

Cambodia

USAID Health Program

Mid-Term Evaluation



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List of Acronyms

AAD	Activity Approval Document
AIDS	Acquired Immune Deficiency Syndrome
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
AOP	Annual Operational Plan
AOTR	Agreement Officer's Technical Representative
ARI	Acute Respiratory Infection
AusAID	Australian Agency for International Development
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
BEST	Best Practices at Scale in the Home, Community and Facilities
BHS	Better Health Services
BS	Birth Spacing
BTC	Belgium Technical Cooperation
CA	Cooperative Agreement
CBD	Community-based distribution
CBHC	Community-based Health Cooperative
CBHI	Community-based Health Insurance
CC	Commune Council
CCT	Conditional Cash Transfer
CDC	Centers for Disease Prevention and Control
CDHS	Cambodia Health and Demographic Survey
C-DOTS	Community Level Directly Observed Treatment – Short Course
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CENAT	National Centre for Tuberculosis and Leprosy Control
C-section	Cesarean Section
C-IMCI	Community Integrated Management of Childhood Illness
CIP	Commune Investment Plan
CMS	Central Medical Stores
CPA	Complementary Package of Activities
CYP	Couple Years of Protection
D&D	Decentralization and Deconcentration
DfID	Department for International Development/UK
DOTS	Directly Observed Treatment Short-Course
DPHI	Department of Planning and Health Information
EmOC	Emergency Obstetric Care
FP	Family Planning
FTI	Fast Track Initiative
GAVI	Global Alliance for Vaccines and Immunizations
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
HBB	Helping Babies Breathe
HC	Health Center

HCMC	Health Center Management Committee
HEF	Health Equity Funds
HIP	Hospital Improvement Program
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSP2	Second Health Strategic Plan 2008-2015
HSS	Health Systems Strengthening
HSSC	Health Systems Strengthening in Cambodia Project
HSSP2	Health Sector Support Project (second)
HQ	Headquarters
ICU	Intensive Care Unit
IEC	Information, Education and Communication
IFA	Iron/Folic Acid
JPIG	Joint Partner Interface Group
IR	Intermediate Result
ISC	Integrated Supervision Checklist
IUD	Intrauterine Device
IYCF	Infant and Young Child Feeding
KAP	Knowledge Attitude and Practice
LMIS	Logistics Management Information System
LSS	Life Saving Skills
M-CAT	Midwife Coordination Alliance Team
MBPI	Merit Based Payment Initiative
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MEF	Ministry of Economy and Finance
M&E	Monitoring and Evaluation
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNCHN	Maternal, Neonatal, Child Health and Nutrition
MoH	Ministry of Health
MPA	Minimum Package of Activities
MW	Midwife
MWRA	Married Women of Reproductive Age
NCDD	National Council of Deconcentration and Decentralization
NCHADS	National Center for HIV/AIDS, Dermatology and STDs
NGO	Non-Governmental Organization
NIPH	National Institute of Public Health
NMCHC	National Maternal and Child Health Center
OD	Operational District
OPHE	USAID/Cambodia Office of Public Health & Education
ORS	Oral Rehydration Salts
PE	Peer Educator
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHD	Provincial Health Department

PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
POC	Priority Operating Cost
MOU	Memorandum of Understanding
PSI	Population Services International
QA	Quality Assurance
QAO	Quality Assurance Office
QI	Quality Improvement
RACHA	Reproductive and Child Health Alliance
RH	Referral Hospital
RFA	Request for Application
RGoC	Royal Government of Cambodia
RHAC	Reproductive Health Association of Cambodia
RTC	Regional Training Center
SDG	Service Delivery Grant
SO	Strategic Objective
SOA	Special Operating Agencies
SOW	Scope of Work
SRC	Swiss Red Cross
STI	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
TOT	Training of Trainers
ToGoH	Together for Good Health
T/P	Travel and Per Diem
TWG	Technical Working Group
UNAIDS	The Joint United Nations Program on AIDS
UNFPA	United Nations Population Fund
URC	University Research Co., LLC
USAID	United States Agency for International Development
VAC	Vitamin A capsule
VCCT	Voluntary Confidential Counseling and Testing
VERS	Village Emergency Referral System
VHSG	Village Health Support Group
WB	World Bank
WHO	World Health Organization

Table of Contents

	Page
Acknowledgements	ii
List of Acronyms	iii
Executive Summary	viii
I. Introduction	1
A. Purpose and objectives of evaluation	1
B. Summary of statement of work	1
II. Background	1
A. Overview of Health Sector	1
B. Health Strategic Plan	2
III. USAID health assistance program	3
A. USAID’s program strategy	3
B. Current program portfolio	3
C. Relationship to USAID Best Action Plan	4
IV. Evaluation Methodology	5
V. Findings/Conclusions	6
A. Implementation Progress	6
A. 1 Community Activities	6
A. 2 Private Sector Service Delivery and BCC	16
A. 3 Health Systems Strengthening	20
B. Project Cohesiveness and Synergy	34
B. 1. Design vs Actual Program and Projects	34
B. 2. Partner Collaboration at National and Sub-national Levels	36
B. 3. Strategic Collaboration with HSSP2	37
B. 4. Strategic Collaboration with D&D Initiative	38
C. Principal External Constraints	38
D. Management and Implementation	39
E. Likelihood of Contributing to USAID’s Program Objectives	42
IR 1: TB and Infectious Diseases	42
IR 2: MCH	42
IR 3: Health System Capacity	45

IR 4: Change in Client Behavior	46
F. USAID Program Management	48
G. Key Conclusion	48
VI. Recommendations	49

Annexes

1. List of documents reviewed
2. List of persons contacted and sites visited (schedule)
3. Evaluation Scope of Work
4. Facility Profile
5. Health Financing
6. M&E Annex
7. OD Map

Executive Summary

In January-February 2011, USAID/Cambodia commissioned a mid-term evaluation of its health program that spans the period from fiscal year 2009 to 2013. The Program is comprised of an inter-related set of activities implemented by four USAID partners, Reproductive Health Association of Cambodia (RHAC), Reproductive and Child Health Alliance (RACHA), University Research Co. (URC) and Population Services International (PSI). The scope of the evaluation included the following areas: maternal, newborn and child health, family planning and reproductive health, water and sanitation, nutrition, infectious diseases (tuberculosis, avian influenza, H1N1); health systems strengthening, private sector health services and products, behavior change communication, and community mobilization. The review focused on the progress and issues across the program areas rather than on a detailed performance assessment of each USAID partner. The evaluation team interviewed a set of stakeholders at the national and sub-national levels, visited six of the ten provinces to view the work of the program at the provincial, district, facility and community levels, and reviewed an extensive set of documents, program performance data and national data sets.

Substantial progress is evident toward establishing reliable health services, especially at the Health Center (HC) and community levels. HCs are better staffed, equipped and supplied, many with 24-hour service. There are a substantially increased number of deliveries happening in facilities, with a higher proportional rise in USAID-targeted provinces than elsewhere. Although there remains a considerable unmet need for emergency obstetric care, a 47% increase in Cesarean sections for obstetrical complications at hospitals in the USAID targeted provinces between 2007 and 2010 indicates progress. Health Equity Funds have visibly increased access to life-saving services for the poor.

USAID's partners have improved their ability to work together at the national level on supporting the development of appropriate policies as well as technical protocols, guidelines and standards of care. Community mobilization and promotion activities are increasing the uptake of health services and improving health behaviors. USAID is contributing to the development of high quality private health services and programs through RHAC clinics, and through PSI's social marketing and work with private providers. All partners are making important contributions to mass media and consumer education to improve knowledge about health products and services. The USAID partners, working at various levels, have contributed to improving the reliability and use of the national health information system. Progress has been made to expand health-financing mechanisms that help ensure access of poor clients, especially for hospital care, and by using vouchers and other payment mechanisms to encourage use of maternal health services. A new model for a community-based health cooperative to strengthen local government involvement in health care, and potentially provide a wider and more cost-efficient safety net for health care costs, is being piloted.

Despite this progress, significant challenges remain which if addressed promptly, will help strengthen the program and ensure better results by 2013. A key finding of the

evaluation is that the partners are not working in a synergistic fashion on addressing important health systems strengthening challenges as envisioned in USAID Health Program Activity Approval Document (AAD). Efforts to strengthen planning, supervision and outreach in Operational Districts (ODs) and health facilities would be more effective if partners worked collaboratively and more strategically at the national, Provincial Health Departments (PHD) and OD levels to address systemic weaknesses related to the flow of resources. Another key finding was that planned partner activities in support of the MoH's Health Sector Support Project (HSSP2)-funded Special Operating Agency (SOA) initiative have not been adequately implemented, constraining the impact of both the USAID and HSSP2 programs.

Problems were also identified with the coverage of the community package of interventions, as well as the need to improve the support to Health Centers. The problems with coverage and strengthening the support to health centers is most acute in the "new" provinces (Prey Veng, Kampong Cham and Koh Kong) where RACHA and RHAC have not had a long presence related to those programs. Some scaling back on expectations of coverage for community-based interventions in the RACHA project will be necessary to ensure that the full package is implemented. Another critical community level issue surrounds improving linkages to and synergy with the Decentralization and Deconcentration (D&D) initiative underway nationwide and supporting improved governance through empowerment of communities with an understanding of their rights as health care consumers. Current strategies for these need revision and collaboration with both governmental and non-governmental entities outside the health sector.

Another area for strategic and technical improvement identified in the report is work related to further development and institutionalization of the Quality Improvement (QI) program and the related referral hospital strategy of the URC Project, which deviates from the intent of USAID's Health AAD and the URC proposal. The evaluation team concluded that the new 'model' hospital strategy may result in less impact on the health system than an approach to improve the quality of obstetrical and newborn care in a much broader set of hospitals in USAID's target provinces. A broader approach would also further USAID's contribution to the important objectives of the "Fast Track Initiative to Reduce Maternal Mortality".

Other major findings relate to strengthening in-service training and clinical mentoring; a need to carefully appraise the targeting and potential impact of financial schemes linked to health service utilization (vouchers, conditional cash transfers); and a need to expand both the range of products and rural availability of PSI's social marketing program commodities.

A full set of recommendations is found in Section VI of the report in bulletized form to facilitate follow-up discussions and decisions. Because USAID/Cambodia and the four implementing partners in its health program are fully committed to achieving the health program's ultimate objective of strengthening Cambodia's health system and the health status of its people, the Evaluation Team is confident that with some adjustments at this juncture, the final objective can and will be achieved.

I. Introduction

A. Purpose and objectives of the mid-term evaluation: In late 2008 USAID designed and approved a five-year health program spanning the period October 2008 through October 2013.¹ Within this overall Program, four cooperative agreements (CAs) or projects were awarded to RACHA, RHAC, URC and PSI to support the specific components of the overall program. In January 2011, USAID commissioned an external mid-term evaluation of its health program with a focus on results achieved to date, assessing health systems capacity development and the harmonization of implementation across the four projects. USAID also requested a review of progress toward meeting the strategic goals within the health program and any recommendations for project modifications and improvements.

B. Summary of scope of work (SOW): The scope of the evaluation included the following areas: maternal, newborn and child health, family planning and reproductive health, water and sanitation, nutrition, infectious diseases (TB, avian influenza, H1N1); health systems strengthening, private sector health services and products, behavior change communication, and community mobilization. The evaluation does not include the HIV/AIDS activities of each of the four partners because a separate evaluation of the HIV/AIDS program, including a broader set of USAID implementing organizations, is scheduled for mid-2011. (For more detail on the SOW, please refer to Annex 3).

The Evaluation Team consisted of two Cambodian and three international consultants with expertise in maternal, child and reproductive health and health systems strengthening. Knowledge of the health care system in Cambodia and experience in the country was deemed important for selecting the consultant team. A USAID/Washington Global Health Bureau Maternal and Newborn Health Advisor joined the team for the first half of the evaluation, which took place between January 18 and February 18 of 2011. The mid-term evaluation examined technical, strategic and management issues related to the Program as a whole rather than conducting a detailed assessment project-by-project.

II. Background

A. Overview of health sector: Cambodia is considered a low-income country with a per capita Gross Domestic Product of about \$2000 (2010). Thirty-one percent of its population lives below the poverty line.² Nevertheless, the country has made substantial progress in improving health and reducing fertility as evidenced by the change in key indicators between the Cambodian Demographic and Health Survey (CDHS) of 2000 and 2005.³ Infant mortality declined from 95 to 66 per 1000 live births and under-five mortality from 124 to 83 per 1000 live births. Fertility declined from 4.0 to 3.4 between

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

² CIA Factsheet, 2011

³ A 2010 Cambodia DHS has been completed but the report had not been released as of this evaluation.

the two surveys despite a low contraceptive prevalence rate of 27% for modern methods. Maternal mortality, however, did not decline significantly and remains a major concern for the Royal Government of Cambodia (RGoC), the MoH, and its development partners.

The health care system is composed of a district-based public health sector and a poorly regulated private sector. As of 2009, there were 992 health centers (HCs) and 79 referral hospitals (RHs) in 77 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. The private providers range from non-medical practitioners like village mobile practitioners (*Pet Phum*), traditional healers, traditional birth attendants and drug sellers, to medical facilities such as pharmacies, clinics and private hospitals. In 2005, the private sector accounted for 69% of the reported curative treatment compared to 22% in public health facilities⁴. Preventive health services and delivery care, on the other hand, are almost exclusively obtained through the public sector, as is the majority of family planning service in rural (but not urban) areas.⁵

B. Health Strategic Plan: The Cambodia Health Strategic Plan: 2008-2015 (HSP2) sets forth an ambitious set of priorities and activities that address the current deficiencies in the health care system. Substantial donor assistance is provided directly to the MoH to support its implementation of the HSP2 through the \$100 million Second Health Sector Support Project (HSSP2). HSSP2 is supported by a World Bank-led consortium consisting of AusAID, DFID, UNFPA, UNICEF and the BTC in addition to the World Bank. All HSSP2 funding flows through the central MoH, but via two distinct mechanisms: a “pooled fund” which provides resources against an overall annual work plan, and “discrete funds” which are specifically earmarked for certain types of activities, e.g. reproductive health activities at provincial/OD level (UNFPA/AusAID).

The USAID health program envisioned a role for the USAID partners to assist the MoH implement some of the innovations for PHD and OD autonomy described in the HSP2. The role was primarily in technical assistance to complement the HSSP2 financing. The MoH is implementing a health sector reform plan in which ODs and tertiary care facilities (Provincial and National Hospitals) deemed to have sufficient capacity are granted semi-autonomous status referred to as a Special Operational Agency (SOA) program. Within SOAs they are provided performance-based Service Delivery Grants (SDGs) to health facilities and hospital departments to improve staff performance and resources. Although 30 SOAs have now been established, the intended PHD role as an SOA “Commissioner” has not developed as hoped. HSSP2 planned to provide PHDs a stake in the process through the “merit based payment initiative” (MBPI). The MBPI mechanism was halted by the RGoC early in the program and an approved substitute, the “Priority Operations Cost” (POC), has only recently been established.

⁴ CDHS 2005

⁵ CDHS 2005.

Each SOA has a Health Equity Fund (HEF) at the hospital level; some HEFs also cover the costs for beneficiaries of HC services. HEFs are established in some non-SOA areas, but do not cover the entire USAID Program geographical focus areas. The HEFs, while established to improve access to services by the poor and decrease impoverishment due to health care costs, also provide indirect staff incentives through increased user fee revenue. The team was informed that the SOA-ODs would gradually be increased in number as better capacity is developed and as budgets allow. Funding comes from both the RGoC and HSSP2.

III. USAID health assistance program

A. USAID's Program Strategy: The strategy as described in the Health AAD is explicitly tied to key health systems strengthening activities described in the MoH's HSP2. While USAID does not "pool" its resources under HSSP2, the intent of the program was to provide technical and managerial support to the MoH at several levels in the system to help strengthen the capacity of the health system to undertake some of the major programs 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 working closely with all stakeholders, including attempting to link its activities with those of the HSSP2.

USAID health strategy targets for 2013 include:

- 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) contribute 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

B. Current program portfolio: USAID's current program in health consists of two major programs, the health program described in the Health AAD and the HIV/AIDS program funded under PEPFAR, as well as other activities outside of these two programs.

The projects in the USAID health program reviewed by this mid-term evaluation are:

Population Services International (PSI) project (February 2008-February 2013) which strengthens Cambodia's health system by improving the private sector's

effectiveness at providing health services to the poor and vulnerable. Some PSI activities are national in scope and others are in more limited geographic areas.

Reproductive and Child Health Alliance (RACHA) project (September 2008-September 2013) focuses on improving services related to safe motherhood, birth spacing, child survival, infectious disease prevention and control, through a set of HC and community interventions in five provinces (Siem Reap, Pursat, Banteay Meanchey, Prey Veng and Koh Kong).

Reproductive Health Association of Cambodia (RHAC) Together for Good Health (ToGoH) project (October 2008 – September 2013) provides private reproductive health services through its own 18 clinics (in Phnom Penh, Kampong Speu, Sihanoukville, Takeo, Kampong Cham, Siem Reap, Svay Rieng, and Battambang) and implements a similar set of community and public health support activities as RACHA in five provinces that do not overlap with RACHA. (Battambang, Kampong Speu, Kampong Cham, Pailin and Preah Sihanouk)

University Research Co. (URC) –Better Health Services (BHS) project (January 2009 – December 2013) works on capacity building of the public health system at various levels to improve the quality of services, scale up innovative financing schemes and work in other areas of health systems strengthening at the national, provincial and districts levels to link services and referrals. The package of activities is designed to provide synergy both within the project and with other USAID partners in the health program in 10 provinces.

C. Relationship to USAID BEST Action Plan: The USAID/Cambodia health program addresses the Global Health Initiative (GHI) principles and fits well within the recommended guidance for the “Best Practices at Scale in the Home, Community and Facilities” (BEST) Action Plan. BEST is a process to ensure that, under the GHI, USAID applies state-of-the-art programming in family planning, maternal and child health, and nutrition programs that draw on evidence-based interventions. USAID/Cambodia’s programs were designed based on the review of epidemiologic data of current causes of maternal and child mortality, disease burden analysis for TB and HIV/AIDS and trend analyses of demographic, service utilization and key health and population indicators using CDHS and other surveys and studies. Such analysis is needed to justify key interventions supported by USAID under the BEST Action Plan.

The USAID program is fully aligned with MoH national priorities for maternal, newborn, and child health, nutrition, and family planning (MNCHN and FP). A new strategic direction was reinforced by the MoH to achieve Millennium Development Goals (MDGs) goals 4 and 5. Realizing that maternal mortality has remained stagnant and at an unacceptably high level over the past decade, the MoH, with major input from USAID partners, developed the “Fast Track Initiative (FTI) Road Map for Reducing Maternal and Newborn Mortality”. The FTI has clear goals and focused objectives to address key issues related to maternal and newborn mortality and implementation of high impact interventions such as scaling up the prevention of postpartum hemorrhage and prevention

and management of eclampsia. Because an increasing proportion of infant mortality is among newborns, USAID is supporting the MoH plans to scale-up the newborn resuscitation (Helping Baby Breathe) program. All other essential newborn services will also be strengthened. With the realization that family planning (FP) services have an important impact on maternal mortality, the MoH includes FP as a key component of the FTI. USAID is supporting MoH plans to expand the availability of long term and permanent methods as well as to strengthening community-based distribution (CBD), a social marketing program for pills and condoms. To address child under-nutrition and maternal anemia, USAID programs integrate infant and young child feeding education, breastfeeding program and Vitamin A supplementation in all community activities as well as providing iron and folic acid supplementation during antenatal care (ANC) visits for pregnant women at the health centers in all USAID focus areas.

The technical interventions, supported by a substantial investment in health systems strengthening, address key approaches recommended for a BEST Action Plan to achieve the desired measurable impact by 2013 for the target population in ten provinces (11 with Phnom Penh) which represents roughly 60% of the population of Cambodia. USAID/Cambodia staff, its implementation partners, other USG agencies and development partners all work on supporting a national health strategic plan led by the RGoC.

IV. Evaluation Methodology

In preparation for undertaking the mid-term evaluation, the Team developed a methodology that included the following:

- (1) Stakeholder interviews - a question guide was used to interview various types of stakeholders (USAID, the USAID partner staff, key MoH policy makers and managers at national, PHD and OD levels, donors, health services providers, and clients and community members).
- (2) Analyses of data - from the semi-annual and annual reports from the USAID partners, CDHSs, the MoH's Health Information System (HIS), and USAID's routine reporting system and other available survey research.
- (3) Analysis of information provided by the USAID partners on mapping of coverage of key interventions
- (4) Site visits – Six provinces were visited (Pursat, Battambang, Siem Reap, Bantay Meanchey, Kampong Cham and Prey Veng) to view facility activities and communities in the four “old” provinces where the partners had worked for many years and two “new” provinces. Visits were done with no prior notification to specific facilities and communities, and selected to include sites with good road access and some more distant from major roads.
- (5) Review of technical reports and other documents from USAID, partners, the MoH and other donors.

Overall progress was assessed based on the AAD and on the program descriptions in each of the four Cooperative Agreements (CAs). The observations made about the strategic

issues were based on the description in the AAD about how each project was to contribute to the overall Program.

V. Findings

A. Implementation Progress

A. 1. Community Activities

The AAD for this Program planned on provision of a uniform and comprehensive package of activities at community level. The winning technical proposals from RACHA and RHAC responded to all of the “Community Package” interventions listed in the respective Request for Applications (RFAs) with the exception of Point-of-Use water disinfection, which was included only by RACHA. These Technical Proposals were accepted and serve as the Program Description for each CA. The activities that both RHAC and RACHA have committed to establish to scale in all applicable villages⁶ are as follows:

- Community-based integrated management of child illnesses (C-IMCI) through Village Health Support Groups (VHSGs) in accordance with MoH C-IMCI guidelines⁷.
- 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 Direct Observation Therapy, Short-Course- (C-DOTS) for TB.
- Behavior change communication (BCC), and information, education and communication (IEC) through community events for MoH-approved key MNCHN messages.
- Community-based distribution (CBD) (i.e., sales) of contraceptives in accordance with MoH guidelines.
- Community-based sales of other 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 HC Management Committees (HCMCs) and Commune Councils (CCs) in community health needs and client rights.

⁶ C-DOTS, CBD and village referral systems would be applicable only to villages a certain distance from the HC. MoH guidelines specify this threshold for C-DOTS and CBD. With regard to Village Emergency Referral System (VERS), the two respective Technical Proposals gave a target in terms of percentage of villages (RACHA= 30%, RHAC = 50%) and indicated these would be selected based on distance barriers.

⁷ Per MoH guidelines, C-IMCI in Cambodia is limited to BCC and referral to services. Hence “C-IMCI” training/introduction simply means that a VHSG has been trained and equipped to provide comprehensive education and referral on a wide range of MNCH and FP topics.

- Advocacy and technical assistance (TA) 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.

RACHA is also committed to promote Point-of-Use water disinfection, hand washing and sanitation in all villages.

Among the interventions listed above, the following were long-standing RHAC and RACHA activities: CBD/village based sales of contraceptives (and, in RACHA’s case, other health commodities) C-IMCI, C-DOTs, community BCC, and mobilization/ referral for HC services. The others were new, responding to such changes as the D&D initiative and recent approval by the MoH of a client rights Charter.

In addition to a widening of the range of technical interventions at community level, the Program calls upon these partners to scale-up coverage by solidifying it in existing geographical areas as necessary and expanding to new Provinces (RHAC: Kampong Cham Province, and RACHA: Prey Veng and Koh Kong Provinces).

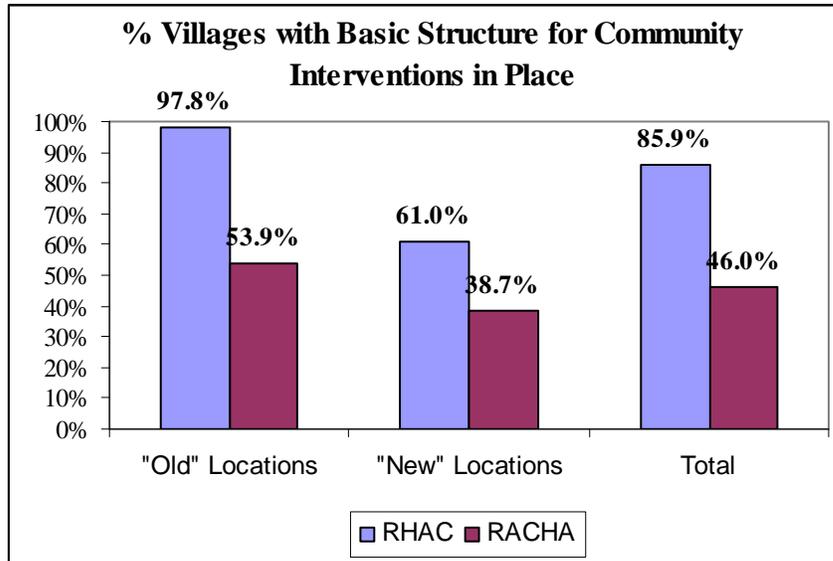
The Program also features a new strategic approach to ensure sustainability of the village volunteers (VHSGs) who deliver community level interventions and BCC through institutionalization under the Commune Council (CC). The Technical Proposals of both partners incorporated this.

