 10%.

Comparison of the CDHS 2005 and 2010 indicates that the programmatic targets for improvements in the maternal mortality rate, under-5 mortality rate and modern contraceptive prevalence rate have been achieved. The maternal mortality ratio (MMR) decreased significantly from 472 per 100,000 live births in 2005 to 206 per 100,000 in 2010, a 56% reduction. The under-five mortality rate in Cambodia decreased from 83 per 1,000 live births in 2005 to 54 per 1,000 live births in 2010, a 35% reduction. Both reductions are significantly larger than the Mission's goal, set at 25%. According to the CDHS 2010, the modern contraceptive prevalence rate amongst married women was 34.9%, a proportional increase of 22% from the 27.9% CPR rate in the CDHS 2005, indicating that the CPR program goal of 35% had already been narrowly achieved in 2010.

Evidence for achieving the 20% decrease in TB prevalence is less available because of infrequent surveys due to population-based TB prevalence data collections being very time and resource intensive. Nevertheless available survey data shows that between 2002 and 2011 there was a reduction in the prevalence of smear-positive TB by 38% and in the prevalence of bacteriologically positive TB by 45% among persons over 15 years of age. Both reductions are very much in line with the USAID Health program goal for TB.

Several factors have contributed to the achievement of these goals. They are the result of an improved socio-economic environment, decreased fertility and improved quality and

accessibility of preventive and curative services delivered by Hospitals, HC and community volunteers. The present (2008-2013) and the previous (2004-2008) USAID health programs have been working towards each of these health goals by intensively supporting public health services of government hospitals and health centers and through the activities of community volunteers. The USAID projects include an impressive number of interventions which directly target improved health outcomes.

Data from the HMIS and from the RHAC and RACHA joint annual surveys show a significant increase of health coverage and service outputs indicators in the USAID program supported provinces since the CDHS 2010. The numbers of deliveries taking place in health facilities in 2012 had increased to 87.1% and 88.1% in the provinces supported respectively by the ToGoH and MCHP projects, while the Cesarean section rate, a proxy indicator for improved CEmONC care, increased by 51.2 % since 2009 to reach 1.6% in 2012.

Between 2010 and 2012 the CPR had further increased from 37.2%<sup>13</sup> to 38.7% and from 32.1% to 46.5% in the provinces supported respectively by the MCHP and ToGoH projects. Annex 7 lists the results of a number of project output and coverage indicators directly underlying the program goals.

Given the direct linkage between the program's interventions and the achieved results, it is very likely that the interventions of the USAID RMNCH/HSS program 2008-2013 have significantly contributed to the USAID Program Goals.

As the HIV component is not part of this evaluation, the HIV prevalence reduction goal is not addressed here.

## **MNCH/HSS PROGRAM – FINDINGS & RECOMMENDATIONS**

### **RMNCH & Nutrition**

#### **FINDINGS**

##### **Reproductive, Maternal, Newborn and Child Health**

Significant improvements have been reported in reproductive, maternal, newborn and child health in Cambodia over the past years and these effects are seen in the 2010 Cambodian DHS (see Table). USAID has contributed to this through its cooperating agencies (CAs) or implementing partners – MCHP, TOGOH and BHS – that have implemented various interventions to improve health services in the country. The CAs are implementing partners of Cambodia's National Maternal and Child Health Center (NMCHC) for the Fast Track Initiative (2010-2015), the government's strategy for quickly addressing the gaps in improving health of mothers and children.

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<sup>13</sup> This is a CDHS 2010 figure as there was no comparable data from the RACHA survey for 2010

The implementing partners have contributed to the noted significant increase in facility-based delivery (FBD) to 54% (CDHS 2010) from 22% in 2005 and 10% in 2000. The Joint Annual Surveys conducted by RACHA and RHAC show even higher figures for FBD than the rest of the country, from 70% (Prey Veng and Kampong Cham) to 92% (Siem Reap). Antenatal care (ANC) has likewise shown a dramatic increase from 69% in 2005 to 90% in 2010; in RACHA areas the average rate for ANC is 93%, and in RHAC areas an average of 95%.

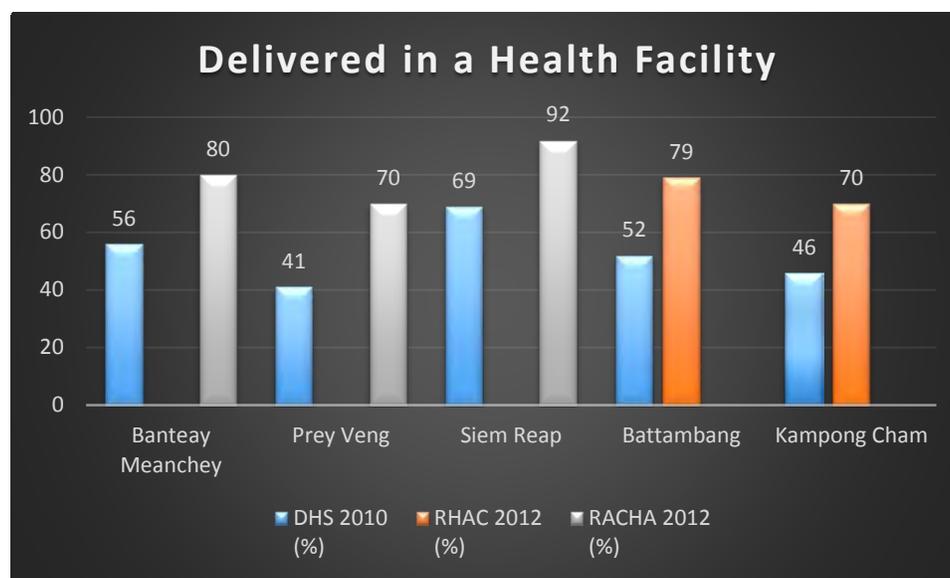


Figure 1. Comparison of facility-based deliveries in RHAC and RACHA supported provinces (2012) versus the data from the CDHS, 2010.

These improvements have likely been influenced by the implementing partners' activities which have focused on improving both demand and supply in their project areas.

**Increasing awareness** of women on the benefits of and risks averted by delivering in facilities contributes to this shift, with information provided by the health facility staff or community volunteers. RHAC and RACHA work with the VHSs through training and supervision visits. **Better access to pregnancy and delivery services** have been provided through assistance to communes in installing emergency transportation arrangements at village level, paid for through savings of villagers (savings box or charity box); provision of Maternal and Newborn Health (MNH) vouchers (RHAC); RACHA support for user fees and transportation costs; and implementation of health equity funds.

The government's **midwife incentive scheme**<sup>14</sup> has also encouraged midwives to motivate women to give birth in facilities. Part of this incentive can also be shared by the midwife, if she wants to, with traditional birth attendants that refer pregnant women to the health center. In the Operational District of Angkor Chum, a "no dual practice rule" is in place which further increases the availability of midwives at the health center. This means a public sector staff is disallowed from having his/ her own private practice.

MCHP, TOGOH and BHS have worked with the NMCHC in **continuing training for health staff** at health center and hospital levels to build confidence and skills in providing maternal and newborn health services in general, and FBD services in particular. This includes training, re-training on emergency obstetrics (EmONC) followed by systematic supervision and coaching of trainees, including introduction of innovations such as the anti-shock garment<sup>15</sup>, balloon tamponade<sup>16</sup> and use of locally made simulation models<sup>17</sup>. Technical assistance on infection control, triage and nursing processes from URC as well as provision of some equipment, even some renovation assistance in selected facilities from all (3) projects have complemented the efforts for improving clinical areas. In some areas provision of maternal waiting rooms, running water and putting up incinerator facilities and placenta pits have also been part of facility-level support. This shift by the implementing partners from the usual classroom type of training to a more comprehensive training package which includes follow-on visits to trainees to further strengthen skills and knowledge is highly appreciated by the counterparts and is deemed effective in the long term.

A BHS assessment on the quality of maternal and newborn care in selected hospitals and one health center (2013) shows good progress observed in the provision of AMTSL, magnesium sulphate for pre-eclampsia/ eclampsia, newborn care (drying, skin to skin care, Vitamin K and eye ointment) and social support for mothers in labor. Performance above the baseline was also seen in newborn resuscitation, provision of iron and mebendazole postpartum, and client satisfaction. Areas that need improvement include fetal heartbeat monitoring, real-time use of partograph, checking of danger signs in both mother and newborn, and newborn immunization. In 2010, BCG coverage for children less than 12 months of age, presumably given soon after birth, was 91% (CDHS). Cashin (2013) reported similar trends in RACHA supported areas, where provision of AMTSL was relatively good at 80-97% of women while newborn care was lower at 70-84%.

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<sup>14</sup> \$15 is given to the midwife for each health center delivery; \$10 for each delivery in a hospital

<sup>15</sup> The Non-pneumatic Anti-Shock Garment (NASG) is made of neoprene (a very stretchy synthetic rubber) segments that wrap around a mother's legs, pelvis, and abdomen and that are held with Velcro straps. It reverses shock by returning blood from the legs and lower abdomen to the heart, lungs, and brain, restoring the woman's consciousness, pulse, and blood pressure. - See more at: <http://www.urc-chs.com/news?newsItemID=300>

<sup>16</sup> URC (Dr Jerker Liljestrand) described using a balloon tamponade as option to address postpartum hemorrhage. [http://www.coregroup.org/storage/Webinars/SMRH/Addressing\\_PPH\\_Dec\\_2012\\_Jerker\\_Liljestrand.pdf](http://www.coregroup.org/storage/Webinars/SMRH/Addressing_PPH_Dec_2012_Jerker_Liljestrand.pdf)

<sup>17</sup> In conducting its training activities, BHS uses pelvic models made of foam and other local materials to provide participants an opportunity to practice their skills at doing internal exams or even IUD insertions without the anxiety of committing mistakes on a real person.

**Improving the referral system between health centers and hospitals** through its work in supporting the Midwife Coordination Alliance Team (MCAT) meetings have significantly enhanced the timely provision of critical care to mothers. The MCAT meeting provides a regular venue for health center midwives and hospital-based midwives to interact to talk about the referral process between their facilities and discuss health care dilemmas encountered by health center midwives. These meetings are conducted in designated hospitals in the province, usually in the referral hospital of the respective health centers. The implementing partners provide support to these meetings through provision of funds for travel and per diems for the midwives attending the event. Sometimes, the implementing partners also invite speakers to talk about special technical topics, as deemed necessary by the midwives.



*Placenta pit (above) and incinerator (right) provided by USAID/ Better Health Service Project in Battambang Provincial Hospital as part of its technical assistance for improving the quality of services in the facility.*

*Photos: MA Evangelista*

PNC is an area requiring further work. Many mothers do not return to the facility for PNC and there is only limited work that can be expected from VHSg for postpartum care in light of all the other tasks given them. In meetings with VHSGs, PNC also does not figure highly in the list of tasks expected of them. Perhaps this needs to be reviewed. Further, while there are anecdotal accounts of why women do not go for regular PNC – they are expected to stay at home for 40 days after delivery, they feel well or the baby is well, there is no one to take care of the children, etc. – there seems to be no solid documentation of the reasons why women do not feel the need to have PNC. It is possible that the importance of such care is not emphasized enough by the midwife at the delivery facility. In field visits, women who were counselled after

delivery and before discharge reported that the midwife assigned to them talked about breastfeeding (primarily) and to go to the health center if they experience danger signs (secondarily). To what extent these danger signs are being discussed well with the new mothers is not known.

To help track actual use of PNC services, URC has also done work with MOH/DPHI and NMCHC to develop a PNC register to support the use of the safe motherhood protocol (PNC service package). The new PNC register tracks provision of counselling for FP during postpartum and the monthly reports of HMIS include postpartum FP data. This PNC register was approved, printed and distributed in the whole country this year.

None of the three projects reported using the EmONC assessment report (2010) in programming their activities for EmONC; they are nonetheless based on what were discussed as critical needs by the facilities, ODs and PHDs, which are presumably informed by the 2010 report.

## **Nutrition**

The USAID implementing partners have been successful in supporting local counterparts to implement its nutrition program, contributing to the reduction of chronic malnutrition among children under 5 years to 40% (CDHS 2010), from 43% in 2005. They successfully equipped local counterparts to implement services for Vitamin A supplementation such that the government is now able to sustain them. Vitamin A rates are higher in TOGOH (average 94%) and MCHP (83%) areas compared to the national average 71% (CDHS 2010). Vitamin A supplementation and nutrition are covered in the community education campaigns of VHSGs and health center staff. Materials (posters, brochures) are provided by USAID implementing partners. Efforts of implementing partners in promoting exclusive breastfeeding have contributed to the gains in newborn feeding at a large scale. The CDHS (2010) reports that in Cambodia, children 0-35 months breastfeed until the age of 20 months, on average, and are exclusively breastfed for an average of 5 months. Counselling on breastfeeding is consistently part of the PNC provided to mothers prior to discharge in facilities supported by USAID.

ToGoH's work in nutrition is linked with ANC counseling at the health center wherein women are informed about immediate and exclusive BF as well as complementary feeding. Screening for anemia is done and up to 97% of women are provided 90 iron-folate tablets, 84% of whom actually take the full dose. Some women fail to return to the health center for the complete set of 90 iron-folate tablets. At the community, VHSG have been trained to provide nutrition messages. RHAC's Annual Survey report shows improvements in iron tablet adherence, noted primarily among women with some level of education.

MCHP also provides a similar program at health center and community levels. Up to 84% of pregnant women are given nutrition counseling and 90 iron-folate tablets, with 78% completing their dose. However, MCHP also notes that nutrition challenges in Cambodia persist due to inadequate counseling at some health centers, low community awareness, and the need for better food security linked with agriculture. They mentioned the World Food Program's food for MCH distribution (corn-soy blend with oil) but coverage is not adequate. They feel that cross

sector linkages are important for food security, and that home gardening and fish raising efforts may help families cope. Water filtration and deworming are among RACHA's activities with Latter Day Saints funding. RACHA also works on food fortification policies.

Acute malnutrition (wasting) however has increased to 11% in 2010 from 8% in 2005. Underweight, or too thin for age, remains at 28% among children under age 5. BHS provides support to the MOH to address this gap and has recently completed the development of Clinical Guidelines and training modules for Severe Acute Malnutrition (2013) in close coordination with government counterparts and partners. Adequate and timely implementation of these critical documents needs multi-sectoral discussion and support to allow not only adequate roll-out and use of the guidelines at facility level, but also to ensure that there is adequate and affordable food sources to sustain nutritious meals thereafter.

#### **RGC Policies on Nutrition**

1. Cambodia Child Survival Strategy 2006-2015
2. Health Strategic Plan 2008-2015
3. National Nutrition Strategy 2009-2015
4. National Policy and Guidelines for Micronutrient Supplementation to Prevent and Control Deficiencies in Cambodia
5. National Rural Water Supply, Sanitation and Hygiene Strategy 2010-2025
6. National Social Protection Strategy for the Poor and Vulnerable 2009-2014
7. National Strategic Development Plan 2009-2013
8. Strategic Framework for Food Security & Nutrition in Cambodia 2008-2012

Cashin, et al 2012

Affordable foods are also hard for many families to obtain. The World Food Program is giving some cash transfers for food in selected areas but many rely on their own efforts for food. The preparation of *bobor kroup kroeung* was mentioned in communities visited by this current evaluation team but feedback from VHSG is this *bobor* is difficult to sustain as a regular meal for children as it requires too much time to prepare for a typical family. There seems to be a misunderstanding with the message from the promotion tool that families think all foods mentioned in the tool should be included in the recipe when in fact, it could be just a few of them.

The USAID implementing partners are part of the national nutrition working group with UNICEF (and many others). The COMBI<sup>18</sup> mass media campaign and interpersonal counseling (IPC) on complementary feeding was started in April 2013; a midline assessment is underway through CDRI (local research institute). USAID contributed to funding this mass media campaign. The IPC is conducted via health fairs and IEC materials. The HARVEST project (USAID) and FAO also assist in coordination and resources. UNICEF sees the need for standard messages with multiple channels used by government and NGOs across sectors to further influence how families think about nutrition.

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<sup>18</sup> Communication of Behavioral Impact

In a recently commissioned evaluation by USAID, Cashin (2012) provides a comprehensive review of the current state of nutrition in Cambodia and goes on to describe a comprehensive strategy to address this complex issue. The report shows that the country is covered adequately in terms of policies on nutrition (see box). Cashin notes that there is a lack of nutrition experts at the policy level and the evaluation team also noted that at facility level not all staff are trained to the same level on nutrition counseling.

Areas of improvement include the quality of nutrition counselling at all visits in the lifecycle (pre-pregnancy, ANC, PNC, immunization visits). The quality of counselling is highlighted as an issue that needs to be looked at further because not all staff at the health facilities had the same level of training for nutrition counseling. Some may have been sent for comprehensive training with NMCHC but others will have only received limited information from partners. This makes them less confident in and less motivated to provide adequate nutrition counseling.

## **RECOMMENDATIONS**

### **Reproductive, Maternal, Newborn and Child Health**

- Increasingly link EmONC training and supervision activities to measurable health outcomes such as safe deliveries, low/no bleeding complications, babies with better APGAR scores, low/ no postpartum infections, etc. This includes, among others, continuing coaching for health staff that fetal heart rate monitoring and real-time recording of partograph findings contribute to better outcomes and should be done routinely for both mother and newborn.
- Advocate to the MOH, using the good lessons of the implementing partners in providing training, to issue appropriate policies and/or guidelines that will transition RMNCH training activities from the usual classroom training modes to “training packages” that utilize simulation models, case practices and include continuing post-training coaching as well as provision of critical supplies and equipment necessary for the application of new skills acquired. This allows full application of newly acquired skills and knowledge and boosts staff confidence in using those skills.
- Conduct systematic FGDs on why women do not routinely go for PNC to better plan for reasonable actions to address this issue.

### **Nutrition**

- USAID is correct in pursuing the integration of nutrition in other RMNCH activities and should continue to support this because this seemingly simple matter is actually very complex and is not limited within the bounds of the health sector. As documented in various reports, nutrition requires not only direct interventions such as food supplementation or nutrition counselling but also necessitates securing diverse and affordable food sources.
- At the policy level, revisit the recommendations of Cashin (2012) on nutrition and engage RGC partners on how to best implement them in a phased manner, including better BCC for nutrition and hygiene behaviors; increasingly linking nutrition with

maternal interventions; reducing anemia in children and pregnant mothers; improving access to diverse and quality food sources; and securing an enabling environment for nutrition overall.

- At the community level, through partners, continue to support technical capacity building of health facility staff and VHSG on counselling for nutrition and increasingly link this to other health services and health education efforts for mothers and children. Explore the possibility of having regular awareness campaigns such as those used for family planning in Takeo e.g. Tuktuk Campaign, where tuktuks are used to go around the village with pre-recorded information on a topic.

## Tuberculosis

### FINDINGS –

The National Guideline on Community DOTS Implementation (2004) and the National Guideline for Diagnosis and Treatment of TB in Children (2008) were issued to expand the gains from the decade after Cambodia began its National TB Program in 1994. By 2012, the WHO recognized Cambodia's success story in reducing the prevalence of tuberculosis by 45% from 2002 baseline in the Global Tuberculosis Report 2012.

Based on a model supported by USAID in the previous program, Community-DOTS was brought to scale by MCHP and TOGOH soon after the issuance of the National Guidelines for Community DOTS. By end of 2007, both organizations were able to report up to 90% compliance of patients with their medications (Cashin 2013) largely because of the efforts of the VHSGs for C-DOTS<sup>19</sup>. Ongoing TA, capacity building, and supervision of health center staff and C-DOTS watchers (VHSGs) has strengthened C-DOTS and PPM-DOTS interventions in target areas. As of March 2013, MCHP reported that 1,741 health providers and VHSGs have been trained in TB. MCHP also supports Public Private Mix (PPM) DOTS interventions in five ODs in Pursat, Siem Reap and Banteay Meanchey.

Childhood TB coverage however remains a challenge. USAID has brought pediatric TB forward as a new area of focus for the National TB Program. Working with USAID's TB Care project, TOGOH and MCHP were instrumental in identifying children who live in close contact with former TB patients or TB patients through CDOTS networks and referred them for diagnosis at referral hospitals, resulting in a significant increase of pediatric cases detected from 3,499 in 2007 to 5,584 in 2012 (in which 4,078 cases were detected in 27 ODs supported by USAID). Interviews with VHSGs supported by USAID implementing partners, in the seven provinces visited for this assessment, show that C-DOTS and contact tracing for families that have a recently diagnosed TB case are emphasized in their trainings. VHSGs report that as they

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<sup>19</sup> Once diagnosed, a patient is assigned to a designated volunteer; the medicines for the week are given to the volunteer. Patient goes to the house of the volunteer daily where he is "observed" while taking the medicines; when the patient does not show up on the designated time, the volunteer visits the patient within the day.

monitor their TB clients, they also make recommendations to the head of the household that other family members, including children, should also be seen at the health center for screening because the bacteria is transmitted by air. Some challenges remain. It is currently implemented only in 27 operational districts. CENAT would like to see this expanded in the coming years as part of its new 7-year plan for TB control (pending official approval as policy). A new algorithm to guide implementers will be distributed by CENAT to health facilities.

Further challenges remain in filling the gaps in implementing strategies addressing TB in children. Limited field visits and interviews show that only in CPA-3 hospitals is TB screening conducted in pediatric wards. While health centers claim that they also do regular screening, there is no standard form at the facility that would show if TB screening was indeed done. The current IMCI form also does not have basic questions that can be used for screening, such as possible exposure to a TB patient, failure to thrive, night sweats, lymphadenopathy, prolonged cough or fever. In the CPA-1 hospitals visited, staff admitted that the children in the pediatric ward had not yet been screened for TB at the time of the interviews.

There remain missed opportunities at the community level because health centers do not routinely screen for pediatric tuberculosis, primarily because TB has been and is still deemed by many as a condition that is managed at the hospital level. A gap is inclusion of key screening questions in the IMCI protocol. The current IMCI form at health center does not have basic questions that can be used for screening for TB.

While in general the national TB program, and consequently the Pediatric TB Program, does not usually experience difficulties in securing TB medicines, there was at least one OD among those visited during this evaluation that reported it was not able to maintain a 2-month buffer. They often only receive at most 70% of their requested amount. CENAT requires a buffer stock of TB medicines of 3-months at the OD level and 9-months at program level. The CENAT also has a vertical response system such that any OD that deems it is almost out of stock can request directly from them.

Finally, CENAT relies on available resources from various partners for the continuation and expansion of its current efforts to reduce TB prevalence. Of particular concern is the fairly new implementation of the TB in children initiative which requires continuing availability of donor and NGO assistance.

## **RECOMMENDATIONS**

- Advocate for the integration of pediatric TB screening in the IMCI protocol by including basic screening questions for pediatric TB in the current IMCI health center form.
- Advocate for provision of TB training to all health center staff to ensure that each is able to apply the screening protocol at any time and for all clients at the facility.
- Advocate for the inclusion of a sample of children <15 years old in the TB prevalence surveys to track progress on childhood tuberculosis.
- Advocate to CENAT that, program buffer permitting, the actual requested amount by OD for TB medicines becomes the basis for distribution.

- Broader consultation on the inclusion of (a) a pre-diagnosis work-up package in the HEF; and (b) incentivising the health providers through HEF to follow-up treatment of TB patients.
- Consider supporting the distribution, roll-out of and getting feedback on the new pediatric TB algorithm of the CENAT.

## **Strengthening Health Systems**

### **FINDINGS**

#### **Quality Improvement**

USAID and its implementing partners have successfully influenced the discourse on quality improvement in health in Cambodia and have been quite effective in providing guidance to the MOH on strategies to achieve this through relevant policies and innovative implementation strategies. The implementing partners have done good work in engaging high level officials of the MOH to give clear directions on how to implement policies. To varying extent, PHD and OD officials, as well as health facility staff have also been engaged by implementing partners such that some have actually initiated local efforts to improve quality of care. In the past years, USAID implementing partners have swayed the direction of TA to actually improving the quality of services more than improving access alone. Policy tools such as the Level 1 Assessment tool<sup>20</sup> have enabled Cambodian health staff to appreciate the concept of quality improvement, while corollary initiatives such as introducing case practice sessions complement trainings and illustrate quality concepts further.

By using the Level 1 tool in health centers and hospitals, staff did self-assessments, either internally motivated or externally driven by donor partners, and led to initiation of local efforts to correct deficiencies such as reorganizing their services, creation of hygiene models, and feedback mechanisms that capture patient satisfaction in hospitals, to name a few. The process has also led to some frustrations when it comes to correcting major deficiencies outside the control of the facility identified by the assessment process such as inadequate manpower, supplies/equipment or infrastructure. Reports and interviews reveal that even when such upgrades are included in quality improvement plans, there is a risk that these will not be immediately responded to by the MOH. These will then be cited again in subsequent assessment cycles. Hence, many times the USAID implementing partners provide stop-gap measures. On the other hand, the MOH reports that such major deficiencies do not get reported at their level for corrective measures.

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<sup>20</sup> Level 1 tools provide a snapshot of available basic health service indicators including infrastructure, equipment, manpower and processes (e.g. referral system)

In the period following the introduction and roll-out of the Level 1 quality assessment tool from 2005-2008, URC, upon request from the MOH and also in response to clamor from providers, has since shifted focus to improving processes of care based on clinical protocols and best practices. This is consistent with National Policy on Quality (2004) and the Quality Improvement Master Plan (2010-2015) where gradual progress towards better performance on various aspects of clinical and management areas in delivering health care is attained. URC has worked closely with the office of the Secretary of State Thir Kruey, the Hospital Services Department, the Quality Assurance Office, various professional specialty groups, health facilities and other partners in order to develop a Level 2 quality assessment tool. This has resulted in rigorous testing and comprehensive review and revision of the tool to its current form.

These Level 2 tools focus on the fundamentals of clinical care and are based on current clinical standards. They are meant to measure the appropriateness of the patient-provider interaction. They are modular and are applied with consideration to local priorities and resources available. Application of these tools will be managed by the ODs, with supervision by QAO. These tools will complement the Level 1 tool which is recognized by the MOH as one that can assess the management aspect of any given health facility. Details of implementing a Level 2 tool are described in a forthcoming document from MOH (2013).

To prepare health service providers for process-of-care assessments, BHS has continued to provide various support to hospitals and health centers, even before a Level 2 tool was ever mentioned. BHS trained health center and hospital staff on RMNCH and family planning, followed by structured coaching and supervision visits. Technical assistance on infection control and triage as well as provision of critical equipment, and renovation assistance in selected facilities have complemented the efforts of USAID for improving clinical areas. Enhancement of the referral system between health centers and hospitals through the USAID CA's work in supporting the Midwife Coordination Alliance Team (MCAT) meetings have significantly enhanced the timely provision of critical care to patients.

The MOH further recognizes the efforts of URC in supporting the development of clinical practice guidelines (CPGs), which Secretary of State Thir Kruey says will be the basis of the Level 2 assessments. These, according to MOH, will likewise serve as primary references in the University of Health Sciences and Regional Training Centers for pre-service training. Plans for dissemination are being made which will include a series of regional meetings to be led by the Cambodian Medical Council. Prof. Kruey anticipates good participation, as with the recent events where doctors who were invited attended the meeting, even when per diems were not provided. Prof. Kruey notes this as a sign that there is a changing paradigm.

The concept of a "model hospital" was initiated through URC during the life of project with the intention of seeing a performance-based payment system supported by a Service Delivery Grant (SDG) linked to continuing improvements in hospital management and provision of quality clinical care that will increase service utilization and bring in more revenue to make further improvements. Implementation though became more and more challenging, "providing SDG to a hospital that does not have SOA status has proven difficult". Efforts were scaled down a bit to allow facilities in supported areas to become SOA first. According to Prof. Kruey, he supports the idea of a model hospital but it should be set up in the context of Cambodia, not

the more advanced types in developed countries, to make it manageable. In time, he says, perhaps the MOH will be able to identify a suitable candidate and build it up further as a showcase for the rest of the country.

USAID implementing partners have focused on improving service provision quality in the past years more than improving access alone. Efforts to improve access have enabled families to reach health services through activities such as providing transportation support for clients using vouchers for MNH and IUD; motivating communes to set up emergency transport arrangements using village funds generated in pagodas; and advocating for HEF coverage of user fees and limited transport costs.

Improving quality of service at facility level has increasingly been given support including:

- Training and re-training of health staff on RMNCH/FP using MOH protocols through innovative teaching modalities, e.g. simulation models
- Complementing clinical training with infection control, triage and nursing processes
- Standardized supervision and coaching visits following trainings to reinforce learnings
- Clinical case practice (BHS, Siem Reap)
- Clinical case discussions (TOGOH, Battambang)
- Client-provider observation (TOGOH, Battambang)
- Continuing education and enhancement of referral process through MCAT
- Supporting Level 1 quality assessment to raise score to >75% to allow higher HEF premium for health centers
- Monitoring HEF provider payment mechanism (spot checks quarterly)
- Introducing comprehensive medical record system combined with a patient registration system
- Limited provision of critical equipment and supplies in some facilities
- Limited renovations in some facilities



*The Maternity unit in Preah Net Preah hospital renovated with the support from the MCHP Project- USAID.*

*Photos: MA Evangelista*

Improving quality at professional level is also underway. BHS has engaged the Medical Council of Cambodia in developing its continuing education and professional credit requirements for registration and re-registration of doctors in Cambodia.

BHS has also assisted, to a more limited extent, the Midwifery Council and the Nursing Council. Discussions have been held on the possibility of developing registration and re-registration requirements in the same way they are assisting the Medical Council. BHS is also helping the Midwifery Council develop a similar but simpler web-based registration system.

### **Capacity Building**

Capacity building in the health sector has been a challenge for many years and USAID support has focused on improving the technical knowledge and skills of health professionals providing critical health services to target populations. USAID implementing partners have in the past five years provided numerous trainings for midwives, nurses, doctors, VHSGs, CBDs, provincial or OD staff, as well as MOH staff.

A key innovation in the past five years is the shift of CA support to training from the usual classroom-only type to more of a “package of training interventions”. This new mode of capacity building has been quite successful in CA project areas and feedback has been quite positive. The new modality complements classroom learning by utilizing simulation models, case practices and followed by post-training coaching. In some cases, necessary critical supplies and equipment are also provided to ensure application of new skills acquired. This allows full use of newly acquired skills and knowledge which boosts staff confidence in using those skills.

USAID implementing partners have also introduced corollary technical areas which further complement skills of staff. These include infection control, information management, and management in general.

Challenges persist. One concern is the **high turnover of volunteers** (VHSG and CBD) primarily because of migration for the purposes of employment. A similar trend is seen **even among staff of the local NGOs** as well where many young staff leave for other opportunities. This requires a continuing cycle of recruitment and training of new volunteers and staff.

Among those that have already received trainings, there is a perception that they still need continuing refresher courses. Information from some midwives interviewed in the field show that **not all midwives in a designated BEmONC/ CEmONC facility are trained** on the signal functions; LSS training for midwives was systematically done at least 10 years ago; and the inclusion of MgSO<sub>4</sub> for management of pre-eclampsia/eclampsia was not part of the module.

Further, interviews reveal that a staff in a given facility can be **trained on the same topic several times** through different sponsors. This is not altogether bad according to one hospital director as it allows reinforcement of previous learning. However, if the same staff goes every time, there might be other staff unable to attend. This repeated training of the same staff might be reduced if the facility keeps a current inventory of trainings of its staff. There seems to be none at the facility level nor at the CA level; more so at the national level.