The Evaluation Team examined the partners’ progress in implementation of this strategy and the scale-up of the package of community interventions in terms of both geographical coverage and technical expansion (introduction of new interventions). Field visits by the Team were deliberately structured to include both provinces where the two partners had been working at community level for many years and their “new” provinces.

A.1.1. Geographical Coverage: The graph below shows the percent of villages with the “basic skeleton” of the community package in place, defined here as a VHSG trained at least in C-IMCI. Not surprisingly, coverage is lower in the areas to which the two partners have newly expanded.

Partners’ management information systems (MIS) data fails to take into account C-IMCI training provided by other non-governmental organizations (NGOs) in the “new” areas. Each of the partner’s “new” areas contains two ODs, which were previously contracted by the MoH to an NGO (CARE in Koh Kong, Save the Children (SCA)/Australia in two ODs of Kampong Cham). CARE and SCA both provided C-IMCI training to VHSGs; it is not known how many of the VHSGs mobilized by RHAC and RACHA had received these inputs, hence, the actual percentage of coverage in the “new” areas may be slightly higher than shown.

Figure 1



As can be seen, RACHA's progress in terms of expanding geographical coverage is considerably slower than is RHAC's. The low levels of coverage in the "old" areas, where this activity had been implemented with USAID support for more than 10 years, was surprising.

Source: RHAC and RACHA MIS.

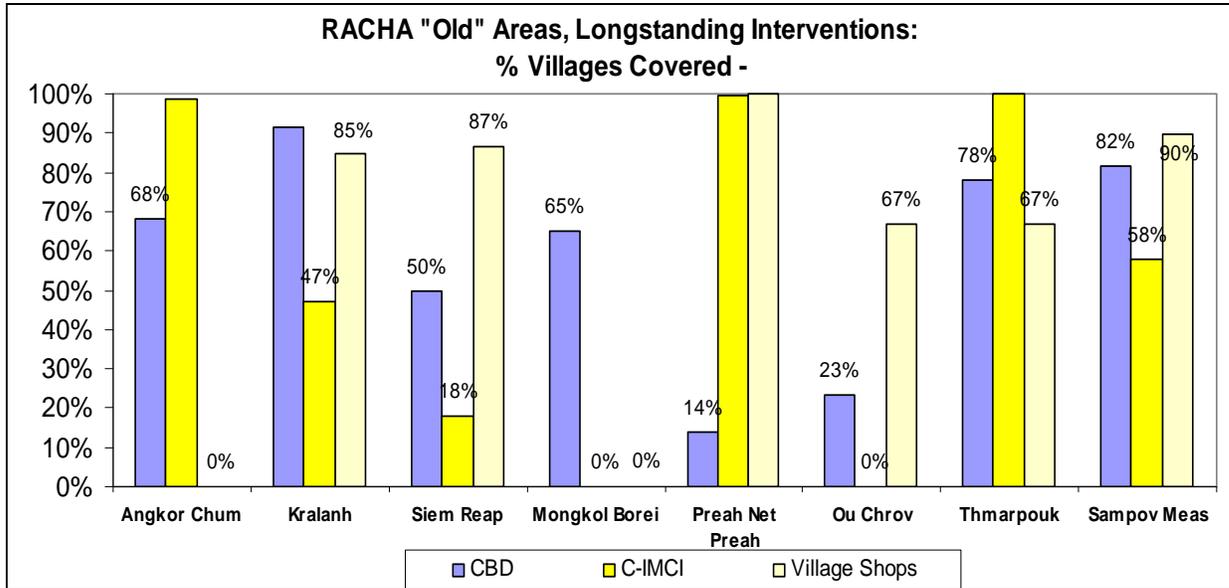
On further examination it was found that there was no clear pattern by intervention, i.e. a village might have CBD but not a C-IMCI trained volunteer, or neither, or both. The same was true with regard to RACHA's "Village Shop" initiative⁸, an activity not undertaken by RHAC but long-standing in the RACHA provinces.

While this analysis was limited to long-standing interventions, it was noted that coverage of "new" interventions reported to the team by RACHA and/or listed in their MIS treated an activity as in place in an OD without regard to scale. For example, Sampov Meas and Siem Reap ODs were listed as having community water systems in place using bio-filtration when in fact this had been done in only one village of each OD.

In RHAC areas, by contrast, it was found that coverage of interventions followed a clear pattern and was much more consolidated. The following graphs show this pictorially; they are limited to long-standing interventions and "old" geographical areas. Note that RHAC does not have a Village Shop program.

⁸ This is an initiative to link small vendors with PSI products and provide related training

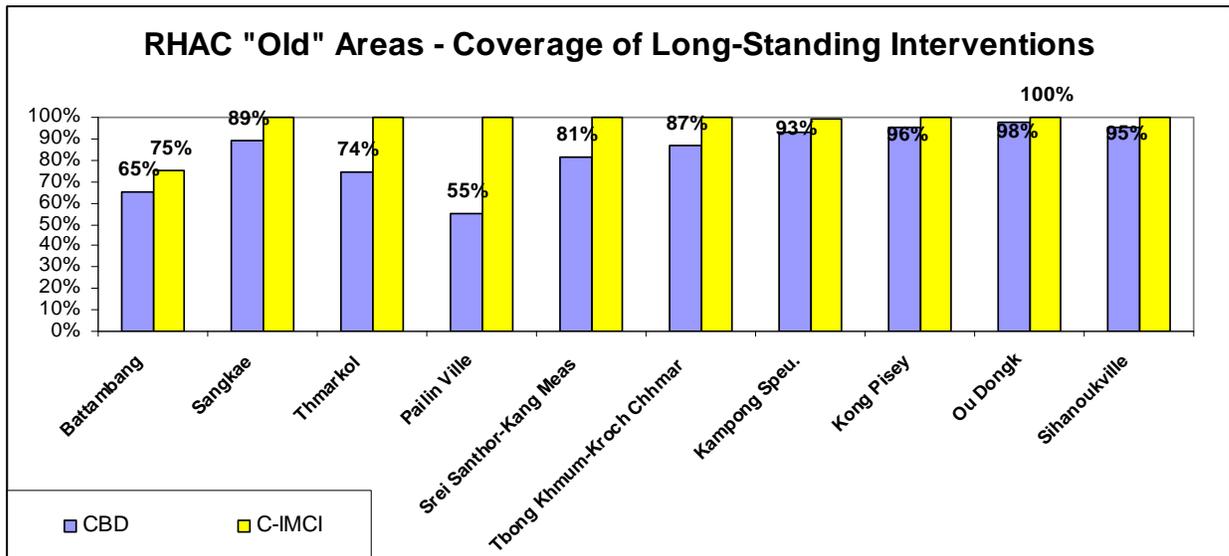
Figure 2



Source: RACHA MIS and National CBD Evaluation⁹.

Note: CBD Coverage in A, Chum, Kralanh and MGK is inclusive of villages implemented by directly by the MoH under HSSP2. In RACHA ODs with both CBD and a village shop there are both gaps and overlap at village level.

Figure 3



Source: RHAC MIS and National CBD Evaluation

⁹ Keller, S. Review Of Community-Based Distribution Of Contraceptives In Cambodia. National Reproductive Health Program October 2010.

On discussion with RACHA field staff the Evaluation Team found that different OD level staff are responsible for different VHSG inputs, which may contribute to the fragmentation of their program. Identification and mobilization of VHSGs falls under the responsibility of a Health Communications Officer, while C-IMCI training for the same VHSGs is the responsibility of a Child Health Officer, and CBD of the Safe Motherhood Officer, etc. Exacerbating this is a failure at central level to adequately guide and monitor field activities. (See section V.D).

RHAC organizes its OD level staff geographically, with each team member responsible for all VHSG inputs in a specific set of villages. RHAC also provides strong programmatic guidance from its central level, includes questions on VHSG activities in its annual population based surveys, and makes extensive use of this data and MIS reports to quantify coverage, and identify and performance issues in the field.

Issues regarding CBD coverage in ODs supported by RACHA were previously identified in the national CBD evaluation last October. That evaluation also noted that RACHA supported “Village Shops” and VHSGs trained/supported for CBD were often present in the same village, and when that was the case, one or the other usually stopped selling contraceptives. An evaluation of the Village Shop initiative was recommended to identify the comparative strengths and weaknesses to contraceptive sales through that channel as opposed to CBD. This has not yet been done or planned. The CBD Evaluation documents an average number of CBD current users of 10 and 18 per VHSG for RACHA and RHAC areas respectively.¹⁰

Based on partner MIS data, CBD appears to be to scale in all “new” RHAC areas except Kampong Cham OD where it is as yet just 50%. In new RACHA areas, it has not yet been initiated in 4 ODs and has very low coverage (i.e. <20%) in another 4 ODs. RACHA field staff in Prey Veng informed the Team that they do not plan to do CBD in many locations because they feel it is too much work. There did not appear to be an understanding of an obligation to bring this or other “Community Package” interventions to scale among RACHA provincial and central level managers and their MIS does not track it in a manner that would make gaps in coverage readily apparent.

Although both partners are struggling to establish community activities in their “new” areas of new geographical expansion (see Figure 1), RACHA’s progress has been slower than RHAC’s and this partner also has a great deal of work to do in consolidating coverage in its “old” areas. It is unlikely that this plus introduction of the newer interventions and geographical expansion into 9 additional ODs can be achieved by RACHA before the end of Project.

A. 1.1.2. Progress in expanding the technical content of community activities

To date the MoH has not endorsed community-based treatment of acute respiratory infection (ARI), so that elements of the Community “Package” may be considered to be

¹⁰ Keller, S. Review Of Community-Based Distribution Of Contraceptives In Cambodia. National Reproductive health Program October 2010.

on hold for reasons beyond the partners' control. The MoH position with regard to community-based treatment of diarrhea with oral rehydration solution (ORS) and zinc remains somewhat unclear.

In addition to the problems with spotty coverage for long-standing interventions in the RACHA areas, both partners are having difficulty incorporating and scaling up those activities, which are new to them. Observations regarding progress in implementing the newer interventions follow:

i. Village Emergency Referral Systems (VERS): RHAC and RACHA have both begun to interact with and seek support from Commune Councils (CCs), and to facilitate HC and OD staff to do likewise, with regard to development and support of VERS. Interfacing with the CCs is something neither MoH staff nor partners traditionally did in the past. In addition to providing support for the development/operation of village referral systems and institutionalizing them within local government, involvement of the CC for this activity sets an important precedent. Shifting the VHSG perception of who they are accountable to, and the source of their support, from NGOs and the MoH to the local government, is an important step in institutionalizing this cadre of worker.

As per its Technical Proposal, RHAC began by holding consultative workshops in each province bringing together health and civil authorities to discuss/clarify roles and responsibilities of CCs in regard to health. The resulting recommendations were circulated to all CCs and follow-up discussions held by RHAC provincial staff. RACHA began its discussions more directly at the commune level, although training of HCMCs (that includes a member from the CC) included participation from the Administrative District. There have been tangible instances of CC commitment of funds (through the Commune Investment Plans -CIPs) for VERS in many but not all ODs, to date more so in RACHA areas than in RHAC. Quantification of this proved impossible: neither partner reported on its indicator related to referral systems in fiscal year (FY) 10, and internal MIS data obtained from both partners was not very helpful due to a lack of a clear definition of what constituted the presence of a referral system. RHAC's FY11 Workplan has set a target of 10% of all villages (end-of-Project target is 50%; obviously not all villages require such a system since some are located nearby a health facility), while RACHA's end of Project target is 30% and its FY11 workplan shows an annual target for that year of 30%, presumably an error, although the evaluation team was not able to obtain a clear answer on that question from RACHA. From discussions with partner headquarter and provincial staff, and with MoH managers and providers in the field, it appears that perhaps a handful of systems have been set up and a few more are in progress in the RHAC provinces. In RACHA areas it appears that at least a dozen systems are already in place and an equal or greater number in progress, all of these being in the "old" provinces, although in Koh Kong some systems had already been developed with support from CARE which may or may not still function. RACHA's efforts have been aided by the availability of micro-credit interest to support VERS in some locations, whereas RHAC lacks that channel.¹¹

¹¹ Under prior USAID Projects RACHA established community micro-credit activities in some villages of Pursat, Siem Reap and Banteay Meanchey Provinces. USAID no longer supports any capitalization costs, but RACHA

Although there is obvious movement on the part of both partners to set up VERS, their current End-of-Project targets are quite ambitious (equaling more than 1,000 villages for each) and are unlikely to be met. There is no overall plan or assessment on which to base such a plan, and thus no way to prioritize which villages should have the intervention, establish OD-level targets, or track progress. The new activity is generating enthusiasm among field staff but proceeding in a fragmented and ad hoc manner.

In several provinces, NGO staff reported that CCs were unsure of the rules and procedures for use of the Commune Social Welfare Funds and that this, more than any unwillingness to fund health activities, was a barrier. Hence what was initially envisioned as advocacy has in some cases extended to technical assistance.

ii. Client Rights Initiative: The MoH is rolling out provider training in client rights, which logically has to precede activities to inform and empower communities. Existing MoH resources are sufficient only for training of trainers (TOT), so partners may need to use Project funds to support training below the OD level. RACHA has already begun to do so in one province.

Only a few of the RHAC/RACHA provincial managers spoken to were aware that publicizing the new client rights directive in communities is part of the community intervention package. It is not included in the current RHAC workplan, although there are other activities related to client rights, such as establishing suggestion boxes in the community and following up on complaints received through that channel. RACHA's current workplan includes training on client rights, but the plan appears to have MoH staff conducting the training of VHSGs, a clear conflict of interest. Discussion with staff at various levels indicates a poor understanding of this initiative and how it differs in objective and content from other types of training/BCC activities. The use of MoH providers as trainers aside, it was noted during field visits that VHSGs are often viewed – especially in RACHA areas – as agents of the health system rather than community advocates/representatives, and indeed the Team witnessed a case where the HC-appointed VHSG attempted to conceal an incidence of alleged malpractice. Hence even involvement of VHSGs in disseminating this information may be questionable, at least in areas where they have been appointed by the HC.

This intervention – a vital step towards improving accountability in a health system and society where it is notably absent - calls on a skill set and vision new to health sector NGOs and that is more commonly found among human rights organizations. In addition, raising community awareness of rights may place partners working closely with MoH service providers in a difficult position. There is a potential conflict of interest and also risk of jeopardizing relations with the MoH, if partners are perceived as responsible for an increase in formal complaints by clients.

continues to use the interest proceeds to support health-related activities and also to capitalize expansion to new locations. It is currently established in 244 villages (from a total of 2182 villages) in 4 Provinces. The funds are implemented by RGoC counterparts at local levels: the Ministries of Rural Development and Women's Affairs, and local CCs.

iii. Safe water/sanitation (RACHA areas only): RACHA’s approach is to promote point of use sales of PSI’s disinfectant Aquatabs in Village Shops coupled with promotion by VHSGs. Field discussions with community members and VHSGs indicated that few VHSGs promote Aquatabs, and as they are not the vendors, there is no financial incentive for doing so. The tablets were also reported to be unpopular due to the chlorine taste. RACHA has also supported the establishment of low-cost community sales of bottled water produced through Bio-Tech Water Filtration Systems, but these systems are thus far serving only two communities, one in Pursat (located near a river) and one in Siem Reap (a floating village, for which it is particularly suited). RACHA’s MIS indicate that 52.6% of villages in their area have a Village Shop, which would have been initially provided with Aquatabs along with other PSI commodities. It is not known how many of these actively sell or continue to stock the Aquatabs. Since the vendors and promoters are different individuals (shopkeeper and VHSG) and not all of the latter are active, coverage for this intervention, if defined as BCC plus product availability, would be much lower. The intervention is clearly not to scale even in the “old” provinces. The FY11 workplan plans expansion of the number of Village Shops but gives no indication of how many or where.

A. 1.1.3. Quality of VHSG activities

In the “old” ODs supported by RHAC and visited by the Evaluation Team, VHSGs were well known in their communities and usually active as indicated by reports from women in the village, descriptions of activities given by the VHSGs, and the possession of updated registers and IEC materials. The same was true of the majority of VHSGs in the long-standing RACHA-supported ODs, but about a third of those interviewed were found to be inactive, a ratio similar to the estimations of RACHA field staff. Among VHSGs who were active, levels of skill/knowledge were highly variable, ranging from excellent to quite weak. Limited literacy was often a factor in weak skills among otherwise active and motivated VHSGs.

RHAC’s annual population-based surveys include questions about VHSG activity and how they are perceived in the community. Among women with a birth in the past two years (i.e., prime VHSG target group) 91.7% of the 2010 sample in “old” focus areas knew their VHSG by name. The percentage reporting that the VHSG mobilizes people to receive immunization, VAC, etc. and/or refer people to the HC was 91% (99.3% among women who knew the VHSG), while the percent reporting that the VHSG did health promotion apart from referral/mobilization for services was 58.7% (63.9% among women who knew their VHSG). In other words, a very high percentage of the target group live in a village where the VHSG meets the minimum activity criteria of promoting service utilization, and completely inactive VHSGs are not common in the areas where RHAC has a long-standing presence. A slight majority can be described as actively doing health education, while the rest confine themselves to mobilizing/referring for service utilization.¹² Similar data is not available for the RACHA areas, but based on field

¹² RHAC Community Health Program survey dataset 2010.

observations and meetings as well as the estimates of RACHA field staff, the percentage of inactive VHSGs is probably higher.

In RACHA areas, VHSGs are usually appointed by the HC (often in consultation with the Village Chief), while in RHAC areas some – but not all – of the VHSGs interviewed by the Team had been elected. Both from the interviews with VHSGs and reports from MoH OD officials, VHSGs tend to view themselves as working for either the HC and/or the NGO. An affiliation with the NGO seems more prominent in RHAC areas and an affiliation with the HC more prominent in RACHA areas, but generally speaking in neither area do VHSGs really view themselves as employed by/working for their communities. This dynamic is unlikely to change until their source of material support changes (see next section). Instances of inappropriate VHSG selection were noted in several ODs, both RHAC and RACHA supported. For example, use of “*Pet Phum*” (untrained village providers of modern medical care, i.e. quacks) as VHSG and there were instances where both VHSGs in a village were male.

Mobilization and initial training of VHSGs does not seem, in either partner’s areas, to optimally build on what already exists; in many villages VHSGs already existed and were at least carrying out mobilization for HC outreach services, and some had already received C-IMCI and other training from other NGOs.

Promotion of post-natal care (PNC) for both mother and newborn, while previously a part of what both partners trained VHSGs to do, has historically met with little success due to the logistical barriers in informing HC Midwives (MWs) of a home delivery so that she can make an outreach home visit. Targets for this in both proposals focused accordingly on achieving PNC within 24 hours of delivery. Recently finalized PNC guidelines (requiring 3 visits—within 24 hours (PNC1), 1 week (PNC2) and 6 weeks (PNC3) respectively) and a MoH directive banning home deliveries and paying an incentive for facility ones render these initial targets, that include PNC provided in homes, somewhat obsolete and opens up a new set of challenges. At present, MoH policy limits the VHSG role to referring women to the HC for PNC. Based on reviews of facility registers and the HIS, PNC1 coverage has increased but almost entirely as a result of facility deliveries, with HC registers showing PNC1 numbers equal to the number of HC deliveries (give or take 1-2 cases) and very, very few or no PNC2 and PNC3 services. This observation held true in both new focus provinces and in those with long-standing NGO assistance. Discussions with VHSGs and women in the community elicited information that, while VHSGs play an important role in encouraging facility delivery (and in some cases facilitating transport), they are not currently playing a role in the provision/uptake of PNC for women who delivered at home or for PNC 2/3.

A. 1.1.4. Monitoring and Support to VHSGs

VHSG contact with NGO staff was regularly reported in the RHAC areas but less often in those supported by RACHA, and it was noted that the RHAC field staff structure has a clear division of responsibility for village level monitoring and supervision among staff

which may facilitate this while RACHA field staff were structured along vertical technical lines with each person equally responsible for all villages.

These differing levels of monitoring/supervision to VHSGs were also evident in discussions with OD and Provincial NGO staff. RHAC personnel in the “old” ODs were able to describe VHSG activity in detail down to exactly which villages had a vacancy or a low-performing VHSG, while RACHA staff in “old” areas could not go beyond vague estimates of what percent overall might be active.

As described in A.2 above, there is enthusiasm for developing village referral systems at field level but it is not being adequately monitored through the two partners respective monitoring and evaluation (M&E) systems or MIS. While field offices report “yes” or “no” to the presence of a referral system by HC and village, there is no uniformly understood definition for what that means and some may indicate “yes” simply because people in the village have been told where to go. In addition, the target villages have not been formally identified or prioritized, although some field level managers have this information in their minds. This would be necessary to then break out the overall end of Project targets into a target number, an exercise that would also shed light on the feasibility of the original end of Project targets.

A. 1.1.5. Institutionalization of VHSGs/Sustainability of Community Interventions

Both RHAC and RACHA Technical Proposals elucidate an intention to work towards institutionalizing VHSGs under local government (the elected Commune Councils) as a sustainable means of ensuring continued support for their comparatively small but essential resource requirements (e.g. transportation costs and per diem to attend a monthly meeting at the HC) after NGO assistance ends. RHAC’s proposal spells out an approach, which starts with building the capacity of CCs and HCMCs (the chair of which is a CC member) “to coordinate and assume responsibility for health services at the community level. The objective will be to make the local authorities to understand their role and assume responsibility for community health activities as part of their mandate.”¹³ RACHA’s proposal is less detailed but refers to integrating its support to VHSGs into the CIP as a “key step in institutionalization within the local government structure”.¹⁴

Field visits confirmed that most Provincial partner staff have facilitated some degree of health system – civil administration linkage and have advocated with CCs for resources, mainly in regard to VERS. While CC resources are being sought (and in some cases, have apparently been obtained/pledged) for VERS, there is as yet no indication of movement towards institutionalization of the VHSG workforce under the CCs. Unmet needs are obviously an easier sell than taking over the costs of ongoing activities historically supported by an NGO. In RACHA areas only, some CCs have incorporated some of the costs of VHSG training in their CIPs. There are no examples as yet of CC resources being sought/obtained for the ongoing recurrent costs of VHSG-HC meetings, the most crucial recurrent cost since this is where information on services and scheduled

¹³ RHAC Technical Proposal pp. 14-15

¹⁴ RACHA technical proposal p. 14

outreach sessions is relayed, VHSG registers reviewed and CBD supplies replenished. CC-health system linkages have been newly created, and both NGO field staff and MoH counterparts are enthusiastic and optimistic about the benefits this will bring in terms of resources at the grass roots level, but it is not clear if the objective of institutionalizing VHSGs under the CCs remains in focus for the projects. At present VHSGs remain wholly dependent on RHAC/RACHA for recurrent costs such as travel costs/per diem for monthly meetings at the HC. The target for this activity in both Technical Proposals is quite modest (10% of villages for RHAC; 5% for RACHA) and thus still potentially achievable.

A.1.1.6. Youth Peer Education

In RHAC areas only, the RFA and responding Technical Proposal includes village-based peer education on a range of reproductive health topics, along with “youth friendly” reproductive services in RHAC clinics. The latter is addressed in section V.A.2.

RHAC’s FY10 Annual Report lists 755 villages covered with Youth BCC activities by a total of 1,640 peer educators (PEs) - normally 1 male and 1 female per village - along with 38 secondary schools, and the FY11 workplan includes expansion to 178 additional villages and 3 more schools. End of Project targets are 938 villages and 34 schools, thus this activity is well on track to reach its planned scale. In addition to BCC, Youth PEs distribute condoms on request and serve as an important channel for informing village youth of the services available at the RHAC clinics and promoting utilization/ referring clients. This is especially critical for services like emergency contraception, post-abortion care and post-rape care, which are otherwise not well known and which youth might hesitate to seek on their own.

In addition to PE, RHAC conducts community events (mobile video shows, karaoke, etc.) aimed at youth around reproductive health topics. A population-based survey in 2010 found that 89.1% of youth had had some contact with the Program, either through PE, community events, and/or the RHAC clinic. Sixty-six % of youth overall reported contact with their Peer Educator, with considerable variation (51% - 86%) by Province. A visit to a randomly selected village in Battambang readily located a RHAC Youth PE who was found to be well informed and enthusiastic about her work.

V. 2. Private Sector Service Delivery and Demand Creation

V.2.1. Clinical Services

Among the USAID partners, only RHAC provides reproductive health care directly from its own network of clinics. PSI is also involved in training and strengthening the quality of clinical care among private sector midwives (who are often government midwives with private clinics). Implementation issues differ between the two organizations.