Technical topics usually covered RMNCH, family planning, nutrition, tuberculosis, infection control and health information systems, to name a few. Training support came in the form of providing trainers, per diems, training fees for attendees, transportation and accommodation. The general observation is that trainers being utilized by USAID implementing partners are performing well, consistent with the observations noted in the Value for Money Assessment for HSSP2 Pooled Fund: Training and Supervision report (2012). Nonetheless, in Battambang, BHS staff mentioned there has been at least one instance when the expertise of expatriate staff was questioned by local doctors. BHS staff attribute this to **trainee bias** – that because the trainers are foreigners, Cambodian trainees feel that the competencies of such trainers may not actually be suitable to the local context hence, they should not be necessarily considered of a higher expertise than the local doctors.

A continuing concern regarding capacity building is striking a balance between providing some incentive for participants to join a training and ensuring that the training design is cost-efficient. For instance, TOGOH has tested and shown that a 2-day training for CBDs is adequate; but the MOH protocol for such a training requires five (5) days which makes it more expensive for both the government and partner NGO to support. More expensive trainings make it more difficult for local counterparts to sustain the activities using government budget. The implementing partners agree that there is **no guaranteed approval/funding** for continuing training activities even if these are included in the AOPs of counterparts. USAID, in its capacity as a donor sitting in national level technical working groups, is in a position to raise this issue for discussion.

### **Health Policy and Strategy Advocacy**

USAID and its implementing partners have significantly influenced and supported the development of a number of national policies and guidelines in 2008-2012, not only the MOH but other ministries as well. The implementing partners sit in various technical working groups of the MOH and their insights are consistently sought in discussions. The implementing partners have contributed to policy development by lending expertise in actual writing of key government documents, providing critical review of its contents and providing feedback from field experience to refine new policies.

The next step and continuing challenge is for USAID, through its implementing partners, to influence the effective implementation of these policies in order to make the desired impact in the health status of Cambodians.

BHS was able to influence the following policies (2008-2012):

1. Guidelines for Diagnosis and Treatment of TB in Children (2008)
2. National Policy for Infection Control (2009)
3. Infection Prevention and Control Guidelines for Health Care Facilities (2010)
4. Safe Motherhood Clinical Management Guidelines for Health Centers (2010)
5. National Interim Guidelines for the Management of Acute Malnutrition (2011)
6. Safe Motherhood Clinical Management Protocols for Referral Hospitals (2012)
7. Protocol for a National Patient Registration and Management System (2012)

8. Guidelines for the Civil Registration Web Based Database (2013)
9. Code of Ethics for Nurses (2013)
10. Protocol for Level 2 quality assessment tool (pending)
11. Guidelines for CME of doctors (pending)

MCHP was able to influence the following policies (2008-2012):

1. Protocol for the Logistics Management Information System, MOH, (2011)
2. National Interim Guidelines for the Management of Acute Malnutrition (2011)
3. Safe Motherhood Clinical Management Protocols for Referral Hospitals (2012)
4. Policy requiring fortification of fish sauce and soy sauce with iron (pending)
5. Policy requiring oil fortification with Vitamin A (pending)
6. Strategy on food security and nutrition (pending)

TOGOH was able to influence the following policies (2008-2012):

1. Safe Motherhood Clinical Management Guidelines (2010)
2. Infection Prevention and Control Guidelines for Health Care Facilities (2010)
3. National Interim Guidelines for the Management of Acute Malnutrition (2011)
4. Safe Motherhood Clinical Management Protocols for Referral Hospitals (2012)

A key challenge for the implementing partners in seeing these policies implemented is to strike a balance between supporting the MOH versus doing the work for them; the latter risks not sustaining the interventions at end of project. This also shifts the focus of the implementing partners to immediately addressing implementation gaps (i.e. buy pills for their supported facilities) rather than becoming conduits that raise the issue to the MOH.

### **Health Care Financing**

USAID/Cambodia has been supporting several Health Care Financing (HCF) initiatives such as Health Equity Funds (HEF), Community Based Health Insurance (CBHI) through Community based Organizations (CBOs), Conditional Cash Transfer (CCTs), Reimbursements of Referrals of Complicated Deliveries, Maternal and Neonatal Health (MNH) Vouchers, long-term and permanent method family planning (LT/PM FP) vouchers, and free access to long-term family planning. The evaluation team was not requested to address general aspects of HEF, CBHI through CBOs with its CCTs or the MNH Vouchers, because those health care financing schemes had already been sufficiently evaluated or are presently being documented. Therefore only aspects of HCF schemes linked directly to RMNCH activities will be addressed. USAID partner voucher schemes for LT/PM FP methods are described and discussed in detail in annex 6.

The MNH voucher scheme, implemented by the ToGoH project since 2007, is a scheme to reimburse the HC for a comprehensive package of maternal services, covering four ANCs, the delivery and the first PNC. The scheme is available to all pregnant women, regardless of ability to pay. Officially the payment is conditional upon the HC staff providing all six services before a payment is made. However, awareness and understanding of the MNH voucher scheme was limited both with mothers and with HC staff. It is likely that the scheme contributed to the greater than average rise of ANC4, Deliveries and PNC1 in the RHAC-supported provinces but probably mainly through unintended self-proclaimed provider incentives<sup>21</sup>. Excluding PNC2 and PNC3 services from the package could be regarded as a missed opportunity. In general, PHDs, ODs and HCs were favorable of the MNH scheme and wanted it to continue.

In 2007 the RGC introduced the Government Midwife Incentives Scheme (GMIS), a HCF scheme promoting deliveries in public health facilities. This government-funded scheme pays midwives for each delivery conducted in the public health facility, \$15 in the HC and \$10 in the hospital. It is generally acknowledged that the introduction of GMIS has no doubt contributed to increasing institutional deliveries as well as assisted deliveries, thereby reducing maternal mortality<sup>22</sup>. Several stakeholders worry about the financial disincentives to refer complicated cases from health centers to referral hospitals. Although the GMIS evaluation states that this concern was rejected by almost all key informants at OD and health center level, USG-supported implementing partners, based on their field experience, claim the opposite. The same GMIS evaluation states that the reported referrals as a percent of total reported institutional deliveries in Cambodia (the highest rate was about 7% in 2011) remains low as compared with a general estimation that around 15% of all pregnant women would develop a potentially life-threatening complication. The USAID evaluation team observed high numbers of complicated deliveries in Prey Veng hospital. The hospital obstetrician explained this by late referrals by HCs and linked it to the GMIS. The ToGoH and the BHS projects have introduced a reimbursement for the lost income when referring, \$15 for referral from HC to Hospital and \$10 for referrals from a BEmONC to a CEmONC hospital. This approach has been piloted for a number of years in a few ODs and is presently being documented jointly by the BHS and ToGoH projects.

HEF is a Social Health Protection (SHP) scheme that finances direct and indirect health expenses of poor Cambodians when using the public health sector services. HEFs have been regarded by MOH, USAID and other partners as an effective mechanism providing accessibility for the poor. USAID and HSSP2 have heavily invested in the development and implementation of HEFs. USAID/Cambodia funding for HEF operational costs has been reduced gradually while its BHS project continues to play an essential role for monitoring, financial verification, technical backstopping and strategic developments of HEFs nationwide. RGC has taken full ownership of this donor-initiated SHP mechanism. The Government has been increasing its financial contribution for HEF operational expenses, including medical benefits, year by year. RGC's

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<sup>21</sup> Assessment of MNCH Vouchers, Reproductive Health Association of Cambodia, March 2012

<sup>22</sup> Evaluation of Government Midwifery Incentive Scheme in Cambodia: An exploration of the scheme effects on institutional deliveries and health system, Final REPORT, May 30, 2012; By Por Ir, Kannarath Chheng, NIPH

contribution flows through the HSSP2 counterpart funds mechanism. In 2013 the share of RGC's contribution increased to 40%, up from 10% in 2009. The HSSP2 Pooled Fund still finances the remaining 60% portion.

By mid-2013, 46 of the 77 ODs had functioning HEFs; it is the MOH's intention to add another 11 ODs in 2013 and to have full HEF coverage by 2015. Very significant numbers of mothers and children have been able to access needed hospital medical care because of HEF. Between 2009 and 2013 (projected for the whole of 2013), HEFs have supported 109,458 normal and complicated deliveries, representing 42.6% of all expected deliveries by the poor in the 46 ODs. Through monitoring, complaint mechanisms and feedback loops, HEFs play also an important role in improving the quality of health services, at least for the HEF beneficiaries. Presently this remains true mainly for the non-clinical aspects of quality.

## **RECOMMENDATIONS**

### **Quality Improvement**

- Ensure broad discussion on the following:
  - a. Accountabilities at various levels (facility, OD, PHD, MOH) for corrective measures/requirements for improving the quality of health services at the front lines.
  - b. Inclusion of funds allocated for quality improvement to OD funds to allow them flexibility in planning for related activities
  - c. Technical and financial requirements of implementing the Level 2 quality tools to clearly work out details with all stakeholders and ensure sustainability of efforts
  - d. Application of provider payment mechanisms, including HEF, to encourage them to pay for their own spot checks (i.e. higher payment for higher scores; which could be based on Level 2 tools)
- USAID implementing partners should follow MOH standards when procuring materials or services to ensure correct specifications of donations, unless not relevant.
- Continue support for the medical and para-medical councils to maximize current interest and efforts in building up the quality of professionals in the health sector.

### **Capacity Building**

- Establish and maintain a training database at facility, program and NGO level to allow tracking of who has been trained to date and on which topics and ensure its link to the MOH training database, annual training plans and funding allocations.
- Ensure broad discussion on the balance between cost-efficient training designs versus providing incentives for trainees.
- Work with NMCHC to further expand EmONC training for all midwives in facilities, especially those whose LSS training was completed years ago.

- Continue to support the shift from usual classroom training approach to “training packages” that utilize simulation models, case practices and include continuing post-training coaching as well as provision of critical supplies and equipment necessary for the application of new skills acquired. This allows full application of newly acquired skills and knowledge and boosts staff confidence in using those skills.

### **Health Policy and Strategy Advocacy**

- Partners need to carefully balance continuing assistance to policy implementation with transfer of technology and accountability to local counterparts to ensure sustainability of activities over time. MOH relies heavily on the continuing support of partners like USAID implementing partners for the dissemination of policy and even in the actual implementation thereof. This reliance has the risk of poor sustainability of the activities.

### **Health Care Financing**

- Because of the achieved progress with facility-based deliveries, because of sustainability aspects and because other HCF schemes are dealing with accessibility to facility deliveries, it is recommended to discontinue the MNH vouchers in their present form.
- USAID and other partners should advocate for making adaptations to the proven successful GMIS. Adaptations should/could address a number of issues: 1) the possible late referrals; 2) the conflicting situations in hospital grounds where both the hospital and the HC are competing for the same delivery; and 3) to include ANC4, PNC3 services as a requirement for the incentive.
- Continue to support the HEF implementation functions while lobbying together with other partners (HSSP2) to put in place a semi-autonomous agency to take over those responsibilities.
- Because of the strong linkage (60%) between HEF payments and staff incentives, HEFs have the capacity to influence health staff and even health facility behavior. The present HEF Standard Benefit Package and Provider Payment Mechanism does not incentivize or even dis-incentivize a number of health services. Long-term family planning methods at HC are considered as a simple consultation being reimbursed at \$0.5 or \$1 when the actual average user fee for IUDs is around \$3 and for implants is around \$20. VSC at RH is only reimbursed \$5 as it does not require hospitalization and is regarded a simple CPA consultation. LT&PFP immediately after delivery is not reimbursed as only one service, the delivery will be reimbursed. A similar situation exists for preventive services and for the so-called free services, those related to TB, HIV, malaria, blood transfusion, nutrition and others. USAID together with HPs should lobby MOH to review the HEF Standard Benefit Package and Provider Payment Mechanism.
  - Increase special reimbursement for TP&PFP: IUD, Implant and VSC.
  - Pay for LT&PFP immediately after delivery as an extra service
  - Introduce HEF payments mechanism for so-called free (preventive services, TB, HIV, malaria, blood transfusion nutrition, etc.)

- Introduce a more dynamic linkage between the Quality Assessment score and the HEF payment rates motivating facilities to be assessed regularly and improve their quality.
- USAID, implementing partners, and HPs should assist MOH with streamlining the multitude of HCF schemes and initiatives around Maternal and Reproductive Health and health in general.

### **Private Sector interventions**

A 2012 MOH Secondary analysis, supported by GIZ, on out-of-pocket spending, based on the 2009, 2007 and 2004 Cambodian Socio-Economic Surveys, showed that the share of health care sought at both public and formal private medical providers increased in from 17% in 2004 to 70% in 2009, and with less visits to informal providers (traditional healers, home care and others). The high utilization of private facilities over that of public facilities is caused, in part, by the fact that public health facilities are considered to be of low quality, due to the lack of appropriate equipment and services, unavailability of staff and the often unwelcoming behavior of staff. Most Out-of-Pocket Payments (OOPs) are spent in the formal and informal private-for-profit sector. MOH regulation focuses mainly on the licensing of private facilities, and is seeking to improve the reporting of health statistics by the private sector. There is no regulation of prices or quality of private health care. This has not only led to the very high OOP expenditure, a major cause of impoverishment, but also exposes patients to unregulated and poor quality services.

Conflicts of interest due to dual practice remain a serious challenge to the development of both public and private health service institutions as well as to the development of sound Private Public Partnerships. Dual practice is tolerated but is not regulated or subject to clear codes of conduct.

This is the context in which the USG-supported projects have engaged with the private sector, as proposed by the AAD, mostly with successful and interesting outcomes. Most interventions directly linked to private sector engagement and implemented under the program are listed below. This section will only cover findings on 4 main interventions but will provide recommendations for several others. Reproductive Health/Family Planning and the commercial private and NGO sectors are addressed in annex 9.

- RHAC reproductive health clinics, private not-for-profit clinics (RHAC)
- Inclusion of private practice statistical data in the national HMIS (URC)
- Continue the Private Public Mix DOTS for TB screening and treatment (RACHA, RHAC)
- Franchise Network of private providers (PSI)
- Social marketing of contraceptive, safe water disinfectant tablets, Orasel kits (PSI)
- Village shops (PSI, RACHA)
- Iron Fortified Fish Sauce and Soy Sauce production via private producers (RACHA)

- Village Shopkeepers as outlets of ORS/DTK, Aquatabs, Iodized Salt, Iron fortified fish sauce/soy sauce, pills and condoms (RACHA)
- Private vehicle owners contracted for emergency referral system (RACHA)
- Technical support to Medical, Midwifery and Nursing association and linkage to continuous professional education (URC)
- Dual practice regulations in Angkor Chum (URC)

## FINDINGS

**RHAC reproductive health clinics** are an NGO network of private not-for-profit clinics. These clinics continue to provide high quality, affordable reproductive and sexual health services for adults, youth, and high-risk groups. The youth services and programs, as well as pap smears, comprehensive post-rape care, and premarital screening/ counseling are unavailable elsewhere in the country. Last year, RHAC clinics conducted 57,364 cervical cancer screenings, 94% of all screenings done in Cambodia in 2012 (MOH Annual Report 2012). Presently 15 RHAC clinics are situated in 12 ODs of 9 provinces, largely serving urban areas. Advised by the MTR and under pressure to improve cost recovery, RHAC has been redefining its market niche, more towards urban areas and towards clients who can afford to pay. The organization invests intensively in strengthening the “RHAC Clinic” brand being associated with Quality and Trust. To improve cost recovery, RHAC regularly adapts its pricing policy based on local pricing studies. RHAC has closed 3 rural clinics with the lowest income. As a result of reasonably priced quality services, the number of clients continues to increase by 10% to 15% on a yearly basis. The cost recovery of their network has improved year by year, from 31% in 2009; and is expected to reach 65% of the forecasted \$3.1 million annual expenditure in 2013. This 65% already considers a loss of \$200,000 due to discounted or exempted fees. Cost recovery of the 15 individual clinics ranges between 35% and 101%. The dichotomy between reaching the poor and achieving sustainability continues to be a challenge.

**HMIS use by private sector.** With support from the USAID BHS project, DPHI MOH has upgraded its HIS database to a web-based HMIS database, which is being modeled elsewhere. Apart from the multiple improvements the HMIS brought about the timely and reliable collection of health data collection and analysis. The HMIS also includes new features allowing data collection from the private medical sector. One of these new features is the creation of specific data entry forms and reports for private sector data. The utilization of the HMIS by NGO clinics and the private for-profit facilities has increased from 0 in 2010 to 260 in mid-2013. Although a rapid increase in those 2 years, this remains only a small fraction of the 5,501 officially licensed private facilities in the country.

**Public Provider Mix (PPM)-DOTS** is a strategy that aims to strengthen both public and private sector TB case management and to increase case detection through the formation of linkages between public and private providers who treat clients with TB or suspected TB cases. Presently the MCHP project supports 604 private providers with PPM-DOTS activities, while the ToGoH project supports 149 private providers. The number of TB cases identified through private

sector channel and put on treatment remains low. Commitment from MOH, PHDs, and ODs to the PPM-DOTS seems to not be very strong. The MCHP project is presently testing an integrated PP-DOTS and C-DOTS approach.

**Support to Medical, Midwifery and Nursing** councils with linkage to continuous professional education is directly related to regulation of the private sector, as registration has become a precondition to licensing of private medical facilities. The Medical Council of Cambodia (MCC) registration and re-registration process could have a long-lasting impact on the quality of services provided in public and private facilities. The BHS project has supported the MCC with upgrading the registration of doctors and medical assistants, including the development of a registration database, professional standards and the creation of a system of Continuing Medical Education (CME) linked to re-registration. While the first two activities have largely been completed, the CME and certainly its linkage to re-registration still require a lot support. Support to the Midwifery and Nursing councils has been quite limited.

## RECOMMENDATIONS

- As the private sector continues to grow, the challenge is to make use of the comparative advantages of this sector to ensure public functions increase. This will require reflection on key issues such as quality standards, accessibility for the poor, dual practice and regulation of the sector. USAID, with other HPs, should play an increasing role in highlighting the importance of regulating the dual practice and regulating the private sector beyond simple licensing. This process might require engagement with the Cambodian Government outside the MOH. USAID could assist MOH to develop the regulatory and enforcement frameworks.
- Health Centers in Angkor Chum OD are functioning much better (process, output and coverage) than the average HC in the country. A major reason seems to be the strong enforcement of the ban on dual practice non-private practice by the HC staff under the leadership of their OD Director, and supported by HEF, CBHC and SDG interventions. It would be useful to document the linkage between the strictly regulated dual practice and the impressive results. The findings could be used as guidance on dual practice regulation and as support for awareness creation amongst authorities.
- USAID should continue to support RHAC clinics under the condition that they further improve their cost recovery. In the meantime donors such as USAID should continue to support the funding required for the exempted and discounted clients and services.
- MSIC has gone through a similar cost recovery process for their clinics to reach around 100% as a network, from only 25% five years ago. They achieved this through a dynamic pricing policy, improved management with emphasis on staff performance appraisals and proper planning with individual clinic business plans. Quality assurance remains a priority of their internationally recognized brand. RHAC should consult MSIC on their cost-recovery and quality assurance strategies for the RHAC clinics.

- Increasing the utilization of the web-based HMIS database by private health facilities will demand enforcement through regulations, possibly linked to the licensing system, and HMIS training for private facility staff. USAID could assist MOH with the development of those regulations and the training package and plans. CCM could contribute to this process by including HMIS trainings in their CME curriculum.
- The MCC still requires further support with the strengthening of their registration system and rolling out to the provinces. This includes further and more intensive support for the re-registration mechanism, its linkage to CME, and with the CME system itself. USAID should continue technical support to the MCC. USAID together with HPs could lobby MOH and RGC to further consolidate and enforce the registration and re-registration conditional upon stringent professional standards and CME. USAID and HPs should identify amongst themselves who to provide similar support to the other health professional councils.

### **Community-Oriented activities**

USAID implementing partners RHAC and RACHA introduced a large number of health-related community activities. The community health activities focused on the two main priority health program areas of the Health Sector Strategic Plan II (HSP-II 2008-2015): 1) Reproductive Maternal Newborn and Child Health and 2) Communicable Disease.

These activities include:

- Promote ANC, birth preparedness, complication readiness.
- Community based-IMCI through VHSG accordance to the MOH C-IMCI guidelines.
- Community mobilization for outreach attendance and follow-up on missed cases.
- Administration of Vitamin A capsules (VAC) to missed cases, i.e., post-VAC distribution campaigns, per MOH guidelines.
- Community-based distribution (i.e., sales) of contraceptives in accordance with MOH guidelines.
- Community-based sales of health commodities as approved by MOH.
- Community mobilization to establish village to health center referral systems.
- Establishment of sustainable mechanisms of financing of referrals from local resources (e.g. Commune Council funds, local fund-raising, micro-credit interest).
- Community mobilization/awareness-raising of client rights as outlined in the MOH client rights Charter.
- Training of Health Center Management Committees (HCMCs) and Commune Councils (CCs) in community health needs and client rights.
- Advocacy and technical assistance to HCMCs and CCs in establishing mechanisms for implementing the client rights Charter and following up on complaints.
- Community-based treatment of common child diseases as approved by the MOH.

- Community-based prevention and surveillance activities related to other infectious diseases, as guided by the MOH.

Based on their respective cooperative agreements, implementing partners support the introduction and implementation of the above activities in coordination with the HCMC and VHSG/CBD/C-DOTS observers in all targeted villages. In order to effectively carry out the above activities, implementing partners worked with local public health counterparts (PHD, OD, HC) and, CC in their targeted areas. They assisted with the establishment of community structures at the health center level, the HCMC and the VHSGs. Initially, implementing partners provided support for the functioning of these community structures in the form of capacity building, funding and coaching. The VHSG and HCMC are crucial local resources to deliver comprehensive community health service packages. Implementing partners have been lobbying health authorities and local authorities to integrate the operational costs of community health activities in both the government health sector and in the government commune budget for social activities. Communes use the Commune Investment Program (CIP) for their activity and budget planning.

USAID implementing partners have also explored different ways to encourage feedback and complaints by clients to hold public facilities accountable. In several areas this resulted in very active feedback and subsequently in improved functioning of the HCs.

The evaluation team looked at the efforts of MCHP and ToGoH to support the local district health system and CCs and their innovative interventions sustaining the community health programs.

## **FINDINGS**

### **Support in establishment and training HCMC/VHSGs**

MCHP project supported 19 ODs and 264 HCs to establish HCMCs/VHSGs. Over the life of the project, 6,764 VHSG members have been selected and trained on health-related topics to enhance their capacity to perform their roles and responsibilities. By the first half of 2012, 100% of the 264 health centers in 19 target ODs had established and mobilized HCMCs and 82% of HCMCs and were conducting three or more meetings per year.

ToGoH project supported 18 ODs and 273 HCs to establish HCMC/VHSGs. A total of 7,803 VHSG members were trained on roles and responsibilities and other health related subjects such as family planning, nutrition, hygiene, water and sanitation, TB, HIV/AIDS and Avian Influenza. The IEC materials such as flipcharts, flyers, posters and booklets were provided to VHSG members to support their education session in their village. RHAC field staff also provided backup assistance to VHSGs during village education activities.

### **Support to HCMC & VHSG Meetings**

After establishment of HCMC/VHSGs, USAID's implementing partners continue to provide technical and financial support for the functioning and the strengthening of these community groups through bi-monthly meetings of the VHSGs and quarterly HCMC meetings. The main purposes of these meetings are to create a dialogue between communities and their HC, to

obtain feedback from the community on the provision of services by their HC, and to communicate on specific health issues.

During field visits, the evaluation team noted the following key issues:

- Several VHSGs were conducting meetings using an agenda model prepared by health centers without agenda points for gathering feedback from the community.
- Often, VHSG trainings were incorporated as a part of VHSG meetings. This arrangement allowed implementing partners to provide payment for both per-diem and transportation cost to VHSGs members. This results in a higher incentive for the VHSG members and hence in increased participation to those meetings. On the other hand it leaves little time left to actually discuss issues related to VHSG work in the field and accustoms members to higher incentives. As a result VHSG meeting cost become considerably higher making it more difficult for commune councils to assume meetings costs in the future.
- Some commune councils used their CIP budget to contribute to the operational costs of the HCMC but so far they have not yet planned financial support for the VHSG meetings.

#### **Advocacy support to CCs for sustainability of community health activity**

Implementing partners have developed a priority list of community health activities to be integrated into local health system and commune councils under CIP. CIP has been established in order to empower local authorities to develop and strengthen their own communities and to address local needs. One budget component of CIP is the allocation for social services focusing mainly on education but also on health.

Under strategies to strengthen local governance for community health, ToGoH project conducted several workshops at the provincial and districts levels. The workshops aimed to build an enabling environment for engaging local health authorities and local governments in health and development. The workshops mobilized various stakeholders including provincial and district governors, commune councilors, PHD and OD directors, and different NGOs. All were involved in reviewing their respective roles and responsibilities in district health system development. More specifically, it was an opportunity to examine the roles of local authorities, their involvement in the District Health Development Committee (DHDC) and of the CCs and their involvement in the HCMC, in accordance with the MoH's guidelines for developing operation district and Community Participation Policy for health. These workshops also covered the D&D concept, elaborating the role of CCs and their responsibilities to utilize the CIP for supporting social and health-related activities.

At a workshop in Kampong Cham, the Provincial Governor expressed his support for these activities. Based on decisions and agreed action points from the workshops, field staff of ToGoH program advocate with the CCs to contribute budget for supporting HCMC meetings. As a result, already 12 HCs out of the 273 HCs in ToGoH project coverage areas have used commune budgets for funding HCMC meetings. Through the HCMC meetings, ToGoH will continue to advocate HCMC members to transfer funding responsibilities for their meetings from the present project funds to the CC budgets or to the health centers' user fee income before the

end of the project.

MCH program developed an exit strategy and sustainability plan for USAID-funded program activities in the final year of the program, including a list of priority community health activities for integration into the CIP plan. MCH program invited a representative from Ministry of Interior to train key staff, PHDs, ODs staff on how to integrate community health-related activities into CIP. As of 2012, 71% of HCs under MCH program target areas have integrated community health activity into CIP plan. Integration of these priority community health activities into the CIP plan does not, however, mean funding by the CC budget. Presently 4.22% of the HCs in MCHP coverage area receive CC budget support for all or some of their HCMC meetings.

Based on the interviews with field staff of implementing partners, commune councilor or chiefs, Commune Committee for Women and Children (CCWC) members, HCMC and VHSG members in assessing stakeholders' reactions to implementing partners' advocacy messages, it was observed that:

- Commune Councils/commune council chiefs did not yet sufficiently understand the rationale for supporting VHSG meeting and health related activities.
- CCWC members require and are interested in technical support to improve their capacity in promoting women and children's health and to enhance their basic advocacy skills.
- Field staffs of partner organizations need additional support from central level so that they can more effectively advocate to CCs to support community-based health activities.

### **Community-based referral system**

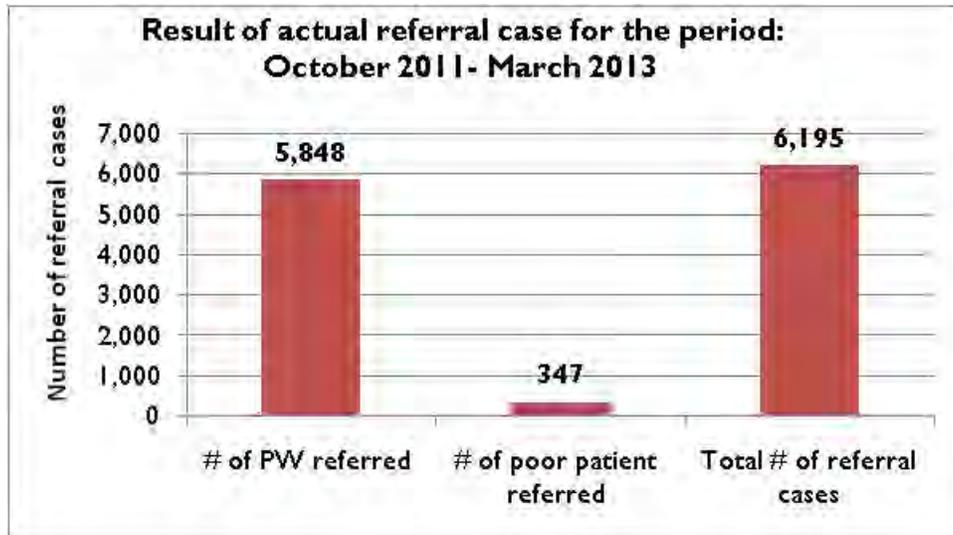
In order to address the delays in referring emergency cases between the village and the HC or hospital, one of the major contributors to maternal death, ToGoH and MCHP have established and scaled-up Village Emergency Referral Systems (VERS).

ToGoH worked with all 18 ODs in five targeted provinces to establish referral systems from village to HC or RH in order to address medical emergency situations, particularly for pregnant women. ToGoH contracted local vehicle owners with predetermined prices for day or nighttime transport. ToGoH works with CC and HCMC to select villages in the HC coverage area. CCs made contract agreements with local vehicle owners to transport women when called. However, patients have to pay for transportation cost to the vehicle owners from their own pocket. At the same time ToGoH has successfully advocated to CCs to allocate CCWC or other commune budgets to support emergency transport for poor pregnant women in their community. As a result, among the 367 communes in ToGoH's coverage areas, 106 communes provided funds in this capacity, with 44 communes documenting actual payment to pregnant women. By March 2013, ToGoH project supported contract agreements with vehicle owners in 1,545 villages, and reached 70% of the eligible villages in the 18 ODs.

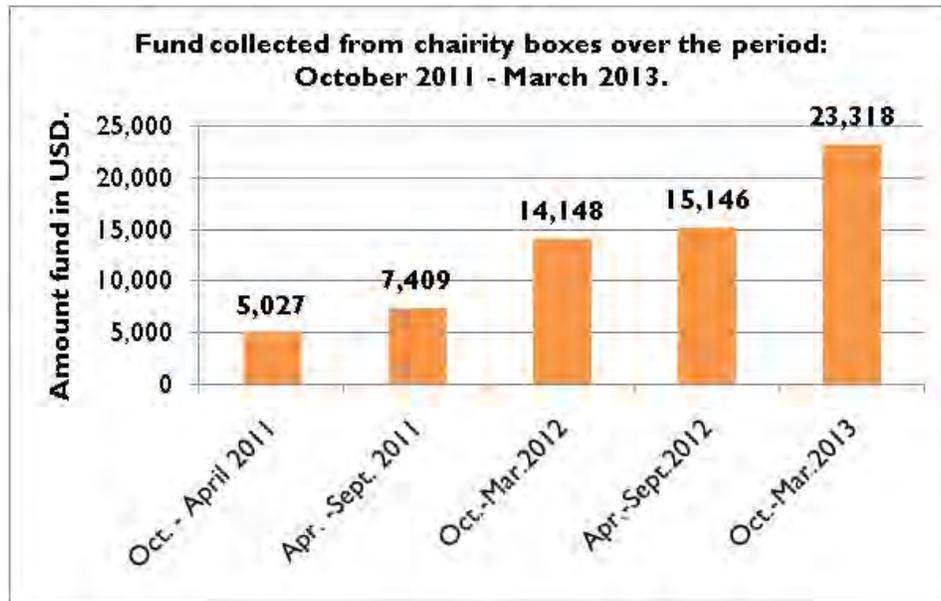
Since mid-2012, and in addition to the above support, ToGoH supports emergency referral

system for pregnant women who deliver at HC but who need referrals to RH for emergency situations according to the agreed criteria. ToGoH pays for transportation costs and related user fees at RH including cesarean section for all women except HEF cardholders. ToGoH made transport reimbursement contracts with RH ambulances and with the villages' HC referral systems. This intervention is only supported in Kampong Speu and Preah Sihanouk provinces.

MCHP also worked to strengthen the referral system. By 2012, 1,563 vehicle owners signed contracts for transporting the pregnant women and poor patients from the village to HC or RH. By March 2013, 794 charity boxes were established and posted at the pagodas and public places. The boxes collected an impressive amount of \$23,318 between the period from October 2011 until March 2013. Up to 5,848 pregnant women and 347 poor, seriously ill patients were able to use this funding source. The graphs below show the number of referral cases and the funds generated funds by the charity boxes.



Source: provided by MCHP during mission



*Source: provided by MCHP during mission*

- At the local level many different funding sources can be used to support the referral system, such as funds from charity boxes, CCs funds, HC fund (user fee, HSSP2, other NGOs) and other schemes such as HEF, Vouchers etc. In this aspect, the evaluation observed that there is an issue with coordinating the use of these local funding sources.

### **Feedback mechanism and client rights**

Implementing partners have been promoting Client Rights through various interventions and have been spreading awareness on client rights throughout the community. They have promoted this through village health support groups and other established structures.

A number of interventions have been set up at both the community and at the facility levels. At community level, VHSG & HCMC members, the VHSG & HCMC meetings, village meetings, community health forums, and community scorecards systems have been used as strategies for gathering complaints and feedback from clients. In the context of different health financing schemes, HEF monitoring systems, client satisfaction surveys, and exit interview mechanisms have been established and are now also dealing with the complaints of the clients. Telephone hotline and suggestion boxes have also been set up at targeted facilities.

ToGoH project worked with PHD, OD, HC and local authorities to set up suggestion boxes for collecting feedback and complaints of clients. ToGoH project assisted CC members to prepare complaint forms, which contain a list of issues that may happen at the HC. These complaint forms were distributed to VHSGs, who encourage clients at the facility to complete those forms and put them in the suggestion box. Based on ToGoH's report, 3990 letters were collected in 2011 and 11,188 letters were collected in 2012. This is an impressive number. At the HCMC meeting, they try to prioritize and solve the most common or important issues, and follow up

on the result in subsequent meetings. Encouragingly, ToGoH reported some changes of staff behavior, friendliness, uniform, and respect for working hours. This support did additionally help to encourage clients, and VHSG members provide feedback to health providers in a constructive way. This initiative has clearly provided opportunities for communities to voice their complaints through their local representatives and to have them addressed by their local health decision makers.

At some health facilities the placement of suggestion boxes was not ideal; sometimes they were hard to find, sometimes they were placed too near HC staff offices making patients uncomfortable when putting their complaints in front of HC staff. Another area for improvement is the follow up of issues requiring OD, PHD or central level intervention, as it is not easy to communicate with them and even more difficult to demand feedback on progress.

With matching funding from the World Bank (WB), USAID implementing partners also introduced WB-designed Community Scorecard (CSC) interventions in selected ODs. The CSC aims to promote civic engagement, improve interaction between clients and health service providers, and empower communities to improve health service provision. Some key successes included:

- Changed ways of community thinking—clients can now fully participate
- Increased awareness of client rights
- Health Center staff more responsible and present at the health center
- Some issues brought up to the upper level.

## **RECOMMENDATIONS:**

### **Support to HCMC & VHSG Meetings**

- Improve quality of VHSG and HCMC meetings to ensure interaction and linkage between health center and the community and to address key evolving issues. This could include revised model meeting agendas prioritizing client feedback over other routine issues.
- In order to assure sustainability of VHSG meetings they should be integrated in and funded through AOPs and CIPs. In that context cost of VHSG meetings should not only consider the minimum required incentives and reimbursement to assure participation by VHSG and HCMC members, but also the available budgets of HC user fee income, CC budgets or other government funding.

### **Advocacy support to CCs for sustainability of community health activity**

- USAID implementing partners should continue providing or even intensifying their efforts to strengthen advocacy skills of HC, VHSG, HCMC and CCWC, including activity and budget planning skills, through technical assistance.
- Some CCWC are duplicating community health activities of VHSGs using CIP budget. Often CCWC members have little knowledge on health issues and effective promotion. USAID implementing partners should evaluate how CCWC and VHSG could both be

involved in community health activities without too much overlap or too many gaps. This will probably also require capacity building and coaching of CCWC members on community health related activities in a comprehensive and efficient way.

- Partner organizations should provide more advocacy skill training to their field staff and further follow up with on-site coaching support.

### **Community-based referral system**

- Thanks to USAID implementing partner efforts, there are now many different sources of funding for VERS. This results in better coverage for emergency transport. Several places have multiple funding sources for different types of services or target groups. Often they differ from one HC to another. Implementing partners should assist HC and CCs to coordinate the use of the different funding sources for supporting referral cases while avoiding duplication or gaps. Regrettably a standardized approach will not work because funding sources differ from place to place.
- In general, the Village Emergency Referral System seems to have been quite successful and should be documented and shared for scaling up.
- With the increasing availability of ambulances, their increased use for emergency transfers to hospitals should also be supported, while avoiding their use as routine transport mode for non-critical issues, as they are very costly.

### **Feedback mechanism and client rights**

- Implementing partners should continue to support and scale up CSC, suggestion boxes and other successful models of feedback and accountability. At the same time an assessment of the different approaches needs to be conducted in order to streamline those that generate better results.
- Implementing partners should find ways to seriously follow up on agreed action points or commitments of health providers for change.
- Implementing partners should document cases of the CSC or the suggestion boxes addressing patient or community complaints successfully and how this was achieved.
- Partners should build the capacity of the HC and CC to address issues that need involvement of higher levels of government.
- Partners should continue to explore how to work directly with MOI as well as with other provincial authorities, including the District Communes and the Governors in order to provide consent and guidance to the CCs on how to use commune budgets for supporting health activities.

### **Behavior change**

Behavior Change Communication (BCC) is one of key strategies used by programs around the world for promotion of healthy lifestyles. USAID partners in Cambodia have used a variety of

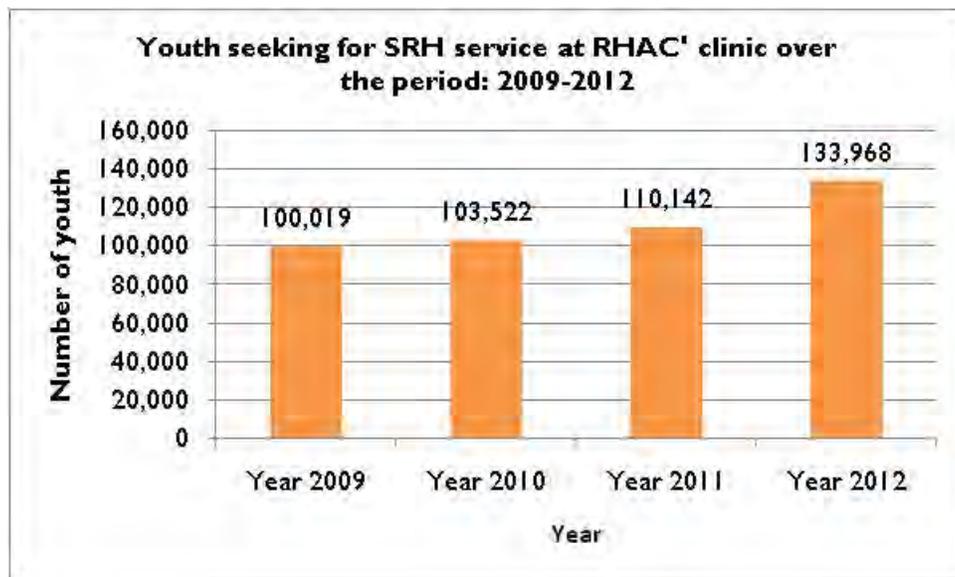
approaches to promote behavior change and improve health-seeking behavior. Their interventions are cross-cutting and cover main health issues such as:

- Increasing demand for reproductive health/family planning services;
- Raising awareness of pregnant and postpartum women of danger signs and when they need to seek medical care;
- Prevention of HIV/AIDS and STIs, and TB;
- Information about the benefits of breastfeeding and complementary feeding;
- Awareness of the benefits of immunization and other child health services;
- Information and counseling to improve nutrition practices, hygiene and sanitation.

A variety of activities were carried out and materials developed by all implementing partners. The greatest impact was achieved through the use of community volunteers or VHSGs. VHSGs are village volunteers charged with linking the community to the health system. Their responsibilities include health education/promotion, referral to health facilities, and mobilization of communities for outreach services. Implementing partners supported C-DOTS observers, peer educators, religious leaders and health workers to disseminate information at the community level.

Community health promotion included the MSI Tuk-Tuk campaign, the MCHP village comedy theatre, traditional music and other community events. SMBCI's multi-media campaigns proved to be highly useful in informing the public about new products and dispelling misconceptions about family planning methods.

Under ToGoH's Youth program, peer educators play an important role to promote reproductive health focused on youth seeking reproductive health services. As a result, the number of youth using reproductive health services at RHAC's clinic has consistently increased over the period from 2009-2012.



Source: provided by ToGoH during mission.

Although all of these BCC activities have been successful and effective, there is evidence of overlap and gaps in health promotion and demand generation. Better coordination among partners, guided by an overarching communication strategy, is needed.

## **RECOMMENDATIONS:**

- USAID should assist the MOH with development of a comprehensive strategy to guide, monitor and coordinate behavior change communication campaigns in Cambodia. To improve coordination, USAID, in collaboration with other donors supporting health promotion activities, need to meet regularly to coordinate their activities and minimize overlap. Together with other health partners, USAID and its implementing partners should consider establishing a joint partner technical working group for health promotion.
- Health Promotion activities should be planned and implemented in closer collaboration with National Center for Health Promotion, the MOH's institution assigned to coordinate behavior changes communication around the health sector.

## **REPRODUCTIVE HEALTH / FAMILY PLANNING**

### **Background**

Cambodia has experienced tremendous progress in family planning and reproductive health over the last five years, with use of modern methods having increased from 27 to 35% between 2005 and 2010<sup>1</sup>. There is widespread acceptance of family planning in Cambodia and knowledge of contraceptive methods is no longer an issue. However, despite these gains, Cambodia missed its Millennium Development Goal (MDG) target for modern contraceptive prevalence by nearly nine percentage points in 2010. The goal of achieving the MDG goal of a CPR of 60% by 2015 is an ambitious, if not somewhat daunting goal. According to the 2010 CDHS, the method mix remains limited, with the oral pill (15%), followed by the injectable (10%) as the most popular methods. Use of long-acting and permanent methods is only 5.9% overall, with 3.1% using the IUD. Furthermore the national program has seen an increase in use of less effective traditional methods (16%) and withdrawal has become the second most popular method in the country, used by 12% of married women aged 15-49, including a large cohort of educated urban women. The oral pill has a high discontinuation rate (with 35% of women discontinuing use during the first 12 months of acceptance) and unmet need is still high at almost 17% (11% for limiting and 6% for spacing). Including those using traditional methods, unmet need totals 33% of "Married Women of Reproductive Age" (MWRA).<sup>23</sup>

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<sup>23</sup> CHDS 2010

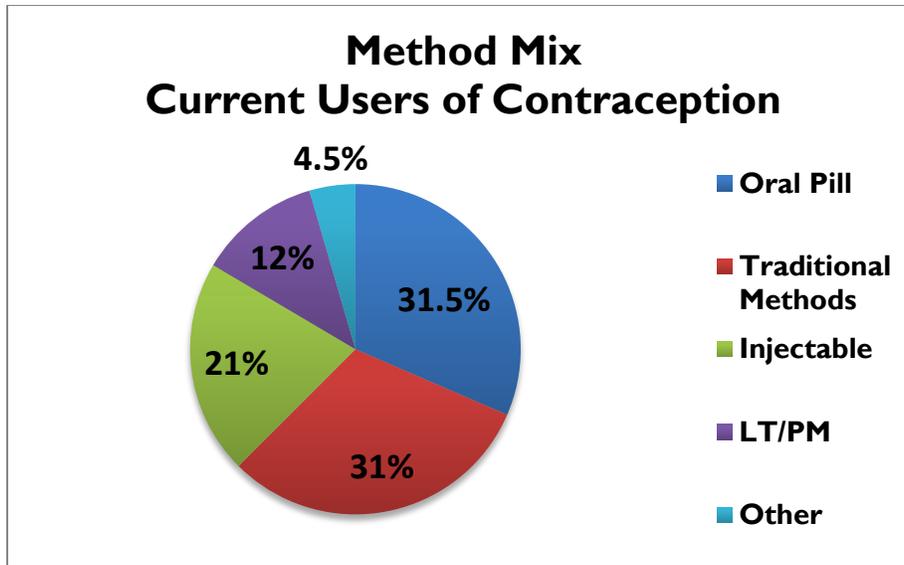


Figure 1: This chart shows the method mix among the 50.5% of MWRA who are currently using a method. Source: 2012 DHS

The large and growing numbers of couples using traditional methods as well as the continuing unmet need for limiting and spacing g illustrates that there is an urgent need to reach non-users with family planning information and services, as well as to motivate users of traditional methods to transfer to a modern method.

Accompanying this rapid increase in contraceptive use is a corresponding decline in fertility levels, from 4.0 in 2000 to 3.0 children per woman on average in 2010.<sup>24</sup> A rapid transition to lower fertility is accompanied by changes in the age structure, making for a smaller population at young, dependent ages and for relatively more people in the adult groups, who comprise the productive labor force. The demographic dividend occurs when falling birthrates improve the ratio of productive workers to child dependents in the population, thus making faster economic growth possible. Cambodia is entering a demographic transition, from high to lower fertility, where it might have an opportunity to access a demographic dividend that could enhance its economic growth if the right social and economic policies are developed, and if employment opportunities and investments in education are made. ***But this “demographic opportunity” will only happen if fertility continues to decline at fairly rapid rates.*** Thus, continued emphasis on provision of family planning services for the large numbers of women entering the of reproductive age group must continue if Cambodia is to be provided with a demographic opportunity and the potential for more rapid economic growth.

### RGC Priorities

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<sup>24</sup> CDHS 2000 and 2010

The passage of the National Strategy for Reproductive and Sexual Health in Cambodia (NSRSHC) in 2006 with an updated version in 2008 makes it clear that the RGC is serious about expanding the provision of voluntary family planning, maternal and reproductive health services. A second phase, 2012-2016 (NSRSH2), builds upon achievements of the first and strengthens the Government response. It provides a strategic framework for an effective and coordinated response to sexual and reproductive health needs in the country. However, this strategy needs to be fully operationalized so that its principles and goals are understood, and so that clearly defined interventions are in place to guide its implementation.

*One of the principal elements of the strategy is the reinforcement of the “right of couples to produce the appropriate number of children and to have access to information and family planning methods in order to make their decision freely and in line with cultural values”.*

In spite of this positive policy environment at the national level, commitment by policy makers and politicians at the regional level is lukewarm. Isolated instances of resistance among senior local-level officials has been reported, possibly resulting from an underlying concern about overall population levels following massive genocide in the 1990s and the much larger populations of neighboring countries.

### **Contribution of Implementing Partners to USAID Program Goals**

USAID projects have made a significant contribution to increased utilization of family planning services in Cambodia. Based on annual surveys, CPR increased from 32% in 2010 to 42.6% in 2012 in the ToGoH assisted provinces; and from 38% in 2010 to 39% in 2012 in the MCHP assisted provinces.<sup>25</sup> The MCHP’s more modest results may be due in part to the project’s inclusion of three new districts in the 2012 survey, where coverage rates were still low, and to under-reporting of LAM users. Other factors may include different approaches to program management. It was reported that RHAC has a more centralized approach to management than does RACHA, which largely delegates planning and decision-making to provincial officials. RHAC has staff posted at the district level and is able to provide more hands-on technical support in the field. In addition, RHAC has historically focused on RH/FP and they continue to make this a very high priority.

### **Facility Based FP Services**

According to the 2010 CDHS, 52% of women obtain their method from a public sector facility, with the health center being the most popular place to obtain services; whereas private sector provision of FP is low in Cambodia at 11.4%<sup>26</sup>. USAID partners have been providing technical and managerial support to the MOH to increase the availability, quality and utilization of public sector health services at both the hospital and clinic level. Among the three USAID partners

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<sup>25</sup> Modern method use without LAM was 37% for RACHA and 30% for RACH in 2012.

<sup>26</sup> 2010 DHS

included in this evaluation, only the ToGoH Project provides reproductive health care directly from its own network of 15 clinics.

Having a broad range of methods available is a key element of quality family planning services and raises the overall level of contraceptive choice. Indeed, USAID partners have helped to make this happen. Pills, condoms and IUDs were available in all of the clinics visit, as well as IUD insertion kits and at least one trained provider present at the time of the site visit. The 234 ToGoH-supported health centers were able to provide IUD services in 2012, compared to only 120 in 2009.<sup>27</sup> Fear of side effects and misperceptions regarding the IUD is still a major challenge to service providers. Furthermore, public sector clinicians are often not highly motivated to provide the IUD because of the pricing structure which keeps the cost of the device and the insertion below the actual cost, and much lower than insertion of an implant.

However, there is evidence that it is possible in Cambodia to transition to long-term methods. Findings from client exit interviews conducted by MSIC at the end of 2012 reveal that 73% of current users of family planning who accessed service provision via MSIC's mobile clinical outreach teams nationally (18 provinces) switched from a short-term to a long-term or permanent method of family planning. Significant progress has also been made in the two provinces funded under the USAID SIFPO project, where IUD uptake more than doubled in one province and increased by 27% in the other.<sup>28</sup> This success can be attributed to effective counseling, health promotion and outreach efforts, and to the quality of services provided at clinics in these two areas, as well as the voucher program where clients knew in advance that they would receive the method free of charge.

Clinical skills and competencies of service providers have been strengthened primarily through in-service training in advanced methods of family planning. Using curriculum developed primarily under previous projects, USAID partners have expanded the training of midwives, which has resulted in increased capacity at the health center level. All of the midwives interviewed confirmed that the training they received has helped them to improve the quality of services they are able to provide. However, several respondents stated that they received training many years ago, and that a refresher course would be helpful. A number of midwives interviewed said that they do not have time to provide FP counseling, and quite possibly do not have the skills to address the real reasons for non-use of modern methods, which is fear of side effects. Improved counseling skills are urgently needed if midwives are to address misinformation and allay client reservations about modern methods.

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<sup>27</sup> RHAC Annual report October 2011-September 2012.

<sup>28</sup> MSCI Presentation to the evaluation team, June 26,2013



Figure 2: Midwife providing family planning services at Kampong Cham Health Center.

As mentioned in the RMNCH Section of this report, USAID implementing partners have been successful in helping the MOH increase the coverage of key maternal health interventions, including ANC, PNC (to some extents) and delivery by a trained provider at health facilities; thus creating a number of opportunities for provision of family planning. The 2010 CDHS reports that three-quarters of non-users neither discussed family planning with a fieldworker nor at the health facility. These data serve to verify what the team observed - that not all women are being provided FP information when they visit the health center.

The increasing number of deliveries taking place at a hospital or health center (RHAC and RACHA surveys report that in 2012 over 80% of births are taking place in a facility) represents an important opportunity for provision of family planning information and services. However, in Cambodia, while counseling is provided post-partum, provision of a method of contraception is rarely provided in the immediate post-partum period. One woman with whom we spoke while still in the ward was simply told to go to the nearest health center after six weeks. It should be noted, however, that an increasing number of newborns are receiving neonatal care, and midwives are consistently providing information and counseling about the benefits of early and exclusive breastfeeding. MCHP reports that close to 90% of new mothers practice exclusive breastfeeding for six months (except in new project areas where rates are lower).<sup>29</sup> It is doubtful, however if these women have actually been trained in LAM as a method of family planning. In any case, since many mothers do not always return to the clinic for PNC, follow-up is needed to ensure a timely transition to a modern method of BS when the mother no longer meets the criteria for LAM.<sup>30</sup>

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<sup>29</sup> RACHA Annual Assessment Report, 2012

<sup>30</sup> The three LAM criteria are: no menstrual bleeding since delivery, no supplemental feeding, and the baby is less than six months old.

Provision of FP in the immediate post-partum period may soon improve with the revision of the Safe Motherhood guidelines which allow for provision of BS methods post-partum. However, the revised guidelines for IUD insertion post-partum are still too restrictive. Current medical guidance internationally indicates that it is appropriate to provide an IUD to both breastfeeding and non-breastfeeding women immediately after delivery of the placenta. (Hubacher et al 1992; Sahin et al 1994). If the IUD is not inserted during the first 48 hours, however, it is advisable to wait four weeks. Receiving an IUD while still in the hospital has several advantages: it is convenient, safe and effective. The MOH SM guidelines need to be reviewed once again if further gains are to be achieved in use of long-term methods. The CPA guidelines, followed at the hospital level, will also need to be revised.

In large part due to effective advocacy provided by AusAID with support from BHS, family planning services are now allowed at the referral hospital. However, a recent URC assessment reveals that family planning methods – both short and long-term methods--were only available in half of the hospitals surveyed. Another major constraint has been the need for hospital staff to pick up FP supplies at the health center. Although this policy was recently changed and facilities are now allowed to order FP commodities directly from CMS, few RHs have adopted this change, including the ones visited by the team. BHS has also developed and recommends that counseling corners be established in all hospitals, but the team was not able to observe dedicated space for counseling during hospital visits.

There remains a large unmet need for permanent methods of family planning in Cambodia, as the majority of women who are in need of a family planning do not want any more children. Although some doctors at CPA2 and CPA3 level hospitals have been trained in VSC services, they report little demand for vasectomy and are not actively providing tubal ligation, either because they lack confidence in their ability, have inadequate resources at the facility, and/or are simply not motivated to provide this service. Through the MSIC mobile outreach teams, which visit a large portion of government referral hospitals on a monthly basis, MSIC is helping to build public sector capacity for VSC services through on-the-job training.

Unplanned and unwanted pregnancy often lead to abortion in Cambodia, with over 5% of the women of reproductive age having had an abortion and a quarter of these women having had more than one.<sup>31</sup> Uptake of FP is high in the RHAC and MSIC clinics where contraceptives are provided on site. However, in the public sector hospitals visited, where PAC services were available, clients were generally advised to follow up with a visit to the clinic for FP services. This represents an important missed opportunity as experience internationally shows that if services are provided prior to discharge, clients are much more likely to adopt a method and avoid the repeat cycle of unwanted pregnancy and abortion as a method of family planning.

**Logistics:** USAID partners have provided technical assistance to strengthen management of contraceptive supplies and to help ensure adequate stocks at health centers. A number of MOH health officials interviewed specifically mentioned the value of assistance with the LMIS system, introduced some years ago under the MCHP. This system enables the OD to quickly identify needs, place orders and detect stock outs. Most health centers visited had adequate stocks of pills, condoms and IUDs. However, the team did observe some issues. One clinic visited was rationing COCs and only provided one blister pack to clients, instead of the three requested. In addition there was a wide shortage of Implanon, preventing some women from obtaining this method following successful demand creation activities. The team was pleased to learn that UNFPA (through funding from AusAid) has delivered an interim emergency supply to fill the gap, and has placed an order for a large shipment of Implanon, which solves the problem of a shortage of implants in the short-term.

## **RECOMMENDATIONS:**

- **Policy:** Sub-national level advocacy efforts are needed to create an enabling environment at the regional and local level and to increase commitment and resource allocation to address RH and FP issues. USAID might consider technical assistance to senior government officials and civil society to strengthen their policy and advocacy skills.
- **Logistics:** The team suggests that USAID continue to work with other donors to help ensure an adequate supply of contraceptives. Additional technical assistance might be considered to modify the system so that it can accommodate a rapid increase in demand, as well as assistance to the Essential Drug Department to further strengthen forecasting and procurement skills.
- **Contraceptive Security:** Eventually the RGC will need to fund contraceptive commodities out of its own budget. In the meantime, USAID, in partnership with HSSP2 donors, could advocate for inclusion of a line item for contraceptives in the national budget.
- It was only possible for the team to visit a fraction of the hospitals and health centers in the country. Implementation of the DHS Service Provision Assessment (SPA) tool would provide a comprehensive review of maternal child health and family planning services offered at health facilities. The SPA collects data on infrastructure, health systems, supplies, and trained staff, and provides reliable information on the proportion of facilities offering family planning, the proportion of sites following accepted standards of care, and the extent to which clients and providers are satisfied with the care received.
- To decrease discontinuation and fear of side effects, the team recommends that USAID and its partners focus on expansion and improvement of FP counseling for midwives, including practical information on ways to integrate FP/BS counseling into their daily work; with clear guidance that their job responsibilities include counseling for FP/BS. This requirement should also be integrated in the supervision checklist for ODs for monitoring purposes.

- **Minimize Missed Opportunities:** There is a need to seize opportunities for FP information and services among woman who come to a facility for MCH services. Opportunities include antenatal and postnatal visits, as well as children’s immunization and sick child visits to the health center. The MOH needs to make FP/BS information and services available at each point of contact with the health system and at every stage of the birth interval to decrease missed opportunities for FP information and services.
- **Expand support and training for PAC:** As mentioned, PAC services have been implemented successfully by several USAID partners. Uptake of FP is high in the RHAC and MSIC clinics visited where contraceptives are provided on site; RACHA reports that 4 ODs have PAC, with 31% FP acceptance. This service needs to be scaled up to cover all public sector hospitals. According to International Best Practices, the provision of on-site counseling and services prior to leaving the hospital is a necessary ingredient for increased method adoption.
- As recognized by the OPHE team, there is a need in Cambodia to motivate couples to transition from traditional to modern methods of family planning, including increased use of long-term methods. However, given the context of significant cultural and capacity constraints, it is optimistic to anticipate a major shift in acceptor behavior from short-term to long-term methods over a short period of time. These constraints notwithstanding, long-term methods (IUDs and implants) appear to be gaining favor among Cambodian women. In addition, USAID is supporting research to better understand why traditional methods have been gaining favor in recent years. Findings from this research will help to formulate behavior change communication strategies during the next phase of assistance.
- **Roll out of new policies:** A number of policies and regulations were successfully revised during this period of assistance. There is a need to ensure that clinicians, particularly at the hospital level, are aware of recent policy changes and protocols which facilitate provision of RH/FP services, such as allowing provision of BS methods post-partum, inclusion of contraceptives in the package of commodities provided to hospitals by CMS, as well as recent changes in HMIS reporting. Orientation, training and increased supervision of service providers is needed to ensure that these guidelines are being utilized effectively in the field.
- It would be beneficial to review the Safe Motherhood guidelines once again to broaden the guidance on IUD insertion in the immediate post-partum.
- Review user fees for IUDs and VSC to help ensure that the low fee structure does not influence providers’ decisions to advance utilization of LT/PM.
- Training remains an important way that services providers are updated in knowledge and skills to provide quality services. With support from USAID, clinical skills and competencies of service providers have been strengthened, primarily through in-service training and to a lesser extent field-based hands-on training. Numerous clinicians have received training in advanced methods of family planning, safe motherhood, management and quality assurance. Continued training needs include:

- ✓ Competency-based refresher training for midwives, particularly in IUD insertion;
  - ✓ Client-centered training on FP counseling;
  - ✓ Orientation to tools for monitoring and use of service statistics;
  - ✓ Practical training for public sector providers in provision of LT/PM;
  - ✓ Field-based hands on training through more frequent and improved monitoring and supportive supervision.
- Combine partner household survey assessments into one instrument to ensure that they are applying the same methodologies for collection and analysis of data, and to reduce costs. Based on the recommendations of the mid-term evaluation, RACHA's population-based survey tool was revised, and methodologies improved. But there are large differences in the use of LAM reported by RACH and RACHA, which could be a result of programmatic interventions or a result of different methods for calculating users of this method. Combining these surveys would prevent such discrepancies in the future.
  - There remains a need to improve program monitoring and the use of data for decision-making at the field level. HC/OD and USAID partner staff need to better understand and utilize the HMIS and survey data collected, and to interpret how it affects their daily work and the health needs of beneficiaries. Partners should consider reducing the total number of indicators and focus on disaggregating key indicators by measures of equity, gender and access.<sup>32</sup>
  - The evaluation team believes that it is important to continue to support RHAC clinics as they have made an important contribution to CPR, by serving 11.5 percent of current users in 2012<sup>33</sup>. They also provide a unique niche through provision of "youth friendly" services and comprehensive, quality reproductive health services for women of reproductive age, including diagnosis and treatment of reproductive tract infections and sexually transmitted disease and screening for cervical cancer.

## Demand Creation

Although awareness is high, misinformation and rumors about contraceptive methods abound. Data from the 2012 RACHA survey shows that although 92.6% of women know at least three modern methods of FP, 52.4% of non-users say they have health concerns about FP methods. Fear of side effects is also the main reason for high rates of discontinuation. Forty-four percent of women interviewed in the 2012 PSI study cited "side effects" as the reason for discontinuing use of a modern method. Clients with whom the team met in the field confirmed that there is a

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<sup>32</sup> Cashin, J. Report on Activities and Achievements of RACHA's MNCH Program (2008-2013).

<sup>33</sup> MOH HIS data

great deal of misinformation about modern methods. Many of the women interviewed were reluctant to use the IUD as they believed that it would affect their ability to perform hard work, that it might migrate in their body, or cause excessive bleeding, cancer or infertility. Negative perceptions about the IUD insertion process itself also affects uptake. Although less well known, similar rumors about the implant were reported. However, where women knew about both methods, they often preferred the implant as it does not require an internal examination.

In a focus group discussion with 12 women who had recently switched to a long-term method, the discussants revealed that they previously believed many of the negative things they had heard about contraception. They were motivated to adopt this new method after talking with a friend or relative who was a recent adopter. All of the women with whom we spoke were highly satisfied with the new method which they felt was much more convenient than the previous short-term method. These women also confirmed that they would continue with the IUD or implant in the future, even in the absence of a voucher.

Both SIFPO and ToGoH voucher schemes aim to increase the uptake of LT/PM of FP by reducing financial barriers to access IUDs and implants, and by increasing awareness that these services are available for free at participating health facilities. The increase in uptake of long-term FP methods in the areas with vouchers schemes is significant. It is likely that increased awareness and the free access created by these voucher schemes contributed significantly to this rapid uptake. (See Annex 6 for more information on these voucher schemes).

Although there was no comprehensive and coordinated communication campaign, as called for in the AAD, each of the USAID partners undertook a number of IEC activities and developed a variety of client education materials. ToGoH and MCHP developed radio programs, village theater, mobile video and karaoke shows and other non-traditional educational activities. SIFPO organized a very intensive awareness campaign using a convoy of tuktuks (a localized passenger carriage pulled by a motorcycle), decorated with highly visible promotional materials, and accompanied by several MSIC volunteers using a sound system to spread messages about the benefits and low cost of long-term methods.

SMBCI's multi-media campaigns proved to be highly useful in informing the public about new products and dispelling misconceptions about family planning methods, with considerable market growth following these campaigns. ToGoH supports successful health education for youth at the clinic and through community activities. The project also works with the MOE to include life planning skills and sexual and reproductive health information through a number of school health education programs. USAID partners have developed a number of client and job aides which are used for counseling and posted on the walls at the facilities visited. The method fan produced by MSIC seems like a particularly good counseling tool and could be more widely disseminated.

Although all of these activities are useful, there is evidence of overlap and major gaps in demand generation. Better coordination among partners, guided by an overarching communication strategy, is needed.