RHAC Clinics: RHAC continues to provide high quality, affordable reproductive and sexual health services for adults, youth, and high-risk groups through a network of 18 clinics in urban and some rural areas. The range of reproductive and sexual health

services (Voluntary Confidential Counseling and Testing (VCCT), post-rape care, pap smears and cryotherapy, treatment of sexually transmitted infections (STIs), circumcision, all FP methods except sterilization, post abortion care, etc) offered along with primary health care is unique in Cambodia. Thirty-two percent of RHAC clients are under 25 years of age, in part because of the strong youth peer education programs attached to the clinics, and implementing measures such as private entrances and waiting areas to ensure clinics are “youth-friendly”. The youth services and programs, as well as pap smears, comprehensive post-rape care, and premarital screening/ counseling are unavailable elsewhere in the country.

RHAC clinics have seen a steady increase in the total number of clients overall. The larger urban clinics appear to be doing well in terms of both client load and reaching youth and high-risk groups that would find using MoH facilities difficult in terms of social acceptability or lacking in the services they need. The urban clinics reported that there are an increasing numbers of clients who are seeking primary health care (PHC) services and if they pay the full cost of services, this may be a sensible cost recovery strategy for RHAC. The urban clinics visited by the evaluation team in Siem Reap reported that about 10% of PHC clients cannot afford to pay the fees. Up to 30% of services provided out of the Siem Reap and Battambang urban clinics are subsidized to some extent, either because of an inability of the client to pay or age; youth are exempted for FP, STI and other reproductive health services even if from middle/upper class households due to barriers in asking their parents for money related to utilization of such services. Such youth services account for a majority of urban clinic exemptions. To date, HEFs will not reimburse non-government facilities, even for services unavailable in MoH facilities.

The picture in at least some rural RHAC clinics seems to be somewhat different. When RHAC first began offering reproductive health services, MoH HCs were a highly unreliable provider. With the advent of HCs that now deliver FP services including intrauterine devices (IUDs), and that are more reliable in terms of having staff and supplies on hand, there may be a decreasing need for RHAC to compete for the same clients, especially if the MoH services are nearby and a HEF covering HCs is in place. Some rural clinics visited by the Evaluation Team had excess capacity and low patient loads, especially for reproductive health services. Furthermore, they were often providing free services as a greater proportion of their clients are poor and cannot pay the established fees.

While the Evaluation Team did not have time to look into these issues more closely, it may be an appropriate time for RHAC to review its client loads at the more rural clinics, assess the availability of similar services, and the cost effectiveness of continuing to provide subsidized PHC care in rural areas. RHAC may find it has a better market niche in urban areas with clients who can afford to pay, and youth and other special groups for whom alternative services are not easily available.

PSI: PSI reports that their Franchise Network of private providers has expanded to 162 providers, 127 clinics in 12 provinces. Supervision visits in 2010 showed 83% of

franchisees meeting minimum quality assurance standards. PSI's support to private providers has to tread a careful line since most of these are also public providers, particularly midwives whose duties in the public sector are substantial and include being "on call" after-hours. PSI training of "private" providers in IUD and implant insertion in locations where the MoH HC is not yet providing those services has the benefit of offering clients a wider choice of FP methods and service providers. However, care is needed to ensure that it does not result in a neglect of duties at the HC or hospital or promote increased leakage of MoH drugs and supplies into the private clinics. This is currently not being monitored, and PSI alone is not in a good position to do so. However, this could be done through closer linkage at provincial and OD level with the partners who support those facilities, e.g. RHAC and RACHA.

The IUD campaigns and promotional activities supported by PSI for public sector midwives are also useful, especially in areas where there is low or no demand for this service, as long as the activities are carefully coordinated with MoH and the USAID partners such as RHAC and RACHA. The Evaluation Team found that most MoH officials appreciated the extra help from PSI and knew in general terms about the activities planned, but several OD managers stated that they were not informed in advance of the dates and locations of PSI IUD campaigns, as did several RHAC and RACHA provincial and OD staff. Visits to facilities found instances where campaigns had been conducted in HCs already regularly providing IUD services while other HCs in the same OD without IUD services were not included. Given RHAC and RACHA's presence at HC level and involvement in expanding HC IUD provision, this activity, could be better targeted to help fill gaps or generate demand for newly established services. Such collaboration would expand IUD availability while the HC training is being rolled out and also help ensure that there is no overlap of efforts.

V.2.2. Social marketing

PSI has had a long history in Cambodia with social marketing of contraceptives and has developed a line of contraceptives branded as "OK" pills, condoms, injectables and implants. PSI reports that 517,632 couple years of protection (CYP) were generated in 2010 from social marketing of their FP products, 7,938 IUD were provided during mobile service training day events, and 1473 providers reached during medical detailing activities.¹⁵

In recent years, PSI has also branched into health and child survival products with support from USAID, and in the case of insecticide packages for treating bednets, with a grant from the Global Fund (GFATM). With USAID funds for diarrhea prevention and treatment, PSI is marketing safe water disinfectant tablets and Orasel kits¹⁶ – 1.4 M disinfectant tablets were sold through 750 outlets in 7 provinces, and 86,300 Orasel kits were sold in 808 outlets. There are opportunities to build on to these programs by adding product lines such as emergency contraceptives, iron folic acid (IFA) tablets and nutritional supplements like Sprinkles, if approved by the MoH.

¹⁵ Medical detailing activities aim to reach private sector health providers with information, tools, and training to improve counseling techniques and knowledge of modern FP and other PSI/IC products.

¹⁶ ORS+zinc in one package

Despite these impressive figures, the 2005 CDHS found that PSI product's market share for contraceptive pills¹⁷ in urban areas was almost double that of rural ones: 72.8% vs. 43.1% of users; the proportionate share of the rural market may have been further diluted by expansions in CBD services since 2005. The Evaluation Team noted that while products were easily found in pharmacies in provincial and district towns, it was difficult to locate them in rural villages, and the only ones found were in ODs where RACHA has implemented a Village Shop initiative to link small vendors with PSI products and provide related training. PSI has a 'memorandum of understanding' (MOU) with RACHA for distribution to such village level outlets. However, only about half of the villages in the RACHA ODs have a Village Shop¹⁸, RHAC does not have a Village Shop activity at all, and neither does any agency working in provinces outside the USAID focus area. To date, PSI products have not been marketed by VSHGs, the only feasible channel for penetration of the rural market in RHAC-supported areas, in RACHA ODs without a Village Shop, and in rural areas outside the USAID coverage area.¹⁹ As noted in Section V.A.1, the Village Shop activity in RACHA areas often overlaps with CBD and needs to be evaluated in terms of its market potential and the advantages and disadvantages of this approach compared to sale by VSHGs.

An additional concern, even in the minority of the Program area with a RACHA-supported Village Shop, is that these look exactly like all other village shops, with no distinctive marking to help consumers locate them or to publicize the fact that they sell commodities the others do not. The Team had great difficulty locating these shops even in villages where they were present, as often the villagers themselves had no idea where the products were sold.

PSI's "United Health Network" of local NGOs for commodity sales is too small in scope and reach to effectively improve rural product placement. Until such a time as improvements in rural infrastructure and economic gains increase rural access to conventional markets, the only apparent means of achieving significant rural market penetration is through the VSHG infrastructure. This would be most easily initiated in areas with a USAID partner present at community level to facilitate logistics.

A.2.3. Behavior Change Communication (BCC) – Mass Media

All of the USAID partners engage in using mass media in various ways to help change and improve health related behaviors in the community or increase demand for services. PSI's multi-media campaigns have been highly useful for informing the public of new products, dispelling misconceptions about family planning methods and involving men in decisions about family planning. RHAC and RACHA have also developed dozens of patient education materials, conducted radio and TV campaigns and developed village theater, mobile video and karaoke shows and other non-traditional educational activities.

¹⁷ Condom use for FP purposes is minimal in Cambodia. PSI has a dominant market share for condom use in high risk settings, which most often arise in an urban setting.

¹⁸ Analysis of RACHA MIS data

¹⁹ USAID support for PSI social marketing is nationwide in scope.

RHAC also produces peer education counseling and teaching aids for youth. Many of these materials were readily available in the sites visited by the Evaluation Team.

URC has not been heavily engaged in mass media work but has developed a BCC strategy for MNCHN and reproductive health/FP. The joint partner family planning strategy identifies a role for URC to work with USAID partners on printing existing BCC material as needed, developing a mass media plan for radio and TV, and an infant and young child feeding (IYCF) media campaign is planned but not yet launched. URC's FY11 work plan states that most BCC activity will focus on the Community Based Health Cooperative (CBHC) pilot areas, but also says that URC will work with RHAC and RACHA in 3 provinces on radio shows dealing with misconceptions about FP methods, TV shows to reduce unnecessary antibiotic and intravenous medicine use, and a radio show about increased awareness about and use of HEF cards. Direct funding of mass media work does not appear to fit well in URC's overall mandate.²⁰ A focus on providing assistance for strategic planning of media work, and ensuring that messages reflect best practice and are technically sound, may be more appropriate.

V. A. 3. Health Systems Strengthening (HSS)

Among the many components that are necessary for a strong health system, the evaluation team looked at factors that directly relate to quality MNCHN and reproductive health services being available physically and financially both in the short-term and the long-term within a functioning system that is decreasingly dependent on external technical, financial, and managerial support. Annex 4 provides a Facility Profile for HCs and RHs within the USAID focus provinces as a reference for some of topics and issues covered in this section of the report.

The evaluation team reviewed HSS in terms of capacity development in a) national capacity in stewardship for health; b) PHD/OD management; c) Special Operating Areas/Service Development Grants (SOA/SDG) to support quality services; d) health financing to remove barriers to access; e) quality improvement; and f) service strengthening. As an overall finding, the evaluation team concluded that while some of the HSS activities envisioned in the AAD are being implemented in strategically coherent way (e.g. HIS, HEFs, CBHC), there are fundamental problems with some of the other approaches employed in areas such as the capacity development work, quality improvement and service strengthening as described in the following sections.

A.3.1. Capacity Development

3.1.1 National level capacity: As part of strengthening policies, protocols, and guidelines that are needed for the MoH to establish standards and improve the quality of health services, URC/RACHA/RHAC routinely participate in national level technical committees and working groups that focus on MNCHN and reproductive health issues

²⁰ The URC program description stresses working with local partners to provide technical support for developing behavior change strategies as well as mobilizing other government entities in addition to the MoH.

and have played key roles in developing key MoH planning documents (e.g., *MoH Fast Track Initiative Road Map for Reducing Maternal & Newborn Mortality*). URC supported the MoH in revising the Integrated Supervisory Checklist (ISC) and helped to get it used by all MoH sub-national levels. They have introduced “best practice” interventions and policies on such topics as Infection Control and Safe Motherhood, and helped to develop guidelines and training materials for these.

There is no evident strategy for addressing the many barriers encountered at PHD/OD/facility level, which are the result of systemic weaknesses, by advocating for central level support and reform necessary for a better functioning health system. While Partners may not be in a direct position to change transparency and accountability, they can contribute to objective and consistent documentation and feedback to higher levels of specific instances where lack of transparency and accountability were evident and contributory to weaknesses in the health system and delivery of health services.

3.1.2. PHD/OD management capacity development

Planning, monitoring, supervision and resource allocation: Partners actively participate in the Annual Operation Plan (AOP) development and implementation process, ensuring that their activities and planned budget contribution are included in the AOP. There are examples of helping PHD/ODs during the AOP process to link specific planned activities to budget requests and providing information to help them to set targets, and of convincing directors to include funds for routine monitoring and supervision into their AOPs. Partners also expressed frustration with not knowing how much of the AOP requested budget actually arrives, and what the line items are.

Improvement in the AOP process is related not only to technical capacity (e.g., how to complete forms, how to ensure that an activity is adequately budgeted, how to use information for decision making) but also to the system within which the ODs and PHDs work. Evidence from field visits and discussions with partner field staff supported the impressions of the team that the MoH management system does not provide the basic framework within which minimum standards of performance are expected and monitored for adherence. The practical result of this is that OD and PHD planning and management practices are based on individual interest and decisions, and thus, the likelihood of sustained system changes is low. Strengthening a system within a weak framework is difficult and requires a high level of competence and experience in the persons trying to implement changes. They cannot simply introduce a new procedure but must understand system weaknesses and how to strategize to effect change. Among the provincial level RHAC, RACHA, and URC staff there did not appear to be the level of experience and seniority needed to sufficiently influence MoH managers with many years experience functioning within a weak health system, to make changes that might require taking a risk of some sort. At present, RHAC, RACHA, and URC are not working in a strategic way to address the systems issues that exist at all levels (i.e., from central to HC levels) that limit the effectiveness of previous and current activities to build planning, monitoring, and supervision capacity within individual OD and PHD managers.

Partners as well as OD/PHD Directors reported some instances of the Partners facilitating use of information from the ISCs, Quality Improvement (QI) assessments, and from specials studies, including community based surveys (RACHA and RHAC) during routine meetings, to review accomplishments, raise issues, input into planning, and discuss solutions. PHDs and ODs are using the ISC, although in many areas not as frequently as planned. Integrated supervision from the OD to HC seems to be more routine than PHD to OD and RH supervision.

Lack of, or late, disbursement of HSSP2 funds plays a large part in reduced supervision visits by many of the PHDs and ODs. RHAC and RACHA provided travel and per diem (T/P) costs, sometimes routinely and sometimes only to “top up” allowed T/P for remote areas, so that OD to HC supervision can take place. It is reported that these Partner financial contributions are decreasing, and in some cases, were discontinued in 2010.

The USAID Partners do not seem to have a clear strategy for leveraging HSSP2 resources, a key source of funding at the PHD and OD levels for the recurrent management costs. Little reliable information is available to the partners on the flow of HSSP2 fund to the periphery. Partner staff at the field level do not have information on the rules and guidelines governing use of HSSP2 funds, which constrains their ability to help or guide counterparts. Furthermore the difficulties encountered at the OD level with the flow of funds is not fed back up the system to the HSSP2 partners who might use this information to solve problems at the national level.

RHAC and RACHA have a long history of working beside, and supporting, the OD and PHD managers and activities. In addition to capacity building for technical and managerial skills, they have filled financial gaps (e.g., paying for per diems or funding procurements of routine equipment and supplies that are lacking) and provided transportation and even supervisory support. These activities result in tangible inputs to the OD/PHD programs, which are immediately mentioned by the OD/PHD directors when asked how RHAC and RACHA work with them. Although under the current projects they are decreasing the gap filling, there are some isolated indications that RACHA and RHAC funds have actually replaced available (albeit irregularly) HSSP2 or GFATM resources. The OD Director in Angkor Chum chose to have RACHA take over CBD activities that had previously been funded partly by HSSP2—specifically because RACHA was a more reliable funding source. In Pursat, RACHA was reported to have requested to fund some activities for which resources were already secured. Some PHDs implied that when their government budget allocation was substantially less than requested (as they have been informed will be the case in 2011), there is a tendency to shift the available budgets away from activities they know Partners will likely support.

Some PHD/OD Directors indicated that URC and PSI need to improve communications and adherence to official MoH communication lines when coming into the PHD/OD for activities. It was acknowledged that since these organizations might not have a routine presence in the PHD/OD that this might have contributed to weak communication and information sharing. One PHD Director noted that these organizations go directly to their implementing (MoH) partner and sometimes plan activities that have budget

consequences for the PHD or OD. In addition to contributing to problems in rational allocation of resources, when URC and PSI do not actively discuss and/or report their activities with OD and PHD managers, they undermine the (yet unrealized) role of the MoH as a steward of the overall health sector—both private and public.

It was evident that the OD/PHDs do not always understand the differences in objectives and resources among the four partners, and this might influence their perceptions of cooperation. They know that all partners provide financial support for training, and that RHAC/RACHA/URC provide support for PHD and some OD planning, but they do not seem clear on why URC and PSI in many provinces do not have staff assigned to work routinely in an OD or PHD (e.g., to attend meetings). Clarifying the roles of each organization might help to improve communication and minimize unrealistic expectations of the types of support that can be expected from the different partners.

Finally, it was evident that many of the issues around program planning, monitoring and supervision are based on the will of individuals—OD and PHD directors. There is no minimum level of performance that they are expected to meet and as such, there is no accountability up the lines of authority to reinforce system strengthening interventions. This is one of the issues that “everyone knows” but feels they cannot influence.

Health Information Systems (HIS): Partners have developed and are implementing systems to improve HIS data content, availability, and quality. URC developed and implemented a web-based HIS system, with full MoH buy-in, for all 24 provinces.²¹ This system allows routine HIS reports to be entered into an easily accessible database on-line providing indirect incentives for more timely, correct, and complete information. Provincial and OD level training is ongoing and the system seems to be functioning reasonably, although some PHD/OD directors expressed a need for more mentoring in the web-based system. Accessing the web-based HIS system down to ODs and health facilities is sometimes a challenge because of the limited access to the internet.

Partners are working with ODs to improve the quality of HIS data using many different methods, with the most common being peer and OD cross checking of registers against monthly reports (using a format developed collaboratively by the three Partners), and at least bi-annual “spot checking” of recorded clients against community reports of service use. The data quality improvement system is dependent on partner funds and still does not have full buy-in/ownership by the PHDs/ODs. In Pursat, RACHA staff conduct the validity checks (with OD counterparts usually in attendance) despite several years of training and TA to the OD, for the stated reason that the OD on its own would not be willing or able to document any inaccuracies identified. Partners are advocating for ODs to include costs for HIS data quality checking in their AOP, a step toward institutionalizing the practice, but the larger issue of accountability remains.

Partners are also working to improve the facility data submitted through the HIS. RHAC and RACHA both follow up to ensure more complete information from CBD is

²¹ URC is also working on web-based HIS input from NGO service providers.

incorporated in the HC monthly reports. URC has worked with the MoH to improve reporting (and investigation) for 12 reportable infectious diseases, with the focus on Siem Reap province, due to active support for this activity there, and in Siem Riep and Battambang Provincial Referral Hospitals (PRHs), in an attempt to encourage the MoH Center for Communicable Diseases to begin collecting information on the 12 reportable diseases from RHs. URC TA enabled the MoH to combine prevention of mother to child transmission (PMTCT) and other antenatal (ANC) services, previously recorded in separate books, into a single register.

RACHA continues to technically backstop the Logistic Management Information System (LMIS) developed under prior USAID programs. The hospital and OD level LMIS has been expanded into new areas to improve drug management and forward planning in ordering. Although the LMIS has been officially “handed over” to the MoH and there is a strong sense of ownership, RACHA still invests much manpower and time for routine problem solving and maintenance of the system.

The RHAC and RACHA community surveys are appreciated, and most PHD/OD staff had attended dissemination meetings on the findings. RHAC has recently begun to make its surveys a “joint exercise”; PHD and RHAC staff in Battambang reported that this has increased PHD willingness to accept the findings. In Pursat and Battambang, OD Directors reported having compared the survey findings to HIS data, particularly for indicators like FP use where the HIS is unable to capture a significant private sector contribution. The value of knowledge-attitude-practice (KAP) information in the surveys, which is not available from HIS, was also mentioned by some.

3.1.3. Special Operating Area/Service Delivery Grant (SOA/SDG)

Partners were expected to actively encourage and support ODs in meeting eligibility criteria and then helping them to apply for SOA status. URC’s Program Description includes considerable assistance to PHDs in enabling them to fulfill their role as Commissioner of SOAs. Partners were also expected to strengthen the capacity of SOA ODs to manage and monitor facility SDGs.

To date, URC has not played its envisioned role at PHD level. Lack of incentives for PHDs has been a constraint as the initial plan for HSSP2 performance-based incentives for this activity collapsed when the RGoC placed a moratorium on such payments pending development of a uniform approach for all Ministries. This has recently been established through the “Priority Operations Cost” (POC) mechanism but a system for this mechanism has not yet been delineated. A standard form for central to PHD level for SOA monitoring exists and PHD to OD SOA monitoring²² is in the process of development by the MoH with HSSP2 financed TA. URC does not appear to have an active role in that process which may contribute to a duplication of effort. Discussions with J-PIG²³ indicated that more TA was being considered to strengthen the SOA reform

²² A central level to PHD monitoring tool has already been developed, although such monitoring has only just begun to take place.

²³ The Joint Partner Interface Group established to monitor implementation of HSSP2

from non-USAID partners because J-PIG was unaware of that such activities are already part of Partners' Program Descriptions. Communications between key MoH offices and structures, such as the SOA Monitoring Group, appear to be limited. If this is not rectified, there is a risk of missing an opportunity for the USAID Program to contribute to a major health sector reform process.

URC worked as the Capacity Building Agency²⁴ for two new SOA/SDG ODs in Prey Veng under an MOU with the MoH, focusing on improving monitoring of HC and RH SDGs and improving decision making in using the SDG budget for incentives. The MOU has since ended but URC staff remain based in the province and continue to accompany the OD on facility monitoring visits. The stated reason was that, in the absence of NGO observers, OD monitors would not document or act on any deficiencies found. While that perception is likely true, the approach is not sustainable. Based on the Team's observations of facilities in one of these ODs, it is doubtful that URC local staff actually succeed in ensuring transparency in the monitoring process. The Team believes that URC should reconsider how best to work further on capacity building in those ODs.

RACHA and RHAC do not play a strong role in strengthening the OD in developing performance-based grants or monitoring the SDGs but do contribute to strengthening the ODs ability to monitor through their data quality improvement efforts. RACHA is also supporting HC level QI self-assessments and OD spot-checking of results. RHAC's involvement of PHDs in annual OD surveys could be a first step towards strengthening PHD monitoring of SOAs, particularly if the issue of PHD incentive to act as Commissioner could be resolved. There as is yet no mechanism to feed this data up to the J-PIG partners or the MoH SOA Monitoring Group, both of who were unaware that these population-based survey data are available for several SOAs.

New candidates for SOA are not being actively identified and supported by the partners. URC has provided some TA to two ODs in development of Business Plans at their request, which was in turn triggered by apparent central MoH interest not shared by J-PIG and thus unlikely to result in approval. A more proactive approach skillfully negotiated with both J-PIG and the MoH is needed and could potentially secure SOA status for a few ODs in the USAID area among those who are interested. The MoH clearly wants to see an expansion in the number of SOAs; from a donor perspective, an interview with the chair of J-PIG indicated that there is still a window of opportunity for funding "a few" additional SOAs in 2012 particularly if it could be done "in a tighter evaluation framework", but that the preliminary work would need to begin immediately.

PHDs and ODs were not clear about the requirements for initiating and following through on SOA application process, and their level of interest varies. One PHD indicated a lack of interest because of the pressure for accountability and a concern about "working too hard". ODs in the same PHD were more open to the idea, having heard from the Provincial Referral Hospital (PRH) staff (which is a SOA) some plus and minus points. Several OD Directors in Pursat and Battambang expressed a desire to obtain SOA status.

²⁴ A J-PIG requirement for the release of HSSP2 funding was the presence of an external agency to build initial PHD and OD capacity.

The OD Director in Bakan, where incentive payments by the GAVI Alliance and RACHA (through micro-credit interest, not USAID funds) have boosted facility performance, expressed an awareness that these mechanisms may be unsustainable and identified securing SOA status as a priority to ensure performance-based financing as a long term strategy to motivate staff.²⁵

A.3.2. Health Financing

In order to address financial barriers to health care, several health financing mechanisms are being used or planned in the program focus areas. These include Health Equity Funds (HEFs), Community-Based Health Insurance (CBHI), vouchers, and conditional cash transfers (CCT). Annex 5 contains more information about the various forms of financing currently underway.

Health Equity Funds: URC is supporting the implementation and expansion of HEFs with a clear strategy to promote greater responsibility by the MoH and reduce dependence on donor inputs in order to improve HEF sustainability. URC is implementing 24 HEF schemes in 28 ODs, covering about 1.5 million indigents in Cambodia. For 14 of these schemes, URC is subcontracted by the MoH-HSSP2 as a HEF implementer and all the costs are born with the government counterpart and donor HSSP2 pooled funds. URC has also managed to get government counterpart and other donor pooled funds to finance the direct benefit cost for another 9 HEF schemes, whereas USAID funds pay for NGO operating costs. Only one scheme in Phnom Penh is fully financed with USAID funds.

Although URC has had great success in establishing HEFs, they remain heavily dependent on donor financing. Donor and MoH counterpart funding under HSSP2 appears insufficient to support further expansion of HEFs (which currently cover about 60% of the nation's poor) within the HSSP2 Program's remaining 2-3 years²⁶. Longer term, the willingness of the RGoC to assume an increasing share of such costs is questionable. A comprehensive Master Plan for Social Health Protection has not yet been ratified, although policy dialogue is ongoing. Several new institutional arrangements to improve HEF efficiency (e.g. standardized price and performance-based payments to providers) have been developed by URC. Continued consultation and engagement of MoH policy makers in any new innovations (or new HEF implementation arrangements) by development partners is needed to improve chances of policy uptake. As described below, efforts are also underway to reduce HEF management costs, which are currently high in relation to the overall HEF distribution for client services.