## RECOMMENDATIONS:

- USAID's emphasis on motivating users of traditional methods to transfer to a modern method and in making quality long-term methods available has to be accompanied by comprehensive and coordinated BCC campaign to educate and inform the public about the availability, utility and safety of these methods.
- Misconceptions about the side effects of modern contraceptive methods are persistent barriers to use. To further stimulate demand for family planning, there is a need to focus on attitudes and behavior change about modern family planning methods through a multi-pronged approach to health promotion. An integrated demand creation communication campaign which focuses on the main barriers to adoption of long-term methods, fears and misconceptions would contribute to increasing demand for FP in Cambodia. Although media is expensive, with significant up-front costs, because it can reach a large number of people quickly and repeatedly, the overall effect can be significant.
- Specific options to further stimulate demand for modern and long-term methods include:
  - ✓ Develop additional communication materials which provide accurate and up-to-date information on modern family planning methods; reproduce/ reprint existing materials;
  - ✓ Use early adopters to tell their stories;
  - ✓ Continue to provide support to the local NGO, PSK for behavior change communication and social marketing of family planning methods;
  - ✓ Continue and expand RHAC youth programs and develop additional channels for reaching youth, such as innovative e-learning approaches;
  - ✓ Increase male involvement by tailoring messages towards male audiences; include men in FP counseling; involve men in decision-making; and use influential community leaders as role models;
  - ✓ Reduce provider bias by utilizing evidence-based training approaches to improving physician's (and midwives) knowledge and attitudes towards hormonal contraceptives and to improve their ability to address women's fears and misperceptions;
  - ✓ Continue voucher schemes to create demand for long-term methods in the short-term.

## Community-Based Services

Community-Based Distribution (CBD) has been successfully implemented in Cambodia by RHAC since 1996 and by RACHA from 1999. CBD is also carried out by the MOH with UNFPA and AusAID funding under the HSSP2 discrete fund. All of the projects generally draw upon the more educated Village Health Support Group (VHSG) volunteers to serve as CBD agents.

CBDs have had a positive effect on modern contraceptive use in rural areas. Data collected by the Projects through their 2012 annual surveys show that 16% of married women of reproductive age in MCHP areas receive supplies from a CBD worker; and 13% in ToGoH areas. According to the same survey data, 43% of women in MCHP supported areas report knowing a CBD agent, with 56% in ToGoH areas.

The socioeconomic profile of women who receive contraceptive pills (condoms are not widely used as a method of family planning) from CBD clients in Cambodia illustrates that these programs serve a higher proportion of the lowest wealth quintile groups than do public sector health facilities, and a much higher proportion than do shops and other private sector sources. This is largely due to the fact that the poor are more likely to live in remote areas and are disproportionately affected by the cost of travel to obtain services.<sup>34</sup> Data from a 2012 PSI survey reports that 45% of pill users in Cambodia obtain the OC from CBD agents. CBD agents provide an attractive source of supply as they are open 24 hours a day, seven days a week. Sources report that other family members often help out with the resupply if the CBD worker is not at home.

In July 2010 the MOH developed standardized training curricula broken into lessons plans for a 5-day course which includes information on a range of methods, as well as ante- and post-natal care and communication skills and reporting. A shorter course was piloted under the USAID ToGoH project. This two-day course, which has the same FP content, appears to be as effective as the five-day course in provision of essential FP information. Additional topics can be covered in supplemental and refresher training as needed.

The MCHP, in addition to CBD, supports a “Village Shopkeeper” initiative in several ODs. This initiative is designed to help petty vendors expand their product line to include contraceptives and other health commodities. However, as these shops are often located in villages with a CBD Agent, they have not been an effective means for provision of FP services.

VHSGs are an MOH-recognized cadre of village volunteers charged with linking the community to the health system. Their responsibilities include health education/promotion, referral to health facilities, and mobilization of communities for outreach services (Keller).

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<sup>34</sup> Keller, S. Review of Community-Based distribution of Contraceptives in Cambodia. National Reproductive Health Program, October 2010.

**Coverage:** Current information provided by the two USAID-funded NGOs shows that the number of villages where VHSGs have been trained to provide family planning has increased steadily since the mid-term review. The MCHP reports CBD coverage in 2,153 villages, 97% of total eligible villages in the 19 districts in 5 provinces where they are working; and ToGoH provides support for CBD activities in 14 out of its 18 ODs (as the other 4 ODs are supported by HSSP2/UNFPA). They cover 2,650 villages, which constitutes over 90% of the total eligible villages in the health center catchment area. However, significant variations exist, with better coverage in old than new ODs, and in areas closer to the health center than those which are more remote. With limited field supervision, it is difficult to ascertain how many of the CBD agents trained to work in a particular village are still active and how well they are performing.

At current pricing levels, the potential profit from CBD sales is minimal. CBD workers with whom we spoke reported serving no more than 20 clients per month. At 500 Riel per packet of pills, income from this work would amount to approximately \$2.25 per month. Since Cambodia is a country of low population density with villages of small size, it is unlikely that any one CBD agent can serve enough clients to make this work profitable. In fact the volunteers with whom we spoke stated clearly that they are doing this work for the benefit of the community, and not for any potential financial gain (CBDs often exempt the truly indigent from paying for the method).<sup>35</sup>

*“Expectations of VHSGs have grown exponentially since their initial creations as “community feedback” representatives and are likely to continue to do so, but there is no overall national policy or mechanism motivating/compensating them for the time and effort that an increasing number of community health responsibilities entail” (Keller).*

That said, many VHSGs recruited and trained by the two USAID projects, ToGoH and MCHP, have resigned to find paid employment. Given the high rate of attrition, at about 25%, USAID partners are having some difficulty finding qualified/literate villagers who are willing to take on this type of work. Nevertheless, both MCHP and ToGoH have included CBD recruitment and training, including counseling, in their 2013 work plans. The SIFPO model, which employs “active” volunteers, appears to have better success at retaining their volunteers, who receive a monthly stipend, additional training, and costs of transportation. They are also able to devote more time and energy to the job, but the MOH is at present not committed to financing CBD agents in that capacity. Senior management at RHAC has initiated discussions with MOH officials to explore innovative ways to recognize CBD workers. Possible options include an official CBD identify badge, health benefits or other types of non-financial rewards. Presently MOH, together with NGOs, are in the process of developing the new Community Participation Guidelines, which involves discussing these financial and non-financial incentives for volunteers.

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<sup>35</sup> Ibid

Substantial progress has been made since the mid-term evaluation in 2011 in improving the technical content of FP information at the community level. VHSGs and CBDs are able to provide counseling on a full range of methods and are generally motivated to refer clients to the HC for long-term methods. In a focus group discussion with eleven volunteers, one VHSG reported that she had referred 20 clients, another 15 clients, and a third had referred 10 to the HC for long-term methods in the past six months. Two of the CBD agents had referred women for VSC. In a discussion with 8 VHSG (five of whom are CBDs) in one district, respondents said that they regularly provide counseling on all methods and put more emphasis on the IUD when women have 4 children or more. The team interviewed VHSG and CBDs at two other sites, all of whom said that they counsel on and refer women for long-term methods. In spite of a high level of knowledge about methods, volunteers mentioned the need for refresher training, especially in the use of the checklist.



**Figure 3: VHSG group meeting with CC members in Prey Veng**

#### **RECOMMENDATIONS:**

- Continue to support the CBD programs as the cornerstone of USAID assistance in the health sector.
- Work with the MOH to review the CBD curriculum. To maximize efficiencies, consider adapting the two-day training, rather than the five-day course currently in use. In all cases, increase the provision of refresher training for CBDs and VHSGs.
- Role of Midwives: The MOH needs to provide additional interactive training to strengthen counseling skills of midwives. To strengthen the CBD program, midwives should be encouraged to provide field-based guidance and supportive supervision to CBD workers. The provision of more direct guidance and supervision to midwives would help to motivate midwives to provide regular support to CBD workers.

- It was concluded that the MCHP “Village Shopkeeper” Initiative has little added value for family planning since it is competing with CBDs in these areas and it provides little or no counseling. However, the decision to phase out or retain VSI should be based on a review of the overall value of the initiative for child health as well as family planning.
- Ensure that all CBDs obtain their contraceptive supplies free of charge; consider increasing the quantity of OCs provided to CBDs or find ways to deliver supplies to CBDs in the field.
- Although CBD workers with whom we spoke were able to adequately explain the benefits and side effects of individual methods, it is unclear how effectively they are able to address clients’ misperceptions and concerns about side effects. Role playing or monitoring of actual fieldwork would help to assess their skill levels and identify future training needs.
- Although significant improvements have been made since the mid-term evaluation, monitoring and reporting issues still remain. It is difficult to accurately monitor coverage without asking the NGO partners, and it is very difficult to determine how many of the CBDs trained are currently active. The team suggests continued efforts to improve monitoring and reporting; including modification of the HIS so that FP data can be disaggregated for CBD and clinic acceptors. Data on active CBD agents per health center catchment area is needed to accomplish this and obtain a better sense of coverage.
- Both ToGoH and MCHP are experiencing a high rate of attrition among village volunteers, largely related to inadequate compensation and subsequent migration to find compensated employment. Discussions with the MOH on non-monetary incentives for CBD workers is commendable and should continue. In addition, the MOH might consider placement of two CBD workers per village to provide better coverage overall and serve as a backup when there are gaps.
- As mentioned, VHSGs are responsible for a multitude of interventions in large geographic areas often making it difficult for them to focus sufficiently on FP, specifically to spend the time needed to motivate non-users to adopt a method. CBD and VHSG workers need direct guidance and supervision to ensure that they focus and report on family planning efforts.
- As mentioned, VHSGs are responsible for a multitude of interventions in large geographic areas, often making it difficult for them to focus sufficiently on FP, and specifically to spend the time needed to motivate non-users to adopt a method. CBD and VHSG workers need direct guidance and supervision to ensure that they focus and report on family planning services. There is as yet no move toward institutionalization of CBD programs by local government. Although CCs have taken on some responsibility for health promotion, family planning does not seem to be a priority among elected leaders at the local level. However, CBD programs are absolutely essential in the short- to medium-term to increase demand and to serve the poor. Keller reports that in almost all cases, when NGO or donor funding ceases, CBD activities cease to exist.

- Options for increasing sustainability of CBD programs include both contributions from the national budget and increased support at the community level. The evaluation team suggests further documentation and dissemination of current successful approaches used and lessons learned from CBD efforts in Cambodia. Sustained policy level discussions will be required to access financial support through the national budget and the HSSP2. Most importantly, local and regional-level advocacy efforts will be needed to increase local government and community level support for family planning.

## GENDER ASPECTS

By the very nature of its goals this USAID RNMCH/HSS Program focused its strategies and activities automatically towards supporting women and children. USAID's implementing partners have worked closely with stakeholders to address gender inequalities in health, to minimize women health risk and to promote access for women and girls to sexual reproductive health services. The projects promoted constructive involvement of male in the reproductive and child health, trained staff and volunteers on gender, empowered women in saving for change (SfC), provided capacity building for CCWC, and expanded outreach activities to address health needs of women are important elements for their gender mainstreaming approaches under USAID supported program.

Furthermore, partner organizations have seriously considered gender equality such as recruitment of service providers, volunteers, and establishment of male counseling services. These activities have increased the number of women accessing sexual reproductive health services; improved knowledge and practice of men on sexual reproductive health and child health and 74.27 % of men in the target areas expressed and acknowledge the importance of their involvement in the reproductive health.



Although the project of partners aimed to address on MCH issues and the majority of beneficiaries are women, only a limited number of the field staff are female. During a provincial meeting with partner staff the evaluation team observed that among 22 staff attending, only 3 were female staff (13%). It was explained that it is close to impossible to find qualified female candidates willing to work in remote rural areas, certainly when this involves travelling on motorbikes from village to village. Given the project's demonstrated focus on women's health issues, with regard for gender inequalities, no recommendations have been formulated.

## CONCLUSIONS

Based on CDHS 2005 and 2010, as well as on more recent project household surveys and HIS data, the evaluation team can conclude with confidence that the USAID Health Program Goals for 2013 have been achieved. Given the intensive and widespread support for interventions directly targeting those goals, it is fair to say that the contribution of the USAID program and its projects towards the achievement of the Program Goals has been significant.

Several recommendations of the MTR have been acted upon by USAID and the implementing partners. Collaboration amongst partners has markedly improved. Project monitoring and survey systems have further improved. Some less active RHAC clinics in rural areas were closed. And to some extent, competency, qualifications issues and program knowledge of provincial and field staff have been addressed. Members of the evaluation team who had worked previously in Cambodia were impressed by the increased level of activity at the HCs and hospitals supported by the projects as well as by improvements in hygiene, equipment and the presence of utilities such as running water and electricity. The same can be said about the very active commune involvement through VHSGs and CBDs.

The team noted the multitude of interesting, innovative and good practices implemented and supported by the projects. They include: support for CBDs and VHSGs; quality training with more hands-on practical approaches; creative materials for training in safe motherhood; hospital and health hygiene interventions; nutrition; FP and many more. Recommendations for Case Studies on some of these practices are included in Annex 11.

The partners have advanced D&D in the health sector through new mechanisms for community feedback and involvement; supported innovative approaches for community-based health education; and adopted best practices for maternal health interventions.

While FP services have definitely improved over the past several years, much remains to be done if the country is to achieve its MDG goals for family planning by 2016. There is a critical need in Cambodia to intensify efforts to reach non-users and to motivate all women to use a modern method of FP. The MOH needs to seize opportunities to provide women with FP information and services at each point of contact with the health system and at every stage of the birth interval. USAID needs to increase its programmatic focus on RH/FP and make it clear to its partners that family planning is a high priority.

Specifically with regards to BCC, the team was of the impression that notwithstanding the many BCC activities supported, there is evidence of some overlap and major gaps in demand generation. Specifically there is a need for an integrated demand creation communication campaign, which focuses on the barriers to adoption of modern methods of family planning. Better coordination among partners working in the area of health communication should be encouraged.

An important strength of the program is its comprehensiveness by supporting a large number of interdependent interventions, such as assuring a good balance between demand creation

and supply side support. Assuring projects' flexibility and allowing them to adapt their approaches to the changing environment has also contributed to their success.

Working with and through MOH and PHD has not become easier in the recent years. In the context of the low remuneration, their professional motivation seems to have suffered further from the abolition of incentives from MBPI and POC and others. With the revised USAID per diem policy it has become more difficult to involve counterparts in the important interventions.

The close collaboration with HSSP2 and JPIG has been very beneficial in general and for specific activities such as HEF. It has allowed for joint leverage on MOH, as was the case with the requirement for regular quality assessments and for keeping the HEF third party payer arrangement. Implementing partners have been advocating for transferring funding responsibilities for service delivery activities from USAID budget to HSSP2/MOH budget through AOP planning. However, with the chronic delays in HSSP2 funding and eventual cuts at the OD and HC level, those activities are frequently postponed, often for several months in the beginning of the year, resulting in cancellation of some activities. Further and closer collaboration with MOH and HSSP2 donors should be encouraged.

USAID implementing partners are very professional and clearly have the required capacity to manage and implement their programs and have achieved the objectives stated in their projects. They are all three well respected by MOH, by other Health Partners and by health staff and communities in the field, both for their technical capacities and for their support for service delivery. As large local NGOs, both RHAC and RACHA have become organizations well known for their expertise in the field of reproductive, maternal and child health and community level health work. They both have strong organizational capacities.

The evaluation did find a number of issues that need to be addressed in several technical domains. Based on those many findings and lessons learned, the report lists a large number of recommendations, ranging from the very detailed to the more general, some of which require policy advocacy interventions by USAID and Health Partners colleagues. Some of these recommendations might be useful when defining or refining future USAID Program activities.

As USAID is contributing to the development of the CDHS 2015 instruments, it should make use of this opportunity to ensure the collection of important baseline data for the next program, obviously without overloading the questionnaire.

At least for the near future, NGO support will continue to play a very important role in Cambodian development in the health sector. Their support and involvement is needed for focusing on quality improvement, capacity building, working with communities and their volunteers, assisting communities to voice their health service needs or complaints, as well as for introducing and piloting innovative approaches which can then later be adopted by the system. External support for some of the present USAID-supported HSS interventions such as HEF implementation, HMIS and QA development is still required.

Finally, it should be highlighted that the USAID Health Program and its implementing partners are very much appreciated by the MOH, the other donors and the various stakeholders in the field, including the community representatives. MOH, PHDs, ODs, RH, HC and communities expressed their hope and wishes for USAID to continue supporting their institutions and

communities. Several MOH authorities articulated their preference for a mix of capacity building interventions with service delivery support projects over pure capacity building support projects.

## ANNEX 1: EVALUATION STATEMENT OF WORK

### Reproductive Maternal Newborn Child Health / Health System Strengthening Final Performance Evaluation USAID/Cambodia

#### STATEMENT OF WORK

The Final Performance Evaluation of USAID/Cambodia's reproductive maternal newborn child health (RMNCH) and health systems strengthening (HSS) activities:

Activity Name:	Implementing Partners	Cooperative Agreement No.
Maternal and Child Health Program	Reproductive and Child Health Alliance (RACHA)	442-A-00-08-00008-00, 2008 - 2013
Together for Good Health	Reproductive Association of Cambodia (RHAC)	442-A-00-08-00007-00, 2008 - 2013
Better Health Services	University Research Co., LLC (URC)	442-A-00-09-00007-00, 2008 - 2013

#### I Purpose:

USAID/Cambodia's Office of Public Health & Education (OPHE) seeks to hire an external consultant team to conduct Final Performance Evaluations of the Mission's Reproductive Maternal Newborn Child Health (RMNCH) and Health System Strengthening (HSS) activities. These evaluations will be used by the Mission and other health sector stakeholders to document lessons learned that will inform the strategic direction of USAID's continuing work in the health sector, and USAID's management of health projects in the future. It has been observed that the health gains Cambodia has quickly attained, including reaching several Millennium Development Goals before 2015, were realized by targeting resources and achieving mass coverage of 'low-hanging fruit' interventions. It is anticipated that further improvements will be more difficult to achieve because they will deal with increasingly apparent systemic problems that require more focused efforts. The lessons learned from these evaluations will be vital to USAID's concentration in the future.

This Final Performance Evaluation will build on the findings and recommendations from the midterm evaluation ultimately looking at the overall program effectiveness of RMNCH activities related to:

- health system strengthening;
- technical assistance to the Ministry of Health (MOH) in policy, protocols, and guidelines;
- improving the capacity of health care providers to deliver quality services including safe routine and emergency pregnancy and delivery care, neonatal care, family planning counseling and services, and Tuberculosis (TB);
- reducing common causes of childhood morbidity and mortality;
- improved nutrition of mothers and children; and

- community education and mobilization for behavior change.

This evaluation will consist of 2 primary components. The first evaluation will be a Final Performance Evaluation of the main RMNCH and HSS projects: 1) Maternal and Child Health Program, 2) Together for Good Health, and 3) Better Health Services. The purpose of this evaluation is three-fold:

- 1 Conduct a final performance evaluation of the RMNCH / HSS projects.
- 2 Review capacity of local partners to manage for results and technically direct USAID programs in the field and at national level.
- 3 Capture lessons learned and provide recommendations which will refine Mission investments in key activities that will be carried forward for the next five years.

The second evaluation will be conducted simultaneously with the first. Provided the minimal change in family planning indicators in Cambodia over the last decade (compared to other health areas), a more detailed assessment of USAID's Family Planning activities, will be conducted at this time. Along with the previously mentioned projects, this evaluation will include selected family planning interventions under the Support to International Family Planning Organizations (SIFPO) implemented in country by Marie Stopes International Cambodia (MSIC) and the Social Marketing and Behavior Change Interventions for HIV/AIDS, Reproductive & Sexual Health & Child Survival in Cambodia (SMBCI) implemented by Populations Services International (PSI). The purpose of this second evaluation is to:

- 1 Evaluate whether family planning goals and objectives were met by each project.
- 2 Identify strengths and weaknesses of the various USAID-funded family planning interventions in Cambodia and identify gaps and missed opportunities that need to be addressed in future USAID-supported family planning projects.
- 3 Identify lessons learned and best practices that should be prioritized for scale-up to contribute to reaching the Royal Government of Cambodia's (RGC) family planning goals.

The evaluation will not directly cover the social marketing of family planning or child survival commodities implemented under SMBCI in Cambodia implemented by PSI because the Social Marketing project was evaluated in October 2012. The report is available as a resource to the evaluation team and should be considered when looking at USAID's family planning investment in Cambodia in its entirety.

## **II Evaluation Questions:**

### **Key Evaluation Questions - Component 1**

*Question 1: Taking into account the project changes as a result of the midterm, to what extent have the USAID-funded health projects achieved its goals and intermediate results in RMNCH and HSS as specified in the Mission's Activity Approval Document (AAD)*

2009 - 2013) and in the existing partner agreements, particularly related to capacity building and advocacy?

Illustrative questions include:

- What contributions has USAID made to RMNCH achievements in the Cambodian Demographic and Health Survey (CDHS) 2010?
- What are some initial lessons learned regarding working with District and Commune Councils to support Village Health Support Groups (VHSGs) and emergency transport? How are USAID partners working with other agencies (i.e. non-government organizations (NGOs) with HSS Global Funds, Ministry of Interior, UNICEF etc.) who are working with commune councils in sustaining health programs?
- What are lessons learned for integration of nutrition interventions in the overall RMNCH package of health service delivery?
- What are lessons learned from the dramatic improvements in ante-natal care and facility deliveries? What are the constraints, missed opportunities, and implementation barriers that have led to limited improvements in full post-natal care, including essential newborn care, coverage?
- How effective have been the new quality improvement (QI) tools and coaching/mentoring methods introduced by the programs at improving facility staff capacity and overall service delivery particularly related to BEmONC and CEmONC<sup>1</sup>? What approaches have been successful in improving the *quality* of care, as opposed to only access?
- What are the factors contributing to an increase in utilization of health services in the facilities? How has this increase in utilization impacted staff performance, motivation, service quality, and facility management?

*Question 2: How well have local NGO partners managed for results and provided technical direction to their USAID funded programs in the field and at national level?*

Illustrative questions include:

- What progress have the local partners made shifting from funding mostly a service delivery program to instead encouraging the use of government budget and playing more of a technical assistance role?
- Based on the midterm evaluation findings, were staffing structure and capacity sufficiently modified to achieve project goals, including achieving complete community coverage? What are the recommended changes in staff structure, numbers, and deployment for future project implementation?
- How well did local partners design, adapt and implement their program to be of the highest technical quality and based on the latest empirical evidence? To what extent are local NGO partners serving as technical leaders and advancing good

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<sup>1</sup> Basic Emergency Obstetric Newborn Care and Comprehensive Emergency Obstetric Newborn Care

and promising practices in RMNCH and TB in their own agencies and for the country as a whole?

- How receptive are local partners to outside technical assistance (i.e. subcontracts, partnerships or hire short-term/long-term technical advisors) both local and internationally?
- How effective have local partners been at being leaders in advocacy at national level and how well do local partners identify and represent at central level the needs of the people they are serving in the community rather than promoting their own agency?
- Provided the integrated nature of the program, how well did the local NGO partners and URC work together to coordinate planning and implementation of activities and support each other to achieve common project results? What can be done by USAID and partners in the future to improve coordination, and ensure an integrated program?

### **Key Evaluation Questions - Component 2 – Family Planning**

To gain additional insights to guide future programming in family planning, a more detailed assessment of family planning interventions will be conducted as part of this Final Performance Evaluation. Component 2 will answer questions around service delivery, behavior change, voucher and other health financing schemes, and monitoring and evaluation. In addition to the 3 USAID RMNCH/HSS activities implemented by RHAC, RACHA, and URC the evaluation will also consider specific interventions implemented under PSI and MSIC.

1. To what extent are USAID-funded family planning interventions contributing to improving the utilization and quality of services in Cambodia? How have these interventions contributed to changes in the health-seeking behavior of family planning methods of women and men?
  - Community based distribution (CBD)
  - Voucher schemes
  - Health equity fund model
  - Mobile medical team
  - Family planning as a part of post-abortion care
  - Family planning as a part of post-partum care in hospitals
2. What are the ongoing bottle necks to family planning uptake/continuous family planning use and are the programs addressing them well (i.e. side-effecting, high drop-out rates, etc.?)
3. Are the CBD agents capable of promoting behavior change for a broad mix of methods beyond oral contraceptives? What is needed to improve the CBD model?
4. How are guidance, policy, and strategy helping or hindering family planning use and access? Are guidelines understood by providers and acted upon? Are policy makers supportive of family planning and what opportunities exist to exploit and influence leaders supporting family planning?

**ANNEX 2: EVALUATION METHODS AND LIMITATIONS**

Covered in detail in the report

**ANNEX 3: DATA COLLECTION INSTRUMENTS**

AREA	Guide Questions	Remarks
RMNCH/FP		
	<p><u>MOH officials – national level</u></p> <p><i>(questions depend on which official we are talking and what falls under his/her responsibility)</i></p> <ol style="list-style-type: none"> <li>1. What are the major health problems in Cambodia?</li> <li>2. The Ministry’s strategy for Reproductive and Sexual Health is very impressive? What are the major constraints to its implementation?</li> <li>3. The Fast Track Initiative is also very ambitious. How has USAID assistance helped to contribute to the national objectives in reproductive health?</li> <li>4. Are you familiar with the USAID assistance implemented by URC, RHAC and RACHA? What was your association with each? What are the major contributions of USAID assistance (or of the individual partners if possible).</li> <li>5. How have they contributed to capacity building at the MOH?</li> <li>6. What are the strengths and weakness of USAID’s assistance?</li> <li>7. What future directions should USAID take to assist you achieve your program goals?</li> <li>8. Capacity building versus support for service delivery / sustainability</li> <li>9. What are the particular strengths of each of these three organizations</li> </ol> <p>Prof EH : Role of Health sector in nutrition activities/ Community DOTS</p>	
	<p><b>GOVERNMENT OFFICIALS at the Provincial and District Levels</b></p> <ol style="list-style-type: none"> <li>1. What are the priority health problems in your district/province?</li> <li>2. What are the major constraints/challenges?</li> <li>3. Are you familiar with the USAID contractor, URC and its two NGOs, RHAC and RACHA? What was your association with each?</li> <li>4. How has USAID assistance helped to contribute to improving the quality of and access to MNCH and RH services? What have been the primary contributions?</li> </ol>	

AREA	Guide Questions	Remarks
	<p>Particularly in the area of RMNCH services. What are the strengths and weakness of the assistance provided?</p> <ol style="list-style-type: none"> <li>5. How has this assistance contributed to capacity building of health staff?</li> <li>6. What future directions should USAID take to assist you achieve your program goals?</li> </ol>	
	<p><u>Health Center</u> <i>(there is no particular order to these questions, it depends when it is appropriate)</i></p> <ol style="list-style-type: none"> <li>1. How is this health facility staffed? What services are provided? Who performs deliveries Who provides FP services? Is staffing adequate to perform RMNH?</li> <li>2. Review data: What are the barriers/obstacles to FP use?</li> <li>3. Are you familiar with the USAID support through RHAC and RACHA? What T/a have they provided to your center in the area of RMNCH? How has this assistance contributed to improving the quality of services at your health center?</li> <li>4. Who has received training? In what subjects? Was the information useful/relevant for your work? Has the midwife received training in IUD insertion? Safe delivery, EOC, AMSTL, Helping Babies Breathe</li> <li>5. Did you receive any refresher training in the past 6 months?</li> <li>6. What are the strengths and weakness of the assistance provided by USAID? RACH, RACHA, URC (depending on where we are)?</li> <li>7. What do you think are the major USAID contributions?</li> <li>8. What information is provided during antenatal visits? Postnatal visits?</li> <li>9. Describe the counseling provided to first time FP users? Do women receive FP counseling immediate postpartum and postnatal? When a woman comes to the clinic with her child? Do you provide counseling to all women or just those who ask specifically for FP?</li> <li>10. Use of Partograph: Ask provider if they know how to use and if they use it regularly? What do you do if the labor is not progressing as it should? Is there a system for referring patients in distress to a higher level of facility?</li> <li>11. What guidelines or protocols are used for RMH? Are safe motherhood protocols used?</li> </ol>	

AREA	Guide Questions	Remarks
	<ol style="list-style-type: none"> <li>12. Have you conducted a supervisory visit in the past six months? How many times have you been out to the field?</li> <li>13. Do you have any informational materials to use? Observe wall to see if wall chart on methods visible.</li> <li>14. What contraceptives are available at this facility?</li> <li>15. What method is in greatest demand? Were there any stockouts in last 6 months? How did you resolve?</li> <li>16. Where do you refer for LT methods? VSC</li> <li>17. What kind of side effects are reported by clients and how do you respond to their complaints?</li> <li>18. CBD program in field. Describe. How does it work? How many clients are served by each CBD worker? Is this sufficient? What training is provided to CBD workers?</li> </ol>	
	<p>Hospitals</p> <ol style="list-style-type: none"> <li>1. PAC guidelines, counseling, and services - Is there a private space for FP counseling? Is this provided to all clients prior to discharge? Are FP commodities available at the hospital?</li> <li>2. Does the hospital provide EMONC or BEMONC? Are standards or guidelines used?</li> <li>3. Is MgSo4 in stock?</li> </ol>	
	<p>RACHA (these questions will vary depending on the level)</p> <ol style="list-style-type: none"> <li>1. How are you helping the Government achieve its objectives under the Fast Track initiative for reducing Maternal and newborn mortality?</li> <li>2. How would you estimate population coverage in the 5 provinces where you provide assistance to the MOH?</li> <li>3. Coverage: How many health facilities are covered under your project? (Mid-term evaluation recommended t/a to better track coverage in old and scale up in new? WAs that t/a provided?</li> <li>4. What other t/a have your received? Was it effective?</li> <li>5. Stagnating CPR: CPR only increased slightly from 2010 to 2012 – 38 to 39% and actually decline in several provinces. There was also a significant increase I the use of Increase in use of traditional method?? Can you speculate as to what is going on? (only at national level)</li> <li>6. What types of training do you provide to public sector? To what extent has the MoH taken on responsibility for</li> </ol>	

AREA	Guide Questions	Remarks
	<p>the training?</p> <ol style="list-style-type: none"> <li>7. Protocols/guidelines used? Do you use protocols developed by URC?</li> <li>8. Impressive results with respect to ANC visits and increase in health facilities deliveries. How do you integrate FP services into these interventions?</li> <li>9. Please describe additional health promotion activities provided by your organization?</li> <li>10. What services to VHSGs provide?</li> <li>11. Numbers of CBD agents trained is impressive. Can you give us some indication of the portion of villages/population covered with CBD? (look at map) Describe how the CBD program works, the content of the information provided by CBD agents? How are they linked with the HC? How are they supervised?</li> <li>12. Results of PP impressive, but it doesn't appear as if FP is a regular part of the program? Please comment on your plans to integrate FP into the postpartum program.</li> <li>13. PAC – counseling high, acceptance low. Do you have data on the percent of clients who received FP counseling? Are services available on site? What do you think are the reasons for not wanting to delay the next pregnancy?</li> <li>14. With the project ending, what activities have already been phased over to MOH? What are the essential interventions that need continued support?</li> </ol>	
	<p>RACH</p> <ol style="list-style-type: none"> <li>1. How are you helping the Government achieve its objectives under the Fast Track initiative for reducing Maternal and newborn mortality?</li> <li>2. What was the CPR or CYP in 2012 as compared to 2010 and 2011</li> <li>3. Please describe services covered by 16 RHAC clinics? Please describe the youth friendly service delivery?</li> <li>4. Coverage: How many public sector health centers are supported by your project?</li> <li>5. When is FP counseling provided? By whom?</li> <li>6. Increase in IUD utilization impressive. Has the voucher system helped to increase users of IUD?</li> <li>7. Number of CBD agents trained is impressive. Who are the agents, how are they recruited? Content of the</li> </ol>	

AREA	Guide Questions	Remarks
	<p>training? How/who conducts supervision? Can you describe how they conduct their community outreach and the content of the information they provide?</p> <ol style="list-style-type: none"> <li>8. Describe HC outreach services. What other demand side creation activities does your organization provide?</li> <li>9. FP policy: is there more that need to be done to help policy makers understand the importance of FP/ the benefits of child spacing on health of mothers and children as well as the impact of high fertility on economic growth and provision of social services. How can USAID assist?</li> <li>10. What t/a has your organization requested from USAID? Was it effective?</li> <li>11. How do you help ensure a consistent supply of commodities in your clinics? Does the MOh still need assistance with this?</li> <li>12. How do you coordinate your activities with other USAID partners? With other donors in the province/district?</li> <li>13. What are your strengths? If you were to narrow the scope and capitalize on what you do best, what interventions would you continue?</li> <li>14. You don't use voucher mechanism but reimburse user fee and transport for IUDs etc. How does this differ from Vouchers, describe the mechanism, utilization and cost</li> </ol>	
	<p>MSI</p> <ol style="list-style-type: none"> <li>1. General description of program.</li> <li>2. How did you select these two provinces?</li> <li>3. Coverage: # clinics in Kandal and Takeo.</li> <li>4. Do you have CYP data? For LT methods.</li> <li>5. What are the barriers/obstacles to FP use? Is cost of FP services a barrier?</li> <li>6. Integration: How is integration of HIV and RH services progressing? How many sites?</li> <li>7. Provider training: implants, 50 in all, 24 from Kandal. How extensively is implant being used in Cambodia? Are providers in other provinces are receiving implant training? Plans for scale up?</li> <li>8. How extensive is your training for VSC. Four provinces? How to expand</li> <li>9. Constraints: supply of LT methods</li> <li>10. Describe your Outreach strategy: work with VHSGs.</li> </ol>	

AREA	Guide Questions	Remarks
	<p>11. What training do VHSGs receive? Is this standardized or just in your focus areas? Has this training improved their skills? You provide a monthly stipend?</p> <p>12. Demand creation: IEC tools: Fan addresses myths and misconceptions about each method. How extensively is this fan used in the country? Explain. Is this fan used only in your two provinces? Describe other promotional activities</p> <p>13. How do you assist PHDs make efficient quarterly requests to CMS? Have you seen an improvement in stockouts as a result of this assistance? When do you think the MOH will be able to handle logistics management effectively without external t/a?</p> <p>14. How do you coordinate your activities with other USAID partners? URC. How often does USAID bring you together? Are these meetings effective?</p>	
	<p>General:</p> <ol style="list-style-type: none"> <li>1. How can our projects better leverage resources from the HSSP 2?</li> <li>2. How effective is the working Group for Contraceptive security?</li> <li>3. Are USAID grantees involved/represented in this working group?</li> <li>4. Does the MOH have adequate capacity to forecast and project contraceptive requirements for a growing market?</li> <li>5. Has there been any improvement in stock outs in past 6 months?</li> <li>6. Does the MOH have a human resource plan?</li> <li>7. Can the MOH implement training using their own trainers, facilities? Do they have a budget line item for FP?</li> <li>8. Are guidelines/protocols being utilized regularly?</li> <li>9. Are supervision visits conducted regularly? How are supervisors advised to monitor work in the field?</li> </ol>	
<b>NUTRITION</b>		
	<p><b>Government</b></p> <ol style="list-style-type: none"> <li>1. To support the BCC priorities outlined in the Fast Track Initiative, how are URC, RHAC, and RACHA activities aligned? What more is needed?</li> </ol>	

AREA	Guide Questions	Remarks
	<ol style="list-style-type: none"> <li>2. How are URC, RHAC, and RACHA supporting the nutritional actions needed for reducing maternal and newborn deaths? How is nutrition integrated into services at the community and facility levels?</li> <li>3. What is being done via URC, RHAC, and RACHA to strengthen access and quality provision of postpartum/postnatal visits? What are the challenges?</li> </ol>	
	<p><b>RACHA/RHCA/URC</b></p> <ol style="list-style-type: none"> <li>1. To support the BCC priorities outlined in the Fast Track Initiative, how are URC, RHAC, and RACHA activities aligned? What more is needed?</li> <li>2. How are URC, RHAC, and RACHA supporting the nutritional actions needed for reducing maternal and newborn deaths? How is nutrition integrated into services at the community and facility levels?</li> <li>3. What can is being done (via URC, RACH, RACHA) to strengthen access and quality provision of postpartum/postnatal visits? What are the challenges?</li> <li>4. How does gender influence health patterns, and what activities do you have to address this?</li> </ol>	
	<p><b>HC</b></p> <ol style="list-style-type: none"> <li>1. What have you learned from RHAC and RACHA about how to improve nutrition in your communities? What are the challenges and successes you have using what you learned to improve maternal and child nutrition?</li> <li>2. When are women counseled about maternal nutrition? (During ANC, Postpartum?) Is the Maternal Book used? How is it used, and is it helpful for counseling women? Why or why not?</li> <li>3. When are women counseled about infant nutrition? (During ANC, Postpartum?)</li> <li>4. Are infants weighed and measured to detect malnutrition at the HC?</li> <li>5. What can is being done (via URC, RHAC, RACHA) to strengthen access and quality provision of postpartum/postnatal visits? What are the challenges?</li> </ol>	

AREA	Guide Questions	Remarks
	<p><b>Commune Council, Local NGO, VHSB and Volunteers</b></p> <ol style="list-style-type: none"> <li>1. What have you learned from RHAC and RACHA about how to improve nutrition in your communities? What are the challenges and successes you have using what you learned to improve maternal and child nutrition?</li> </ol>	
<b>QUALITY IMPROVEMENT</b>		
	<p><u>ASK RHAC/RACHA/URC staff at the province</u></p> <ol style="list-style-type: none"> <li>1. What are RHAC/RACHA/URC activities that support improvement of quality of services at the health center/hospital?</li> <li>2. Does RHAC/RACHA/URC provide support for using the Level 1 health center tool – per diem for assessor, TA on how to comply with requirements, some equipment/supplies, etc.?</li> <li>3. How does RHAC/RACHA/URC head office provide capacity building to local staff in the province? Continuing supervision and mentoring?</li> <li>4. Does RHAC/RACHA/URC provide capacity building to your staff?</li> <li>5. Do RHAC/RACHA/URC staff find acceptable the assistance of external consultants, both international and local?</li> <li>6. Does RHAC/RACHA/URC head office monitor staff performance? How is this done?</li> <li>7. How do RHAC/RACHA/URC staff in the provinces provide feedback to head office in Phnom Penh? Is it done regularly?</li> <li>8. In your opinion, has implementation of Level 1 actually improved quality of services in your supported facilities?</li> <li>9. What have been the challenges in implementing the QA tools of MOH?</li> <li>10. What would facilitate understanding of quality improvement at the facility level? At local staff level?</li> </ol>	
	<p><u>ASK Health Center</u></p> <ol style="list-style-type: none"> <li>1. Is RHAC/RACHA/URC supporting use of the Level 1 QA assessment tool (HC tool) in this health center?</li> <li>2. What kind of support does RHAC/RACHA/URC provide –</li> </ol>	

AREA	Guide Questions	Remarks
	<p>per diem for assessor, TA on how to comply with requirements, some equipment/supplies, etc.?</p> <ol style="list-style-type: none"> <li>3. After the assessment, how does RHAC/RACHA/URC continue to support the health center for developing and implementing its QI plan?</li> <li>4. Can the health center continue to use the Level 1 tool without RHAC/RACHA/URC support?</li> <li>5. Is the facility ready for a Level 2 tool?</li> <li>6. What kind of assistance would the facility need to implement a Level 2 tool?</li> <li>7. Does the facility receive continuing supervision and mentoring? From whom? How often?</li> <li>8. In your opinion, has implementation of Level 1 actually improved quality of services in your supported facilities?</li> <li>9. What have been the challenges in implementing the QA tools of MOH?</li> <li>10. What would facilitate understanding of quality improvement at the facility level? At local staff level?</li> </ol>	
	<p><u>Addtl questions for hospital</u></p> <ol style="list-style-type: none"> <li>11. Is the hospital capable of providing CEmONC services?</li> <li>12. What assistance did URC provide for this capacity building effort?</li> </ol> <p>Where possible, ASK a random patient at the maternity ward to rate the facility in terms of quality of service, 1-5, with 5 being the highest score.</p>	
	<p><u>OBSERVE</u></p> <ol style="list-style-type: none"> <li>1. Cleanliness</li> <li>2. Availability of basic equipment/supplies</li> <li>3. Availability of medicines in the stock room or pharmacy; see FP commodities</li> <li>4. Registry of patients</li> <li>5. Examining/ observation room</li> <li>6. Delivery room</li> <li>7. Availability of clean water</li> </ol>	

AREA	Guide Questions	Remarks
	8. Waste disposal	
<b>HEALTH FINANCING</b>		
	<p><b>General</b></p> <ol style="list-style-type: none"> <li>1. What are the official user fees by institution for nutrition intervention, family planning, deliveries, anc, pnc, DOTS, TB?</li> <li>2. Vouchers, CCT, HEF, CBHI support for nutrition intervention, family planning, deliveries, anc, pnc, DOTS, TB?</li> <li>3. Under table payment when out of pocket payer, CBHI, HEF, Voucher?</li> </ol>	
	<p><u>MSI and RHAC</u></p> <ol style="list-style-type: none"> <li>1. Why use voucher mechanism</li> <li>2. Why change from paying to free vouchers</li> <li>3. What services covered?</li> <li>4. Geographical coverage Vouchers, why not in other areas?</li> <li>5. Different types of vouchers in different areas, depending on funding agencies?</li> <li>6. How introduced? What is the best communication channel to promote these schemes among target populations and service providers?</li> <li>7. Do you see it as a SHP or a promotional tool? Sustainability? Exit strategy?</li> <li>8. Did you share findings with other USAID partners</li> <li>9. Sharing lessons with KfW, Medicam, MOH</li> <li>10. Differences with KfW vouchers</li> <li>11. Accreditation, Quality assessment criteria</li> <li>12. RHAC clinic, public health institutions, private clinics</li> <li>13. Why not more private clinics</li> <li>14. Cost structure from the voucher activities (admin cost, user fee)</li> <li>15. Do you pay institutions same price as user fees? Are user fees standardized? If not explain.</li> <li>16. Are voucher schemes the right intervention to address the problem (e.g., user fees set too low so low motivation of health staff to provide FP, etc.)</li> </ol>	

AREA	Guide Questions	Remarks
	<p>17. Monitoring of use of services</p> <p>18. Private clinic same prices as public</p> <p>19. How do the voucher schemes of family planning complement the MOH health financing policy frameworks (e.g. Health Equity Fund and incentive for midwives)?</p> <p>20. Are there any distortionary or unintended consequences on the service delivery system such as double-charging by health centers (regular user fee plus cashing the payment value)?</p> <p>21. Should and how might these approaches be sustained in the long-term?</p> <p>22. Are there other demand-side and supply-side approaches to increase uptake of reproductive health and family planning services that are more effective/sustainable/cost-efficient? Why vouchers?</p>	
	<p><u>MOH, PHD, OD, Partners,</u></p> <ol style="list-style-type: none"> <li>1. Do you know about the MSI Vouchers for FP? Please describe?</li> <li>2. Does this fit within the MOH HF schemes? SHP tool or a promotional tool?</li> <li>3. How did you learn about it? Are there other schemes with similar vouchers?</li> <li>4. Which services and what expenses do they cover</li> <li>5. What are the target groups?</li> <li>6. How does it relate to KfW Vouchers?</li> <li>7. Did RHAC or MSI request permission to introduce the Voucher scheme?</li> <li>8. How do the voucher schemes of family planning complement the MOH health financing policy frameworks (e.g. Health Equity Fund and incentive for midwives)?</li> <li>9. Should and how might these approaches be sustained in the long-term?</li> </ol>	
	<p><u>Service Providers</u></p> <ol style="list-style-type: none"> <li>1. Do you know about the MSI Vouchers for FP? Please describe?</li> <li>2. How did you learn about it? Are there other schemes</li> </ol>	

AREA	Guide Questions	Remarks
	<p>with similar vouchers?</p> <ol style="list-style-type: none"> <li>3. What was the process for being contracted in the Voucher Scheme?</li> <li>4. Which services and what expenses do they cover</li> <li>5. What are the target groups?</li> <li>6. What proportion of your income comes from Vouchers</li> <li>7. How do you use that income?</li> <li>8. Benefits/Advantages/ recommendations</li> <li>9. How do the voucher schemes of family planning complement the MOH health financing policy frameworks (e.g. Health Equity Fund and incentive for midwives)?</li> <li>10. Are there any distortionary or unintended consequences on the service delivery system such as double-charging by health centers (regular user fee plus cashing the payment value)?</li> <li>11. What is the best communication channel to promote these schemes among target populations and service providers?</li> <li>12. Are voucher schemes the right intervention to address the problem (e.g., user fees set too low so low motivation of health staff to provide FP, etc.)</li> <li>13. Are there other demand-side and supply-side approaches to increase uptake of reproductive health and family planning services that are more effective/sustainable/cost-efficient?</li> </ol>	
	<p><u>Beneficiaries</u></p> <ol style="list-style-type: none"> <li>1. Did you get Voucher for free?</li> <li>2. Did you buy Voucher?</li> <li>3. What is the cost of the Vouchers?</li> <li>4. Why did you not buy Voucher?</li> <li>5. Where can you use the Voucher?</li> <li>6. Are staff happy when you use the Voucher?</li> <li>7. What services covered by that Voucher?</li> <li>8. What services are not covered that you would need?</li> <li>9. What is advantage for you of that Voucher?</li> <li>10. Are there disadvantage of the Voucher?</li> <li>11. Are there still extra expenses when you use Voucher (UTP, transport, other medicine, etc.)?</li> <li>12. Are there different types of vouchers?</li> </ol>	

AREA	Guide Questions	Remarks
	<p>13. Why did you not use the voucher?</p> <p>14. Are there any distortionary or unintended consequences on the service delivery system such as double-charging by health centers (regular user fee plus cashing the payment value)?</p>	
	<p><u>Communes</u></p> <p>Awareness and opinion of the voucher schemes?</p>	
	<p><b>Health Equity Funds/CBHI</b></p> <p><u>HEF (CBHI) and Quality</u></p> <p>Is there any linkage between HEF/CBHI and quality of services? Explain mechanism, effectiveness, weaknesses</p> <p><u>HEF (CBHI) and Deliveries, ANC, PNC,</u></p> <p>Compare data for population groups</p> <p><u>HEF (CBHI) and Family Planning</u></p> <p>Compare data for population groups</p> <p><u>HEF (CBHI) and Nutrition</u></p> <p>Compare data for population groups</p>	
	<p><b>SOA SDG</b></p> <p>Capacity Building</p> <p>Incentives</p> <p>More questions to be developed</p>	
	<p><b>Midwife Incentives</b></p> <p>Questions to be developed (in context of voucher and HEF schemes and directly relevant to MCH aspects)</p>	

AREA	Guide Questions	Remarks
Community Participation		
Community	<p style="color: #e67e22;">For Implementing partners:</p> <ol style="list-style-type: none"> <li>1. Could please you describe your key community interventions that were implemented during the timeframe of USAID funded project?</li> <li>2. What are the most significant changes at the community level came out from those interventions?</li> <li>3. What are the factors to bring about these successes?</li> <li>4. If there are resources available in future what interventions are you going to carry on? Why?</li> <li>5. What interventions are you going to drop out? Why?</li> <li>6. Based on your lesson learnt, are there are new intervention or approaches are you intend to introduce for future funding proposal? Why?</li> </ol>	<p>(We ask for successful story/or their case study if any)</p> <p>(Ask for the issues raised and feedback recorded log)</p>
	<p>Community, Health Center, OD and PHD</p> <ol style="list-style-type: none"> <li>1. Do you think the support of RACHA /RHAC are really helpful your community and health center?</li> <li>2. Is there a complaint/ feedback mechanism at community and Health center? How do you response to complaints from clients?</li> </ol>	
	<p>Policy maker:</p> <p>HCMC, Village Health Support Group (VHSGs) were chosen by health center (health Sector), practically, it seems that the group own and lead by the health center. Do you think this current practice is the direction or would it be shifted to community own?</p>	
Governance	<p>Implementing partners:</p> <ol style="list-style-type: none"> <li>1. What interventions have contributed to the formulation or rolling out the government frameworks such as D&amp;D, social accountability, engaging community, client rights</li> </ol>	

AREA	Guide Questions	Remarks
	<p>etc.</p> <ol style="list-style-type: none"> <li>2. Are there mechanism or support system to promote social accountability? How did you contribute, specify?</li> <li>3. How do you engage local authority in supporting your program implementation? What kind of support?</li> <li>4. Did the commune council allocate some resources (CIP budget) for any health interventions? If so, how did you motivate them? What percent of target communes had used CIP budget for support community health interventions (referral system, transportation?)</li> <li>5. Did you receive training on the local planning process (CIP process)? (for field staff and health center chief)</li> <li>6. Did you (RACHA and RHAC) discuss together prior attending the CIP plan meeting to identify key areas of community health for seeking support from commune council support?</li> </ol>	
	<p>Commune councils:</p> <ol style="list-style-type: none"> <li>1. Who did you invite to join your CIP formulation?</li> <li>2. Did health center chief or NGOs advocate for commune council resources for health intervention? For what intervention?</li> <li>3. What kind of health related activities did you allocated your CIP resources?</li> <li>4. Did you integrated your plan into MoH's AOP?</li> <li>5. What are the most significant change that came out from the about mentioned efforts?</li> </ol>	

## ANNEX 4: SOURCES OF INFORMATION

### List of persons met during the evaluation

No	Name	Position/ Organization	
USAID-OPHE			
1	Rebecca Black	Mission Director -USAID	20 June, 2013
2	Ms. Monique Mosolf	OPHE Director–OPHE	20 June, 2013
3	Ms. Tara Milani	Deputy Director of OPHE, USAID	20 June, 2013
4	Ms. Michelle M. Lang-Alli	Health Officer, OPHE	20 June, 2013
5	Dr. Chak Chantha	Infectious Disease	20 June, 2013
6	Dr. Sek Sopheanarith	Development Assistance Specialist-OPHE	20 June, 2013
7	Dr. Sam Sochea,	Project Management Specialist-OPHE	20 June, 2013
8	Ms. Ros Peoulida	Development Assistance Specialist –M&E	20 June, 2013
RACHA- Phnom Penh and Provinces			
9	Ms. Chan Theary	Executive Director, RACHA	20 June, 2013
10	Dr. Mam Sochenda,	Deputy Director, CHM, RACHA	20 June, 2013
11	Dr. Chhin Lan,	Deputy Director, RMNCH, RACHA	20 June, 2013
12	Mr. Ngeth Lavan,	Deputy Director-FO, RACHA	20 June, 2013
13	Dr. Sun Nasy,	Program Implementation Advisor	20 June, 2013
14	Dr. Juliet Uy,	M & E Advisor, RACHA	20 June, 2013

15	Dr. Chris Newsome,	Newborn Care Advisor	20 June, 2013
16	Ms. Julia Lwin,	Newborn Care Advisor	20 June, 2013
17	Mr. Pol Sambath,	FF Project Director	20 June, 2013
18	Ms. Kay Lefevre, M	M & E Officer	20 June, 2013
29	Mr. Chuon Satharidh,	HR Coordinator	20 June, 2013
20	Mr. Yong Sopheak,	IT Team Leader	20 June, 2013
21	Mr. Kov Buntor,	LMIS Team Leader	20 June, 2013
22	Dr. Sol Sowath,	M & E team leader	20 June, 2013
23	Dr. Lim Nary,	CB Team Leader	20 June, 2013
24	Dr. Nou Sovann, ID	ID Team Leader	20 June, 2013
25	Mr. Koy Wanartih.	CHE-ATL	20 June, 2013
26	Dr. Thach Lykhann,	PC-RACHA-Siem Reap	20 June, 2013
27	Dr. Khun Chanpha,	Health Communication Team Leader	20 June, 2013
28	Dr. Chan Ketsana,	Child Health Nutrition Team Leader	20 June, 2013
29	Dr. Pot Phaly,	PC, RACHA, Koh Kong	20 June, 2013
30	Dr. Kun Vuth	PC. RACHA Bantey Mean Chey	20 June, 2013
31	Dr. Oum Navuth,	PC. RACHA,-Prey Veng	25 June, 2013
32	Dr. Em Mony,	RMNCH PC, RACHA-Prey Veng	25 June, 2013

33	Mr. Meth Chhay,	APC, RACHA-Prey Veng	25 June, 2013
34	Mr. Phol Punloeu,	LNIS, RACHA, Svay Antor-Prey Veng	25 June, 2013
35	Mr. Men Roth, APC,	APC, RACHA-Pearing OD	25 June, 2013
36	Mr. Prum Sokhom,	APC, RACHA- Preah Sdach OD	25 June, 2013
37	Mr. Maosangwath,	Neak Leung OD	25 June, 2013
38	Mrs. Ouk Vanny,	APC.RACHA-Preah Sdach OD	25 June, 2013
39	Dr. Cheak Leangsim,	APC, RACHA, Measag OD	25 June, 2013
40	Mr. Chin Samphea	APC,RACHA Kamong Trabek OD	25 June, 2013
41	Mr. Phoeung Pirom	Program Manager, CBHI & CSC	25 June, 2013
42	Mr. Chea Sam Ath,	HC Officer, RACHA, Prey Veng	25 June, 2013
43	Dr. Kun Navuth	PC, RACHA –Bantey Mean Chey	2 July, 2013
44	Mr. Duong Heing	LSO, RACHA, Bantey Mean Chey	2 July, 2013
45	Mr. Theuy Chanbona	AA, LSO, RACHA, Bantey Mean Chey	2 July, 2013
46	Mr. Thorng Chharran	APC, LSO, RACHA, BBMC	2 July, 2013
47	Mr. Thean Soyoeun	HC Officer, LSO, RACHA, BMC	2 July, 2013
48	Mr. Horm Hong	HC Officer, RACHA, BMC	2 July, 2013
49	Mr. Nhim Lin	ID Officer, RACHA, BMC	2 July, 2013
50	Mr. Chheurng Reurng	CH Officer, RACHA, BMC	2 July, 2013
51	Mr. Sam Veng	ID Officer, RACHA, BMC	2 July, 2013
52	Mrs. Chhat Sopharth	APC, RACHA, BMC	2 July, 2013
53	Mr. Bin Sreung	CH Officer, RACHA, BMC	2 July, 2013
54	Mr. Chhun Hak	ID Fa, RACHA, BMC	2 July, 2013
55	Miss. Hoeun Sor	SM/BS Officer, RACHA, BMC	2 July, 2013

56	Mr. Krung Siv	ID Officer, RACHA, BMC	2 July, 2013
57	Mr. Kleb Tyn	SFC PO, RACHA, BMC	2 July, 2013
58	Mr. Sok Sakun	APC, RACHA, BMC	2 July, 2013
59	Mr. Prach Chea	HC Fa, RACHA-BMC	2 July, 2013
60	Mrs. Pok Nimol	SM/BS Officer, RACHA, BMC	2 July, 2013
61	Mr. Phal Vimean	ID, RACHA, BMC	2 July, 2013
62	Mr. Nget Leaksmy	APC, RACHA, BMC	2 July, 2013
63	Mr. Samuth Ponlok	CH Officer, RACHA, BMC	2 July, 2013
64	Mr. Sam Vannak	HC Officer, RACHA, BMC	2 July, 2013
65	Mr. Pin Bo	SFC PO, RACHA, BMC	2 July, 2013
RHAC-			
66	Dr. Var Chivorn	Associate Executive Director, RHAC	21 June, 2013
67	Dr. Ping Chutema,	Director of Clinic, Deputy Chief of party	21 June, 2013
68	Mr. Ngudup Paljor,	Advisor, RHAC	21 June, 2013
69	Dr. Aun Hemrin,	Deputy Chief of Party, M & E Chief	21 June, 2013
70	Dr. Iv Ek Navapol,	Planning Chief. RHAC	21 June, 2013
71	Ms. Kruy Kimhourn,	M & E Specialist, RHAC	21 June, 2013
72	Ms. Sek Sisokhom,	M & E Specialist, RHAC	21 June, 2013
73	Dr. Or Sivarin,	Community Health Specialist, RHAC	21 June, 2013
74	Dr. Veth Sreng,	Community Health Specialist, RHAC	21 June, 2013
75	Dr. Chea Meng Tieng,	Community Health Specialist, RHAC	21 June, 2013
76	Dr. Keo Mao,	Deputy Director of RHAC Clinic	21 June, 2013

77	Dr. Mao Vannak,	Clinical Training Coordinator	21 June, 2013
78	Dr. Soun Bophea,	Youth Health Program Manager	21 June, 2013
79	Dr. Deng Serongkea,	Vulnerable Group Program Manager	21 June, 2013
80	Mr. Khiev Makara,	Senior Program Manager, RHAC	21 June, 2013
81	Mr. Ly Seak Meng,	Finance Chief, RHAC	21 June, 2013
82	Mr. Pheng Phearak,	Admin Coordinator, RHAC	21 June, 2013
83	Mr. Kea Bou,	PC, RHAC Kampng Cham.	26 June, 2013
84	Mr. Yang Sopheap,	PO, CHP, RHAC, Kampong Cham	26 June, 2013
85	Mr. Kak Hongry,	PO, CPHSP, RHAC, Kampong Cham	26 June, 2013
86	Ms. Huth Sokleang,	PO, CPHSP, RHAC, Kampong Cham	26 June, 2013
87	Dr. Oum Vanna,	PC, RHAC, Battambang	1 July 2013
88	Dr. Sok Phany, Clinic	Clinic Director, Battambang	1 July 2013
89	Ms. V Sovanna,	Midwife Trainer, RHAC, Battambang	1 July 2013
90	Mr. Chea Sovanna,	Amin Officer, RHAC, Battambang	1 July 2013
91	Ms. By Thida,	Midwife Promoter, RHAC, Battambang	1 July 2013
URC.			
92	Dr. Chistophe Grundmann,	Chief Party, URC	21 June, 2013
93	Katherine Krasovec,	Technical Advisor, URC	21 June, 2013
94	Mr. Paul Freer,	Deputy Country Director	21 June, 2013
95	Ms. Joan Woods,	Hospital Improvement Program Leader	21 June, 2013

96	Dr. Mean Reatanak	M & E /Informatics Program Leader	21 June, 2013
97	Dr. Ang Satia,	MNH/FP Senior Technical Advisor	21 June, 2013
98	Dr. Ouk Putharath,	SOA Team Leader	21 June, 2013
99	Mr. Tapley Jordanwood,	Health Financing	21 June, 2013
100	Mr.Sun Sopheak,	CBH Deputy Program Leader, RUC	21 June, 2013
101	Mr. Chean Rithy Men,	Deputy Director for research	21 June, 2013
102	Ms. Nathalie Cervantes Abejero,	QI Team Leader	21 June, 2013
103	Dr. Som Hun,	Regional Office Director, URC, BTB	1 July, 2013
104	Ms. Janice Hay,	HIP, URC, BTB	1 July, 2013
105	Rady Yen, HIP Officer	HIP Officer, URC, BTB	1 July, 2013
106	Dr.Esther Wilson,	HIP Consultant, URC, BTB	1 July, 2013
MSI/MSC			
107	Ms. Stefanie M. Wallach,	Country Director, MSIC	24 June, 2013
108	Mr. Emerson Mar,	Deputy Country Director, MSIC	24 June, 2013
109	Mr. Mao Lan, Project	Project Manager, MSIC	24 June, 2013
110	Ms. Sok Davy,	SIFP, MSIC	24 June, 2013
111	Ms. Liv Ratha,	QTA, MSIC	24 June, 2013
112	Mr. Song Sophat,	LT, MSIC	24 June, 2013
UNICEF			
113	Ms. Penelope Camprelle	Chief of Health & Nutrition, UNICEF	24 June, 2013

114	Mr. Joel Conkle	Nutrition Specialist, UNICEF	24 June, 2013
UNFPA			
115	Dr. Marc DERVEEUW	Representative, UNFPA	24 June, 2013
116	Mr. May Tum	Assistant Representative	24 June, 2013
EPOS-AFH			
117	Mr. Marcel Reyner,	Team Leader, Voucher for Reproductive health project, EPOS for KfW.	24 June, 2013
118	Dr. Long Leng	Executive Director, AFH,	24 June, 2013
119	Dr. Sieng Rithy	Deputy Team Leader, Voucher Management Agency (VMA)	24 June, 2013
Population Services Khmer (PSK)			
120	Dr. Sok Sokun	Deputy Country Representative, PSK	9 July, 2013
121	Ms. Yasmin Mdan	Country Representative, PSK	9 July, 2013
MOH, National Programs, PHDs, ODs, HCs, community group			
122	H.E Eang Huot	Secretary of State, MoH	8 July, 2013
123	H.E. Thir Kruy	Secretary of State, MoH	9 July, 2013
124	Dr. Lo Veasnakiri	Director of DPHI, MoH	24 June, 2013
125	Prof. Tung Rathavy	Director of NMCHC, MoH	28 June, 2013
126	Dr. Mao Tan Eang	Director of CNAT, MoH	
127	Dr. Sok Po	Deputy Director, Hospital Service Department, MoH	8 July, 2013
128	Dr. Voeung Virak	Deputy of QIO, MoH	
129	Dr. Ing Chanthourn,	Deputy PHD director, Prey Veng	25 June, 2013
130	Dr. Nou Sophal,	Chief of Technical Office, PV-PHD	25 June, 2013
131	Dr. Pich Bola,	Chief of MCH, Prey Veng PHD	25 June, 2013

132	D. So Sa Kheun,	Chief of TB, Prey Veng PHD	25 June, 2013
133	Mr. Thun Thol,	OD director, OD Svay Antor,	25 June, 2013
134	M.You Vannary,	Chief Admin, OD Svay Antor	25 June, 2013
135	Ms. Heak Kim Yeng,	Vice OD director,	25 June, 2013
136	Ms. Ket Malay,	MCH chief, OD Svay Antor	25 June, 2013
137	Mr. Heng Try,	Vice OD chief, OD Svay Antor	25 June, 2013
138	Mr. Torn Sam Ol,	HIS, Planning OD, Svay Antor	25 June, 2013
139	Mr. Un Peng Srin,	Chef of EPI, OD Svay Antor	25 June, 2013
140	Dr. Ly Buntheun	Director, Provincial Hospital, PreyVeng	25 June, 2013
141	Ms. Thong Somaly	Vice director of hospital	25 June, 2013
142	Ms. Y Kim Ron	Chief Gyneco-Obstetric	25 June, 2013
143	Dr. Hout Kalyane	Director of Pearing OD,	26 June, 2013
144	Dr. Ou Vanda	Deputy Battambang PHD (BTB)	1 July, 2013
145	Dr. Nuth Sinath	Deputy PHD director, Takoe province	26 June, 2013
146	Dr. Prak Sonnarith	Chief MCH, PHD Takoe	26 June, 2013
147	Dr. Sao Chantha	Director CPA 1 Bati Referral Hospital,	26 June, 2013
148	Ms. Mom Malin	Midwife, Bati Referral Hospital	26 June, 2013
149	Ms. Pheurn Sreyneang	Midwife, Bati Referral Hospital	26 June, 2013