Community Based Health Cooperative (CBHC): To date, HEFs have been managed at facility level through sub-contracts to local NGOs, which has added to the overall transaction cost per beneficiary and was difficult to standardize. URC recently initiated a

²⁵ The SOA arrangement, while still donor-dependent, is the official MoH strategy for improving staff remuneration and facility performance

²⁶ According to J-PIG, this may change depending on investment decisions pending among some HSSP2 donors.

new approach in Angkor Chum OD, where there is strong ownership and commitment by the OD director, local authorities, including commune councils, and community. The CBHC and the OD Director's strong leadership have resulted in the public health facilities in this OD performing reasonably well and have also resulted in enforcement of the MoH regulation against unregistered private practices. It is the first locally registered community-based health financing scheme officially approved by the MoH, and it incorporates elements of CBHI, HEF, pay-for-performance, CCT, and health promotion.

The CBHC in Angkor Chum is an important and very useful experiment, and there is a general consensus around the problems it is intended to address in current HEF implementation arrangements. Experience and lessons learned need careful documentation and publicity. Given the particularly conducive leadership context in Angkor Chum, other CBHC pilots may be important to reveal the pre-conditions needed for successful replication and expansion.

Voucher schemes: RHAC has implemented vouchers (called Purchasing Maternal and Newborn Health Services) in 18 ODs in the five target provinces, aimed at promoting safe deliveries. RHAC purchases services (4 ANC visits, delivery, 1 PNC visit 24 hours after delivery) from all health centers for all identified pregnant women regardless of their socio-economic status (at \$10 per case of the complete service package). Cards are distributed to pregnant women through VHSG or HCs, which entitles them to receive those services for free. In case of complications requiring hospital referral, the HC still receives the \$10 payment, but transportation and hospital fees are not covered. This system is being implemented in ODs both with and without HEFs that cover HC services. Measures are reportedly in place to avoid double payment for HC services supported by the HEF.

Although no in-depth assessment of the voucher scheme and its impact has been conducted so far, some available data showed encouraging results. Analysis of data from three ODs in Kampong Cham and Sangke OD in Battambang suggest that this scheme has contributed to an uptake in the services covered. However, utilization of these services was already increasing, and it appears that many of the beneficiaries are women who were paying and could pay themselves for these services, while the largest cost barrier – emergency obstetric and neonatal care (EmONC) – is not addressed.

There are also several voucher schemes being implemented outside the USAID Program, all of them with differences and similarities. There is a need to capture lessons learned to make decisions about improving voucher strategies. Possible options include a larger benefits package that includes transportation and costs for further referrals (including C-sections), or selling vouchers at subsidized cost to non-HEF beneficiaries/non-poor with free provision for the poor where no HEF is available.

In addition to the current voucher scheme, RHAC plans to institute conditional cash transfers (CCTs) tied to utilization of specific MCH services. There are issues in need of further consideration with regard to any incentivization of health service utilization, such as: (1) targeting to avoid overlap with HEFs where the user fees for the poor are already

covered; (2) assessing the relative cost barrier of different services as some services are low cost enough to be affordable for most of the population; (3) targeting in terms of behaviors (paying for services for which demand is already strong may prove counter-productive in the long run), and (4) sustainability and congruence with long-term national strategies for social protection.

A.3.3. MoH Service Quality Improvement

Training and mentoring: The partners are very active in training activities, particularly in-service education. They participate in curriculum revision for pre-service training, initiate activities such as ensuring harmonization of the content between different related trainings, and have developed short-course in-service training courses for particular subjects. They also support the training process by working with the Battambang Regional Training Center (RTC) and financially supporting national level training of trainers (TOT) and then helping to fund these trainers to come for regional/provincial training, and trainees to attend the in-service training at PHD and OD levels. Partners also develop educational materials for service providers.

URC/RACHA/RHAC all routinely support (technically and financially) quarterly meetings of the Midwife Coordination Alliance Team (M-CAT) that includes the MNCH Director and PHD/OD level personnel and midwives from the HC and RH. These meetings are a review of technical issues in service provision as well as accomplishment and problems, and are seen as a functioning system for improving maternal health services and quality review of issues, including those related to referrals and counter-referrals for emergency obstetric care between HCs and RHs, and improving maternal health programs. Partners report coordinating closely on M-CAT—initially about how to initiate the meetings and currently as part of preparation for M-CAT meetings by discussing agendas with the OD and PHD. The focus of meetings is on findings from HC supervision, but it is also a forum for dissemination of new information. The actual impact of the meetings is uncertain, however, the OD/PHD and partners have all expressed the opinion that these meetings are a useful first step in technical and managerial improvement for maternal health activities. There is an impression that relationships between RH staff and HC staff are improving, and that this is resulting in larger numbers of appropriate referrals and more discussion about the problems that midwives are facing in their work, as well as identification of strategies to address the problems.

Roll-out of training for key maternity topics such as Helping Babies Breathe (HBB) and Active Management of Third Stage Labor (AMTSL) varies by OD with the influencing factors being the length of time the partner has worked in the OD, and the staffing levels for HCs. In the RACHA working area training in both topics was almost universal, while in RHAC working areas roughly 70% of eligible midwives had received training in AMTSL and 40% in HBB (See Annex 4). MoH guidelines restrict training even where services are being offered. The MOH requires that there be two midwives at the HC for one to go off for training. In addition, midwives who are “floating” staff (contracted rather than MoH employees) are not eligible for training.

An assessment of need and then a strategic plan for rolling out essential MNCH training in the provinces where partners are newly expanding their work was noted for RHAC at the central level. However, neither RHAC nor RACHA Provincial Coordinators discussed strategies for ensuring that all eligible HC and RH staff would receive the planned training. Planning for effective post-training follow up both to assess the effectiveness of training and to provide on-the-job mentoring/coaching to solidify skills was also not evident. RHAC, RACHA and URC all provide on-the-job coaching and mentoring to HC/RH midwives, but these activities take a “cookie cutter” approach without individualized training needs assessments/plans and without clearly defined expected outputs. Mentoring/coaching activities have certainly had benefit, especially in the “old” provinces where they are of the longest standing, but would be more effective and cost-efficient if better planned and targeted. In the RHAC areas, there is also a need for a more intense level of MW coaching than the current human resource allotment (1 MW per 3 plus ODs) allows.

Findings from interviews in the field with MWs trained in AMTSL and HBB were that around half of those questioned appropriately quoted all essential steps in these procedures, and half missing key steps—indicating that they most likely are not practicing these methods or else are practicing them poorly. One case of life-threatening misapplication of the cord traction taught in the short course on “Key Interventions” was found on the part of a primary MW with no prior experience with the technique. The AMTSL content of that course is based on a formal assessment done in large hospitals, where midwives are usually secondary level and have had prior competency-based training/clinical preceptorships that included all elements of AMTSL. It is thus designed as a refresher for clinicians who already have the basic skills, but is in fact being given to a much more heterogenous group. A short classroom-only presentation of cord traction is insufficient for ensuring its safe application. There is an urgent need to either revise the criteria for receipt of this training or, better yet, to develop a separate version for primary MWs who have not had prior clinical competency-based training in AMTSL.

Doctors and medical assistants manage the most critical emergency obstetric cases in triage areas, intensive care units (ICUs), operating theaters and post-surgical wards. URC has recognized the practical need to ensure the availability of well-qualified physicians for mentoring of doctors and medical assistants for improved EmONC practices. URC conducts clinical case reviews of maternal deaths and “near misses” in a few hospitals, has worked with NMCHC and UNFPA to design EmONC training for physicians, and supported Continuing Medical Education for physicians and midwives in EmONC topics. In 12 of the focus area’s 38 RHs, URC also provides on-the-job coaching to RH midwives. However, there is an unmet need for on-the-job training/coaching of physicians/medical assistants – especially those not assigned to the maternity service -- in the clinical management of critically ill obstetric patients. Such coaching would have to be undertaken by physicians, while at present the RH-based mentors are all midwives, and sometimes comparatively young/inexperienced ones. It was also found that URC’s midwife coaches were not well accepted by midwives who considered themselves to be more senior, e.g. those in Battambang Provincial Hospital who are LSS trainers.

There is not yet an overall plan among the partners to provide mentoring/coaching toward improving the skills and maternity practices of all cadre of service providers in maternity wards in the other hospitals in the USAID Program area beyond where URC is working. There is also no explicit strategy yet to include providers of emergency, ICU and surgical services in training and mentoring for case management of emergency obstetric cases, focusing on the main causes of maternal deaths among the cases they receive.

Discussions with the maternity service personnel in several hospitals found that they were highly sensitized to the priority being given to reducing maternal mortality and made every effort to transfer women likely to die off the service and into ICU or surgery as appropriate. The head of Maternity in one provincial RH, when challenged about her claim that there had been no maternal deaths in the past year, responded by explaining that deaths “did not count” if they occurred on another service. While the improved referral of critical cases to surgery or ICU is a positive development, it brings with it an increased demand for improving the skills and practices there. The level of “ICU” care in several of the RHs visited was found to be extremely poor (e.g. vital signs taken only once a day) and the staff not sensitized on the issue of maternal mortality as a priority nor familiar with some relevant protocols e.g. guidelines on management of severe anemia in the context of pregnancy.

Quality Improvement (QI) systems:

QI tools: URC has been a leader in developing QI tools including succeeding in institutionalizing Level 1 tools for RH and HC. They successfully integrated some quality items in the ISC, which has also been adopted by the MoH and incorporated minor revisions in the Level 1 tool to include additional aspects for infection control. At the suggestion of the OD director, URC is experimenting with conducting the Level 1 QI assessment quarterly, using sub-sets of the tool for RH and for HC in Angkor Chum OD, and with adjusting HEF reimbursement to the score.

In order to improve adherence to AMTSL standards, URC is piloting adding a specific section for this on the partograph.

URC recognized the need for a Level 2 tool with more depth related to the quality of clinical care than the Level 1 QI tool provides. A draft was tested in several Provincial RHs, with initial feedback from some the directors that this is time consuming, complex, and difficult to achieve a successful assessment using this tool.

Progress on moving the Level 2 tool forward has stalled, and there is insufficient buy-in from the MoH Quality Assurance (QA) Department eager to have a second level tool but uncertain what the URC plan is with regards to this. URC is using the Level 2 obstetrics and pediatrics modules in Battambang Provincial RH, with the objective of testing and refining the tool. The experience with Level 1 QI tool was that with testing and intense interactions with the MoH at relevant levels- including facilities where it was used - resulted in compromises so that the tool could be fully endorsed, and that most users

(including other donors) believe that the Level 1 tool does result in an awareness of MPA and CPA²⁷ standards and provides an incentive to work on improving the quality of services. This successful precedent for institutionalizing a QI process is not being followed for Level 2.

QI Implementation: URC has trained partners to conduct self-assessments using the Level 1 tool so that they can help HCs in ODs where they work. The ODs are then spot-checking the self-reported findings. This is being implemented in RACHA areas where OD and HCs were enthusiastic about the process. In cooperation with URC, RACHA is training PHD and OD staff to conduct QI assessments (for HEF certification). RACHA is also using the Level 1 tool maternity section in a few RHs as one of their activities to improve the quality of maternity care.

RHAC helped the MoH to conduct initial QI assessments for a number of RHs and HCs in 2009 and used this information as a baseline for improving quality. RHAC has not followed up on promoting self-assessment or subsequent repeating of QI checks in the facilities they assessed in 2009 because they do not see the use of the results, mainly in the absence of HEFs or SOA/SDGs.

Although the MoH expresses strong support for Level 1 annual assessments, they have not mobilized sufficient funds to carry this out. For 2010 they were able to use HSSP2 funds for 10 RH assessments, and to convince other donors (VSO²⁸ and French Corporation) to fund additional QI assessments in ODs that these donors support. URC's recently introduced system of encouraging HCs themselves to pay for the cost of the external Level 1 assessments to maintain eligibility for participation in a HEF seems to be a promising alternative to a more centralized source of financing for these assessments.

URC/RACHA/RHAC all support the PHD level leadership in conducting maternal death audits and verbal autopsies, participating in the review of findings at the PHD level. URC is also conducting a review of "near misses" in Battambang and has introduced general death audits in Battambang and Preah Net Preah RHs. Partners have advocated for inclusion of clinical practitioners in the process, which has thus far been carried out primarily by managers.

There is considerable backlog in investigation of reported maternal deaths in some provinces, and the numbers of reported deaths are low given the national maternal mortality ratio (MMR). URC reported discussing this issue at the central level, however, none of the partners mentioned the need for advocacy to improve reports on maternal deaths at all levels. There was no expression of awareness from the RHAC or RACHA coordinators that this was an issue of concern, which may be more related to a lack of expertise in the systems aspects of maternal death audits (i.e., investigating reported deaths being one aspect and improving reporting of deaths being another).

²⁷ MPA – Minimum Package of Activity (HC level) and CPA – Complementary Package of Activity (RH level)

²⁸ Volunteers in Service Overseas—a British organization

URC selected 8 sites from among 38 hospitals in the 37 ODs where USAID partners are working (which includes 7 Provincial and District RHs and 1 former district hospital in Pouk, Siem Reap) for QI inputs in a program called Hospital Improvement Program (HIP). URC's MNCH activities are also implemented at these 8 sites and in 5 additional RHs where the HIP QI inputs are not be implemented. The MNCH sites include midwifery coaching and mentoring, support for M-CAT and other training.

In one of the HIP/MNCH hospitals, Battambang Provincial Hospital, intensive clinical training/mentoring and pilot system development activities are underway to develop a "Model Hospital". This pilot-type activity is not included in URC's Program Description or the USAID AAD, and there is no indication of buy-in to the concept by the MoH QA or Hospital departments.

The lack of QI input from URC in the remaining 26 hospitals²⁹ in the ODs where USAID partners are working poses a significant constraint to ensuring the availability of quality emergency EmONC services. (See discussion in Section A.3.4.) The intent of the program described in the AAD and the URC Program Description was to apply QI systems broadly, not in a small number of selected institutions. RACHA and RHAC have in some cases made inputs to try to fill this gap but neither organization has the resources to do this at a sufficient scale and it is outside the scope of their program descriptions.

There are many examples of model hospitals in Cambodia-including private facilities and many previously contracted RH in the USAID focus provinces. Evidence is that with external management and funding support developing a well functioning facility is very feasible. Experience has shown that these deteriorate after pilots are completed when the OD and RH management returns to the MoH system, except those having exceptionally good leaders. It is unlikely that anything new with regards to quality improvement and HSS will be realized with URC's model hospital strategy.

A.3.4. Service strengthening

Service conditions: In addition to activities discussed previously—almost all of which contribute to service strengthening - partners are successfully focusing on ensuring that needed supplies and commodities are consistently available in HCs, including critical work-aids such as posters with emergency obstetric interventions and IMCI guidelines. The same is being done on a less comprehensive scale in some of the RHs.

Partners have provided specific new equipment and facility refurbishment directly related to activities they are promoting (infection control, improved delivery services) but in addition, they continue to fill gaps by replacing equipment (all Partners using project funds, and RACHA using micro-credit interest), installing water systems, and refurbishing service areas when HSSP2 funds are not available. While this practice supports service delivery, it is not a strategy for strengthening the health system in the long term.

²⁹ 38 RHs minus the 12 RHs where URC is implementing EmONC activities, 13 sites if also including the 1 former district hospital still classified as an HC.

Delivery services, available 24-hours, were universal in the “old” provinces where partners have a longer presence. MWs reported receipt of the government incentive of \$15 (with some reports that they actually receive less, or “share” the money with other staff). There was a noticeable difference in the availability of 24-hour services, the attitudes of staff, and the health center operations where the HCs were working under SDGs or HEFs.³⁰ A similar effect has been achieved in Pursat and Banteay Meanchey where there are no SDGs, but there is the incentive of increased user fees (due to the presence of a HEF) and in Pursat with additional performance-based incentives provided by the GAVI Alliance and out of the interest from community micro-credit implemented by RACHA in Pursat. The additional monetary incentives are not sustainable mechanisms and some OD managers expressed a sense of urgency in obtaining an SOA so that services will not regress when their support ends. RACHA’s performance contracts with staff for 24-hour services began prior to the HEF; however, there is no indication that they plan to discontinue this incentive even though the HEF is now in place.

The main service conditions that were identified as problems in these HCs included expired items in emergency delivery kits, inadequate general hygiene and poor disposal of contaminated waste.

HC services in the newer working areas for RACHA and RHAC (Prey Veng and Kampong Cham) were noticeably less consistently available, even where there were SDGs and HEFs. Although HCs in Kampong Cham had most of the key commodities and infrastructure assessed, they were not as well equipped with protocols and guidelines—and more likely to be open mornings only with on-call staff for emergencies. Community members did confirm that staff do come when called. In Prey Veng, several HCs and one RH were found to be “ghost” facilities, completely locked and unstaffed.

Roll out of new policies and services: The MoH has recently, as part of its Fast Track Initiative, designated specific health facilities in each OD to provide CEmONC or BEmONC. All RHs are designated as either CEmONC or BEmONC, generally in keeping with their CPA level, e.g. all CPA 3 RHs are designated to provide and CEmONC and all CPA 1 RHs are designated to provide BEmONC. Most CPA 2 RHs are also designated for CEmONC although in some cases they have only a BEmONC designation. In a few cases, HCs which are former district hospitals (“HCs with beds”) have also been designated as BEmONC facilities.

RHAC and RACHA are actively supporting the HCs within their geographic catchment areas to provide BEmONC wherever they have been designated to do so by the MoH, and have also advocated with the MoH to add HCs not currently designated as BEmONC but with the potential to provide all BEmONC signal functions. They report being told that there is no restriction on assisting additional locations to provide BEmONC if they have

³⁰ In Cambodia, 172 of the total 992 HCs have a HEF, all of which (except 9 supported by BTC) are supported by URC.

the capacity.³¹ In the RHs where URC has a presence, they are following up to ensure that the designated level of EmONC is available. RHAC has taken the initiative to conduct a needs assessment of the RHs in the provinces where it works to determine what if any inputs are required to deliver the designated level of EmONC, but it is unclear how/by whom these gaps will be addressed.

Equally important is the need to ensure that EmONC services are of sufficient *quality* to have their intended life-saving effect. The evaluation team directly observed several instances where this was not the case, including a woman at imminent risk of death due to medical mismanagement and neglect after a caesarean section and an inadequately monitored woman with placenta previa. As noted in the prior section, URC's QI activities to date are found in a sub-set of RHs. This is a major concern that if unaddressed, will constrain the potential mortality impact of EmONC services.

Partners are actively rolling out components of the new Safe Motherhood Protocol (AMTSL, HBB and MgSO4 for eclampsia), advocating and facilitating construction and refurbishment so labor and postnatal care (PNC) waiting areas are available. RHAC reports tracking ANC and PNC activities (weight, counseling, IFA, VAC) from the HC1 report and providing feedback to the OD and HCs to improve the components of these services.

The “linked response” for HIV testing for pregnant women has been rolled out in all ODs and HCs by RACHA and RHAC, and both observation and the HIS confirm that HIV testing is now integrated into ANC. Partners are also supporting the linked-response for HIV testing for TB clients (and TB tests for HIV positive clients), and for syphilis screening of pregnant women.

Partner efforts are increasing the availability of long acting FP methods. RHAC has an IUD service expansion plan and is rolling out training and services where HCs meet the eligibility criteria. A dramatic increase in IUD use has ensued in ODs where the rollout has been completed. RACHA has not yet developed such a plan for ODs it supports. PSI has carried out training for private sector providers followed by demand creation campaigns to expand IUD utilization.

RHAC and RACHA are expanding their child health and nutrition activities, rolling out IMCI training. Zinc with ORS is being used universally in HCs, with most staff reporting their training came from IMCI. Both RACHA and RHAC have plans to expand their activities for Infant and Young Child Feeding (IYCF).

V. B. Program Cohesiveness and Synergy

B.1. Design vs Actual Program and Projects

³¹ There may, however, be difficulty in obtaining some equipment from the MoH as the officially designated BEmONC sites will get first priority; this will primarily be a problem with regard to vacuum extractors and MVA kits.

The AAD is explicit about the partners working together in a strategically coherent approach to address the objectives of USAID’s health program and to support the HSP2 on capacity building of the health care system, both public and private. Each partner’s specific project was designed to depend upon the inputs and contribution of the others.

URC’s project has evolved considerably and diverged from the original Technical Proposal, which serves as the CA Program Description. The activities listed in the RFA for the health systems strengthening component of the program directed the recipient to work primarily at the national and PHD levels while the local partners, RHAC and RACHA were to focus at OD, HC level and the community. URC’s mandate was to develop and strengthen MoH systems – in particular, the performance based grants and health service agreements now called SOA/SDGs.

In addition to nationwide efforts to further develop MoH QI systems, URC’s Program Description details plans to provide, in the focus provinces, TA to health facility staff (implicitly those in hospitals) in development and implementation of facility-specific quality improvement plans and coaching in best clinical practices for inpatient care (explicitly a hospital activity). The URC Program Description states that each province will assign one Assistant Provincial Coordinator (APC) “whose sole duty is to work with facility staff to improve service quality.”³² It also states that URC’s provincial staffing will include a “quality mentor who also works with clinicians to improve compliance with best practices.....placed in every grouping of 3 ODs”. Although not specified in the text, these staffing inputs are implicitly for hospitals, since they would hardly be feasible in number to work at HC level, and CAs were already known to be in place with RHAC and RACHA.³³ The MNCH section of the URC proposal describes working at the national level on policies, guidelines, systems and then says it will be working with the USAID partners on strengthening implementation at the lower levels. URC’s MNCH activities were delayed until the second year due to changes in the staffing in the MNCH team.

URC has no activities to date to strengthen inpatient clinical care in the provinces of Kampong Speu, Sihanoukville and Prey Veng³⁴ nor in the referral hospitals of Thmar Pouk and Mongkolborei ODs of Banteay Meanchey Province, Thmar Kol OD in Battambang Province, or in Pailin. Clinical mentoring and TA in quality improvement is being given in a subset of hospitals at a much greater level of intensity than described in its Program Description and a very ambitious, resource-intensive “Model Hospital” effort is underway in one hospital. Lack of QI inputs beyond the 13 sites in the HIP and MNCH programs is constraining the activities of RHAC and RACHA, whose efforts to strengthen HCs leads to increased referrals to the higher level, especially obstetric emergencies. (See Annex 7 for a map depicting the quality improvement activities of the USAID partners by level in the health care system.)

³² URC Technical Proposal p. 9

³³ URC’s CA was awarded a year after that of RHAC and RACHA.

³⁴ With the exception of short-term assistance focused on Infection Control in 2 of Prey Veng’s 7 RHs.

In recent years, both the MoH and its development partners have become galvanized around the challenge of reducing maternal mortality given that it remains stubbornly high. Essential to achieving maternal mortality reduction goals articulated in the Fast Track Initiative is strengthening EmONC services at hospitals. The capacity of Provincial and OD hospitals to manage obstetrical emergencies with an acceptable level of quality is clearly a critical rate-limiting factor for reducing maternal mortality. URC's mandate should include providing leadership in this area, which was clearly anticipated by the other USAID partners who have little experience working at the hospital level. In keeping with its Technical Proposal/Program Description, URC should be involved in assessing the capacity of each RH in the USAID Program area to deliver the level of EmONC designated by the MoH in a manner consistent with generally accepted medical standards of care. That should include determining gaps and deficiencies and then working with all available partners in the MNCH program to address needs. Improving maternal health services at the HC level depends on having reliable appropriate intervention at referral hospitals to ensure that avoidable pregnancy and childbirth related deaths can be averted.

The AAD also envisions all partners working on managerial capacity development (OD/PHD/HC) in a coordinated way. The team observed that the partners working at the OD level on helping with AOP development or improving supervision were simply continuing to work as they always have, with little in terms of a strategy or understanding the problems that interrupt smooth financial flows, or the rules and regulations applying to the HSSP2 funds. Activities in support of the HSSP2-funded SOA reform process were included in URC, RHAC and RACHA's Technical Proposals/Program Descriptions but have for the most part not been implemented. Initially, this may have been partly due to delays in the MoH setting up its own systems and implementing bodies. RACHA informed the Evaluation Team that its project has completely dropped the I.R. for those activities. See further discussion on the impact of this in B.3.

B.2. Partner Collaboration at National and Sub-national Level

The three partners working on public sector capacity development have taken some very positive steps, especially at the national level, to work more collaboratively. Joint work plans have been developed in family planning and nutrition. It remains to be seen how well this will work out operationally. As noted in Section V.A.3, collaborative efforts at the national level have resulted in important new protocols, guidelines and changes in policy. There have been important victories in effecting policy change (MgSO₄, PMW and PP IUD insertion). However these policy achievements have not always been followed up with assistance in implementation at facility level.

None of the partners appear to have a clear vision about the program synergies and how they were expected to work at various levels to achieve goals. Practical joint work at the provincial and OD levels appears to be fairly minimal and it is difficult to change old proprietary nature of each organization despite directives from headquarters about working together. The expected collaborative activities of each partner are not being effectively orchestrated from the central level of each organization.

The need for USAID partner collaboration and joint action is strongest in areas where specific operational problems and challenges are encountered and need to be fed back to PHD and national levels. Overlap is less of an issue than gaps and missed opportunities for increasing impact through joint action.