150	Mr. Chou Seuth	Head Technical Office, BTB	1 July, 2013
151	Mr. Chea Peou	Department Director, PHD, BTB	1 July, 2013
152	Dr. Gnek Viphou	Chief of Gyneco-Obstetric, BTB hospital	1 July, 2013
153	Ms. Hok Doung Chay	Technical Officer, PHD BTB	1 July, 2013
154	Hor Sinthavary	MCH, PHD	1 July, 2013
155	Mr. Seng Chhunly	TB in Charge, BTB PHD	1 July, 2013
156	Mr. Doung Chantha	Vice Chief Health Promotion, PHD	1 July, 2013
157	Chhourn Leap	MCH, OD	1 July, 2013
158	Dr. Sirv Leang Sang	Chief Battambang OD	1 July, 2013
159	Mr. Mok Preung	VHSG/CBD, Kampong Resey HC	26 July, 2013
160	Ms. Sao Vathny	VHSG/CBD	26 July, 2013
161	Mrs. Vong Sak	VHSG Kampong Resey HC	26 July, 2013
162	Mr. Ya Kim Yean	VHSG/CBD Kampong Resey	26 July, 2013
163	Ms. Sirk Ny	VHSG/CBD Kampong Resey	26 July, 2013
164	Ms. Men Nary	VHSG/CBD Kampong Resey	26 July, 2013
165	Mr. Pov Sarom	VHSG/CBD Kampong Resey	26 July, 2013
166	Mr. Theip Pra	Commune clerk	26 July, 2013
167	Ms. Toun Sina	CBD Voucher, Sreronong HC	26 June, 2013
168	Ms. Marm Kimsras	CBD Voucher, Sreronong HC	26 June, 2013
169	Ms. Sok Chamreun	CBD Voucher, Sreronong HC	26 June, 2013
170	Ms. So Sameun	CBD Voucher, Sreronong HC	26 June, 2013
171	Ms. Toun Sovanna	CBD Voucher, Sreronong HC	26 June,

			2013
172	Ms. Ngem Sokhy	CBD Voucher, Sreronong HC	26 June, 2013
173	Ms. Sokleany Hy	VHSG/ CBD Voucher, Sreronong HC	26 June, 2013
174	Ms. Pin Navy	VHSG/ CBD Voucher, Sreronong HC	26 June, 2013
175	Ms. Nem Nime	VHSG/ CBD Voucher, Sreronong HC	26 June, 2013
176	Meas Sophorn	VHSG/ CBD Voucher, Sreronong HC	26 June, 2013
177	Ms. Ou Soly	VHSG/ CBD Voucher, Sreronong HC	26 June, 2013
178	Ms. Phou Sola	VHSG/ CBD Voucher, Sreronong HC	26 June, 2013
179	Ms. Siv Maly	VHSG/ CBD Voucher, Sreronong HC	26 June, 2013
180	Ms. Nil Chanthy	VHSG/ CBD Voucher, Sreronong HC	26 June, 2013
181	Ms. Phou Sarith	VHSG/ CBD Voucher, Sreronong HC	26 June, 2013
182	Ms. Gnek Sotheary	VHSG/ CBD Voucher, Sreronong HC	26 June, 2013
183	Ms. Nov Sokay	VHSG/ CBD Voucher, Sreronong HC	26 June, 2013
184	Dr. Kim Sour Phirun,	Director PHD, Kampong Cham.	27 June, 2013
185	Dr. Men Bunnan,	Head Technical office, PHD Kg. Cham	27 June 2013
186	Dr. Tang Bun Sreng,	Chief of MCH, PHD Kampong Cham	27 June, 2013
187	Dr. Peang Nara,	Vice Chief of MCH	27 June, 2013
188	Dr. Theu Sophanna,	Chief HPU, Kg. Cham PHD.	27 June, 2013

189	Mrs.Sam Sophay,	Chief of CE Unit, PHD, Kg. Cham	27 June, 2013
190	Dr. Meas Chea	Director of Hospital, Kg. Cham	27 June, 2013
191	Mr. Kong Try	Chief of HC, Teok Chrov HC	27 June, 2013
192	Mr. Song Hor	OPD in charge, Teok Chrove HC	27 June, 2013
193	Tonge Sary	EPI in Charge,	27 June, 2013
104	Chhoun Narith	Pharmacy dispenser/IMCM in charge	27 June, 2013
195	Ms. Ny Cheom	Pharmacy assistant and EPI	27 June, 2013
196	Ms. Hing Sam	In charge for birth spacing	27 June, 2013
197	Ms. Hong Chan	In Charge of obstetric and ANC	27 June, 2013
198	Ms. Sine Huch	Birth Spacing Assistant	27 June, 2013
199	Mr. Roeung Sophorn	OPD, Toek Chrov HC	27 June, 2013
200	Chhim Thorn	CBD, Toek Chrov HC	27 June, 2013
201	Ms. Rath Sinat	CBD, Toek Chrov HC	27 June, 2013
202	Mr. Some Try	CBD/VHSG, Toek Chrov HC	27 June, 2013
203	Mr. Dine Sytha	VHSG, Toek Chrov HC	27 June, 2013
204	Ms. Eth Hane	VHSG Toek Chrov HC	27 June, 2013
205	Ms. Srine	CC member, Toek Chrov Commune	27 June, 2013
206	Ms. Chamreun Khean	CCWC, Toek Chrov Commune	27 June, 2013

207	Nil Saron	DHF	27 June, 2013
208	Mr. Y Sareth	Chief HC Anlong Chrey	27 June, 2013
209	Rirn Ny	EPI in charge	27 June, 2013
210	Ms. Heang Sopheang	Midwife, HC Anlong Chrey	27 June, 2013
211	Ms. Hay Nai Sim	Birth spacing	27 June, 2013
212	Ms. Chea Sinat	HC Pharmacy in Charge	27 June, 2013
213	Mr. Chhun Ratana	OPD, HC Anlong Chrey	27 June, 2013
214	Ms. Oum Lim Phalkun	Chief of HC Sdeung Chey	28 June, 2013
215	Mr. Samreth Sithorn	Vice HC Chief.	28 June, 2013
216	Ms. Phor Phean	CBD- for Sdeung Chey HC	28 June, 2013
217	Mr. Hang Song	VHSG for Sdeung Chey HC	28 June, 2013
218	Mr. Chea Sreng	HC Chief, Roveang HC	28 June, 2013
219	Penh Sal	Deputy HC chief	28 June, 2013
220	Mern Thida	Midwife, Roveang HC	28 June, 2013
221	Mon Kimsras	VHSG, Roveang HC	28 June, 2013
222	Sok Chamreun	VHSG, Roveang HC	28 June, 2013
223	So Savanna	VHSG, Roveang HC	28 June, 2013
224	Toun Savanna	VHSG, Roveang HC	28 June, 2013

225	Nhem Sokly	VHSG, Roveang HC	28 June, 2013
226	Mr. Y Vicheth	Vice chief of HC Tumnub	28 June, 2013
227	Meuy Preung	Midwife HC Tumnub	28 June, 2013
228	Aurn Chanthy	Midwife HC Tumnub	28 June, 2013
229	Hourn Sotheurn	EPI HC Tumnub	28 June, 2013
230	Hong Chaya	Pharmacy dispenser HC Tumnob	28 June, 2013
231	Mr. Soeun Thik	Chief HC, Preknorin HC	2 July 2013
232	Ms. Vong Thida	Midwife, Preknorin HC	2 July 2013
233	Ms. Yin Teveatithya	Pharmacy in Charge, Preknorin HC	2 July 2013
234	Mr. Seng Yi	Commune Chief, Preknorin Commune	2 July 2013
235	Mr. Chheurk Sao	Chief HCMC, Preknorin HC	2 July 2013
236	Mr. Tit Thoeurn	Commune Clerk	2 July 2013
237	Mrs. Chhom Sokun	VHSG, CBD, Preknorin HC	2 July 2013
238	Ms. Seurn Sokun	VHSG, CBD, Preknorin HC	2 July 2013
239	Ms. Teas Somaly	VHSG, CBD, Preknorin HC	2 July 2013
240	Ms. Ven Sokun	VHSG, CBD, Preknorin HC	2 July 2013
241	Ms. Veun Vira	VHSG, CBD, Preknorin HC	2 July 2013
242	Ms. Yane Sokea	VHSG, CBD, Preknorin HC	2 July 2013
243	Mr. San Chanda	VHSG Boeng Pring HC	2 July 2013
244	Mr. Choun Sophon	VHSG Boeng Pring HC	2 July 2013
245	Ms. Longn Am	CBD Boeng Pring HC	2 July 2013
246	Ms. Chin Reum	VHSG Boeng Pring HC	2 July 2013
247	Mr. Em Theim	CBD Boeng Pring HC	2 July 2013
248	Mr. Kheav Kimsane	VHSG Boeng Pring HC	2 July 2013
249	Mr. Long Sinath	CBD Boeng Pring HC	2 July 2013
250	Mr. Khann Chhoung	VHSG Boeng Pring HC	2 July 2013

251	Mr. Kosal	CBD Boeng Pring HC	2 July 2013
252	Mr. Phum Kosale	Chief of Chub Veary Health Center	3 July 2013
253	Ms. Nith Peou	Midwife, Chub Veary Health Center	
254	Mr. Long Chhorn	Vice CC, HCMC Chub Veary	3 July 2013
255	Ms. Nuth Kimny	CC member, HCMC Chub Veary	3 July 2013
256	Mr. Preim Sarom	CC member, HCMC Chub Veary	3 July 2013
257	Ms. Gnoun Phob	CBD, Chub Veary	3 July 2013
258	Mr. Morn Sokheurth	CBD/ C-DOTS Watcher	3 July 2013
259	Mr. Roth Chum,	Angkor Chum District Gov. STSA BoD Chairman.	3 July 2013
260	Dr. Mak Sam Oeun,	Director, OD Angkor Chum	3 July 2013
261	Mr. Phuong Sam	STSA, Executive Director	3 July 2013
262	Mr. Sean Narong,	Program Associate, STSA	3 July 2013
263	Ms. Chhom Thean,	Admin & Accountant STSA	3 July 2013
264	Mr. Luon Treas,	Account Assistant, STSA	3 July 2013
265	Mr Dorn Vireak,	Database Officer, STSA	3 July 2013
266	Mr. Mang Sam Bath,	Acting Director, RH Angkor Chum	3 July 2013
267	Mr. Pich Hata	PC, URC Siem Reap	4 July 2013
268	Dr. Kros Sarath	PHD director, Siem Reap	4 July 2013
269	Dr. Kheng Chheng	Medical Doctor /trainer, Angkor Hospital for children	4 July 2013
270	Mr. Tiej Choeurn	Nurse, Angkor hospital for children	4 July 2013
271	Ms. Vanna Dary	Executive Secretary, Angkor hospital for children	4 July 2013
272	Ms. Tep Nary	COO, Angkor hospital for children	4 July 2013

**Name of Organizations and Institutions visited during the evaluation mission**

No	Name of institution
1	U.S. Agency for International Development USAID-OPHE
2	University of Research Co., LLC (URC)
3	Reproductive and Child Health Alliance (RACHA)

4	Reproductive Health Association of Cambodia (RHAC)
5	Maries Stopes International Cambodia (MSIC)
6	Population Service International (PSI)
7	Australian Agency for International Development (AusAID)
8	United Nation Population Fund (UNFPA)
9	United Nation International Children's Emergency Fund (UNICEF)
10	German Development Bank (KFW), Cambodia
11	Angkor Hospital for Children, Siem Reap
12	Ministry of Health (MOH)
13	National Maternal and Child Health Center (NMCHC)
14	Department of Planning and Health Information System (DPHI)
15	National Center for Tuberculosis and Leprosy Control (CENAT)
16	Hospital Service Department
17	Quality Assurance Office, MOH
18	Takeo Provincial Health Department
19	Bati Referral Hospital
20	Prey Veng Provincial Health Department
21	Pearaing Operational District
22	Kampong Resei Health Center
23	Savay Antor Operational District
24	Mebonn Health Center
25	Kampong Cham Provincial Health Department
26	Kampong Cham Provincial Referral Hospital
27	Ponhea Krek-Dambae Operational District
28	Tuek Chrov Health Center
29	Anlong Chrey Health Center
30	Cheung Prey Operational District
31	Sdeung Chey Health Center
32	Tumnub Health Center
33	Battambang Provincial Health Department

34	Preknorin Health Center
35	Beong Pring Health Center
36	Banteay Mean Chey Provincial Health Department
37	Chub Veary Health Center
38	Siem Reap Provincial Health Department
39	Siem Reap Provincial Referral Hospital
40	Angkor Chum Operational District

**List of documents reviewed or consulted**

2. AusAID. Value for money Assessment for HSSP2 Pooled Fund: Training and Supervision (DRAFT), 2012
3. Cashin, J. et al. Integrated Nutrition Investment Framework (INIF): USAID/Cambodia. 2012
4. Cashin, Jennifer. Report on Activities and Achievements of RACHA'S USAID-funded Maternal, Newborn & Child Health Program (2008 – 2013). June 2013
5. Chan Soeung S. et al. Health Policy Plan.2012; healpol.czs092
6. Chivorn, V. et al. Remunerating Obstetric Emergency Referrals in Beanteay Meanchey and Battambang provinces. 2012
7. Fronczak, N. et al. A Strategic Assessment of Three Integrated Health Projects in Cambodia, 2007
8. Medical Council of Cambodia.,(MCC), About Medical Council of Cambdia,2013
9. MOH Cambodia, Code of Ethics for Nurses, 2013
10. MOH Cambodia, Community Participation Policy for Health, 2008

11. MOH Cambodia. Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality 2010-2015.
12. MOH Cambodia, Guidelines on Community DOTS Implementation, 2004
13. MOH Cambodia, Guidelines for Diagnosis and Treatment of TB in Children, 2008
14. MOH Cambodia, Health Strategic Plan, 2008-2015
15. MOH Cambodia, Infection Prevention and Control Guidelines for Health Care Facilities, 2010
16. MOH Cambodia, National Interim Guidelines for the Management of Acute Malnutrition, 2011
17. MOH Cambodia, National Policy for Infection Control, 2009
18. MOH Cambodia, National Policy for Quality, 2004
19. MOH Cambodia, Cambodian Socio-Economic Survey Analysis—Out-of Pocket Expenditure on Health, 2012.
20. MOP Cambodia, Labor and Social Trends in Cambodia, 2010
21. MOH Cambodia, Protocol for a National Patient Registration and Management System, 2012
22. MOH Cambodia, Quality Improvement Master plan 2010-2015
23. MOH Cambodia, Safe Motherhood Clinical Management Guidelines for Health Centers, 2010

24. MOH Cambodia, Safe Motherhood Clinical Management Protocols for Referral Hospitals, 2012
25. MOH and MOP, Cambodia DHS 2005
26. MOH and MOP, Cambodia DHS 2010
27. MOI Cambodia, Guidelines for the Civil Registration Web Based Database, 2013
28. Reproductive and Child Health Alliance (RACHA). Maternal, Newborn and Child Health Program Annual Workplan (October 2012 - September 2013). July 2012.
29. Reproductive Health Association of Cambodia (RHAC). Together for Good Health (ToGoH): Fifth Year Annual Workplan (October 2012 - September 2013). August 2012.
30. Riggs-Perlas, Joy; et al. USAID-Cambodia Health Program Mid-Term Evaluation. March 2011
31. University Research Co., LLC (URC). Clinical Practice Guidelines and Training Kit for Management of Severe Acute Malnutrition, 2013
32. University Research Co., LLC (URC). Health Systems Strengthening Technical Proposal, 2009
33. University Research Co., LLC (URC). Quality of Care Assessment Toolkit – MOH QAO [DRAFT], 2013
34. University Research Co., LLC (URC). Technical brief, Better Health Service Project: Improving Maternal and Newborn Health in Cambodia, 2011
35. University Research Co., LLC (URC). Better Health Services Project: Health Equity Funds: Improving Pro-poor Health Financing, 2011.

36. University Research Co., LLC (URC). URC Project Introduces Innovation to Reduce Maternal Death in Cambodia. Accessed 20 July 2013 <http://www.urcchs.com/news?newsItemID=300>
37. USAID. Cambodia Health Program Design FY2009 – 2013.
38. USAID. Project brief: View on Family Planning and Long-Acting and Permanent Method. 2013
39. WHO, Global Tuberculosis Report 2012

**Schedule implemented by for Evaluation team of USAID funded projects (URC, RHAC, RACHA, and SIFPO)**

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<b>TIME</b>	<b>ACTIVITIES</b>	<b>LOCATION</b>	<b>ACCOMPANYING PERSON (S)</b>	<b>Remarks</b>
<b>Thu-Fri June 13-14, 2013 (Outside Cambodia): Review documents</b>				
<b>Mon June 17, 2013 (In Cambodia)</b>				
8:00-9:30	Team meeting to define roles and responsibilities	The team needs to identify venue.	No Mission support is needed	
9:30 – 11:00	Briefing meeting with OPHE to discuss logistic issues and clarify SoW	USAID (Conference Room B)	Monique, Robin, Pam, Michelle, Narith, Chantha, and Sochea	Confirmed
13:00-17:00	Develop study framework and work plan	The team needs to identify venue.	No Mission support is needed	
<b>Tue June 18, 2013</b>				
13:00-17:00	Develop study framework and work plan	The team needs to identify venue.	No Mission support is needed	
<b>Wed June 19, 2013</b>				

13:00-17:00	Develop study framework and work plan	The team needs to identify venue.	No Mission support is needed	
<b>Thu June 20, 2013</b>				
09:30 – 11:00	Present study framework and work plan to OPHE Team	USAID (Conference Room B)	Monique, Robin, Pam, Michelle, Narith, Chantha, and Sochea	Confirmed
11:00 – 11:30	Briefing meeting with Mission Director	USAID (MD Office or Conference Room A)	Monique, Robin, and Michelle	Confirmed
15:00-17:30	All team members meet RACHA Team (Chan Theary, Mam Sochenda, Chinn Lan)	#160, Street 71, Tel: 023 213 724, Mobile: 012 333 383, email: ctheary@racha.org.kh,	No mission staff	Confirmed
<b>Fri June 21, 2013</b>				
8:30-12:00	All team members meet URC Team	Building #10, Street 214, Sangkat Chey Chum Neas, Khan Daun Penh, on 3rd and 4th floor. Tel: +855 (0) 17781111	No mission staff	Confirmed
14:00-17:00	All team members meet RHAC Team (Ouk Vong Vathiny, Var Chivorn, Ping Chutema and Aun	#14 Street 335, Sangkat Boeung Kok1, Khan Toul Kork, Phnom Penh, tel: (855	No mission staff	Confirmed

	Hemin)	23) 883 759/ mobile: 017 608 888, email: chivorn@rhac.org.kh,		
<b>Sat June 22, 2013</b>				
Morning	Team	Home work		
15:00 - 17:30	Team meeting	Himawari Biz coffee		
<b>Mon June 24, 2013</b>				
7:30 - 8:30	Meet Penelope Campbell  Chief, Health and Nutrition  United Nations Children's Fund (UNICEF – HSSP2)	Brown's Coffee bar street 51;  Tel:(+855) 023 426 214/5 (Ext. 161)   Mob: (+855) 12788221   Fax: (+855) 023 426 284  E-mail: pcampbell@unicef.org		Confirmed
09:00-11:30	All team members meet Wallach Stefanie, Country Director, MSI	# 12Eo, street 41,( Village 10 ) Sangkat Tonle Basac, Khan Chamkar Mon, Phnom Penh, Tel: 012-222-380 stefenie.wallach@mariestopes.org.kh	No mission staff	Confirmed

11:30 - 13:00	Meet Dr. Derveeuw Marc G.L, Country Representative UNFPA	#225 ConerSt. 310 Street Pasteur 51, Tel: 023-215- 519  Email: <a href="mailto:derveeuw@unfpa.org">derveeuw@unfpa.org</a>	Evaluation Team 2	Confirmed
14:00-15:30	Marcel Reyners, Team Leader Vouchers for Reproductive Health Services Project, EPOS for KfW	#16A, Street 310, Boeung Keng Kang,  Tel: 023 22 3089 H/P: 012 927 754  Email: vann.kiet@kfw.de,	Evaluation Team 2	Confirmed
15:30-16:30	Meet Dr. Lo Veasnakiri, Director of Planning and Health Information System Department, Ministry of Health	No 151-153 Kampuchea Krom Blvd., Phnom Penh, Tel: 012 810 505 <a href="mailto:veasnakiry@online.com.kh">veasnakiry@online.com.kh</a> , <a href="mailto:veasnakiry@gmail.com">veasnakiry@gmail.com</a> ,	valuation Team 1	Confirmed
16:30 - 18:00	Briefing with Elisa Ballard	Himawari Hotel.		Confirmed
<b>Tue-Fri, 25-28, June, 2013: Field visit to Takeo, Kandal, Prey Veng, and Kampong Cham Province.</b>				
	Trip to Kampong Cham and Prey Veng	KC: RHAC PV: RACHA and URC	Evaluation Team 1	See detailed consolidate d schedule
	Trip to Takeo and Kandal	SIFPO Site (only 2 days – team can proceed to KC /	Evaluation Team 2	See detailed consolidate

		PV afterwards.		d schedule
<b>Friday 28, 2013</b>				
14:00 - 15:30	Meet Prof. Tung Rathavy, Director, National Maternal and Child Health Center	French street, Sangkat Srash chork, Doun Penh, Phnom Penh. Tel: 012 222 773; <a href="mailto:rathavy@online.com.kh">rathavy@online.com.kh</a> ,	Evaluation Team 2	Confirmed
14:30 - 15:30	Meet Dr. Dr. Mao Tan Eang, Director of National Center for Tuberculosis & Leprosy Control (CENAT)	Street 95/278, Sangkat Boeung Keng Kang II, Khan Chamcar Mon, Phnom Penh, Tel: 012-916-503, Email: mao@online.com.kh	Mary Ann Evangelista	<b>Confirmed</b>
15:45-17:00	Meeting with AusAID, Chris Vickery, Health Advisor and team	AusAID; 168 National Assembly Street, Phnom Penh, Cambodia.  Ph +(855) 23 213 470 Ext. 573   Fax +(855) 23 213 466   Mobile +(855) (0) 7872 3397  <a href="http://www.usaid.gov">www.usaid.gov.au</a>		Confirmed
<b>Sun-Fri: 30 June - July 4, 2013</b>	Trip to Battambang, Bantey Mean Chey and Siem Reap	BTB: RHAC and URC Sites BMC: RACHA and URC SR: RHAC, RACHA, URC		See detailed consolidate d schedule

<b>Friday July 5, 2013</b>				
8:00-12:00	Travel from Siem Reap to Phnom Penh			
14:30 - 16:00	Follow up meeting with MSI and discussion on Vouchers	MSI offices		Confirmed
<b>Sat July 6, 2013</b>				
14:00 - 17:00	Afternoon team meeting in Himawari Biz Cafe	Review and discuss progress and findings, Plan next steps, report, presentations, etc.		
<b>Monday July 8, 2013</b>				
10:00-11:00	Meet H.E. Prof. Eng Huot, Secretary of State, Ministry of Health	#151-153, Kampuchea Krom, Phnom Penh; Tel: 016 813 161 Fax: 855 23 427 956 Email: dghhuot@online.com.kh	No mission staff TEAM	confirmed
11:00-12:00	Dr. Sok Po, Deputy Director, HSD, MOH	QA office at the MOH	No mission staff Mary Ann	confirmed

11:00-12:00	Meeting with RACHA	#160, Street 71, Tel: 023 213 724, Mobile: 012 333 383, email: <a href="mailto:ctheary@racha.org.kh">ctheary@racha.org.kh</a>	No mission staff Dirk, Laura, Rith	Confirmed
13:00-17:00	Meeting with Christophe A. Grundmann and Katherine Krasovec, URC	Building #10, Street 214, Sangkat Chey Chum Neas, Khan Daun Penh, on 3rd and 4th floor. Email: <a href="mailto:cgrundmann@URC-CHS.COM">cgrundmann@URC-CHS.COM</a> ,	No mission staff Dirk, Mary Ann, Rith	Confirmed
<b>Tuesday, July 9, 2013</b>				
9:00 - 11:00	USAID mid-point meeting and update on progress to OPHE	USAID (Conference Room A)	Monique, Robin, Pam, Michelle, Narith, Chantha, and Sochea	Confirmed
13:30-15:00	Meet Yasmin Madan, and Sok Sokun, PSI,	#29 St. 334 Sangkat Boeung Keng Kang 1, Tel: 012-222-380 Email: <a href="mailto:ymadan@psi.org.kh">ymadan@psi.org.kh</a>	Laura	Confirmed
15:30-16:30	Meet H.E. Prof. Thir Kruey, Secretary of State, Ministry of Health.	#151-153, Kampuchea Krom, Phnom Penh	Mary Ann, Rith	Confirmed.
<b>Wednesday July 10, 2013</b>				

<b>8:00-11:00</b>	Follow up meeting with RHAC and discussion on Vouchers	At RHAC Office		
<b>Wednesday to Saturday, July 10, 2013:</b> Data crunching and preparation of presentation				
<b>Monday July 15, 2013</b>				
10:00-12:00	Presentation to USAID Mission	USAID Room A	Monique, Robin, Chantha, Rebecca, Liz, Kendra, Mealea, Narith, Sochea, Chantha	
14:00-16:00	Presentation to Partners	URC Office	Monique, Robin, Pam, Michelle, Narith, Chantha, and Sochea	Confirmed
<b>Tuesday July 16, 2013:</b> Departure from Cambodia				
<b>Wed-Sun July 17-22, 2013:</b> Write Report				
<b>Tuesday July 23, 2013:</b> Submission of draft report to OPHE				

### Field Visit Schedule of USAID's Evaluation Team (25 June -5 July 2013)

(Evaluation Team: 1- Dirk Horemans, 2- Ms. Laura Sloby, 3- Mary Ann EVANGELISTA, 4- Sok Sovannarith, 5- Elisa Ballard)

#### I. Schedule for field trip to Kandal & Takoe (Tue-Fri: 25-26 June 2013)

<b>Date: 25 June, 2013: Departure from Himawari Hotel to MSIC MSIC-Kandal at 7:30</b>				
Time	Activity	Respondent group	Location & contact person	Remark
8:30-11:00	▪ Visit MSI clinic	<ul style="list-style-type: none"> <li>▪ Clinic Manager and Technical staff.</li> <li>▪ Clients</li> </ul>	MSIC-Clinic Kandal Province	
11:00-12:00	<b>Back to Phnom Penh</b>			
12:00-13:30	Lunch break			
	Phnom Penh			
<b>Date: 26 June 2013: Departure from Himawari Hotel to Prey Veng at : 6:30am</b>				
<b>9:00-10:00</b>	▪ Meeting with Takeo PHD	<ul style="list-style-type: none"> <li>▪ PHD director</li> <li>▪ Chief of Technical office</li> <li>▪ MCH focal point</li> <li>▪ PHD Health Promotion</li> <li>▪ TB in charge</li> <li>▪ HCF officer (if any)</li> <li>▪ Continuing Education</li> </ul>	PHD Takeo	
<b>10:00-12:00</b>	▪ Meet Voucher holder group	<ul style="list-style-type: none"> <li>▪ Voucher holder group</li> <li>▪ (8-12 V.holders)</li> </ul>	Sre Ronoung HC	
12:00-13:30	Lunch break			

14:00-16:00	<b>Meeting with community group:</b> HCMC/VHSG, CBD distributor, CDOTS Watchers, Commune councilor in Charge Children and women	<ul style="list-style-type: none"> <li>▪ HCMC/VHSG (6 p)</li> <li>▪ CBD distributor (3 p)</li> <li>▪ Voucher holders (5 p)</li> <li>▪ Commune councilor in Charge Children and women</li> </ul>	HC nearby Bati hospital	
16:00-17:00	<b>Visit Bati hospital</b>	<ul style="list-style-type: none"> <li>▪ Director Hospital</li> <li>▪ Pediatric</li> <li>▪ Obstetric</li> </ul>	Bati hospital	-

## II. Schedule for field trip to Prey Veng and Kampong Cham (Tue-Fri: 25-28 June 2013)

Time	Activity	Respondent group	Location & contact person	Remark
9:00-10:30	<ul style="list-style-type: none"> <li>▪ Meeting with RACHA team in Prey Veng</li> </ul>	<ul style="list-style-type: none"> <li>▪ Provincial coordinator</li> <li>▪ Technical Staff</li> </ul>	RACHA-Prey Veng  (Dr. Oum Navuth : 012726 857)	
10:30-12:00	<ul style="list-style-type: none"> <li>▪ Meeting with PHD-Prey Veng</li> </ul>	<ul style="list-style-type: none"> <li>▪ PHD director</li> <li>▪ Chief of Technical office</li> <li>▪ MCH focal point</li> <li>▪ PHD Health Promotion</li> <li>▪ TB in charge</li> <li>▪ HCF officer (if any)</li> <li>▪ Continuing Education</li> </ul>	PHD meeting room	

12:00-13:30	Lunch break			
13:30-14:30	Meeting OD Savy Anthon	<ul style="list-style-type: none"> <li>▪ OD Chief</li> <li>▪ OD MCH</li> <li>▪ TB in charge</li> <li>▪ DO in charge of supervision team</li> </ul>	Svay Anthon OD.	
14:30-17:00	Visit provincial hospital	<ul style="list-style-type: none"> <li>▪ Director Hospital</li> <li>▪ Pediatric</li> <li>▪ Obstetric</li> </ul>	Provincial hospital	
Date: 26 June, 2013				
7:30-8:30	Meeting with URC-Prey Veng	<ul style="list-style-type: none"> <li>▪ Provincial coordinator</li> <li>▪ Technical Staff</li> </ul>	URC-Prey Veng (Dr. Ouk Puthearoth 012 977525)	
8:30-9:30	<b>Meeting with OD-Pearaing</b>	<ul style="list-style-type: none"> <li>▪ OD Chief</li> <li>▪ OD MCH</li> <li>▪ TB in charge</li> <li>▪ DO in charge of supervision</li> </ul>	OD: Pearaing	
9:30-12:00	<b>Visit Hospital</b>	<ul style="list-style-type: none"> <li>▪ Director Hospital, Midwife</li> </ul>	Pearaing Referral hospital	
12:00-13:30	Lunch break			
13:30-14:30	<b>Meeting with community group:</b> HCMC/VHSG, CBD distributor, CDOTS Watchers, Commune councilor in Charge Children and	<ul style="list-style-type: none"> <li>▪ HCMC/VHSG (6 p)</li> <li>▪ CBD distributor (3 p)</li> <li>▪ DOTS Watchers (2 p)</li> <li>▪ Commune councilor in Charge Children and women (1p)</li> </ul>	Kampong Resei HC	<ul style="list-style-type: none"> <li>- 3 close to HC</li> <li>- 2 far away from HC</li> <li>- 1 Chairman of HCMC Commune</li> </ul>

	women	Total: 12 people		response for CIP
14:30-16:00	<b>Visit Health Center</b>	<ul style="list-style-type: none"> <li>▪ Health Chief</li> <li>▪ Midwife</li> <li>▪ DOTS responsible</li> <li>▪ Pharmacy in charge</li> </ul>	Kampong Resei HC	
16:00-17:30	<b>Visit Health Center (Mebonn)</b>	<ul style="list-style-type: none"> <li>▪</li> </ul>	Mebonn HC	
16:30-17:30	Travel to Kampong Cham & Checking hotel in Kampong Cham			
<b>Date: Thursday 27 June 2013</b>				
7:30-9:30	Meeting with RHAC-Kampong Cham	<ul style="list-style-type: none"> <li>▪ Provincial coordinator</li> <li>▪ Technical Staff</li> </ul>	RHAC-Kampong Cham  (Mr. Kea Bou-017 393999)	
9:30-12:00	Visit Ponheakrek RH.	<ul style="list-style-type: none"> <li>▪ Director Hospital</li> <li>▪ Doctor –nurse at Pediatric ward.</li> <li>▪ Doctor-nurse at Obstetric ward.</li> </ul>	Ponheakrek RH	
9:30-12:00	Meeting Ponheakrek OD	<ul style="list-style-type: none"> <li>▪ OD director</li> <li>▪ MCH in charge</li> </ul>	OD.Ponheakrek	
12:00-13:30	Lunch break	<ul style="list-style-type: none"> <li>▪</li> </ul>		
13:30-15:30	Visit HC (Tuk Chrov-HC)	<ul style="list-style-type: none"> <li>▪ HC staff</li> </ul>	Toek Chrov-HC	

		<ul style="list-style-type: none"> <li>▪ HCMC/VHSG/CBD</li> </ul>		
	Visit HC (Anlong Chrey-HC)	<ul style="list-style-type: none"> <li>▪ HC staff</li> <li>▪ HCMC/VHSG/CBD</li> </ul>	Anlong Chrey HC	
15:30-: 17:00	Meeting with PHD- Kampong Cham	<ul style="list-style-type: none"> <li>▪ PHD director</li> <li>▪ Chief of Technical office</li> <li>▪ MCH focal point</li> <li>▪ PHD Health Promotion</li> <li>▪ TB, HCF and CE in charge</li> </ul>	Kampong Cham PHD	
	Visit Kampong Cham Provincial hospital	<ul style="list-style-type: none"> <li>▪ Hospital director</li> <li>▪ Chief pediatric ward</li> <li>▪ Maternity ward</li> </ul>	Kampong Cham Hospital	
<b>Date: Friday 28 June, 2013 ( Kristina travel back to PP- as she flies out at 11:20)</b>				
8:30-11:30	Evaluation team 1: Visit HC- Sdeung Chey	<ul style="list-style-type: none"> <li>▪ HC staff</li> <li>▪ HCMC/VHSG/CBD</li> </ul>	Sdeung Chey-HC	
8:30-11:30	Evaluation Team 2: Visit Tom Nub HC.	<ul style="list-style-type: none"> <li>▪ HC staff</li> <li>▪ HCMC/VHSG/CBD</li> </ul>	Sdaeung Chey HC	
11:30-	Travel back to Phnom Penh.			

### III. Schedule for field trip to Battambang, Bantey Mean Chey and Siem Reap. (June 30- July 5, 2013)

Sunday, 30 June, 2013: Departure from Himawari Hotel to Battambang province at 1:30				
Monday 1 <sup>st</sup> July 2013.				
Time	Evaluation Team	Activity	Respondent group	Location & Contac person
8:00-9:30	1 & 2	<ul style="list-style-type: none"> <li>Meeting with URC officers in Battambang</li> </ul>	<ul style="list-style-type: none"> <li>URC in Batambang</li> </ul>	Battambang PHD (Contact: Dr. Sam Hun, URC. Battambang: Tel: 012 530 276)
9:30-10:30	1 & 2	<ul style="list-style-type: none"> <li>Meeting with RHAC team</li> </ul>	<ul style="list-style-type: none"> <li>Provincial Coordinator &amp; Technical team</li> </ul>	RHAC office in Battambang
10:30-12:00	1&2	<ul style="list-style-type: none"> <li>Introduction Meeting with Battambang PHD director and PHD team</li> <li>OD Battambang OD Sangke</li> </ul>	<ul style="list-style-type: none"> <li>PHD director</li> <li>Chief of Technical office</li> <li>MCH-PHD focal point</li> <li>TB in charge</li> <li>OD director Battambang &amp; Sangkeo</li> <li>MCH OD Battambang &amp; Sangke.</li> </ul>	PHD office in Battambang
12:00-13:30	Lunch break			

13:30-15:30	1	<ul style="list-style-type: none"> <li>Visit Battambang provincial hospital</li> </ul>	<ul style="list-style-type: none"> <li>Director Hospital</li> <li>Pediatric</li> <li>Obstetric</li> </ul>	
	2	<ul style="list-style-type: none"> <li>Life Saving Skill Center</li> </ul>	<ul style="list-style-type: none"> <li>RACHA &amp; LSS in charge</li> </ul>	Ask RACHA in PP
15:30-17:00	1	<ul style="list-style-type: none"> <li>Visit RHAC Clinic</li> </ul>	Clinic Manager & Team.	
<p>Date: Tuesday 2<sup>nd</sup> July 2013. Leave Battambang town to Samlot at 7:30</p>				
9:00-12:00	1	<ul style="list-style-type: none"> <li>Visit Prek Norin HC</li> </ul>	<ul style="list-style-type: none"> <li>Visit HC</li> <li>CBD</li> <li>CDOTS</li> <li>HCMC/VHSG</li> <li>Visit house &amp; meet Client</li> <li>CBD</li> </ul>	Sangke OD
	2	<ul style="list-style-type: none"> <li>Visit Beong Pring HC</li> </ul>	<ul style="list-style-type: none"> <li>Visit HC</li> <li>CBD, CDOTS, HCMC/ VHSG</li> <li>Visit house &amp; meet Client</li> </ul>	HC/ Thmarkol OD
12:00-16:00	Lunch break and Travel to Bantey Mean Chey, and hotel check-in			
16:00-17:00	1 & 2	<ul style="list-style-type: none"> <li>Meeting with RACHA-Bantey Mean Chey</li> </ul>	<ul style="list-style-type: none"> <li>Provincial Coordinator and technical staff</li> </ul> <p><b>Contact person:</b> Dr. Kun Vuth <b>Tel: 092 949 456</b></p>	

Date: Wednesday 3<sup>rd</sup> July, 2013 (Leave Battay Mean Chey to Peah Net Preah at 7:30am)

8:30-9:30	1	<ul style="list-style-type: none"> <li>Meet OD Prenet Preah Net Preah.</li> </ul>	<ul style="list-style-type: none"> <li>OD Chief</li> <li>MCH in Charge</li> <li>TB in Charge</li> </ul>	
9:30-11:30	1	<ul style="list-style-type: none"> <li>Visit referral hospital in Preah Net Preah OD and meet patient.</li> </ul>	Hospital director & Technical Team <ul style="list-style-type: none"> <li>Meet Patients</li> </ul>	
8:30-11:30	2	<ul style="list-style-type: none"> <li>Visit Chub Veary HC</li> </ul>	<ul style="list-style-type: none"> <li>Health Center Chief</li> <li>CBD, CDOTS, HCMC /VHSG, CC chief</li> </ul> Visit house & meet Clients	
11:30-14:00	Travel from Preah Net Preah to Kralagn + Lunch break and Travel to Angkor Chum			
14:00-15:30	1 & 2	<ul style="list-style-type: none"> <li>Meeting with CBHC in Angkor Chum</li> </ul>	<ul style="list-style-type: none"> <li>CBHC -Angkor Chum</li> </ul> Contact person: Mr. Hatha-URC Mr. Phoung Sam On	Will ask URC to organize
15:30-16:30	1	<ul style="list-style-type: none"> <li>Visit hospital in Angkor Chum</li> </ul>	<ul style="list-style-type: none"> <li>Hospital Director, Midwife</li> <li>Director of hospital</li> </ul> Maternity ward in charge	
16:00-17:00	2	<ul style="list-style-type: none"> <li>Visit HC under Angkor Chum OD</li> </ul>	Have to be identified later	On the back to SR

Thursday 4<sup>th</sup> July, 2013

8:00-9:30	Team 1 & 2	<ul style="list-style-type: none"> <li>Meeting URC</li> </ul>	URC provincial Coordinator in Siem Reap	
9:30-12:00	2	Visit Provincial Hospital	<ul style="list-style-type: none"> <li>Hospital Director</li> <li>Technical staff works at the Maternity Ward.</li> </ul>	
9:30-10:00	1	Meeting PHD director	<ul style="list-style-type: none"> <li>PHD meeting room</li> </ul>	
10:00-12:00	1	Join Group 2 at Provincial Hospital	<ul style="list-style-type: none"> <li>At Provincial RH</li> </ul>	
12:00-14:00	Lunch break and travel to Angkor Thum Health Center at 13:00			
14:00-16:00	2	<ul style="list-style-type: none"> <li>Visit Angkor Hospital for children</li> </ul>	<ul style="list-style-type: none"> <li>HC Chief and Staff</li> </ul>	
17:00-19:00	1 & 2	<ul style="list-style-type: none"> <li>Team Meeting</li> </ul>	<ul style="list-style-type: none"> <li>Borie Angkor Hotel</li> </ul>	

Friday 5<sup>th</sup> July, 2013 (Depart from Siem Reap- Phnom Penh at 8:00)

## **ANNEX 5: LONG TERM AND PERMANENT METHOD FAMILY PLANNING VOUCHERS**

In order to increase the low uptake of long-term and permanent FP methods, USAID's implementing partners have introduced different Health Care Financing (HCF) approaches. In 2012 RACHA made IUD insertion and VSC free of charge by paying clients for the transport and reimbursing the user fee directly to the 9 RH and 163 facilities covered. RHAC had been doing the same for IUDs since 2010 but decided to change to a voucher mechanism for IUDs and VSC starting from January 2012. MSIC has a number of LT FP voucher schemes in the country, which are funded by other donors, and in March 2012 they started a LT FP voucher program covering IUDs and implants with USAID support. Funded by KfW, the EPOS-AFH-OPM-PWC conglomerate is running a reproductive health voucher scheme, which also covers LT/PM FP.

The USAID health program evaluation team paid special attention to the MSIC and RHAC LT/PM of FP voucher scheme with the aim of producing this more detailed description of the USAID supported LT/PM vouchers. These findings are based on the following data collection methods: a) voucher-dedicated semi-structured interviews with MSIC, RHAC and EPOS-AFH; b) semi-structured interviews with MSIC's "active" VHSGs and with CBDs responsible for distributing vouchers in the field; d) with PHDs, ODs, and HC staff; e) focus group discussion with women having adopted long-term methods using the MSIC LTFP vouchers program; and e) review of summaries of RHAC and MSIC LT/PM FP voucher programs.

### **Description of different aspects of the USAID supported MSIC and RHAC LT/PM voucher schemes**

#### *Purpose of the voucher scheme:*

Both MSIC and RHAC schemes aim to increase the uptake of LT/PM FP by reducing financial barriers to access IUDs and implants; and by increasing awareness that these services are available for free at participating health facilities.

#### *Beneficiaries*

For both organizations the target groups are the poor and non-poor married women of reproductive age living in the catchment areas of the HC.

#### *Services covered*

For both organizations vouchers cover IUD and Implant placement. RHAC vouchers also cover Voluntary Surgical Contraception. The MSIC vouchers also cover IUD and implant removal. RHAC vouchers cover vasectomy but not tubal ligations, and assure 2 follow up visits by CBDs.

#### *Facilities providing the services and coverage area*

MSIC vouchers can be used in 41 public health facilities in Kandal province and 29 facilities in Takeo province as well as in the MSIC clinics. RHAC vouchers can be used in 219 HCs and in RH of 18 ODs in five Provinces, as well as in the RHAC clinics. MSIC has an agreement with a single private practice to use the vouchers; RHAC does not work with commercial private practices.

#### *Quality of services*

Both RHAC and MSIC make sure that the staff of HCs or hospitals providing voucher-related

services have adequate competencies and that they are well equipped. Before partnering with facilities for the voucher component, MSIC conducted health facilities baseline assessments to identify which facilities MSIC would work with and what support those facilities needed. MSIC supported trainings on implant and IUD insertion. MSIC's QA team visits facilities monthly, bi-monthly or quarterly to assess capacity and to provide follow-up support as needed. RHAC has organized IUD trainings for many midwives and provided IUD equipment to many HCs. But no specific quality assessment of the voucher schemes has been conducted, partially because facilities are not officially contracted into these schemes. RHAC technical staff, often in conjunction with MCH OD staff, do conduct routine supervision visits to make sure that HC midwives are competent to provide the services.

#### *Supplies of FP commodities*

All medical supplies, IUDs and implants included are provided by MOH<sup>36</sup>. Since the fast increase in uptake of implants, due to effective demand creation country-wide, a number of HCs have experienced shortages of Implanon. Presently supplies cannot keep up with the demand for implants. Both implants and IUDs are provided free of charge to public HCs and RHs.

#### *Voucher Distribution, CBDs and "Active" VHSGs*

Initially MSIC was selling vouchers to the non-poor while providing them free of charge to the poor. The selling approach ceased after finding that this scheme was not working well. Distribution of vouchers is carried out by "active VHSGs" and CBDs. CBDs do not get paid per numbers distributed or number of users, although RHAC does provide them \$1 for each of the 2 follow up visits of IUD users. MSIC uses "active VHSG", who receive more intensive 3 days training and become responsible for a larger number of villages (12 to 28). Under SIFPO, MSIC selected and trained 56 "active VHSGs" or so-called MSIC volunteers. They receive a stipend of \$25 per month and travel costs based on distance traveled. Active VHSG focus on community awareness raising and support. They travel to conduct group discussions at other villages under the HC catchment areas. CBDs also sell oral contraceptives and condoms. But the financial incentive for this work is very small, about \$1-\$3 per month, depending on the number of clients. "Active VHSG" claim to spend around 4 full days working for the program.

#### *Promotion, and awareness raising*

During the introduction of the voucher scheme, RHAC organized an initial awareness campaign. Thereafter promotion is conducted by the CBDs. When HC IUD activities drop below 5 per month, RHAC will organize a special follow-up awareness campaign.

MSIC organizes intensive awareness campaigns using a convoy of Tuktuks decorated with highly visible promotional materials, and accompanied by several MSIC volunteers, who use a sound system to make sure their message is heard. Hereafter the "active VHSGs" visits different villages regularly.

#### *Provider Payment Policy*

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<sup>36</sup> Since 2013 MOH has stopped supplying FP commodities to RHAC clinics.

RHAC pays a fixed price of \$3 for the placement of IUDs in all HCs, disregarding the official user fees. RHAC does not reimburse its own clinics for provision of voucher services. MSIC reimburses the HC user fees, which are standardized by OD or province at around \$5 for placing an IUD and \$10 to \$20 for an implant. Until May 2013, MSIC reimbursed its own clinics their standard user fees around \$5 for the IUD and around \$25 for the implant, but this practice has since stopped. RHAC reimburses transport to the clients, but MSIC does not.

In the case that the beneficiary has an HEF card, MSIC will deduct the \$1 consultation fee paid for by the HEF from their reimbursement. RHAC will pay the full amount but will try to avoid double payments. When in RHAC areas a client comes without a voucher she will have to go back to her village to request a voucher from the CBDs or pay for the IUD herself. In MSIC areas the HC would provide the service and receive the voucher later through the MSIC volunteer.

#### *Reimbursement Mechanism*

Each month RHAC reimburses the HCs directly based on the IUD user list, the vouchers and supportive documentation. In MSIC areas the facilities send their monthly report on vouchers services through the OD MCH officer, who verifies it before forwarding, together with a reimbursement claim to MSIC. This claim is again verified before reimbursement is made through the OD MCH to the HC.

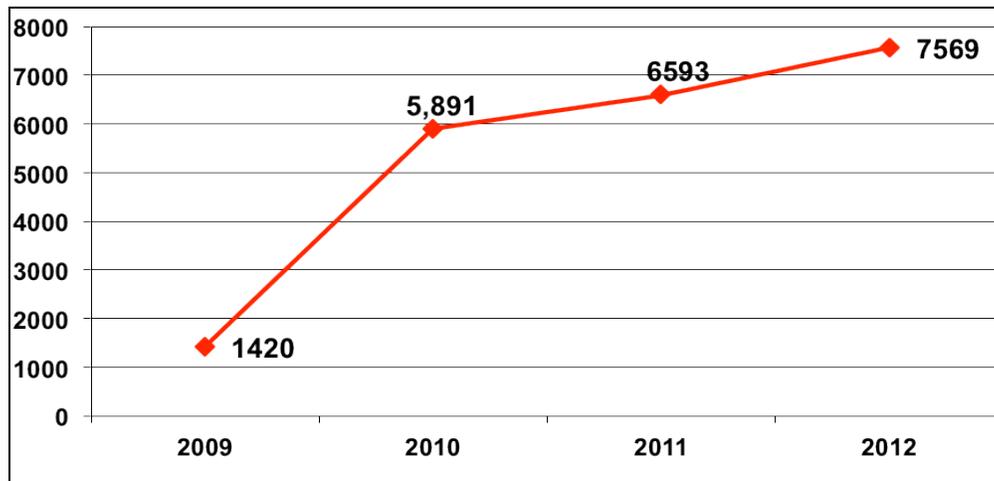
#### *Financial Verification and spot checks*

To monitor fraud, MSIC carries out quarterly spot-checks on 5% of vouchers using a checklist. They call some clients to double check that they have received the service and have not been asked for payment, and get feedback from VHSG on voucher implementation during regular VHSG meetings. Their monitoring of fraud is very thorough. RHAC field staff uses similar spot-checks but visits the women in their household to confirm that the service was provided as claimed. Spot checks are fairly random without a standard sample size for spot-checking.

#### *Distribution, utilization, redemption rate and data monitoring*

Neither MSIC nor RHAC seems to have a solid monitoring framework allowing them to measure the impact of the vouchers on LT/PM FP use. MSIC intends to conduct an evaluation of their voucher projects later this year, and RHAC plans further analysis from their routine data collection systems. Both do, however, collect data on distribution and utilization by period and by time. The number of IUD vouchers used in 2012 in HCs in RHAC ODs was 6,470, or 11% of the 57,815 vouchers distributed, and represented 86% of 7,569 IUDs inserted in those HCs. Between the start of the project, in March 2012 until May 2013, 4,500 (77%) of the 6,000 IUD or Implant vouchers distributed by MSIC were used. The graph below shows the yearly number of IUD acceptors, with or without vouchers, in RHAC provinces.

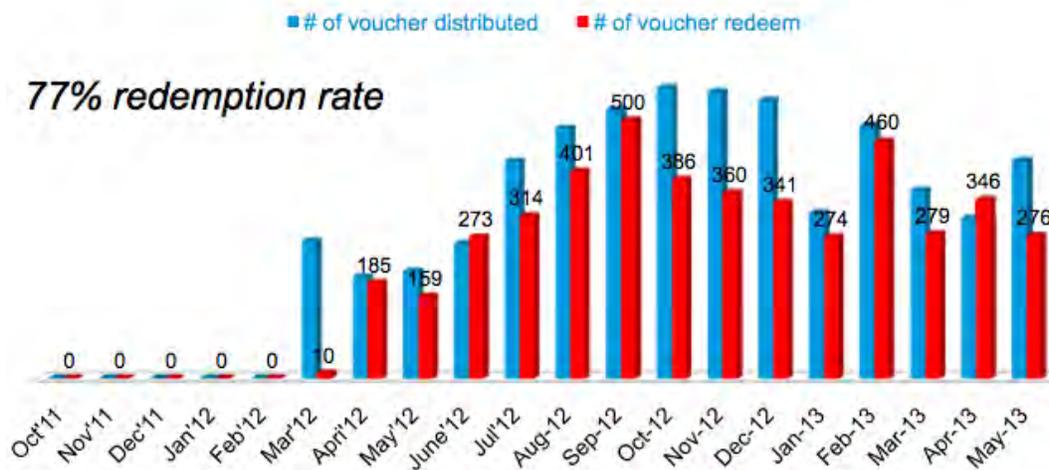
Figure: Total IUD acceptors per year in RHAC provinces



Source: provided by RHAC during mission

The graph “Vouchers Distributed vs. Redeemed” shows the monthly numbers of vouchers used against those distributed. The first five months without activity were the preparation months.

## Vouchers Distributed vs. Redeemed



Source: provided by MSIC during mission

### Perception by users (MSIC focus group discussion)

After selecting Rovieng Health Center at random from the OD list, the team requested MSIC to organize 8 to 12 voucher users for a focus group discussion. Eleven female voucher users were selected at random from the register, and came from villages between 2 and 8 km away from the HC. Six amongst them had an implant, 5 of them an IUD. All were very happy with their new method, after using oral contraceptives or injections for many years, some with side effects.

Previously they had been afraid of LT methods because of several misconceptions and because of the high cost. They had been motivated by the “Tuktuk awareness campaign” and by the MSIC volunteers, which they described very enthusiastically. The combination of clear messages addressing their fears on misconceptions, combined with the fact that the product was free of charge motivated them to switch to a LT FP method. Today they were convinced that it was a good choice, and said that they would happily pay themselves for replacements in the future. They were actively promoting the LT FP to their female friends and family

### *Costing Data*

Very little costing data were available. The team did not follow up on that.

### *KfW Funded Vouchers implemented by EPOS*

EPOS with AFH as the Voucher Management Agency implements a large-scale reproductive and maternal health voucher scheme on behalf of MOH and financed by KfW. Apart from their Safe Abortion vouchers, their scheme targets only the poor. Prior to contracting HCs, hospitals or private clinics as service providers, facilities have to pass a quality assessment. Public HC and hospitals not qualifying do however get support to implement their improvement plans, through training and equipment provided by the project. EPOS works with MSIC clinics and with the RHAC clinic in Kampot, and intends to contract to the commercial private sector but only for FP and SA, and conditional upon passing the QA and having no dual practice staff. Presently only one private clinic has been contracted. Their provider payment mechanism has its own fee structure, which differs from the facility user fees, from HEF, and from MSIC and RHAC vouchers. As a result of their fee structure HC staff prefer inserting implants over placing IUDs. EPOS-AFH have a solid monitoring and evaluation framework that allows for detailed monitoring as well as measuring impact. Their annual project reports give interesting distribution, utilization and costing information. With MOH chairing the project Steering Committee this voucher scheme is fully recognized with data being presented in the MOH Annual HCF Report. They are presently active in three provinces, Prey Veng, Kampot and Kampong Thom, but intend to expand their voucher scheme to other provinces and possibly to other non-reproductive maternal health services.

### **Discussion**

The increase in uptake of LT FP methods in the areas with MSIC and RHAC LT/PM FP voucher schemes seems to be significant. It is likely that increased awareness and the free access created by these voucher schemes have contributed significantly to reducing previously identified barriers. All women of the FGD highlighted that their decision to change to a LT FP was based on the effective message content of the promotion campaign and the free access.

The time frame and data available did not allow a proper impact, effectiveness or efficiency evaluation. Both schemes, although with a similar goal, have different promotion strategies, distribution mechanisms, price structures, monitoring mechanisms, etc. In some ODs both schemes are present but within different HCs or complimentary to each other. A combined evaluation of both projects would allow for some level of impact measurement, as well as sharing the many lessons learned, without necessarily having to lead to standardized approaches.

As the LT/PM FP voucher scheme is mainly aimed at increasing awareness, the sustainability is less of an issue once broad awareness is created. To ensure accessibility in the future, HEF could later take over the financing responsibility for these services, at least for the poor.

**Recommendations:**

- Given the possible impact on increasing awareness and uptake of LT FP it is recommended to continue the LT/PM FP voucher schemes for the short-term, while possible expansion should depend on the findings of a more solid impact evaluation.
- Continuation of the LT/PM FP voucher schemes should be done as part of a larger, more comprehensive LT/PM FP awareness campaign.
- RHAC needs to put much more emphasis on the awareness aspects of its vouchers, possibly through more village campaigns, possibly through similar approaches used in the MSIC Tuktuk campaign, as well as through their work with CBDs.
- For long-term accessibility, the HEF Provider Payment Mechanism should correctly reimburse HC and Hospitals for those services. USAID, other HPs and the implementing partners should lobby the MOH to make these changes to the HEF Benefit Package and Provider Payment Mechanism. This recommendation is elaborated under the chapter on HCF in the main report.
- RHAC, MSIC and RACHA should maintain and strengthen proper control mechanisms to avoid double payments by HEF and Vouchers for the same service.
- Implementing partners should provide field level feedback on the FP commodity shortages to USAID and central level MOH. USAID together with other partners in the FP commodity security group should lobby MOH and responsible donors to assure ample supplies of LT FP commodities.
- Among the 18 ODs in which RHAC has LT/PM FP voucher schemes, 238 HCs have IUD services. Of those, 219 are using the RHAC-supported voucher scheme, while 19 have the MSIC-supported voucher scheme. In the overlapping ODs, MSIC is generally only active in 2 HCs. In those HCs RHAC does still support the transportation of the IUD clients to the HC. Having multiple LT/PM FP voucher schemes by different agencies in one OD has no obvious advantage and complicates administration and reporting for authorities and for the agencies themselves. It is therefore recommended to have only one LT/PM FP voucher scheme per OD.
- It would be useful if the Voucher Evaluation planned by MSIC (to be funded by AusAID), could be expanded to cover RHAC and possibly the other LT/PM FP voucher schemes. This will require USAID to convince AusAID, MOH, KfW, and MSIC of the value of such a study. It would be important to have these studies also look at the different costing aspects of these schemes.
- Presently the different NGOs implementing LT/PM FP voucher schemes -- RHAC, MSIC and EPOS-AFH -- are not communicating formally about their experiences. It would be helpful if they communicated on a regular basis sharing their experiences, lessons learned and plans.

This could avoid further overlap. Some standardization, such as on the fee structures might be useful.

- USAID and implementing partners should inform the Bureau of Health Financing under the DPHI (MOH) of their voucher schemes and report on them periodically.
- The “active” VHSG or MSIC volunteers, who are more intensively trained than CBDs and receive small monthly stipends, are very effective at raising awareness and promoting behavior change. This approach should be studied further and possibly adopted for similar promotion and voucher distribution tasks.

## **ANNEX 6: OUTPUT AND COVERAGE RESULTS AND TRENDS IN USAID-SUPPORTED PROVINCES**

This annex lists relevant project activities and a number of indicators with their results and trends demonstrating the likelihood of the USG supported projects contributing to the USAID Health Program Goals.

### ***Reduction of maternal mortality rate by 25%.***

The CDHS 2005 and 2010 showed a decrease in MMR from 472/100,000 to 206/100,000 or a **56% reduction**.

Increase of Facility Deliveries

- 2012 RHAC and RACHA surveys showed high proportions of facility deliveries, 88.1% in RHAC survey provinces and 87.1% in RACHA survey provinces
- The proportional increase of facility deliveries between 2009 and 2012 was 40.8% in USG supported provinces areas, and higher than the nationwide increase of 31.0% (based on HIS data)

Increase in Cesarean Section Rate (a proxy indicator for Cemonc care)

- In USG supported provinces between 2009 and 2012 the CS rate increased considerably by 51.2% to reach 1.6% in 2012. This was lower than the nationwide increase for the same period of 66.0% reaching a CS rate of 3.0%. (based on HIS data)

The following USG supported activities targeted directly improvement in maternal health services: development and advocacy for several policies and guidelines, Midwife trainings, MCAT meetings, training of other RH and HC staff, patient record systems, different BCC approaches, VHSG training and support, HEF, MNH vouchers, referral reimbursements, infrastructure works (maternal waiting rooms, water supply systems), supply medical equipment and instruments, HC and hospital hygiene, emergency transport systems, etc.

### ***Reduction of Under-5 mortality rate by 25%.***

The CDHS 2005 and 2010 showed a decrease in Under-5 mortality rate from 83/1000 to 54/1000 or a **35% reduction**.

Vaccination Rate of Children 12-23 months fully immunized:

- In RHAC survey provinces: from 76.3% in 2009 to 80.9% in 2012 (Survey)
- In RACHA survey provinces: from 92.6% in 2010 to 74.4% in 2012 (Survey)

Correct ARI treatment in RH and HC

- In RHAC survey provinces from 26.1% in 2009 to 68.4% in 2012 (Survey data)
- In RACHA survey provinces from 97% in 2010 (HIS) to 63.4% in 2012 (Survey data)

Diarrhea treatment with ORT and Zinc

- In RHAC survey provinces from 2.5% in 2010 to 23.5% in 2012 (Survey data)
- In RACHA survey provinces from 26.6% in 2010 (ORS & Zinc) to 32.3% in 2012 (Survey data)

The following USG supported activities targeted directly improvement in child health services: development and advocacy for several policies and guidelines, training of HC and hospital staff, different BCC approaches, Helping baby breath, IMCI, C-IMCI, MAM, SAM, Breastfeeding practices, deworming, Vit A supplements, micronutrients, supplements training of other RH and HC staff, VHSG training and support, patient record systems, HEF, infrastructure works (water supply systems), supply medical equipment and instruments, HC and hospital hygiene, etc.

***Increase in modern contraceptive prevalence to at least 35%.***

The CDHS 2005 and 2010 showed an increase in modern contraceptive prevalence rate (CPR) of married women of reproductive age from 27.9% to **34.9%**, or a proportional increase of 22%

CPR increased further after 2010

- In RHAC survey provinces from 32.1 in % 2010 to 46.5% in 2012 (Survey data)
- In RACHA survey provinces from 37.2 in 2010 (CDHS) to 38.7% in 2012 (Survey data) (different case definition in 2010 RACHA survey))

The following USG supported activities targeted directly improvement in Family Planning services: development and advocacy for several policies and guidelines, training of Midwives and other HC and hospital staff, different BCC approaches, VHSG and CBD training and support, LTFP Vouchers, RHAC clinics, LMIS, mobile clinics, etc.

***Reduction of TB prevalence of 20%.***

Tuberculosis prevalence surveys of 2002 and 2011 show a decline of 45% in bacteriologically positive TB cases and 38% in smear positive TB cases.

Very High Smear Positive TB Cure Rates in USG supported areas

- In RHAC areas 93% in 2012 (RHAC report)
- In RACHA areas 94% in 2012 (RACHA report)

Rolling out and support of Community DOTS in USG supported areas

- RHAC areas in 8 ODS (RHAC Report)
- RACHA areas in 10 ODS (RACHA Report)

The following USG supported activities targeted directly improvement in Family Planning services: training of HC and hospital staff, BCC, VHSG training and support, C-DOTS, PPM DOTS, Pediatric TB, etc.

## ANNEX 7: REPRODUCTIVE HEALTH/FAMILY PLANNING: PRIVATE AND NGO SECTORS

The role of the commercial private sector in provision of FP is low in Cambodia at 11.4%<sup>37</sup>, but as incomes rise, the potential exists to increase the role of the private sector in provision of RH/RP services. Among the three USAID partners included in this evaluation, only the ToGoH Project provides reproductive health care directly from its own network of clinics. MSI also has its own clinics, but these are not supported by USAID. RHAC clinics have made an important contribution to CPR by serving 11.5 percent of current users in 2012<sup>38</sup>.

The 15 RHAC clinics offer a comprehensive package of quality reproductive health services for women of reproductive age, including diagnosis and treatment of reproductive tract infections and sexually transmitted disease and screening for cervical cancer. RHAC clinics also have a unique niche in provision of “youth-friendly” services, which includes comprehensive post-rape care and premarital screening and counseling unavailable elsewhere in the country. RHAC clinics also reach women with FP information in their place of work, primarily garment factories; and provide other high-risk groups with HIV/AIDS information, counseling and services.

RHAC charges fees that are higher than those charged by the government, but significantly less than those found in the private commercial sector and is a viable option for middle to lower income clients. However, RHAC clinics still provide free services to about 25% of their clients as well as disadvantaged youth. The dichotomy between reaching the poor and achieving sustainability continues to be a dilemma. RHAC senior management is exploring ways to increase cost recovery and continues to conduct research on pricing policies to determine the extent to which their market can withstand pricing increases which are needed to ensure the sustainability of their clinics over the long-term.

The RHAC clinic in Battambang visited by the evaluation team has succeeded in increasing the use of long-term family planning methods, with 43 percent of clients using the IUD and 25 percent using the implant as compared to six percent nationwide. An increase in uptake post abortion was also evident in this same clinic, with over 60 percent of clients accepting a method of family planning after receiving PAC services.