B.3. Strategic Collaboration with HSSP2

Design of the USAID Program followed the (other donor-financed) design of HSSP2, and was explicitly structured to interface with HSSP2 in such a way as to leverage its considerable resources and address anticipated problems both with the overall flow of funds and with the performance-based aspect of the SOA reform. As noted above and in Section V.A.3, few of the planned interventions have been implemented to date. This has the effect of weakening both the USAID Program and the HSSP2, which could greatly benefit from the strategic presence of USAID-supported NGOs at provincial and OD levels, and from national level assistance in strengthening systems related to fund disbursement and Monitoring of SOAs. URC is best placed to liaise with J-PIG and relevant MoH agencies on various issues and challenges, with feedback to and from RHAC and RACHA at the periphery. URC has so far done this effectively only with regard to the HEFs. USAID staff participation in communications with J-PIG is very important given that URC cannot represent USAID.

Delays in developing a MoH unit responsible for SOA coordination at national level had caused uncertainty for USAID partners. Now with the recent establishment of a functional SOA Monitoring Group,³⁵ it is critical for USAID and partners to liaise with that unit and work more explicitly on SOA ‘readiness’ activities. While SOA expansion is felt to be desirable in general, concerns remain about how their impact can be evaluated. Dialogue on SOA development calls for skillful dealings with both J-PIG and the MoH, identifying and taking advantage of areas where the interests of these two entities potentially coincide.

B.4. Strategic Collaboration with the D & D Initiative

USAID partners could do more to support governance activities with HCMCs and Commune Councils, including assistance in programming resources in the CIP for community health priorities. Unfortunately this aspect of their mandate is not clearly understood, even at the headquarters level, and is outside their comfort zone. This needs a push from USAID. In fact, a meaningful contribution from the partners on governance of the health system at the community level could be a most productive ‘private sector’ contribution to the HSP2 and the D&D initiatives contemplated by the RGoC, World Bank and other donors. The team found that the World Bank, for instance, was not aware that USAID partners, RHAC and RACHA, have a mandate to work on this issue and have begun to work with Commune Councils; this would be an appropriate topic for one

³⁵ The Monitoring Group was established more than a year ago but did not function; in late 2010 it was restructured and its membership expanded to allow 5 subgroups each responsible for a specific province(s). Active monitoring occurred during the course of this Evaluation, although the quality of same remains to be determined.

of the regular J-PIG meetings. It would also create a valuable synergy with past and present USAID/Cambodia investments in strengthening governance/civil society.

Working on governance, however, means that one of the partners must liaise with the National Council for Deconcentration and Decentralization (NCDD) within the Ministry of the Interior to have a better sense of the overall plans for strengthening Commune Councils, obtain practical information on guidelines for CIP preparation and disbursement of funds, and advocate for TA to help CCs better understand the concept of decentralized planning and empower them to use the resources at their disposal. URC seems to be a good candidate for doing this at the national level, with two-way feedback to/from RHAC and RACHA.

The recently enacted MoH client rights Charter is potentially a very powerful tool for empowering communities and placing demands on the health system for improved accountability. However, partners at the community level (RACHA and RHAC) need to move beyond their normal institutional working relationships with the MoH and reach out to human rights and other community based organizations to work on issues such as disseminating information about client's rights. Doing so would also serve to broaden their organizational capacities and position them favorably to increase their non-US government funding bases, as resources for such activities are expected to increase.

V. C. Principal External Constraints

The Program operates in an environment that, like all developing countries, imposes constraints. An over-arching one is of non-transparency and impunity at all levels of government, including the MoH. More specific constraints include:

Health Financing: There is an evident lack of political will to provide resources for expansion of the HEF to the approximately 40% of the country not currently covered by it. This results in serious financial constraint to accessing EmONC in 11 of the Program's focus ODs³⁶ and calls into question the long-term sustainability of existing schemes. A national Master Plan for Social Health Protection – which would include mechanism for assuring access for both poor and non-poor -- was developed but has yet to be ratified by the RGoC. Funding for even the existing HEFs is assured only through the end of HSSP2 in 2013.

SOAs/SDGs: SOAs/SDGs, while far from perfect, offer potential for improving resources for service provision and staff motivation. HSSP2 resources for expansion of the number of SOAs (22 ODs and 8 Provincial RHs) are sufficient for only a few more. This means that less of the USAID focus ODs than had been hoped for can come under the scheme. In addition, the likelihood of post-HSSP2 donor support for SOAs will depend on current performance. The MoH's refusal to allow external monitoring of SOA

³⁶ All 3 ODs in Kampong Speu Province, 5 of the 7 ODs in Prey Veng Province. 3 of the 10 ODs in Kampong Cham

performance creates a risk that payments may not really be performance based.³⁷ An additional constraint to SOA performance at the start of the USAID Program was an RGoC directive halting donor-funded incentive payments to non-service providers, which resulted in PHDs having no incentive to fulfill their role as SOA Commissioners. The RGoC has, however, recently enacted a mechanism whereby such payments can resume/be instituted, the “Priority Operation Cost”.

Human Resources: Although midwife coverage at HCs has been extended considerably, there is a nationwide shortage of trained midwives, especially secondary level. Approaches are underway to address this but progress is slow and incremental. In some Provinces matters are exacerbated by lack of PHD cooperation in removing “ghost staff” from the rolls and in rationally allocating staff between urban Provincial hospitals and rural facilities.

Technical Policies and Guidelines: Although there has been progress in developing technically sound and feasible guidelines, barriers remain with regard to community-based treatment of child illnesses such as ARI, and provision of PNC by VHSGs.

Low population density in rural areas and lack of market access: many of the country’s rural dwellers – and a disproportionate number of those below the poverty line – live in very small villages where market forces do not lend to the establishment of shops. Normal distribution channels do not effectively reach the numerous petty vendors in such villages. While this does not render Social Marketing approaches impossible, it certainly makes them more difficult and costly to implement outside urban centers.

V.D. Management and Implementation

As pointed out in earlier sections of this report, each of the USAID partners has its strengths and weakness in relation to program management and implementation. Issues identified by the evaluation team are discussed below.

Provincial coordinators and field staff of RHAC and RACHA are inadequately informed as to Project strategies and interventions, including the contents of the “Community Package” they are supposed to implement. This is especially the case in the “new” focus provinces. In RACHA areas, there is also a lack of awareness that interventions are expected to be to scale and what the definition of “scale” is, i.e. all applicable villages in all ODs in the case of community activities and to all HC in the case of facility inputs.

Partner staff in the “new” areas are in many instances weak and/or inexperienced and have not received sufficient technical and managerial support. To accelerate work in the new provinces, the evaluation team would suggest intensified programmatic help from headquarters staff, as well as long term intensive (at least 6 months) TA from well-oriented Cambodian consultants with experience managing field programs to assist with

³⁷ As suggested earlier, RHAC and RACHA (once methodological problems are addressed) annual surveys are a reasonable model for monitoring SOA performance on service coverage and their use for this purpose might be explored further.

planning and implementing all Project components. For RACHA, shorter-term TA should also be provided to the 'old' provinces to introduce better methods of tracking the coverage of community interventions and strategies for rapid consolidation. RACHA's planning processes are highly decentralized which fosters creativity and encourages innovation, but on the negative side, contributes to the tendency not to bring interventions to scale, since field staff are more enthusiastic about new ideas than consolidating coverage of existing programs. Stronger programmatic guidance from the central office is needed.

All partners would benefit from management reviews to strengthen their ability to implement their respective projects. USAID has already commissioned such a review of RACHA, but needs to ensure that the follow-up on the recommendations is implemented completely, particularly with regard to full delegations of authority to the new senior management positions. URC needs a management review to help improve communications among its own staff and strengthen the understanding of field staff about the key project strategies. Communications with government counterparts at the national level could also be strengthened. PSI needs a review to help its efforts to create a new a Cambodian NGO, in particular to look at managerial capacities and readiness issues. RHAC could benefit from a review of divisions of labor between senior and middle management, the adequacy of human resources at the level of middle/senior management (including Provincial Coordinators) and systems for technical and managerial support to the field.

Monitoring and Evaluation: Partner Performance Monitoring Plans (PMPs) have been adopted directly from their respective Technical Proposals and are not harmonized for partners with similar objectives and activities. Although there are a number of common indicators for health services and practices, harmonizing indicators relevant to health system strengthening, including PHD/OD management, and creating new indicators for the roll-out of the new Safe Motherhood Protocol and EmMOC plans will contribute to USAID being able to monitor individual projects as well as the overall Program. After agreeing upon common indicators where these are needed but do not exist, new Project PMPs and then an overall Program PMP should be developed.

These indicators should be outcome rather than process based whenever possible so that partners are free to use different strategies to achieve the same objective. The process of negotiating HSS indicators will help to clarify weaknesses in some of the strategies for HSS. New Safe Motherhood indicators might include a) percent of BEmONC/CEmONC facilities currently providing all signal functions for that level and b) percent of HCs trained in eclampsia management and with MgSO₄ on hand. Examples of PHD/OD management strengthening indicators might include a) percent of ODs/HCs receiving ISC supervision from the PHD/OD within a reasonable time period; and b) percent of PHDs/ODs submitting AOPs with [reasonable level] supervision T/P fully costed. Thought should also be given to indicators of transparency and increased ability to problem-solve, and ability to access HSSP2 funds.

It is recognized that many HSS activities and practices are beyond the capacity of the Partners to influence at OD or PHD level, so where a target is not reached, an explanation of where the system did not support the achievement of the target needs to be provided, to document explicitly barriers to strengthening health systems and to develop a body of objective evidence for consideration at donor and MoH policy levels. This will happen if there is a section in the M&E reporting form beside the HSS indicators for writing this information.

RACHA and RHAC both conduct community-based surveys which should yield interim information for progress in achieving impact and coverage in their projects and that, if methodologically sound, can be used by government and HSSP2 donors to help monitor SOAs. Previously, RACHA conducted the survey twice a year, but reduced this to an annual survey, which is sufficient for project monitoring and providing evidence to crosscheck HIS results. The RHAC survey methodology with regards to sampling methods and selection of respondents seems methodologically sound and implemented with good practices. The RACHA survey methodology with regards to sampling methods and selection of respondents has weaknesses that probably bias the results toward better findings. Both surveys use different questions and slightly different definitions for measuring indicators where harmonization is desirable and should be feasible. Specific recommendations for RACHA regarding the community-based surveys are provided in Annex 6. These would need to be addressed before promoting data usage by others.

Although most partner monitoring systems and methods are basically strong, some project-specific issues were noted. These include the following:

1. PSI project monitoring does not present a clear picture of coverage—particularly of rural, most vulnerable populations in most need of availability of Child Survival commodities promoted through PSI. There is a need for indicators that reflect rural population access and use of PSI commodities. This information can be collected through the RACHA/RHAC community based surveys.
2. RACHA reporting on indicators in progress reports is confusing and easily lends itself to misinterpretation. Suggestions for improving the way that progress toward achieving indicators is reported are included in Annex 6.
3. None of the projects appear to have a systematic methodology for central level monitoring/validating of provincial reporting on non-service related indicator information (e.g., reports from field on health system strengthening indicators such as ISCs completed by OD). Periodic random validation of program reports from the field by headquarters is essential to ensure the quality of information.
4. The RHAC and RACHA program monitoring requires information on community service coverage. Monitoring and evaluation reports should indicate coverage by percent of villages within a catchment area. There should be scope to indicate where other organizations are providing the coverage as well as the coverage supported by the Partner, so that Partners and USAID can identify if gaps exist.

V.E. Likelihood of Contributing to USAID's Program Objectives

IR 1 – Reduce impact of HIV/AIDS, TB and other infectious diseases

Program inputs are contributing to improved integration of VCCT with ANC within the framework of the linked response. Nationwide, only 22.0% of public sector ANC client received an HIV test in 2008, whereas 51.3% of women surveyed reported it in the RHAC supported provinces in 2010 -- an increase from 35.5% in 2009. Similar survey data is not available for the RACHA area, but dividing the number of ANC HIV tests reported by them in the second half of FY10 by an estimated number of ANC visits derived from the HIS suggests about 24.7% coverage for public sector clients; the actual may be higher as neither numerator nor denominator include services at RHAC Clinics.³⁸

C-DOTS coverage is to scale in the target provinces, although often implemented by non-USAID funded agencies. RHAC is tracking whether or not there are any gaps in such coverage and coordinating with the agency in question to assure such are addressed. RACHA appears to take a more hands-off approach when another agency is implementing C-DOTS and needs to monitor better to ensure that all villages far from the HC are covered. All in all, though, access to TB treatment in the coverage area is good, and likely to contribute to the decline in TB prevalence already occurring in Cambodia. National TB Program data confirm that the cure rate in the USAID area is above 85%.

URC, RACHA and RHAC have implemented activities likely to improve community awareness and to strengthen health facility capacity to recognize and respond to outbreaks of infectious disease. RHAC's population-based survey shows very high awareness (>97%) of H5N1.

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

The provision of **ANC, delivery and child health** services is definitely improving at HC level. More than 70% of recent deliveries in the focus provinces took place in a health facility in 2010³⁹. There is no percentage available for the rest of the country yet, but based on the total number of deliveries performed in government HCs and RHs since the start of the Project⁴⁰, it appears that the proportional increase occurring in the USAID area is greater than in the rest of the country (186% vs. 131% between 2007 - 2010).⁴¹ Perhaps more importantly, the pace of upward trajectory was maintained in the program

³⁸ MoH Health Information System, RHAC population-based survey 2010, RACHA 4th Annual Report. Although Siem Reap Province falls within the general RACHA catchment area, RHAC has a clinic there. In addition, the RHAC clinic in Battambang gets clients from the adjacent RACHA-supported provinces of Pursat and Banteay Meanchey. RACHA's reporting (PEPFAR indicator) relates only to facilities they assist and thus would also not reflect any HIV testing or ANC done at RHAC Clinics

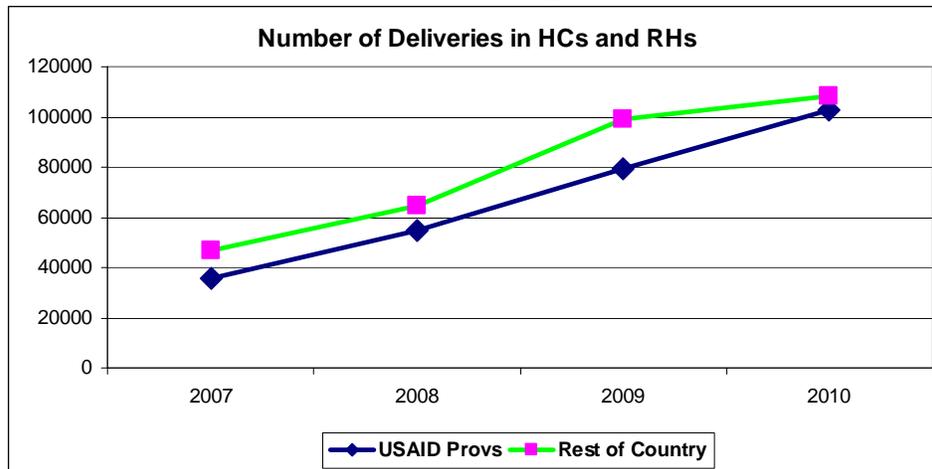
³⁹ RHAC and RACHA population-based surveys 2010. These do not include Phnom Penh, which is a focus province only for selected activities such as RHAC clinics.

⁴⁰ Source: MoH Health Information System.

⁴¹ For the purposes of this analysis the USAID focus areas consist only of the 9 provinces with activities at community, HC and RH level, and do not include Phnom Penh.

areas from 2009 – 2010 while it has begun to level off elsewhere. The MoH midwifery bonus payments were introduced nationwide in late 2007; as the graph below shows, considerable increase continued to occur in the focus provinces well after that.

Figure 4



Source: MoH Health Information System

Data from the RACHA annual survey make evident that transportation barriers in particular must be addressed to continue this upward trajectory: 74.5% of women who had an untrained birth attendant (N= 98) in 2010 cited either lack of transportation or lack of a trained midwife nearby as the reason.⁴² As noted in Section V.A., progress in putting village transport systems in place has thus far been slow and fragmented.

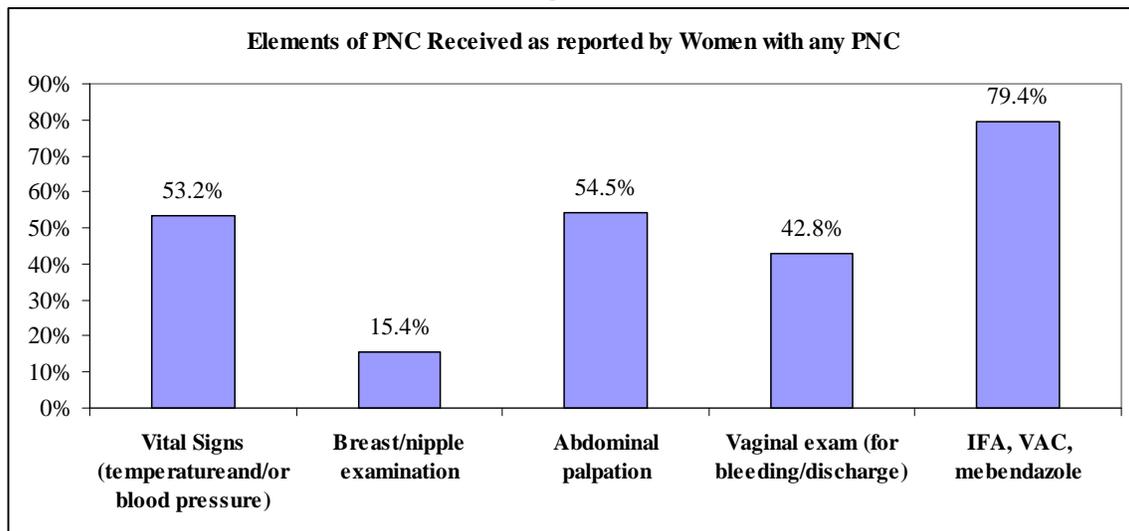
Provision of **CEmMOC** is increasing as evidenced by a 77% increase in the total number of C-sections performed in public facilities in the focus provinces: 1371 in 2007 vs. 2427 in 2010. However the overall C-Section rate (about 2%) remains far below the 10% known to lead to measurable reductions in maternal mortality. The cost of CEmMOC remains a significant barrier. Eleven of the 37 USAID focus ODs have no HEF. Even in locations with a HEF, the current RH pricing structures (official and “under-the-table”) are unaffordable even for the rural middle classes; total RH charges for a C-Section requiring transfusion are generally reported to range close to \$200 in rural areas, and the families of non-HEF beneficiary patients with recent C-Sections interviewed by the Evaluation Team all reported sales of assets (including all or most of their farmland) and/or borrowing money to meet the costs. In addition to cost barriers, many of the facilities that are designated to provide BEmONC/CEmONC either do not yet provide it or do so in a sub-standard manner. Lack of capacity building inputs in most of these RHs, if not addressed, will prevent this from being rectified.

PNC: PNC1 coverage has improved but mainly as a byproduct of increased facility deliveries. Both the Evaluation Team’s field observations and the HIS indicate little improvement in PNC2 and PNC3. In terms of post-partum infection, it is PNC2 that is most critical and this is not improving, nor is likely too until MoH guidelines are revised

⁴² RACHA population-based survey tables, 2010

as it is not proving feasible to get women to travel to the HC for a routine PNC check in the first week after delivery. An additional constraint, which will likewise limit impact on maternal morbidity/mortality is that when PNC is provided, it often does not include all key elements. Medications (IFA, VAC and mebendazole) are given more reliably than is physical examination. Between this and the fact that there is seldom a second PNC, there is still little proactive early detection of post-partum infection occurring. PNC at this stage focuses more on maternal health than the health of the newborn.

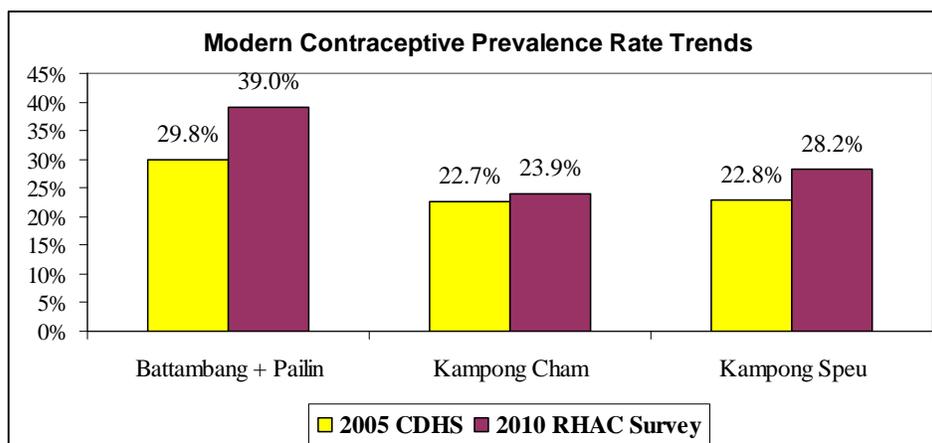
Figure 5



Source: RACHA population-based survey 2010

RHAC and RACHA survey data suggest that levels of child **immunization** have increased and are now around 80%, as is **VAC** coverage in the RHAC areas. The RACHA surveys did not include questions on VAC. It would be advantageous for both partners to use the same questionnaire and methodology.

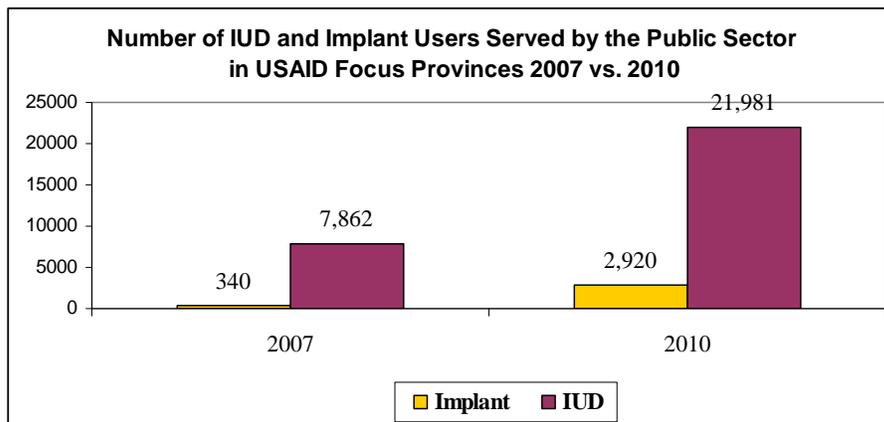
Figure 6



The following graph compares the percent of married women of reproductive age (MWRA) using a modern method of

family planning by province in the 2005 CDHS to that estimated from the 2010 RHAC survey.⁴³ As can be seen, there has been a significant increase in use in the provinces of Battambang, Pailin, and Kampong Speu where RHAC had an established presence at the start of this current Program, but little change as yet in Kampong Cham, its expansion area. Methodological problems with sample selection preclude the use of data from the RACHA surveys⁴⁴, and the CDHS combined Koh Kong and Sihanoukville. The overall modern CPR in the RHAC area is about 30% including Kampong Cham, and 35% without it. Given its very large population, improving access to/use of FP in that province will be critical. The same would apply to Prey Veng Province in the RACHA area, where the 2005 modern CPR was 24.5%.

Figure 7



Although still very under-represented in the overall method mix, HIS data show that the use of **longer acting methods of FP** have increased considerably during the

Program as shown in Figure 7. Most of the increase occurred in IUD use. The greatest proportional increase took place between 2009 and 2010, and field observations indicate that the momentum is ongoing. Both increased service availability – with more HCs offering IUD insertions – and decreased cost barriers have played a role in this.

IR 3: Build Health Systems Capacity

The Program is making progress in building health system capacity in many ways. HEFs have reduced financial constraints on **access to and provision of quality care** in 26 of the 37 ODs in the program area and for the urban poor in Phnom Penh. Partner activities to increase CC involvement and utilization of D&D funds for health hold the potential, if scaled up and strengthened, to effect a redirection of local funds to support health needs of the communities, reducing financial barriers to care even further.

⁴³ Respondents in the RHAC survey were women with a birth in the past 24 months, a group containing many recently post-partum women among whom FP use is typically low (and who are often protected by lactational amenorrhea). A projection of CPR for all MWRA was made from the measured prevalence in a random sample of this group by assuming the same relationship between CPR among all MWRA and among MWRA with a birth in the past 24 months as seen in the 2005 CDHS. It is therefore only an estimate. See the RHAC 2010 survey report for a full discussion of this.

⁴⁴ Selection bias in which women were interviewed regarding FP led to a disproportionate number of them being women without a recent birth, see Annex 6.

Analysis of HIS and HEF data show that in areas where a HEF is in place, the number of deliveries performed by c-section equals about 1.8% of expected births among HEF beneficiaries and 1.4% of the expected births among non-beneficiaries, i.e. non-poor. Since some of the non-poor may have accessed private hospitals or hospitals in Thailand/Viet Nam, the actual rates of C-Section are probably about equal, indicating that, while EmONC remains under-provided, HEFs have succeeded in achieving parity between poor and non-poor for this essential service.⁴⁵

Partner training and coaching/mentoring have contributed to improvements in quality of care at HCs, although there is potential for greater impact if this becomes more systematic. The Program is not currently positioned to achieve a sustainable improvement in the quality of care at RH level, due to the issues identified in Section V.A.3.

To date, contributions towards the **strengthening other organizational and management systems** to support service delivery have primarily been in the area of data for decision-making, where significant improvements have been made and institutionalized in the accessibility and reliability of the Health Information System. Improvements in other parts of the management system have been limited and are of questionable sustainability. There is still much financial and supplies “gap filling” by partners, which, while contributing to immediate service provision, removes the pressure from the MoH system to reform and thus may have a negative long term impact. Potential synergy with relevant HSSP2 inputs is thus far underexploited, weakening the impact of both Programs.

Related to the above, the Program is not currently on track to make a sustainable contribution towards MoH **ownership/stewardship** of the planning and implementation process for reforms remain dependent on individual leadership at PHD and OD level, and current partner strategies do not adequately address the need to improve accountability and transparency. This weakness in turn limits the potential sustainability of improvements in specific parts of the system.

In summary, although there has been some progress in strengthening specific aspects of the health system, the key items that form the base for these improvements to be sustained—transparency and accountability within the government management—remain very weak. The Team feels that for sustainable change these must be addressed.

IR 4: Change key client health behaviors

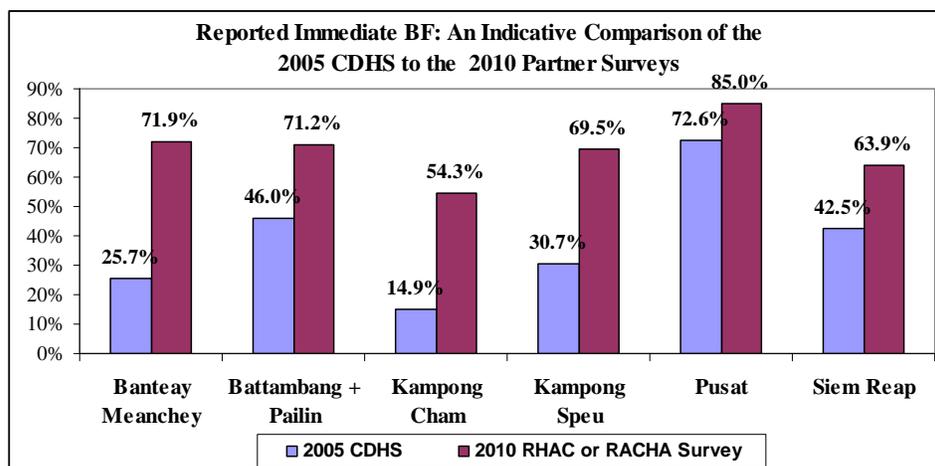
As noted under IR2, utilization of many key maternal, child and reproductive health services has improved under the Program. This reflects both supply side and demand side interventions; one of the Program’s strengths is that it does work both sides of this equation and, in the case of behavior change, through multiple channels.

⁴⁵ MOH Health Information System for 2010 and HEF MIS data. Expected number of births assumed a Crude Birth Rate of 26‰ and used Ministry of Planning population projects based on the 2008 census.

In terms of behaviors not contingent on service provision, RACHA and RHAC’s annual surveys indicate considerable improvement in immediate breast-feeding (BF) practices. The following graph compares the most current provincial level data from RHAC or RACHA surveys (2010) to findings in the 2005 CDHS for that province for births that occurred in 2005/6.⁴⁶ It should be noted that this is only an *indicative* comparison, as there are methodological differences between the CDHS, RHAC’s surveys and RACHA’s surveys. Prey Veng data is not shown because RACHA’s 2010 survey included only 4 of its 7 ODS; Koh Kong and Sihanoukville are not shown because the CDHS combined them in one stratum. Their combined 2005 baseline for Koh Kong and Sihanoukville was 47.2%; RHAC’s 2010 survey shows 54.1% in Sihanoukville and RACHA’s, 76.5% in Koh Kong.

While the RHAC sampling approach appears fairly sound, possible selection biases were identified in RACHA’s, which may have led to some inflation of results. However, as seen below, the magnitude of change is so large as to make it unlikely that this behavior has not improved in their provinces as well.

Figure 8



Source: CDHS 2005 dataset, RHAC 2010 Survey, RACHA 2010 Survey

Exclusive BF is harder to measure than immediate and more subject to variations in definition and methodology; hence even an indicative comparison was not attempted.

The impact of RHAC’s Youth Peer Education is documented in annual community youth surveys. The 2010 survey indicates a strong, statistically significant correlation between exposure to the RHAC PE program⁴⁷ and knowledge related to FP and HIV/STI prevention, and also to receipt of VCCT at a RHAC clinic. Most of the respondents were unmarried, and the percentage of youth reporting pre-marital sex was too low to assess correlations between program exposure and either high-risk behavior or FP use.

⁴⁶ The CDHS 2005 report presents data for all births in the past 5 years. Births in 2005/6 only were isolated through analysis of the CDHS 2005 dataset.

⁴⁷ A scale value composed of such things as number of times (if any) RH topics were discussed with the PE, number (if any) of group discussions attended, number (if any) of pamphlets read, etc.

In summary there is strong evidence to indicate that Program BCC activities – along with those of other development partners—are having a favorable impact on behavior.

V.F. USAID Program Management

The original vision of this Program was for the four partners to work in areas of their comparative advantages but in coordination toward achieving a common result. This vision has been lost, with the projects each being implemented in ways that do not create synergy or integrate as needed to achieve the Program objectives. Stronger coordination and direction will be needed from USAID to ensure that each partner fully understands their responsibilities as regards the Program, and as such, coordinates and strategizes with other partners when relevant to improving achievements.

Since the original award of the Cooperative Agreements there have been changes in the strategy and technical approach originally approved, as well as changes in geographical scope. The changes are most significant in the case of URC where their envisaged role in the Program was to provide the Program a national and PHD level policy interface as well as to support strengthening of RHs so that they would be able to meet emergency obstetric and child health needs. These changes carry significant implications for the other partners and if their revisions continue to be implemented the last two years of the project, both URC and RHAC/RACHA Program Descriptions and expected outputs would need amendment.

Changes in the URC Project and in some of the indicators for RACHA and RHAC are included in annual work plans, but the justifications for the revisions to the original program descriptions were reportedly discussed verbally but are not documented. There is now a wide gap between the official Program Description and what some of the partners are actually implementing. While USAID's approval of annual work plans does signify concurrence with the changes, it is also important to document clearly the rationale for the changes so that the implications of any change can be understood in light of their impact on the program as a whole rather than on a piece meal basis within each project.

A review of the CAs, which use the technical proposals as Program Descriptions, is needed to ensure that they are responsive to the overall Program requirements and revisions negotiated, where necessary, in order to achieve the Program objectives. Key programmatic issues of concern are addressed in the evaluation recommendations. USAID should work with the partners to facilitate revising the Program Descriptions to yield a clear, concise description of each partner's program in terms of the overall approach, key interventions and geographical scale.

Section V. G. Conclusions

In summary, the mid-term evaluation of the USAID Health Program revealed a number of program areas where partners are making good progress, building on previous efforts

but introducing new elements. More reliable and functioning health services, especially at the HCs in provinces where partners have worked for many years, is readily evident and opportunities exist for even greater achievement during the next two years. Partners have worked well together at the national level with efforts to influence policies and develop practical protocols and guidelines, and on other systems strengthening activities such as the national HIS.

On the other hand, the evaluation revealed that partners are missing important opportunities to improve the impact of their efforts by not working together in a coordinated fashion at different levels in the health care system as envisioned and described in the AAD. Problems also exist with the coverage of community level interventions in some partner areas requiring a reduction in the geographic areas of coverage to ensure that the complete package of services reaches every village. Adjustments are recommended to develop a more strategic approach to working with referral hospitals to ensure that the objectives of the Fast Track Initiative, a high priority in Cambodia, are better addressed. All partners need to undertake steps to ensure the institutionalization of the program innovations and to function as catalysts to roll out new programs. The development of private sector services and products should be expanded and deepened in rural areas to ensure maximum accessibility and choice.

USAID should take steps to ensure that the four partners are contributing synergistically to achieving the objectives of the whole program and continue to interface with the government and development partners on important policy issues related to the MoH's HSP2. The mid-term review of the HSP2 this year also provides additional impetus to ensure that the HSSP2 partners understand and exploit the capacity development role the USAID program partners play at the lower levels in the system. Clearly USAID and all of its partners share a common vision and goal for the health program and therefore the evaluation team is highly optimistic that the actions recommended can and will be acted on to strengthen the likelihood of achieving USAID's objectives in the sector.

V. Recommendations

A. Overall Program

Community Program

1. RHAC, RACHA, and URC should develop a joint strategy to strengthen governance of the community health services (including HCs) through the CC.

- URC and USAID should liaise at national level with the National Council on Decentralization and Deconcentration (in the Ministry of Interior) and donors and partners working on D&D to clarify the rules and regulations governing use of CIP resources. They should then share this information with RHAC and RACHA so that they can more effectively build CC capacity in accessing resources.
- RHAC and RACHA should continue/strengthen efforts to increase CC ownership of community health services in tandem with other organizations such as human rights groups and MEDICAM.

- RHAC/RACHA should identify the training and TA needs of CCs relative to their newly decentralized role and collaborate with URC in seeking appropriate support from the NCDD and other partners.
2. Partners must remember that sustainability of the VHSG structure depends upon institutionalization within the local government structure:
 - Promote CC understanding of health and of the role and importance of VHSGs
 - Negotiate a gradual transfer of responsibility for VHSG recurrent costs from project budgets to the CIP
 3. RHAC and RACHA should strengthen and systematize efforts to develop village emergency transportation systems in partnership with CCs:
 - Identify and prioritize target villages in each OD
 - Develop realistic, OD specific targets
 - Revise end of project overall targets accordingly
 - Monitor progress towards targets in each OD, ensuring that all parties have a common definition of what constitutes establishment of VERS.
 4. RHAC and RACHA should give increased attention and priority to client rights:
 - Support expansion of provider training on client/provider rights
 - Sub-contract community dissemination of the client rights Charter to civil society/human rights groups not directly linked with the health system
 - Assist CCs in developing effective, credible complaint mechanisms.
 5. RHAC and RACHA should ensure that new locations have the benefit of strong and experienced provincial managers, and increase management and technical support to provincial staff through:
 - Increased frequency and duration of HQ field visits and monitoring
 - Full-time TA (approximately 6 months) for each organization from an experienced local consultant to help field staff organize and plan activities so as to achieve coverage/targets
 6. USAID/RACHA should critically reappraise and consider reducing the geographical area where RACHA is expected to achieve coverage targets for the full package of activities given the current coverage and achievements.
 7. Future increases in the level of effort and time required by VHSGs should be avoided unless accompanied by a clear compensation mechanism.

Private Sector Services and Demand Creation

8. RHAC needs to reexamine its market niche for some of its more rural clinics to review the client loads, assess the availability of similar services, and the cost effectiveness of continuing to provide subsidized PHC care in rural areas. RHAC may have a better market niche in urban areas with clients who can afford to pay, and youth and other special groups for whom alternative services are not easily available.

9. PSI, RHAC and RACHA should collaborate in making FP and child survival products available for sale in rural areas by:
- Developing appropriate indicators and monitoring mechanisms to measure the percentage of the population with an known nearby source of supply and establishing provincial/OD targets for same
 - Establishing a commodity supply chain which enables marketing by VHSGs in villages without a commercial outlet for these products
 - Ensure the visibility of sites (e.g., with signage) where commodities are sold.
10. If funding allows, PSI should widen its product line by:
- Reactivating efforts to market EC
 - Developing products that address common nutritional problems, e.g. Sprinkles and IFA.
11. Both PSI and RHAC need to strengthen the process of reporting on private sector services to the OD MoH with the objective of supporting the MoH as a steward for both private and public sector health services, and to improve coordination among private/public activities in ODs.
12. PSI IUD campaigns and promotional activities should be planned in coordination with MoH, RHAC, and RACHA IUD expansion strategies.
13. URC should not be involved with direct implementation of national level/mass media BCC activities, but rather focus on strategic technical inputs in message formulation working closely with the other USAID partners.

Health Systems Strengthening

Management

14. URC, RACHA, RHAC with support from USAID should collaboratively and strategically address strengthening PHD/OD management capacity:
- Clarify HSSP2 fund flow issues and address constraints at the appropriate level
 - In close coordination with MoH, J-PIG and other donors, conduct targeted needs assessment of PHD and OD management in relation to evidence based AOP planning process; supervision; budgeting for recurrent field management costs; re-budgeting decisions based on approved budget; setting appropriate targets and linking budget and activities to these targets
 - Develop PHD/OD specific priorities and interventions based on the above, with indicators for monitoring progress in capacity strengthening
 - Develop mechanism for feedback from field level to central level for constraints and issues not resolvable at the local level.

15. RACHA/RHAC/URC should identify ODs where SOA status is feasible/desired and when ready, help them improve the system to meet the requirements and initiate request for SOA status.

16. URC (national/PHD level) should, in partnership with the MoH SOA Monitoring Group, DPHI and J-PIG, help develop systems to operationalize the PHD role as SOA commissioner taking advantage of the recently approved POC mechanism.

17. RHAC and RACHA should involve PHDs in their OD level annual surveys and help them to use existing results for cross-checking HIS data, setting/revising AOP targets, and (where applicable) monitoring SOA Performance.

18. URC should work closely with the MoH Hospital Department, in particular the QA office, in determining how best to apply/modify the Level 2 QI tool, giving priority to the need to establish MoH ownership of this and any future QI tools.

19. All USAID partners should promote the use of QI Level 1 tool in health facilities it supports.

20. URC model hospital activities should be scaled down and resources refocused to support a minimum level and **quality** of maternal/newborn services in all RHs within the USAID working area.

- URC/RACHA/RHAC should conduct a rapid assessment of the present capacity of RHs to provide their planned BeMOC/CeMOC level services and the current quality of these services. This assessment should include, not only the skills, training and practices of staff on the maternity services, but also (where present) of staff assigned to surgical wards and ICU.
- Based on the above, a plan to ensure that all RH provide their designated BeMOC/CeMOC level services safely and in accordance with generally accepted standards of care should be developed among the partners in collaboration with the relevant MoH programs/departments.
- URC should expand its on-the-job coaching on EmONC to target, in addition to midwives, doctors and medical assistant, including those assigned to ICU and surgical services.
- URC should ensure that staff assigned to provide on-the-job coaching have qualifications and experience sufficient to render them acceptable and credible to their target group.

21. With regard to the “Key Intervention” course, partners in collaboration with NRHP should re-assess the advisability of relying only on classroom training for elements of AMTSL such as cord traction for primary midwives who have not had LSS or other competency-based clinical training.

22. URC/RHAC/RACHA should provide training/TA to ensure that provincial/OD midwife coaches are able to conduct on-the-job mentoring in a systematic manner, individualized to fit needs and with clearly defined expected outcomes.

Health financing

23. The experience and lessons learned from the Angkor Chum and planned Pursat CBHC pilots need careful documentation and dissemination.

24. Experience with voucher schemes (both among partners and other implementers) needs to be analyzed and lessons learned captured. Voucher schemes supported under the partner projects should take into account the results of this analysis with particular attention to who is targeted, how, in what locations, and for what services.

25. Caution should be used before starting any cash transfer schemes in terms of how they fit within the draft social protection framework; who is targeted/where, and with what conditionalities. Incentivization of behaviors that are already good or improving should be avoided.

26. URC should continue and expedite efforts in rationalization of RH pricing structures

27. Partners should continue policy dialogue with MoH around midwifery bonus/referral problem and document experiences with replacement payment mechanism.

Services expansion

28. Partners should prioritize and expedite a pro-active implementation of the new Safe Motherhood protocol.

29. Partners should develop a systematic strategy for rollout of the new Infection Control guidelines including follow-up measures to address behavioral adherence.

30. RACHA should strengthen FP interventions by 1) mapping out which HCs currently provide IUDs and developing an expansion plan accordingly; (2) incorporating counseling on timing/spacing of births into all ANC training and MW ANC coaching; and (3) ensuring that all villages not close to a HC have at least an active CBD agency or a shop selling contraceptives.

Program Management

31. RACHA's population based survey methods should be revised with the assistance of short term TA from an expert in sample design.

32. Partners need to develop systematic methodology for central level validation of indicators reported from field offices, especially as regards HSS.

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RACHA Semi-annual Survey Results (SAR4). August 2010

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IUD Service Expansion Plan – 2010-2013, RHAC,

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Annex 2

Name List of participants of partners/stakeholders for the Mid-Project Evaluation- USAID funded Projects

No.	Name	Organization and Position	Date
	USAID-OPHE		
1	Mr. Flynn Fuller	Mission Director - USAID	18 Jan 2011
2	Ms. Monique Mosolf	OPHE Director -USAID	18 Jan 2011
3	Ms. Robin Martz	OPHE - DLI	18 Jan 2011
4	Ms. Tara Milani	OPHE –Deputy Director	18 Jan 2011
5	Dr. Sek Sopheanarith	OPHE – Development Assistance Specialist	18 Jan 2011
6	Dr. Chak Chantha	OPHE – Infectious Diseases Team Leader	18 Jan 2011
7	Dr. Sotheara Nop	OPHE - DAS	18 Jan 2011
	RACHA		
8	Ms. Chan Theary	ED-RACHA	20 Jan 2011
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10	Dr. Em Mony	Team Leader for Maternal and Reproductive Health	20 Jan 2011
11	Dr. Chan Ketsana	Child Health Team Leader	20 Jan 2011
12	Mr. Nou Samouen	HCC Team Leader	20 Jan 2011
13	Mr. Oum Navuth	PC Prey Veng	20 Jan 2011
14	Mr. Kun Navuth	PC BTM	20 Jan 2011
15	Dr. Khoy Dy	PC Pursat	20 Jan 2011
16	Dr. Thach Lykhan	PC Siem Reap	20 Jan 2011
17	Dr. Pot Phally	PC Koh Kong	20 Jan 2011
18	Dr. Pen Sophea	DED for Health Systems Strengthening	20 Jan 2011
19	Mr. Nget Lavann	Deputy Executive Director for Finance Operation	20 Jan 2011
20	Dr. Nou Sovann	Infectious Disease Team Leader	20 Jan 2011
21	Ms. Juliet C.Uy	Advisor for Monitoring and Evaluation	20 Jan 2011
22	Dr. Sol Sowath	M & E Team Leader	20 Jan 2011
23	Ms. Huth Sokleang	Asisstant Team Leader for Maternal Reproductive Health/FP	20 Jan 2011

24	Dr. Lim Nary	Capacity building team leader	20 Jan 2011
25	Chris Newsome	Advisor for Maternal Reproductive Health	20 Jan 2011
26	Mr. Chuon Satharidh	Human Resource Coordinator	20 Jan 2011
27	Mr. Koy Wanarith	Assistant Team Leader for Community Health Financing	20 Jan 2011
28	Ms. Mey Nary	Assistant Team Leader for Maternal Reproductive Health/ Safe Motherhood and PMTCT	20 Jan 2011
29	Ms. Unn Khlemchann	Assistant Team Leader for Logistic Management Information System (LMIS)	20 Jan 2011
30	Mr. Sin Sery Rith	Informatics technology team leader	20 Jan 2011
	PSI		
31	Mr. Chris Jones	PSI Director	20 Jan 2011
32	Dr. Heng Kheng	Director of Health Services	20 Jan 2011
33	Ms. Heng Sotheavy	Senior Manager for Reproductive Health Marketing and Communication	20 Jan 2011
	KfW		
34	Mr. Volker Karl,	Director KfW	20 Jan 2011
35	Vann Kiet	Local Expert/Programme Officer KfW	20 Jan 2011
	UNICEF		
36	Dr. Viorica Berdaga	Head of Health Unit	20 Jan 2011
37	Ms. Malelay	Health Unit Officer	20 Jan 2011
	MoH		
38	Prof. Koum Kanal,	Director National Maternal and Child health Center, MoH	20 Jan 2011
39	Dr. Lo Veasnakiri	Director of DPPI, MoH	20 Jan 2011
40	Prof. Sann Chansoueng	Deputy Director General, MoH	20 Jan 2011
	RHAC		
41	Mr. Sek Sisokhom	M & E Coordinator - RHAC	21 Jan 2011
42	Katherine Kasovec	Senior Advisor - RHAC	21 Jan 2011
43	Dr. EK Navipol	Planning chief - RHAC	21 Jan 2011
44	Veth Sreng	Community Health Specialist -RHAC	21 Jan 2011
45	Dr. Ping Chuttema	Director of Clinical Service -RHAC	21 Jan 2011
46	Dr. Ouk Vong Vathany	Executive Director - RHAC	21 Jan 2011
47	Dr. Chivorn Var	AED - RHAC	21 Jan 2011

48	Dr. Aun Hemrin	Director of Operation - RHAC	21 Jan 2011
49	Mr. Ly Seak Mal	Finance chief - RHAC	21 Jan 2011
50	Dr.Suon Bophea	Youth Health Program Manager- RHAC	21 Jan 2011
51	Kouy Kim Horn	Research Manager - RHAC	21 Jan 2011
52	Mr. Sek Sisokhom	M & E Coordinator - RHAC	21 Jan 2011
53	Katherine Kasovec	Senior Advisor - RHAC	21 Jan 2011
	URC		
54	Mr. Christophe Grundmann	Chief of Party	21 Jan 2011
55	Dr. Jerker Liljestrang	MNCH Manager	21 Jan 2011
56	Paul Freer	Deputy Chief of Party	21 Jan 2011
57	Sun Sopheak	Admin/finance director	21 Jan 2011
	Dr. Frances Daily	Chief HIP - former	4 Feb 2011
58	Mr. Tabley Jordanwood	Health Financing and CBHI program advisor	21 Jan 2011
59	Dr. Peng Vanny	Senior Technical Advisor	21 Jan 2011
60	Dr. Mean Rattanak Sambath	Team Leader M & E	21 Jan 2011
61	Joan Woods	HIP Program Leader	21 Jan 2011
	BTC		
62	Dr. Dirk Horemans	BTC Technical Advisor	21 Jan 2011
	MoH		
63	H.E.Prof. Eng Huot	Secretary of State - MoH	Feb 9 – 2011
64	Dr. Loveasna Kiry	Director, Dept of Planning and Health Information	
65	Dr. Sok Po	MoH – Deputy Director of Hospital Department	31 Jan 2011
66	Dr. Cheap Srun	Chief of QAO	31 Jan 2011
67	Dr. Sok Kanha	Chief of Health Financing, DPHI	4 Feb 2011
66	Dr. Mey Sambo	Director of Personnel Department	4 Feb 2011
68	Dr. Prak Sophoanary	Deputy Director of MNCH	9 Feb 2011
69	Dr. Ou Ketvanna	NNP Manager	9 Feb 2011

	UNFPA		
70	Dr. Sok Sokun	UNFPA	31 Jan 2011
71	Ms. Sarath Knibbs,	Deputy Representative, UNFPA	31 Jan 2011
	USAID-HIV & OPHE		
72	Prateek Gupta	Strategic Information Technical Advisor	4 Feb 2011
73	Dr. Sok Bunna	HIV/AIDS Program - USAID	Feb 8- 2011
74	Dr. Mike Cassell	HIV/AIDS - USAID	Feb 8- 2011
People met for 6 provinces during field visit			
75	Dr. Ky Kien Hong	Director of Provincial Hospital Sampov Meas	24 Jan 2011
76	Mrs. Men Phalla	MCH Chief of PHD Pursat	24 Jan 2011
77	Dr. Pov Manuth	Sampov Meas OD Director	24 Jan 2011
78	Mrs Suong Ranny	Sampov Meas OD MCH chief	24 Jan 2011
79	Dr. Koe Sanphalbun	Barkan OD Director	25 Jan 2011
80	Mr. San Kunnary	Bakan RH Deputy Director	25 Jan 2011
81	Mrs. So Kanha Thavary	Bakan MCH chief	25 Jan 2011
82	Dr. Chhun Phally	URC PC - Pursat	24 Jan 2011
83	Dr. Khoy Dy	Pursat RACHA PC	24 Jan 2011
84	Mr. Nuth Panak	APC RACHA Purest	24 Jan 2011
85	Pol La Ine	APC RACHA Pursat	24 Jan 2011
86	Sien Kim Seng	Child Health/Nutrition officer - RACHA Pursat	24 Jan 2011
87	Ouch Sophal	CHN officer - RACHA Pursat	24 Jan 2011
88	Lov Sokun	RACHA Health Communication officer - RACHA Pursat	24 Jan 2011
89	Hor Sinang	Infectious diseases officer - Pursat	24 Jan 2011
90	Mrs. Seang Sovannary	BS/Safe Motherhood Officer -RACHA Pursat	24 Jan 2011
91	Mrs. Tim Kantheara	BS/Safe Motherhood Officer – RACHA Pursat	24 Jan 2011
92	Chheng Kheng	LMIS Officer - RACHA Pursat	24 Jan 2011