Through the SMBCI Project, PSI/PSK works with the private sector to increase the availability of health and family planning products and improve the quality of services provided by private health-care providers, while simultaneously educating the public about the availability, safety and efficacy of family planning methods. As demonstrated by the PSI experience, it is possible to engage the private sector and increase the number of private sector providers who provide RH/ FP methods and services.

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<sup>37</sup> 2010 DHS

<sup>38</sup> MOH HIS data

## Recommendations:

Below are suggestions to increase the availability and quality of RH/FP services in the private sector.

- Strengthen the MOH stewardship role and their capacity to review, regulate and monitor the quality of care in private sector health facilities, and so as not to undermine the services provided by the public sector which is still the mainstay for the majority of Cambodians who remain poor.
- Continue to provide support to the local NGO, PSK for behavior change communication, social marketing of family planning methods, and for improving the quality of FP services in the private sector;
- Improve private sector quality standards through competency based training in clinical skills and counseling.
- Increase engagement with the commercial private sector to increase the range of FP methods available in the market and expand distribution of modern methods;
- Continue successful medical detailing to disseminate factual information on modern method to private providers, in partnership with local pharmaceutical firms;
- Expand the role of pharmacists in provision of FP by continuing to build their capacity and professionalism through training, certification and re-licensing; Support business management training to improve the viability of pharmacies;
- Develop continuing medical education for physicians and nurse/midwives in FP/RH topics; and register these courses with the MCC so that participants can obtain credit for their participation;
- Utilize evidence-based approaches to improve physician's knowledge and reduce provider biases towards hormonal and long-term methods. Evidence-based medicine (EBM) is a proven strategy that combines contraceptive research, patient management best practices and interactive communication with doctors. The EBM approach provides a consistent message based on the best available research, thus making the information less vulnerable to individual interpretation. This could be developed as a public-private partnership with the private pharmaceutical sector.
- Strengthen capacity of the professional midwifery association to provide leadership and regulate and monitor the quality of services provided by midwives;

## **ANNEX 8: GENERAL AND POLICY RECOMMENDATIONS**

Recommendations requiring policy advocacy are marked by having the words *(For Policy Advocacy)* behind the recommendations.

### **MNCH/HSS PROGRAM**

#### **Reproductive, Maternal, Newborn and Child Health**

- Increasingly link EmONC training and supervision activities to measurable health outcomes such as safe deliveries, low/ no bleeding complications, babies with better APGAR scores, low/ no postpartum infections, etc. This includes, among others, continuing coaching for health staff that fetal heart rate monitoring and real-time recording of partograph findings in order to contribute to better outcomes and should be done routinely for both mother and newborn.
- Advocate to the MOH, using the good lessons of the Implementing partners in providing training, to issue appropriate policies and/or guidelines that will transition RMNCH training activities from the usual classroom training modes to “training packages” that utilize simulation models, case practices and include continuing post-training coaching as well as provision of critical supplies and equipment necessary for the application of new skills acquired. This allows full application of newly acquired skills and knowledge and boosts staff confidence in using those skills. *(For Policy Advocacy)*
- Conduct systematic FGDs on why women do not routinely go for PNC to better plan for reasonable actions to address this issue.

#### **Nutrition**

- USAID is correct in pursuing the integration of nutrition in other RMNCH activities and should continue to support this because this seemingly simple matter is actually very complex and is not limited within the bounds of the health sector. As documented in various reports, nutrition requires not only direct interventions such as food supplementation or nutrition counseling but also necessitates securing diverse and affordable food sources. *(For Policy Advocacy)*
- At the policy level, revisit the recommendations of Cashin (2012) on nutrition and engage RGC partners on how to best implement them on a phased in manner, including better BCC for nutrition and hygiene behaviors; increasingly linking nutrition with maternal interventions; reducing anemia in children and pregnant mothers; improving access to diverse and quality food sources; and securing an enabling environment for nutrition overall. *(For Policy Advocacy)*
- At the community level, through partners, continue to support technical capacity building of health facility staff and VHSG on counseling for nutrition and increasingly link this to other health services and health education efforts for mothers and children. Explore the possibility of having regular awareness campaigns such as those used for

family planning in Takeo e.g. Tuktuk Campaign, where tuktuks are used to go around the village with pre-recorded information on a topic.

### **Tuberculosis**

- Advocate for the integration of pediatric TB screening in the IMCI protocol by including basic screening questions for pediatric TB in the current IMCI health center form. *(For Policy Advocacy)*
- Advocate for provision of TB training to all health center staff to ensure that each is able to apply the screening protocol at any time and for all clients at the facility. *(For Policy Advocacy)*
- Advocate for the inclusion of a sample of children <15 years old in the TB prevalence surveys to track progress on childhood tuberculosis. *(For Policy Advocacy)*
- Advocate to CENAT that, program buffer permitting, the actual requested amount by OD for TB medicines become the basis for distribution. *(For Policy Advocacy)*
- Broader consultation on the inclusion of (a) a pre-diagnosis work-up package in the HEF; and (b) incentivizing the health providers through HEF to follow-up treatment of TB patients. *(For Policy Advocacy)*
- Consider supporting the distribution, roll-out of and getting feedback on the new pediatric TB algorithm of the CENAT.

### **Quality Improvement**

- Ensure broad discussion on the following *(For Policy Advocacy)*:
  - e. Accountabilities at various levels (facility, OD, PHD, MOH) for corrective measures/ requirements for improving the quality of health services at the front lines.
  - f. Inclusion of funds allocated for quality improvement to OD funds to allow them flexibility in planning for related activities.
  - g. Technical and financial requirements of implementing the Level 2 quality tools to clearly work out details with all stakeholders and ensure sustainability of efforts.
  - h. Application of provider payment mechanism, including HEF, to encourage them to pay for their own spot checks (i.e. higher payment for higher scores; which could be based on Level 2 tools).
- USAID Implementing partners should follow MOH standards when procuring materials or services to ensure correct specifications of donations, unless not relevant.
- Continue support for the medical and para-medical councils to maximize current interest and efforts in building up the quality of professionals in the health sector.

### **Capacity Building**

- Establish and maintain a training database at facility, program and NGO level to allow tracking of who have been trained to date and on which topics and ensure its link to the

MOH training database, annual training plans and funding allocations. *(For Policy Advocacy)*

- Ensure broad discussion on the balance between cost-efficient training designs versus providing incentives for trainees. *(For Policy Advocacy)*
- Work with NMCHC to further expand EmONC training for all midwives in facilities, especially those whose LSS training was completed years ago.
- Continue to support the shift from usual classroom training approach to “training packages” that utilize simulation models, case practices and include continuing post-training coaching as well as provision of critical supplies and equipment necessary for the application of new skills acquired. This allows full application of newly acquired skills and knowledge and boosts staff confidence in using them those skills.

### **Health Policy and Strategy Advocacy**

- Partners need to carefully balance continuing assistance to policy implementation with transfer of technology and accountability to local counterparts to ensure sustainability of activities over time. MOH relies heavily on the continuing support of partners like USAID Implementing partners for the dissemination of policy and even in the actual implementation thereof. This reliance has the risk of poor sustainability of the activities.

### **Health Care Financing**

- Because of the achieved progress with facility based deliveries, because of sustainability aspects and because other HCF schemes are dealing with accessibility to facility deliveries, it is recommended to discontinue the MNH vouchers in their present form.
- USAID and other partners should advocate for making adaptations to the proven successful GMIS. Adaptations should/could address a number of issues: 1) the possible late referrals; 2) the conflicting situations in hospital grounds where both the hospital and the HC are competing for the same delivery; and 3) to include ANC4, PNC3 services as a requirement for the incentive. *(For Policy Advocacy)*
- Continue to support the HEF implementation functions while lobbying together with other partners (HSSP2) to put in place a semi-autonomous agency to take over those responsibilities.
- Because of the strong linkage (60%) between HEF payments and staff incentives, HEFs have the capacity to influence health staff and even health facility behavior. The present HEF Standard Benefit Package and Provider Payment Mechanism does not incentivize or even dis-incentivize a number of health services. Long-term family planning methods at HC are considered as a simple consultation being reimbursed at \$0.5 or \$1 when the actual average user fee for IUDs is around \$3 and for implants is around \$20. VSC at RH is only reimbursed \$5 as it does not require hospitalization and is does regarded a simple CPA consultation. LT&PFP immediately after delivery is not reimbursed as only one service, the delivery will be reimbursed. A similar situation exists for preventive services and for the so-called free services, those related to TB, HIV, malaria, blood transfusion, nutrition and others. USAID together with HPs should lobby MOH to review

the HEF Standard Benefit Package and Provider Payment Mechanism. *(For Policy Advocacy)*

- Increase special reimbursement for TP&PFP: IUD, Implant and VSC.
  - Pay for LT&PFP immediately after delivery as an extra service
  - Introduce HEF payments mechanism for so called free (preventive services, TB, HIV, malaria, blood transfusion nutrition, etc.)
  - Introduce a more dynamic linkage between the Quality Assessment score and the HEF payment rates motivating facilities to be assessed regularly and improve their quality.
- USAID, implementing partners, and HPs should assist MOH with streamlining the multitude of HCF schemes and initiatives around Maternal and Reproductive Health and health in general. *(For Policy Advocacy)*

### **Private Sector Interventions**

- As the private sector continues to grow, the challenge is to make use of the comparative advantages of this sector to ensure public functions increase. This will require reflection on key issues such as quality standards, accessibility for the poor, dual practice and regulation of the sector. USAID, with other HPs, should play an increasing role in highlighting the importance of regulating the dual practice and regulating the private sector beyond simple licensing. This process might require engagement with the Cambodian Government outside the MOH. USAID could assist MOH to develop the regulatory and enforcement frameworks. *(For Policy Advocacy)*
- Health Centers in Angkor Chum OD are functioning much better (process, output and coverage) than the average HC in the country. A major reason seems to be the strong enforcement of the ban on dual practice non-private practice by the HC staff under the leadership of their OD Director, and supported by HEF, CBHC and SDG interventions. It would be useful to document the linkage between the strictly regulated dual practice and the impressive results. The findings could be used as guidance on dual practice regulation and as support for awareness creation amongst authorities.
- USAID should continue to support RHAC clinics under the condition that they further improve their cost recovery. In the meantime donors as USAID should continue to support the funding required for the exempted and discounted clients and services.
- MSIC has gone through a similar cost recovery process for their clinics to reach around 100% as a network, from only 25% five years ago. They achieved this through a dynamic pricing policy, improved management with emphasis on staff performance appraisals and proper planning with individual clinic business plans. Quality assurance remains a priority of their International recognized brand. RHAC should consult MSIC on their cost-recovery and quality assurance strategies for the RHAC clinics.

- Increasing the utilization of the web-based HMIS database by private health facilities will demand enforcement through regulations, possibly linked to the licensing system, and HMIS training for private facility staff. USAID could assist MOH with the development of those regulations and the training package and plans. CCM could contribute to this process by including HMIS trainings in their CME curriculum. *(For Policy Advocacy)*
- The MCC still requires further support with the strengthening of their registration system and rolling out the province. This includes further and more intensive support for the re-registration mechanism, it's linkage to CME, and with the CME system itself. USAID should continue technical support to the MCC. USAID together with HPs could lobby MOH and RGC to further consolidate and enforce the registration and re-registration conditional upon stringent professional standards and CME. USAID and HPs should identify amongst themselves who to provide similar support to the other health professional councils. *(For Policy Advocacy)*

### **Support to HCMC & VHSG Meetings**

- Improve quality of VHSG and HCMC meeting to ensure interaction and linkage between health center and the community and to address key evolving issues This could include revised model meeting agendas prioritizing client feedback over other routine issues.
- In order to assure sustainability of VHSG meetings they should be integrated in and funded through AOPs and CIPs. In that context cost of VHSG meeting should not only consider the minimum required incentives and reimbursement to assure participation by VHSG and HCMC members, but also the available budgets of HC user fee income, CC budgets or other government funding.

### **Advocacy support to CCs for sustainability of community health activity**

- USAID implementing partners should continue providing or even intensifying their efforts to strengthen advocacy skills of HC, VHSG, HCMC and CCWC, including activity and budget planning skills, through technical assistance.
- Some CCWC are duplicating community health activities of VHSGs using CIP budget. Often CCWC members have little knowledge on health issues and effective promotion. USAID implementing partners should evaluate how CCWC and VHSG could both be involved in community health activities without too much overlap or too many gaps. This will probably also require capacity building and coaching of CCWC members on community health related activities in a comprehensive and efficient way.
- Partner organizations should provide more advocacy skill training to their field staff and further follow up with on-site coaching support.

### **Community based referral system**

- Thanks to USAID implementing partner efforts, there are now many different sources of funding for VERS. This results in better coverage for emergency transport. Several places have multiple funding sources for different type of services or target groups. Often they differ from one HC to another. Implementing partners should assist HC and CCs to coordinate the use of the different funding sources for supporting referral cases while

avoiding duplication or gaps. Regrettably a standardized approach will not work because funding sources differ from place to place.

- In general, the Village Emergency Referral System seems to have been quite successful and should be documented and shared for scaling up.
- With the increasing availability of ambulances their increased use for emergency transfers to hospitals should also be supported, while avoiding their use as routine transport mode for non-critical issues, as they are very costly.

#### **Feedback mechanism and client rights**

- Implementing partners should continue to support and scale up CSC, suggestion boxes and other successful models of feedback and accountability. At the same time an assessment of the different approaches needs to be conducted in order to streamline those that generate better results.
- Implementing partners should find ways to seriously follow up agreed action points or commitments of health providers for change.
- Implementing partners should document successful cases of the CSC or the suggestion boxes addressing patient or community complaints successfully and how this was achieved.
- Partners should build the capacity of the HC and CC to address issues that need involvement of higher levels of government.
- Partners should continue to explore how to work directly with MOI as well as with other provincial authorities, including the District Communes and the Governors in order to provide consent and guidance to the CCs on how to use commune budgets for supporting health activities.

#### **Behavior Change**

- USAID should assist the MOH with development of a comprehensive strategy to guide, monitor and coordinate behavior change communication campaigns in Cambodia. To improve coordination, USAID, in collaboration with other donors supporting health promotion activities, need to meet regularly to coordinate their activities and minimize overlap. Together with other health partners, USAID and its implementing partners should consider to establish a joint partner technical working group for health promotion. *(For Policy Advocacy)*
- Health Promotion activities should be planned and implemented in closer collaboration with National Center for Health Promotion, the MOH's institution assigned to coordinate behavior changes communication around health sector.

## **REPRODUCTIVE HEALTH / FAMILY PLANNING**

## Facility-Based FP Services

- **Policy:** Sub-national level advocacy efforts are needed to create an enabling environment at the regional and local level and to increase commitment and resource allocation to address RH and FP issues. USAID might consider technical assistance to senior government officials and civil society to strengthen their policy and advocacy skills.
- **Logistics:** The team suggests that USAID continue to work with other donors to help ensure an adequate supply of contraceptives. Additional technical assistance might be considered to modify the system so that it can accommodate a rapid increase in demand, as well as assistance to the Essential Drug Department to further strengthen forecasting and procurement skills.
- **Contraceptive Security:** Eventually the RGC will need to fund contraceptive commodities out of its own budget. In the meantime, USAID, in partnership with HSSP2 donors, could advocate for inclusion of a line item for contraceptives in the national budget.
- It was only possible for the team to visit a fraction of the hospitals and health centers in the country. Implementation of the DHS Service Provision Assessment (SPA) tool would provide a comprehensive review of maternal child health and family planning services offered at health facilities. The SPA collects data on infrastructure, health systems, supplies, trained staff and provides reliable information on the proportion of facilities offering family, the proportion of sites following accepted standards of care, and the extent to which clients and providers are satisfied with the care received.
- To decrease discontinuation and fear of side effects, the team recommends that USAID and its partners focus on expansion and improvement of FP counseling for midwives, including practical information on ways to integrate FP/BS counseling into their daily work; with clear guidance that their job responsibilities include counseling for FP/BS. This requirement should also be integrated in the supervision checklist for ODs for monitoring purposes.
- **Minimize Missed Opportunities:** There is a need to seize opportunities for FP information and services among woman who come to a facility for MCH services. Opportunities include antenatal and postnatal visits, as well as children's immunization, and sick child visits to the health center. The MOH needs to make FP/BS information and services available at each point of contact with the health system and at every stage of the birth interval to decrease missed opportunities for FP information and services. *(For Policy Advocacy)*
- **Expand support and training for PAC:** As mentioned, PAC services have been implemented successfully by several USAID partners. Uptake of FP is high in the RHAC and MSIC clinics visited where contraceptives are provided on site; RACHA reports that 4 ODs have PAC, with 31% FP acceptance. This service needs to be scaled up to cover all public sector hospitals. According to International Best Practices, the provision of on-site

counseling and services prior to leaving the hospital is a necessary ingredient for increased method adoption.

- As recognized by the OPHE team, there is a need in Cambodia to motivate couples to transition from traditional to modern methods of family planning, including increased use of long-term methods. However, given the context of significant cultural and capacity constraints, it is optimistic to anticipate a major shift in acceptor behavior from short-term to long-term methods over a short period of time. These constraints notwithstanding, long-term methods (IUDs and implants) appear to be gaining favor among Cambodian women. In addition, USAID is supporting research to better understand why traditional methods have been gaining favor in recent years. Findings from this research will help to formulate behavior change communication strategies during the next phase of assistance.
- Roll out of new policies: A number of policies and regulations were successfully revised during this period of assistance. There is a need to ensure that clinicians, particularly at the hospital level, are aware of recent policy changes and protocols which facilitate provision of RH/FP services, such as allowing provision of BS methods post-partum, inclusion of contraceptives in the package of commodities provided to hospitals by CMS, as well as recent changes in HMIS reporting. Orientation, training and increased supervision of service providers is needed to ensure that these guidelines are being utilized effectively in the field.
- It would be beneficial to review the Safe Motherhood guidelines once again to broaden the guidance on IUD insertion in the immediate post-partum. *(For Policy Advocacy)*
- Review user fees for IUDS and VSC to help ensure that the low fee structure does not influence providers' decisions to advance utilization of LT/PM. *(For Policy Advocacy)*
- Training remains an important way that services providers are updated in knowledge and skills to provide quality services. With support from USAID, clinical skills and competencies of service providers have been strengthened primarily through in-service training and to a lesser extent, field-based hands-on training. Numerous clinicians have received training in advanced methods of family planning, safe motherhood, management and quality assurance. Continued training needs include:
  - ✓ Competency based refresher training for midwives, particularly in IUD insertion;
  - ✓ Client-centered training on FP counseling;
  - ✓ Orientation to tools for monitoring and use of service statistics;
  - ✓ Practical training for public sector providers in provision of LT/PM;
  - ✓ Field-based hands on training through more frequent and improved monitoring and supportive supervision.
- Combine partner household survey assessments into one instrument to ensure that they are applying the same methodologies for collection and analysis of data, and to

reduce costs. Based on the recommendations of the mid-term evaluation, RACHA's population based survey tool was revised, and methodologies improved. But there are large differences in the use of LAM reported by RACH and RACHA, which could be a result of programmatic interventions or a result of different methods for calculating users of this method. Combining these surveys would prevent such discrepancies in the future.

- There remains a need to improve program monitoring and the use of data for decision-making at the field level. HC/OD and USAID partner staff need to better understand and utilize the HMIS and survey data collected, and to interpret how it affects their daily work and the health needs of beneficiaries. Partners should consider reducing the total number of indicators and focus on disaggregating key indicators by measures of equity, gender and access.
- The evaluation team believes that it is important to continue to support RHAC clinics as they have made an important contribution to CPR, by serving 11.5 percent of current users in 2012. They also provide a unique niche through provision of "youth friendly" services and comprehensive, quality reproductive health services for women of reproductive age, including diagnosis and treatment of reproductive tract infections and sexually transmitted disease and screening for cervical cancer.

### **Demand Creation**

- USAID's emphasis on motivating users of traditional methods to transfer to a modern method and in making quality long-term methods available has to be accompanied by comprehensive and coordinated BCC campaign to educate and inform the public about the availability, utility and safety of these methods.
- Misconceptions about the side effects of modern contraceptive methods are persistent barriers to use. To further stimulate demand for family planning, there is a need to focus on attitudes and behavior change about modern family planning methods through a multi-pronged approach to health promotion. An integrated demand creation communication campaign which focuses on the main barriers to adoption of long-term methods, fears and misconceptions would contribute to increasing demand for FP in Cambodia. Although media is expensive, with significant up-front costs, because it can reach a large number of people quickly and repeatedly, the overall effect can be significant.
- Specific options to further stimulate demand for modern and long-term methods include:
  - ✓ Develop additional communication materials which provide accurate and up-to-date information on modern family planning methods; reproduce/reprint existing materials;
  - ✓ Use early adopters to tell their stories;
  - ✓ Continue to provide support to the local NGO, PSK for behavior change communication and social marketing of family planning methods;

- ✓ Continue and expand RHAC youth programs; develop additional channels for reaching youth such as innovative e-learning approaches;
- ✓ Increase male involvement by tailoring messages towards male audiences; include men in FP counseling; involve men in decision-making; and use influential community leaders as role models;
- ✓ Reduce provider bias by utilizing evidence-based training approaches to improving physician's (and midwives) knowledge and attitudes towards hormonal contraceptives and to improve their ability to address women's fears and misperceptions;
- ✓ Continue voucher schemes to create demand for long-term methods, in the short-term.

### **Community-Based Services**

- Continue to support the CBD programs as the cornerstone of USAID assistance in the health sector.
- Work with the MOH to review the CBD curriculum. To maximize efficiencies, consider adapting the two-day training, rather than the five-day course currently in use. In all cases, increase the provision of refresher training for CBDs and VHSGs. (*For Policy Advocacy*)
- Role of Midwives: The MOH needs to provide additional interactive training to strengthen counseling skills of midwives. To strengthen the CBD program, midwives should be encouraged to provide field-based guidance and supportive supervision to CBD workers. The provision of more direct guidance and supervision to midwives would help to motivate midwives to provide regular support to CBD workers.
- It was concluded that the MCHP "Village Shopkeeper" Initiative has little added value for family planning since it is competing with CBDs in these areas and it provides little or no counseling. However, the decision to phase out or retain VSI should be based on a review of the overall value of the initiative for child health as well as family planning.
- Ensure that all CBDs obtain their contraceptive supplies free of charge; consider increasing the quantity of OCs provided to CBDs or find ways to deliver supplies to CBDs in the field. (*For Policy Advocacy*)
- Although CBD workers with whom we spoke were able to adequately explain the benefits and side effects of individual methods, it is unclear how effectively they are able to address clients' misperceptions and concerns about side effects. Role playing or monitoring of actual fieldwork would help to assess their skill levels and identify future training needs.
- Although significant improvements have been made since the mid-term evaluation, monitoring and reporting issues still remain. It is difficult to accurately monitor coverage without asking the NGO partners, and it is very difficult to determine how many of the CBDs trained are currently active. The team suggests continued efforts to improve

monitoring and reporting, including modification of the HIS so that FP data can be disaggregated for CBD and clinic acceptors. Data on active CBD agents per health center catchment area is needed to accomplish this and obtain a better sense of coverage.

- Both ToGoH and MCHP are experiencing a high rate of attrition among village volunteers, largely related to inadequate compensation and subsequent migration to find compensated employment. Discussions with the MOH on non-monetary incentives for CBD workers is commendable and should continue. In addition, the MOH might consider placement of two CBD workers per village to provide better coverage overall and serve as a backup when there are gaps. *(For Policy Advocacy)*
- As mentioned, VHSGs are responsible for a multitude of interventions in large geographic areas often making it difficult for them to focus sufficiently on FP, specifically to spend the time needed to motivate non-users to adopt a method. CBD and VHSG workers, need direct guidance and supervision to ensure that they focus and report on family planning efforts.
- As mentioned, VHSGs are responsible for a multitude of interventions in large geographic areas, often making it difficult for them to focus sufficiently on FP, specifically to spend the time needed to motivate non-users to adopt a method. CBD and VHSG workers need direct guidance and supervision to ensure that they focus and report on family planning services. There is as yet no move toward institutionalization of CBD programs by local government. Although CCs have taken on some responsibility for health promotion, family planning does not seem to be a priority among elected leaders at the local level. However, CBD programs are absolutely essential in the short- to medium-term to increase demand and to serve the poor. Keller reports that in almost all cases, when NGO or donor funding ceases, CBD activities cease to exist. *(For Policy Advocacy)*
- Options for increasing sustainability of CBD programs include both contributions from the national budget and increased support at the community level. The evaluation team suggests further documentation and dissemination of current successful approaches used and lessons learned from CBD efforts in Cambodia. Sustained policy level discussions will be required to access financial support through the national budget and the HSSP2. Most importantly, local and regional-level advocacy efforts will be needed to increase local government and community level support for family planning. *(For Policy Advocacy)*

## **ANNEX 9: RECOMMENDED TOPICS FOR CASE STUDIES**

### **Creative Solutions to Community Outreach**

The team observed successful community outreach under two different models: one used by MSIC under the SIFPO Project and the other by the USAID funded NGOs, RACH and RACHA, and the community program funded by UNFPA/MOH. The Active VHSBs under the SIFPO project employ a unique approach to reaching remote villages with family planning information. The Active VHSBs are impressive: they receive more training, are provided a monthly stipend and are responsible for a larger number of villages. They also are compensated for their travel costs. Results in the two provinces supported by MSIC show an impressive uptake of long-term family planning methods, which must be attributed in large part to the motivational efforts of the Active VHSBs.

The team also observed highly successful VHSB/CBD efforts in communities they visited in Battambang and Prey Veng. Even though the volunteers with whom the team spoke are unpaid they are highly motivated and effectively motivating and referring clients to the HC for long-term method use. In addition, a large portion of these VHSBs are serving as CBDs and selling contraceptives, primarily pills, at the community level, providing a major contribution to overall program impact. CBDs provide an attractive option for clients who cannot afford transport to the clinic or prefer to obtain their method after clinic hours. The volunteer VHSBs and CBDs with whom we met were knowledgeable about FP methods and felt that they were providing a service to their community.

Although the two models are not comparable in terms of outputs, as one includes CBD, documentation of the two approaches, would provide useful information on the different approaches used and possibly insight into the motivating factors and effectiveness of volunteers employed under these two different models.

This study would require extensive field work by a local consultant(s) who would need to interview volunteers in the field and accompany them on their promotional activities. A second person skilled in documentation would also be needed to guide the study and finalize the document.

### **Innovative Programs for Reaching Youth: RACH's "Youth Friendly Services"**

RHAC clinics provide "youth-friendly" reproductive and sexual health information and services, to the growing youth population in Cambodia. Their 15 NGO clinics provide quality, integrated reproductive health services for youth, including comprehensive post-rape care, premarital screening and counseling, and HIV/AIDS services in the privacy of a youth-friendly environment. RHAC also provides support for community peer education activities and assists the MOE to include life planning skills and sexual and reproductive health information through a number of school health education programs.

A case study would document the multi-faceted RHAC clinic services and program activities focused on youth, which could serve as a model for other NGOs in Cambodia and elsewhere.

## Excellent Health Centers

### TUM NUP HEALTH CENTER

On a surprise visit, the evaluation team was pleasantly surprised to find a busy health center which was located about 30 minutes to the interior. It was amidst fields and several households, along an unpaved road, with a tattered health promotional banner hung by its gate. Stepping into the threshold of the center, one immediately notices the rows of slippers on the steps and the low hum of voices. The health center chief, a staff and an insurance representative huddled around a small table while a half-dozen clients wait patiently. Walking further inside, one notices a small room filled with several women; they were waiting to talk to the midwife for their resupply of pills. Further on, another room was abuzz. A staff sat together with a roomful of mothers for their postnatal counselling. An old woman walks up to the team to inform us that her daughter was in the next room and she had just given birth, then she turns and walks towards the center's cooking area. The team was able to talk to several clients before they left and most of them said they like coming back to this health center where they think the "service is good". A young man accompanied his wife for her first ANC; he said it was their first time at the center but they had heard good things about it.

### CHA CHOUK HC,

Another HC surprise visit in Angkor Chum OD was equally impressive. Cha Chouk HC, also rurally located was equally busy, queuing mothers and children and an ongoing delivery. A welcoming reception lady busy registering, friendly staff attending to patients, nicely painted walls well-decorated with health messages, a children weighing scale in use offered us a pretty image. The HC chief, proud of his satisfied clients, very high utilization and coverage rates explained that the quality of care provided twenty four seven was the result of his dedicated team. All staff had agreed to forego private practice, but working at the busy HC they made now as much or more money than previously from their dual practice work, and this without all the hassle. Receiving RACHA and URC support and having a CBHI did certainly help.



A case study would document two to three exceptionally successful HCs, in USAID-supported areas, and describe the aspects which make them well-functioning and liked by their communities. This assignment would require a team of two persons, a Khmer-speaking (public) health person for 8 days and an international public health person for 12 days.

### **MCAT meeting, a successful approach of case based training.**

In many provinces the MCAT meetings were a very good example of synergy between RHAC or RACHA and URC. They were also very well appreciated by the HC and RH nurses, who found them very useful to improve communication between those two levels, to help them improve the referring system of complicated deliveries and to learn about difficult cases from each other's experiences. URC and RHAC or RAHCA could be asked to document a case study on this collaborative activity.

### **Happy satisfied early adopters of LTFP**

The team interviewed a number of women in Takeo province who had switched from short to long-term methods of family planning. With support from the MSIC SIFP Project they were motivated to adopt long-term methods in spite of pre-existing fears and misconceptions regarding long-term method use. The team learned that these new adapters were very satisfied with their new method and intended to continue with it, even in the absence of a voucher.

It would be interesting to document their experience and explore the motivational aspects of their conversion to long-term method use, i.e. how their fears and misconceptions about the IUD and Implanon were addressed. This would help in any subsequent behavior change efforts to find the best approaches to addressing fears and misconceptions about modern and long-term methods.

### **Dual practice regulations, Angkor Chum HC**

Angkor Chum OD has prohibited dual practice, i.e. public HC staff conducting private practice. A strong OD director using SDG, performance-based contracting, CBHI and supported by local authorities managed to ban dual practice by the OD staff. As a result HCs function exemplarily, are open twenty-four seven and are loved by the communities. Staff who signed the non-private practice agreement are now satisfied with this approach. This approach has not been carried out anywhere else in Cambodia. This case study would document the history and circumstances, including USAID project support, that made it possible to shift from an unregulated dual practice situation to a non-private practice regulated OD. The documentation would be based on interviews with the OD director and management, the local authorities, the PHD director, some of the HC and RH staff as well as with the MOH personnel department, which was involved in related disciplinary case hearings. It could use data/findings from the "Excellent Health Center" case study. This assignment would require a team of two persons, a Khmer-speaking (public) health person for 6 days and an international public health person for 10 days.

### **RHAC Hands-on CBD and VHSG support**

RHAC uses a special type of field staff to support VHSGs and CBDs in their areas. They differ from the staff supporting the HCs on more technical issues. These VHSG and CBD support staff

received training on all community health activities. They have a number of VHSGs/CBDs (20-40) to whom they are dedicated, which means that these community volunteers receive support from and exchange with the same NGO staff, resulting in a trusted relationship and improved coaching. This differs fundamentally from approaches from other NGOs, where VHSGs/CBDs are approached by different advisors depending the technical domain.

The documentation would compare the CBD support approach amongst the implementing partners, describe the different approaches and different results. It will require interviews with staff of the implementing NGOs at national, provincial and field level, with HC and OD staff and with the VHSGs/CBDs themselves as well as their activity and survey data. This assignment would require a team of two persons, a Khmer-speaking (public) health person for 6 days and an international public health person for 10 days.

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