93	Hor Sy	Infectious Diseases Officer- RACHA Pursat	24 Jan 2011
94	Dr. Pov Manuth	OD Director – Sampov Meas OD	25 Jan 2011
95	Mrs. Suong Rany	OD MCH chief - Sampov Meas OD	25 Jan 2011
96	Mrs. Kim Phanny	SMW- HC Trapaing Chong – Bakarn OD	25 Jan 2011
97	Mr. Sou Kosal	Vice Chif HC - Trapaing Chong – Bakarn OD	25 Jan 2011
98	Mrs. Kim Vannak	PMW - HC Trapaing Chong – Bakarn OD	25 Jan 2011
99	Dr. Kuy Sok	Deputy Director - PHD Battam Bang	26 – Jan 2011
100	Mrs. Morl Monlika	MCH Chief for PHD Battam Bang	26 – Jan 2011
101	Dr. Oum Vanna	PC RHAC Battam Bang	26 – Jan 2011
102	Mrs. Sok Neang	PO Community Health Program – RHAC BTB	26 – Jan 2011
103	Mrs. Nun Kimthav	PO MCH - RHAC BTB	26 – Jan 2011
104	Mrs. Kak Ora	Team Leader OD Sangke – RHAC BTB	26 – Jan 2011
105	Mrs. Sok Phany	Clinic Director – RHAC BTB	27 Jan 2011
106	Dr. Bun Heang	Vice Director Provincial Hosptal BTB	27 Jan 2011
107	Dr. Oum Nhel	Vice chief of Technical Bureau – PRH BTB	27 Jan 2011
108	Dr. Ngo Sithy	Director of RTC BTB	27 Jan 2011
109	Dr. Im Chetra	Director of OD Sangke	27 Jan 2011
110	Dr. Eng Sam Nang	Vice Director of OD Sangke	27 Jan 2011
111	Dr. So Sok	Director of RH – Mong Russey	28 Jan 2011
112	Dr. Hou Sotheara	MCH chief for OD and RH Maternal Service Chief	28 Jan 2011
113	Mr. Peam Mony	URC-BTB Administration Officer	26 Jan 2011
114	Mr. Sam Hun	URC-BTB - PC	26 Jan 2011
115	Mrs. Kim Sophoan	URC-BTB -MCH officer	26 Jan 2011
116	Dr. Dy Bun Chhem	Provincial Health Director – Siem Reap	24 Jan 2011
117	Dr. Kheng Darasy	Deputy Director MCH – Siem Reap	24 Jan 2011
118	Dr. Pen Phalkun	Director Provincial Hospital	24 Jan 2011
119	Thark Lyhhann	RACHA Provincial Coordinator – Siem Reap	25 Jan 2011

120	Mr. Pich Hatha	URC Asst. Provincial Health Coordinator	25 Jan 2011
121	Dr. Camrouen Sosivann	Clinic Manager RHAC	25 Jan 2011
122	Mr. Choeun Chautheng	Project Officer Youth RHAC	25 Jan 2011
123	Mr. Sareth Moth	Technical Officer, Vulnerable Groups RHAC	25 Jan 2011
124	Dr. Nov Lay	OD Director – Siem Reap	24 Jan 2011
125	Ith Sak Hoeun	OD Deputy Director – Siem Reap	24 Jan 2011
126	Mr. Lorn Touch	HC Chief – OD Siem Reap	24 Jan 2011
127	Dr. Ney Phorlen	OD Director – Sotnikum	24 Jan 2011
128	Ph Eng Kheang	Vice Director - Sotnikum	24 Jan 2011
129	Mr. Duch Yokly	Technical Chief - Sotnikum	24 Jan 2011
130	Dr. Mak San Oeun	Angkor Chum OD Director	25 Jan 2011
131	Mr. Sao Kuy	HC Chief, Nokor Pheas HC	25 Jan 2011
132	Mr. Eng Kamsan	Executive Director for CBHC –Angkor Chum	25 Jan 2011
133	Mr. Mee Roon	Member of CBHC – Angkor Chum	26 Jan 2011
134	Mr. C'Dorn Vitreak	HIS programme assistant	26 Jan 2011
135	Ms. Chin Bun Leah	Secondary Nurse_RHAC Clinic Pouk	26 Jan 2011
136	Chihouk Kunnary	Secondary Midwife and Team leader	26 Jan 2011
137	Dr. Keo Sopheaktra	PHD Director – Banteay Mean Chey	28 Jan 2011
138	Mr. Soy Samphos	Vice Technical - Office Banteay Mean Chey	28 Jan 2011
139	Samith Soriya	URC Provincial Coordinator Mongol Borey	28 Jan 2011
140	Dr. Kun Navuth	RACHA Provincial Coordinator Mongol Borey	28 Jan 2011
141	Dr. Theing Nhean Veith	OD Director Preah Net Preah	27 Jan 2011
142	Mr. Thip Soew	HC Chief, Panley –PNP OD	27 Jan 2011
143	MA. Sem Visith	Deputy Hospital Director PNP Referral Hospital	27 Jan 2011

144	Jon Shearu	VSO volunteer PNP Referral Hospital (Nurse)	27 Jan 2011
145	Dr. Seng Sopharun	Deputy Director PHD Kg Cham	2 Feb 2011
146	Dr. Taing Bunsreng	Chief MCH PHD Kg Cham	2 Feb 2011
147	Dr. Hen Bunnan	Chief Technical Bureau PHD Kg Cham	2 Feb 2011
148	Dr. Chhun Ly Pich	Chief of HIV/AIDS program PHD Kg Cham	2 Feb 2011
149	Mr. Kea Bou	PC RHAC Kg Cham	2 Feb 2011
150	Dr. Meas Chea	Provincial Hospital Director Kg Cham	2 Feb 2011
151	Dr. Heng Kim Ean	Acting OD Director – RH Director – OD Srey Santhor	1 Feb 2011
152	Mr. Chhoun Vannnda	HIV/AIDS program officer- OD Srey Santhor	1 Feb 2011
153	Dr. Mao Bunleng	TB Program Officer - OD Srey Santhor	1 Feb 2011
154	Ms. Chuun Bphea	Secondary MW - OD Srey Santhor	1 Feb 2011
155	Dr. Kao Rada	MCH Coordinator - OD Srey Santhor	1 Feb 2011
156	Toeh Vouch Kheang	Secondary Midwife (OD Gynecology Ward and PSI trained IUD and Implant)	1 Feb 2011
157	Mr. Um Nol	Chief HC - Preak Dumbok_ - OD Srey Santhor	1 Feb 2011
158	Ms. Oem Leakhena	Primary Midwife HC Preak Dumbok_ - OD Srey Santhor	1 Feb 2011
159	Ms. Tan Phala	Primary Midwife HC Preak Dumbok_ - OD Srey Santhor	1 Feb 2011
160	Ms. Hiean Malida	VHSG - HC Preak Dumbok_ - OD Srey Santhor	1 Feb 2011
161	Dr. Haung Thol	OD Director – OD Cheung Prey	1 Feb 2011
162	Ms. Seak Phary	MCH chief – OD Cheung Prey	1 Feb 2011
163	Heun Kimhoeung	PMW – HC Sandek - OD Cheung Prey	1 Feb 2011
164	Khork Phalla	PMW – HC Sandek - OD Cheung Prey	1 Feb 2011
165	Mr. Von	VHSG Svai Prey village - OD Cheung Prey	1 Feb 2011

166	Dr. Chea Sokha	Director OD – Kg Ckam OD	2 Feb 2011
167	Dr. Tau hak leang	Vice Director - Kg Ckam OD	2 Feb 2011
168	Ms.Try Dalen	MCH chief OD - Kg Ckam OD	2 Feb 2011
169	Mei Sina	NIP OD - Kg Ckam OD	2 Feb 2011
170	Ms. Chiang Thai	Primary Nurse - Tuol Preah Khleang HC	3 Feb 2011
172	Yuy Kim Leah	Primary MW - Tuol Preah Khleang HC	3 Feb 2011
173	Cherai Kem Leang	Primary Nurse, Deputy Chief - Tuol Preah Khleang HC	3 Feb 2011
174	Dr. Pich Horn	PHD Director – Prey Veng	1 Feb 2011
175	Dr. Pich Bola	PHD MCH Chief – Prey Veng	1 Feb 2011
176	MR. KREAL REOUNG	OD Director – OD Pearaing	1 Feb 2011
177	Mrs. CHAN SAMBATH	MCH chief – OD Pearaing	1 Feb 2011
178	DR. HUOT KALIAN	RH Director – V Director OD- Pearaing	1 Feb 2011
179	Mr. Pick Norn	OD Director – Kamchay Meas	2 Feb 2011
180	Dr. Chea Seng Huot	RH Director – Kamchay Meas	2 Feb 2011
181	Mr. Khan Vannarath	OD Vice Director - Kamchay Meas	2 Feb 2011
182	Mrs. Mann Vannara	OD MCH Chief - Kamchay Meas	2 Feb 2011
183	Mrs. Chin Sokha	SMW – Kra Nhoung HC - Kamchay Meas	2 Feb 2011
184	Mrs. Sar Lina	PMW - Kra Nhoung HC - Kamchay Meas	2 Feb 2011
185	Mr. Chan Naran	HC Chief – Cheach HC - Kamchay Meas	2 Feb 2011
186	Mr. Thun Thol	OD Director – Svay Antor	2 Feb 2011
187	Mr. Mean Meoun	OD MCH chief – Svay Antor	2 Feb 2011
188	Dr. Heng Try	OD Vice Director - Svay Antor	2 Feb 2011
189	Dr. Oum Navuth	PC RACHA –Prey Veng	3 Feb 2011

190	Ms. Ouk Vannay	APC – Preah Sdach OD	3 Feb 2011
191	Chin Samphoas	APC – Kampong Trabek OD	3 Feb 2011
192	Mr. Mao Sang Wath	APC – Svay Antor OD	3 Feb 2011
193	Mr. Prum Saly	SM/BS officer - Kampong Trabek OD	3 Feb 2011
194	Ms. Heang Leang Sorn	SM/BS officer – Pearaing OD	3 Feb 2011
195	Keo Ean	SM/BS officer – Nak Leung OD	3 Feb 2011
196	Mr. Mang Say	APC – Pearaing OD	3 Feb 2011
197	Im Sokea	SM/BS officer – Kamchay Meas OD	3 Feb 2011
198	Sambath Sophea	SM/BS officer - Svay Antor OD	3 Feb 2011
199	Mr. Chhay Sokheng	APC -- Kamchay Meas OD	3 Feb 2011
200	Mr. Khul Ponleu	LMIS – Prey Veng	3 Feb 2011
201	Dr. Ouk Putharat h	Health System Management Team Leader-URC	3 Feb 2011
202	Mr. Kao Savin	District Health Advisor – URC Pearaing OD	3 Feb 2011

SCOPE OF WORK

Cambodia Mid-Term Evaluation of USAID funded health programs implemented by:

- Population Services International (PSI) under Cooperative Agreement number 442-A-00-08-00001, 2008 - 2013
- Reproductive and Child Health Alliance (RACHA) under Cooperative Agreement number 442-A-00-08-00008-00, 2008 - 2013
- Reproductive Association of Cambodia (RHAC) under Cooperative Agreement number 442-A-00-08-00007-00, 2008 - 2013
- University Research Co., LLC (URC) under Cooperative Agreement number 442-A-00-09-00007-00, 2008 - 2013

I. Identification of the Tasks:

In early 2011, the USAID/Cambodia Office of Public Health & Education (OPHE) will engage a team of consultants to conduct a mid-term evaluation of four major integrated health projects, which constitute a major part of the Mission's Health Program. The projects aim to reduce the leading causes of maternal, child and neonatal mortality and morbidity; address nutritional deficiencies; improve reproductive health services; reduce the burden of and mitigate the impacts of infectious diseases of major importance including tuberculosis, HIV/AIDS, and emerging infectious diseases; and, in order to obtain these objectives and sustain progress, strengthen health systems in Cambodia.

The evaluation described here will focus on Reproductive, Maternal and Child Health (RMCH) and other infectious diseases (OID). Additionally, since health system strengthening (HSS) is fundamental to achieving progress and sustainability in all areas of health, HSS activities are included.

The mid-term evaluation will be conducted in January / February 2011, in order to make course corrections and to guide program planning for the remainder of the current USAID health sector program (through September 2013).

The mission will seek the services of a five person consultant team, one expatriate team leader, two expatriate team members and two local technical consultant team members.

II. Background

Cambodia remains one of the world's poorest countries (per capita income is \$600) as it slowly builds a market-based economy and moves towards more open governance. Social and economic status indicators are among the lowest in Asia as almost 7 of every 100 babies born die prior to their first birthday (IMR at 66/1000 LB) and nearly 10% of children born die before age 5. Maternal mortality is 40 times higher than in the U.S. and has remained stagnant for over a decade (MMR over 450/100,000 LB). Poverty indicators are similarly poor: female adult literacy rate is 57%, net enrollment in primary school is 67%, and the average household monthly expenditure is only US \$104. Relatively high fertility rates, low contraceptive prevalence and a large youth population will ensure continued population pressures. Social and public administrative structures in Cambodia still largely reflect fragmented, post-conflict arrangements and remain heavily dependent on international donors for financing and for technical and managerial innovations. The USG is one of the largest bilateral contributors and its role is especially pronounced in the health sector where efforts support civil society/NGO service delivery and address public sector capacity and institutional strengthening through a holistic sector-wide approach.

Health Sector

The Cambodian Demographic Health Surveys (CDHS) and the 2008 National Census data indicate both remarkable progress and a compelling need to remain engaged in the health sector. The 2005 CDHS data indicate that 57% of married women do not want more children, yet only 27% are using a modern method of family planning. The overall maternal mortality ratio has not improved since 2000 and remains unacceptably high (472 deaths per 100,000 live births). Infant, child and under-five mortality rates decreased by almost one-third between 2000 and 2005, but both infant (66/1000) and under-five mortality (83/1000) rates remain among the highest in Southeast Asia. Babies and children continue to die of diarrheal diseases, acute respiratory infections and vaccine-preventable diseases, while high neonatal mortality is particularly troubling. High levels of malnutrition and micronutrient deficiencies exacerbate maternal and child mortality and illness. The population remains vulnerable to endemic infectious diseases such as tuberculosis, malaria and dengue while facing emerging threats such as Highly Pathogenic Avian Influenza (H5N1). Chronic diseases, such as diabetes and hypertension are on the rise. Improved health systems are needed to ensure effective and quality delivery and financing to address these issues.

The Ministry of Health (MOH) Sector Strategic Plan aims to make affordable, quality health care services available to all Cambodians, but limited public sector capacity and institutional weaknesses contribute to fragmented and poor service delivery, particularly in poor and rural areas. Non-governmental organizations (NGOs) and other donors are working with the MOH to strengthen health systems but, until recently, these efforts have been limited in scope and

somewhat ad hoc. Cambodians' out-of-pocket expenses for health care are significant (70-80% of expendable income). Most Cambodians seek curative care in the private sector where quality is questionable and practices are largely unregulated. Utilization of public health services is quite low; the 2005 CDHS data indicated only 22% of household members who have experienced illness or injury in 30 days before the interview sought care at public sector facilities, while 69% sought care at the poorly regulated private sector or non-medical sector. Commune councils are elected bodies, with decentralized authority to influence health and education at the community level. However, their capacity to mobilize and effectively allocate resources to support health care in the community is limited.

The MOH has begun development of a National Health Financing Strategy but current health financing structures and initiatives are small-scale and lack uniformity. Public health funding flows are uneven and difficult to track, resulting in significant geographical variations in the accessibility and quality of services (and consequently of health indicators). Despite the many challenges, the Royal Government of Cambodia (RGC)/MOH have made notable progress in the past decade and key health partners are committed to the principles of donor harmonization and alignment as outlined in the Paris Declaration.

USAID-Funded Health Programs

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. USAID does not provide funds directly to the Government. Rather, USAID funds NGOs that support the public health system, private health providers, and communities. Over the past ten years, USAID has invested significant resources in four integrated health projects, implemented by PSI, RHAC, RACHA, and URC. The projects work to overcome the key constraints to effective health service delivery, such as lack of managerial and technical capacity among health care providers and managers, poor quality of health services, gaps in community awareness and health seeking behavior, and to reduce accessibility barriers to prevention and treatment services among poor Cambodians.

This evaluation will look at the effectiveness of RMCH/OID activities of the four partners related to:

- health system strengthening (HSS);
- technical assistance to the national 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, family planning counseling and services, and address current and emerging infectious diseases, such as avian influenza, H1N1 and dengue fever;
- reducing common causes of childhood morbidity and mortality through improved water and sanitation;

- improved nutrition of mothers and children; and
- community education and mobilization for behavior change.

As a key partner of the RGC of Cambodia, Population Services International (PSI) supports strengthening Cambodia's health systems by improving the private sector's effectiveness at providing health services to the poor and vulnerable. Through a portfolio of interventions that include medical detailing, training programs, and targeted outlet support to improve the behaviors of private sector providers – from pharmacies and drug sellers to clinics, entertainment establishments to small shops -- PSI markets attractive, quality, and affordable products and services. Reproductive health interventions include social marketing of family planning spacing methods, intensive support to health facilities to improve service delivery supporting long term family planning methods (LTFP) such as the IUD and implant, and communication to motivate use. PSI's child survival program prioritizes diarrhea prevention and treatment in children under five by increasing access to safe water through the promotion of point-of-use water treatment tablets and ORS and zinc diarrhea treatment kits (DTK). Using evidence-based innovations as a foundation of all programs, PSI encourages healthier behaviors by ensuring that poor and vulnerable populations are equipped with the opportunity, ability, and motivation to make healthier choices.

Established in 1996, the Reproductive Health Association of Cambodia (RHAC) is an indigenous NGO implementing activities to improve RMCH and reduce the transmission and impact of HIV/AIDS and infectious diseases. Through the current 5-year USAID-funded project, Together for Good Health (ToGoH), RHAC operates 18 clinics in eight provinces and implements community and public health support activities in five provinces (Battambang, Kampong Speu, Kampong Cham, Pailin, and Preah Sihanouk). The latter activities include building the capacity of health center staff to deliver quality RMCH care, providing health education to communities through existing structures and promoting demand for quality public health services. RHAC implements Behavior Change Communication projects with young people. RHAC clinic services include ante-natal care, post-natal care, family planning, voluntary counseling and testing for HIV/AIDS, prevention of mother-to-child transmission of HIV, diagnosis and treatment of reproductive tract infections, and post-abortion care. In 2010, RHAC began to build the capacity of commune councils to identify health priorities and include them in the commune development plan.

The Reproductive and Child Health Alliance (RACHA) was established as a local NGO in early 2003, having evolved from a USAID-funded project implemented by EngenderHealth (AVSC), Family Planning Service Expansion and Technical Support (SEATS), and Basic Support for Institutionalizing Child Survival (BASICS). The current RACHA program focuses on the improvement of services related to safe motherhood, birth spacing, child survival, infectious disease prevention and control, HIV/AIDS prevention, the improvement of national

capacity in essential drug management at health center level, and building community networks and initiatives to support community based health activities. The program covers 19 Operational Districts (ODs) in five provinces (Siem Reap, Pursat, Bantey Meanchey, Prey Veng and Koh Kong).

The University Research Co, LLC (URC) Better Health Services (BHS) project began implementation in late 2008, building on the lessons learned from the first Health System Strengthening Project of USAID. The project focuses on capacity development of the public health system at various levels (including referral hospitals and provincial and district health offices) to improve the quality of services; increase the uniformity and scale-up of innovative health care financing schemes; and improve referral systems with linkages between communities, health centers and hospitals. The system strengthening approach is a package of interventions designed to fit together and provide synergy, both within the project and with the other USAID partners, and among the government and all health partners. At referral hospitals the program emphasizes the improvement and integration of clinical and managerial capacity in RMCH, HIV/AIDS, TB and infection control. In health financing, BHS provides technical and financial support to MOH to harmonize the implementation of health financing schemes, including health equity funds (HEF) and community-based health insurance (CBHI), to support access by the poor to quality public health services. At the implementation level, BHS works with both public health facilities and local NGOs to improve transparency and efficiency of health financing implementation.

II. Purpose/Objectives/Key Evaluation Questions

Purpose: Conduct a mid-term evaluation of the major USAID-funded RMCH, HSS, and OID activities implemented by PSI, RHAC, RACHA and URC, with a focus on results achieved to date, health system strengthening and the harmonization of implementation across the projects. Also, assess how the individual projects interrelate, coordinate and cross-fertilize/reinforce each other to produce results and impact relating to USAID and RGC strategic goals.

Objective: Based on the findings, assess current progress towards project RMCH, HSS and OID goals and make recommendations for project modifications, improvements, scale-up of particular activities, dissemination of best practices, etc. In addition, assess the synergy and compatibility of the approaches across the four projects and make recommendations for improvement.

Key Evaluation Questions

- 1) Evaluate the major achievements to date, constraints and gaps of the USAID/Cambodia RMCH, HSS and OID projects implemented by PSI, RHAC, RACHA and URC (October 2008 – September 2013).
 - a) Are the various projects on track to deliver the interventions specified in their respective Cooperative Agreements in terms of both geographical coverage and technical content?
 - b) What has been each of the projects' progress to date in relation to planned RMCH, HSS and OID results and performance indicators (provided in the Results Framework and the projects' Performance Monitoring Plans)?
 - c) Does the breakdown of project activities align with funding levels for each program element?
 - d) How do the health system strengthening activities contribute to overall health service improvement (including access to services by the poor, improvement of clinical capacity and managerial responsibilities / accountability) and potentially impact on some specific USAID health elements?
 - e) What planned result targets are not on track to be met or exceeded? Why?
 - f) What have been the greatest constraints to achieving results?
 - g) Were there specific project management policies, structure or practices that contributed to either success or failure of intervention implementation?
 - h) How well are the projects working together to coordinate planning and implementation of activities, avoid duplication and support each other? What can be done to improve coordination, and maximize potential synergies?
 - i) Are the staffing structure and capacity sufficient to achieve project goals? Are there any changes needed?

- 2) Make strategic recommendations for the projects to focus on or shift their direction toward maximizing the results by the end of Life of Project.
 - a) Identify lessons learned, successful interventions for continuation or replication, best practices, significant products and tools of the above projects for possible dissemination and replication.
 - b) Identify problems and/or issues that appear to impede progress and suggest potential courses of action.

III. Methodology

- The SOW will be shared with the team members for comment and clarification. Parts I and II will be shared with the USAID partners as part of the planned explanation of the evaluation activity.
- Review relevant national documents including RGC/MOH strategic documents, national surveys, policies, guidelines, etc. supplied by OPHE prior to teams arrival in country.
- Review project documents; proposals, implementation plans, monitoring and evaluation plans, progress reports, review/evaluation reports, training curricula, etc.
- The team will conduct a 2-3 day team planning meeting (TPM) upon arrival in Cambodia and before starting the in-country portion of the evaluation. The TPM will review and clarify any questions on the evaluation SOW, draft an initial work plan, develop a data collection plan, finalize the evaluation questions, develop the evaluation report table of contents, clarify team members' roles, and assign drafting responsibilities for the evaluation report. OPHE will participate in relevant sections of the TPM and the TPM outcomes will be shared with USAID/Cambodia.
- Literature review as required.
- Field visits to selected project sites.
- Interview key informants including USAID Mission management/staff, PSI, RHAC, RACHA and URC staff, and key Ministry of Health staff and partners (MOH national programs, provincial and operational district teams, health center staff and community representatives); key health partners (HSSP2, UNFPA, UNICEF, WHO); and relevant NGO partners.

IV. Illustrative Tasks and Level of Effort

Week 1		
Day 1 - 2	Document Review (prior to arrival for international consultants)	2 days
Day 3	Meeting with OPHE	2 hours
Day 3 - 6	Team Technical Planning Meeting (TPM)	3 days
Day 6	Introductory meeting with USAID Mission Director and senior management	1 ½ hours
Week 2		
Day 7 - 10	Meetings with key partners in and around Phnom Penh	4 days
Day 11 - 12	Field Visits	2 days

Week 3		
Day 13 - 18	Field Visits	6 days
Week 4		
Day 19 - 20	Field Visits / Follow up meetings	2 days
Day 20	Mid-point debrief to OPHE	2 hours
Day 21 - 24	Write draft report	4 days
Week 5		
Day 25 - 26	Write draft report / Follow up meetings	2 days
Day 27	Submit draft report and debrief USAID/Cambodia	1 day
	OPHE will have one week to review the draft report and return it to the team leader with comments	
Day 28	Each team member has one day to review OPHE's comments and provide feedback to the Team Leader	1 day
Team Leader will need extra days to finalize report:		
Day 28 - 31	Team Leader finalizes report, submits to USAID/Cambodia	4 days
Travel days	For international team members, 2 days each way + one day per week off in country, which is not shown above.	9 days
Total days		28 days (Local Team Members) 37 days (International Team Members) 41 days (Team Leader)

Total timeframe for the evaluation is estimated to be approximately 28 days for Local Evaluation Team Members, 37 days for International Evaluation Team Members and 41 days for the Evaluation Team Leader.

V. Schedule and Logistics:

The OPHE team will organize a tentative schedule of meetings and field visits before the evaluation team arrives. OPHE will facilitate and coordinate field visits with local provincial and district officials. The schedule will be finalized by the

team in the TPM during their first days of the consultancy in coordination with OPHE.

Selected OPHE staff will accompany the evaluation team, as required.

OPHE will send letters informing key RGC and partners of the nature, timing, and scope of the evaluation and of the evaluation team members.

A six-day work week is authorized during the consultancy.

The evaluation team will be responsible for any necessary international travel and related expenses, as well as renting available local vehicles for field work in Phnom Penh and the provinces.

VI. Deliverable & Report Timeline:

1. **Evaluation Framework:** Present USAID with the framework and work plan for the evaluation on day 3 of the assignment. This will include the materials produced during the Team Planning Meeting described in Section III above. OPHE staff will be available for consultation during the TPM.
2. **Draft Report:** The first draft of the final evaluation report will be due at the end of the team's visit. The draft report will include key findings and recommendations for mission review. The report will present findings, conclusions/lessons learned and recommendations for the four project(s) and program components evaluated.
3. **Debriefings:** The team will conduct one mid-point and two final debriefings. The mid-point debriefing will take place after the field visits to discuss preliminary findings and report outline with USAID. The first final debriefing will be with USAID and the second will be with OPHE and the four partners. The debriefing should present key findings and recommendations in a power point format.
4. **Final Report:** USAID/Cambodia will provide the team with comments on the draft report within 10 days of receiving it. The final report will be due within 10 days after the team receives comments from USAID/Cambodia. USAID/Cambodia requests an electronic version of the final report (Microsoft Word or PDF format).

The final report shall be direct and brief but still provide a sufficiently detailed presentation. Annexes shall be included with the final report. The report should be structured as follows:

- Executive summary;
- Introduction – purpose, audience, summary of statement of work;

- Background – a brief overview of RMCH, infectious diseases and health issues in Cambodia, including the main trends and challenges to increasing service uptake, to improving quality, and to expanding access to essential services in RMCH /EID;
- USAID assistance to date - a description of the USAID program strategy and activities implemented in response to the problem (coverage, implementing partners, funding levels) as well as strategic directions
- Methodology
- Annexes
 - List of persons contacted
 - Other, as needed
- Findings/Conclusions/Recommendations - based on the questions and the objective outlined in Section II above, and presented across each of the technical domains, these should include but not necessarily be limited to:
 - key findings and issues identified in management and implementation of the projects;
 - project achievements;
 - project gaps, issues and areas needing improvement;
 - recommendations for improving implementation of RMCH, EID and health system strengthening activities;
- Annexes
 - List of persons contacted
 - activity timeline / schedule; and
 - bibliography.

VII. List of relevant documents:

USAID will collect the following key documents and share them with the team in advance of their arrival in-country:

- Cambodia Health Program Design FY 2009 – 2013 Activity Approval Document
- MOH Health Strategic Plan 2008-2015
- A Strategic Assessment of Three Integrated Health Projects in Cambodia: RACHA, RHAC and URC, 2007
- An Assessment of Cambodia's Reproductive and Child Health Alliance (RACHA) – October, 2002
- Final Evaluation of the Reproductive Health Association of Cambodia – July, 2003
- RACHA and RHAC annual population based survey results
- 5 year and yearly workplans, and progress reports of the 4 programs
- MOH Health Facilities Assessment Tools, supported by URC
- HEF Evaluation Report

- Master Plan for Social Health Protection
- AMSTL and management of eclampsia, 2009
- Status Report on Midwifery In-Service Training in Cambodia, 2009
- EmONC Assessment Final Report, 2009
- Repositioning FP in Cambodia—Respond Concept Paper, July 2010

Annex 4_A
Health Center Profiles

	Provinces and Operational Districts	HC	HP ¹¹	Status			# HC with					
				SOA/SDG (# HC)	HEF # HC	CBHI	Secondary MW	Primary MW	2 or more MW (any level)	Total # MW secondary or primary ⁹	24 hour service ¹⁰	IUD service ³
				(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
	RACHA supported											
1	BANTEAY MEANCHEY											
	OD Mongkul Borey	19	3	0	19	0	18	19	20	37	19	19
	OD Or Chrov	11	4	0 (planned)	11	0	21	24	11	45	11	7
	OD Thmor Pourk	10	2	0	0	CAAW	9	22	10	31	10	7
	OD Preah Net Preah	12	2	0	13	0	4	30	11	34	12	8
2	KOH KONG											
	OD Smach Mean Chey	7	3	7	0	0	6	6	5	12	7	6
	OD Sre Ambel	5	0	5	0	0	1	10	5	11	5	2
3	PREY VENG											
	OD Prey Veng (Svai Anthor)	17	0	0	0	0	6	14	8	20	12	9
	OD Neak Loeung	17	0	0	0	0	5	15	10	20	5	10
	OD Peareang	15	3	15	0	9 HC (HNI/R ACHA)	1	15	10	16	15	10
	OD Kampong Trabek	11	0	0	11	0	3	10	6	13	1	5
	OD Preah Sdach	9	0	9	0	0	2	9	4	11	9	1
	OD Kamchay Mear	11	0	0	0	0	3	10	5	13	10	3

Annex 4_A
Health Center Profiles

	Provinces and Operational Districts	HC	HP ¹¹	Status			# HC with					
				SOA/SDG (# HC)	HEF # HC	CBHI	Secondary MW	Primary MW	2 or more MW (any level)	Total # MW secondary or primary ⁹	24 hour service ¹⁰	IUD service ³
				(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
	RACHA supported											
	OD Mesang	10	1	0	0	0	1	10	7	11	10	7
4	PURSAT											
	OD Sampov Meas	22	3	0	21	URC	38	28	21	66	8	16
	OD Bakan	10	0	0	10	0	12	14	9	26	1	9
5	SIEM REAP											
	OD Siem Reap	20	1	20	0	0	18	16	16	34	20	11
	OD Angkor Chum	18	2	15	17	CBHI	12	29	15	41	16	7
	OD Soth Nikum	24	1	24	0	0	14	20	15	34	23	4
	OD Kralanh	10	0	9	0	0	4	9	4	13	9	1
	Total	258	25	104	102		178	310	192	488	203	142
	Percentage			40%	40%				74%		79%	55%

Annex 4_A
Health Center Profiles

	Provinces and Operational Districts	HC	HP ¹¹	Status			# HC with					
				SOA/SDG (# HC)	HEF # HC	CBHI	Secondary MW	Primary MW	2 or more MW (any level) ²	Total # MW secondary or primary ⁹	24 hour service ¹⁰	IUD service ³
				(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
	RHAC supported											
1	BATTAMBANG											
	OD Battambang	23	2	0	23	0	21	17	19	102	23	23
	OD Sangke	15	0	0	15	0	12	12	15	66	15	15
	OD Thmar Koul	17	0	0	0	0	10	12	13	39	17	15
	OD Mong Russey	13	0	0	13	0	6	12	12	45	13	13
	OD Sampov Luon ⁸											
2	KAMPONG CHAM											
	OD Kampong Cham	23	0	0	0	0	14	18	17	49	23	11
	OD Prey Chhor	15	0	15	3	0	12	10	13	33	15	14
	OD Cheung Prey	14	0	14	3	0	5	14	14	35	12	12
	OD Chamkar Leu	14	0	14	3	0	6	13	12	26	14	6
	OD Kroch Chhmar	11	0	11	0	0	1	8	4	14	11	4
	OD Tbong Khmum	16	0	0	14	0	10	14	11	31	16	7

Annex 4_A
Health Center Profiles

Provinces and Operational Districts	HC	HP ¹¹	Status			# HC with						
			SOA/SDG (# HC)	HEF # HC	CBHI	Secondary MW	Primary MW	2 or more MW (any level) ²	Total # MW secondary or primary ⁹	24 hour service ¹⁰	IUD service ³	
			(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
RHAC supported												
OD Ponhea Krek	16	0	16	6	0	4	10	4	13	16	11	
OD O Reang Ov ¹ (8HC)	Supported by Save the Children, Australia											
OD Memut	10	0	10	6	No	2	10	7	22	10	8	
OD Srey Santhor (6 of 13 HC not constructed)	13	0	0	0	No	1	11	2	13	8	5	
3 KAMPONG SPEU												
OD Kampong Speu	22	0	0	0	No	6	22	19	65	22	22	
OD Oudong	9	0	0	0	No	1	9	8	27	9	9	
OD Kong Pisey	19	0	0	0	No	7	17	17	59	19	19	
4 Pailin												
OD Pailin	6	0	0	0	No	3	6	6	16	6	6	
5 SIHANOUK PROVINCE												
OD Sihanouk Ville	12	2	0	7	No	9	11	11	32	12	12	
Total	268	4	80	93		130	226	204	687	261	212	
Percentage			30%	35%				76%		97%	79%	

Annex 4_A
Health Center Profiles

	Provinces and Operational Districts	Program			# MW trained (by any organization)			Most recent external QA		Most recent level 1 QA by OD	Conducts self QI assessment-most recent quarter
		Onsite testing ⁵	# HC covered by linked response HIV test blood drawn or testing	# HC covered by linked response syphilis blood drawn or testing	AMTSL*	HBB*	IUD*	# of HC	Assessment Year		
		(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)		
	RACHA supported										
1	BANTEAY MEANCHEY										
	OD Mongkul Borey	5 (US-CDC)	19	19	71	71	32	19	2009	19	19 (2010)**
	OD Or Chrov	2 (US-CDC)	11	11	23	23	14	11	2009	11	11 (2010)**
	OD Thmor Pourk	2 (US-CDC)	10	10	22	22	7	10	2010	10	10 (2010)**
	OD Preah Net Preah	2 (US-CDC)	12	12	26	26	19	12	2009	12	12 (2010)**
2	KOH KONG										
	OD Smach Mean Chey	1 (RACHA)	7	7	12	0	0	0	No	No	7 (2010)
	OD Sre Ambel	1 (RACHA)	5	5	10	4	4	0	No	No	5 (2010)
3	PREY VENG										
	OD Prey Veng (Svai Anthor)	3 (RACHA)	14	14	30	30	11	0	No	No	12 (2010-ongoing 2011)
	OD Neak Loeung	3 (Clinton Foundation)	17	17	41	41	12	0	No	No	0
	OD Peareang	4 (RACHA)	15	15	27	27	16	15	2010	15 ⁶	15 (2010)
	OD Kampong Trabek	2 (Clinton Foundation)	11	11	21	21	7	0	8	8	8 ongoing
	OD Preah Sdach	2 (Clinton Foundation)	9	9	18	18	1	0	9 Planned for March 2011	9 ⁷	9
	OD Kamchay Mear	2 (Clinton Foundation)	11	11	0	0	14	0	No	No	No

Annex 4_A
Health Center Profiles

	Provinces and Operational Districts	Program			# MW trained (by any organization)			Most recent external QA		Most recent level 1 QA by OD	Conducts self QI assessment-most recent quarter
		Onsite testing ⁵	# HC covered by linked response HIV test blood drawn or testing	# HC covered by linked response syphilis blood drawn or testing	AMTSL*	HBB*	IUD*	# of HC	Assessment Year		
		(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)		
	RACHA supported										
	OD Mesang	2 (Clinton Foundation)	10	10	21	21	0	0	No	No	5 (2011 ongoing)
4	PURSAT										
	OD Sampov Meas	6 (US-CDC)	22	22	69	69	29	21	Q2 2010	21 HC Q4 2010	21 (2008)
	OD Bakan	3 (US-CDC)	10	10	28	28	14	10	Q2 2010	10 HC Q3 2010	10 (2009)
5	SIEM REAP										
	OD Siem Reap	3 (Clinton Foundation)	18	18	40	40	33	16	Q2 2009	16 HC Q4 2010 ⁶	7 (2010)
	OD Angkor Chum	3 (RACHA)	18	18	49	49	14	16	Q3 2010	15/Q4 2010 ⁷	None 2010
	OD Soth Nikum	4 (Caritas)	23	23	48	48	6	22	Q2 2009	Q4 2010 ⁶	No
	OD Kralanh	2 (RACHA)	10	10	24	24	2	1	Q1 2009	10 HC ⁷	10 (2010)
	Total	52	252	252	580	562	235	153			
	Percentage	20%	98%	98%	119%	115%	48%	59%			

* May include some MWs trained more than once or MWs assigned to hospitals.

Annex 4_A
Health Center Profiles

	Provinces and Operational Districts	Program			# MW trained (by any)			Most recent external QA		Most recent level 1 QA by OD	Conducts self QI assessment-most recent quarter
		Onsite testing ⁵	# HC covered by linked response HIV test blood drawn or testing	# HC covered by linked response syphilis blood drawn or testing	AMTSL*	HBB*	IUD*	# of HC	Assessment Year		
		(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)		
	RHAC supported										
1	BATTAMBANG										
	OD Battambang	5 (US-CDC)	23	23	69	23	41	23	2009	2010	2010
	OD Sangke	2 (RHAC)	15	15	43	15	18	15	2010	2010	2010
	OD Thmar Koul	3 (FHI)	17	17	23	17	27	0	No	No	No
	OD Mong Russey	3 (US-CDC)	13	13	15	13	24	12	2009	2010	2010
	OD Sampov Luon ⁸										
2	KAMPONG CHAM										
	OD Kampong Cham	³ (NCHADS/GF)	23	23	43	41	16	0	No	No	No
	OD Prey Chhor	4 (RHAC)	15	15	40	28	28	15	RHAC 2009	No	No
	OD Cheung Prey	² (NCHADS/GF)	13	13	47	35	24	14	RHAC 2009	No	No
	OD Chamkar Leu	3 (RHAC)	13	13	26	14	8	13	RHAC 2009	No	No
	OD Kroch Chhmar	2 (NCHADS/GF)	11	11	14	5	8	0	No	No	No
	OD Tbong Khmum	4 (FHI)	16	16	37	32	14	0	No	No	No

Annex 4_A
Health Center Profiles

	Provinces and Operational Districts	Program			# MW trained (by any organization)			Most recent external QA		Most recent level 1 QA by OD	Conducts self QI assessment-most recent quarter
		Onsite testing ⁵	# HC covered by linked response HIV test blood drawn or testing	# HC covered by linked response syphilis blood drawn or testing	AMTSL*	HBB*	IUD*	# of HC	Assessment Year		
		(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)		
	RHAC supported										
	OD Ponhea Krek	3 (NCHADS/GF)	16	16	17	17	16	0	No	No	No
	OD O Reang Ov ¹ (8HC)	Supported by Save the Children, Australia									
	OD Memut	2 (NCHADS/GF)	10	10	18	12	21	0	No	No	No
	OD Srey Santhor	4 RHAC	13	13	18	8	5	7	RHAC 2009	No	No
3	KAMPONG SPEU										
	OD Kampong Speu	6 (WVI/ NCHADS/GF)	22	22	22	0	40	0	No	No	No
	OD Oudong	2 WVI	9	9	1	0	27	0	No	No	No
	OD Kong Pisey	3 RHAC	19	19	7	0	34	0	No	No	No
4	Pailin										
	OD Pailin	3 FHI	6	6	16	6	12	5	2009	No	No
5	SIHANOUK PROVINCE										
	OD Sihanouk Ville	3 RHAC	12	12	30	11	13	6	2010	No	6
	Total	57	266	266	486	277	376	110			
	Percentage	21%	99%	21%	71%	40%	55%	41%			
	* May include some MWs trained more than once or MWs assigned to hospitals.										

Annex 4_A Health Center Profiles

Footnotes for HC profiles:

1: SCA responsible for OD--RACHA not working here

2: MDs and Mas: Preah Nek Preah: 1 HC has MD; Smach Mean Chey: 1 HC 1MD+1Ma and 1 HC 1MA; Kampong Trabek: 3 HC each have 1 MD (1 the MD has not appeared for work); Mesang: 1 HC 1 MD and 1 HC 1MA. Sampov Meas: 2MAs and 1 MD; Preah Sdach two secondary MW in administrative positions

3: IUD services supported some HC by RACHA and some by UNFPA/MOH; Bakan: 9 MNCH; Sampov Meav 1 UNFPA; Mongkol Borei: 9 UNFPA; Or Chrov: 2 UNFPA; Thmor Pourk: 4 UNFPA; Smach Mean Cheu: all HC MSI/KFW; Sre Ambel 2 HC MSI; Peareang: only mobile services (PSI 2HC and MSI 10HC)

4: Both in administration positions

5: May include Referral Hospitals in onsite testing sites-RH most often has a HC in the same compound.

6: Spot checked (by OD or RACHA)

7: Coaching (by OD or RACHA)

8: URC supports MNCH services. RHAC does not work in this OD as it was not a part of the original proposal.

9: The numbers do not include "floating" (contract) midwives hired by the OD to provide services in the HC, but not MOH staff.

10: 24-hour services may be provided with onsite staff 24 hours or staff oncall after normal working hours.

11: Some HPs are in the process of becoming HCs so have shifted from HP to HC

Annex 4_B
Hospital Profiles

	Provinces and Operational Districts	Status						Functioning Service				
		OD	OD RH	SOA/SDG	HEF	HEF (HEF implementer)/ voucher implementer	CBHI	Operating theater--c-section capacity	Blood Bank	Blood transfusion	IUD	High-energy incinerator
		(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)
	RACHA supported											
1	BANTEAY MEANCHEY											
	OD Mongkul Borey	1	1 PRH	0	1	PRH (URC)/PFD	No	1	1	1	0	2
	RH SereiSopong		1	0	1	(URC)/PFD	No	0	0	0	0	0
	OD Or Chrov (Poipet)	1	1	0	1	(URC)/PFD	No	1	0	0	0	1
	OD Thmor Pourk	1	1	0	0	No	CAAWS (other)	0	0	0	0	0
	OD Preah Net Preah	1	1	0	1	(URC)/PFD	0	0	0	0	0	1
2	KOH KONG											
	OD Smach Mean Chey	1	1PRH	1	1	(URC)/RHAC	No	1	1	1	0	0
	OD Sre Ambel	1	1	1	1	(URC)/RHAC	No	1	0	0	0	0
3	PREY VENG											
	OD Prey Veng (Svai Anhor)	1	1 PRH	0	0	No	No	1	1	1	0	1
	OD Neak Loeung	1	1	0	0	No	No	1	1	1	1	1
	OD Peareang	1	1	1	1	(URC)/AFH	Yes (9HC) (RACHA) ²	1	0	1	0	0
	OD Kampong Trabek	1	1	SOA in March 11	1	PHD/ODO ³	No	1	0	1	1	0
	OD Preah Sdach	1	1	1	1	(URC)/AFH	0	0	0	0	0	0
	OD Kamchay Mear	1	1	0	0	No	No	0 ⁹	0	0	0	1
	OD Mesang	1	1	0	0	No	No	0	0	0	0	0
4	PURSAT											
	OD Sampov Meas	1	1 PRH	0	1	(URC)/PFD	CBHI	1	1	1	0	1
	OD Bakan	1	1	0	1	(URC)/PFD	No	0	0	0	0	0

Annex 4_B
Hospital Profiles

	Provinces and Operational Districts	Status						Functioning Service				
		OD	OD RH	SOA/SDG	HEF	HEF (HEF implementer)/ voucher implementer	CBHI	Operating theater--c-section capacity	Blood Bank	Blood transfusion	IUD	High-energy incinerator
		(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)
	RACHA supported											
5	SIEM REAP											
	OD Siem Reap	1	1 PRH	1	1	URC/CBHI-(BTC)/CHHRA	CBHI	1	1	1	0	1
	OD Angkor Chum	1	1	1	1	(RHAC)/RHAC	CBHC	0	0	0	1	0
	OD Soth Nikum	1	1	1	1	(BTC)/CHHRA	No	1	0	0	0	1
	OD Kralanh	1	1	1	1	(BTC)/CHHRA	No	1	0	0	0	0
	Total District Hospitals		15									
	Total Provincial RH		5									
	Total Numbers	19	20	8	15			12	6	8	3	10
	Percent of Hospitals (PRH+DH)			40%	75%			60%	30%	40%	15%	50%

Annex 4_B
Hospital Profiles

	Provinces and Operational Districts	Status						Functioning Service				
		OD	OD RH	SOA/SDG	HEF	HEF (HEF implementer)/ voucher implementer	CBHI	Operating theater--c-section capacity	Blood Bank	Blood transfusion	IUD	High-energy incinerator
		(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)
	RHAC supported											
1	BATTAMBANG											
	OD Battambang	1	1 PRH	0	1	(URC)/AFH	No	1	1	1	0	1
	OD Sangke	1	0	0	1	(URC)/AFH	No	0	0	0	0	0
	OD Thmar Koul	1	1	0	0	No	No	0	0	0	1	0
	OD Mong Russey	1	1	0	1	(URC)/AFH	No	1	0	1	0	0
	OD Sampov Luon ¹¹		1	0	1	URC/PFD	No	1	0	1	0	1
2	KAMPONG CHAM											
	OD Kampong Cham	1	1 PRH	1	1	(BTC)/AFH	No	1	1	0	0	1
	OD Prey Chhor	1	1	1	1	(BTC)/AHRDH E	No	0	0	0	0	0
	OD Cheung Prey	1	2	1	1	(BTC)/AFH	No	0	0	1	1	0
	OD Chamkar Leu	1	1	1	1	E	No	0	0	0	0	0
	OD Kroch Chhmar	1	1	0	0	No	No	0	0	0	0	0
	OD Tbong Khmum	1	1	0	1	HSSP2/RHAC	No	1	1	0	0	0
	OD Ponhea Krek	1	1	1	1	HSSP2/RHAC	No	0	0	1	1	0
	OD O Reang Ov ¹²											
	OD Memut	1	1	1	1	HSSP2/RHAC	No	1	1	1	0	0
	OD Srey Santhor	1	1	0	0	No	No	1	0	0	0	0
3	KAMPONG SPEU											
	OD Kampong Speu	1	1 PRH	0	1	PHD/ODO ³	No	1	1	1	1	1
	OD Oudong	1	1	0	0	No	No	1	0	0	0	1
	OD Kong Pisey	1	1	0	0	No	No	0	0	0	1	0

Annex 4_B
Hospital Profiles

	Provinces and Operational Districts	Status					Functioning Service					
		OD	OD RH	SOA/SDG	HEF	HEF (HEF implementer)/ voucher implementer	CBHI	Operating theater--c-section capacity	Blood Bank	Blood transfusion	IUD	High-energy incinerator
		(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)
	RHAC supported											
4	SIHANOUK PROVINCE											
	OD Sihanouk Ville	1	1 PRH	0	1	(URC)/BFH	No	1	1	1	1	1
5	PAILIN											
	OD Pailin	1	1 PRH	0	1	PHD/ODO ³	No	1	1	1	0	0
	Total District Hospital		14									
	Total Provincial RH		5									
	Total Numbers	18	19	6	14			11	7	9	6	6
	Percent of Hospitals (PRH+RH)			32%	74%			58%	37%	47%	32%	32%

Annex 4_B
Hospital Profiles

	Provinces and Operational Districts	Number				Year most recent level 1 QA				URC focus activities	
		2ndary midwives	MD	MW trained AMTSL	MW trained HBB	MW trained IUD	RH-full Level 1 tool	Most Recent Assessment Year	Level 1 for Maternity section only	MNH Support	HIP support
		(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)	(t)	(u)
	RACHA supported										
1	BANTEAY MEANCHEY										
	OD Mongkul Borey	19	26	8	8	0	0	No	0		
	RH SereiSopong	10	7	6	6	1	1	2010	0	1	1
	OD Or Chrov (Poipet)	6	11	4	4	0	1	2010	0	1	1
	OD Thmor Pourk	3	4	3	3	0	0	No	0	1	
	OD Preah Net Preah	1	3	2	2	0	1	2010	0	1	1
2	KOH KONG										
	OD Smach Mean Chey	9 ⁸	7	2	2	0	1	2009	2010 RACHA		
	OD Sre Ambel	3 ⁸	3	6	6	0	1	2009	2010 RACHA		
3	PREY VENG										
	OD Prey Veng (Svai Anthor)	10	12	5	5	9	0	2010	2010 RACHA		
	OD Neak Loeung	4	15	3	3	2	0	No	0		
	OD Peareang	0	8	4	4	0	0	No	0		
	OD Kampong Trabek	3	11 ⁶	4	4	5 ⁵	0	2010	2010 RACHA		
	OD Preah Sdach	1	5	0	0	0	0	No	0		
	OD Kamchay Mear	0	8	0	0	0	0	No	0		
	OD Mesang	2	3	5	5	0	1	No	0		
4	PURSAT										
	OD Sampov Meas	8	2	7	7	0	1	2010	0	1	
	OD Bakan	3	1	5	5	0	1	2010	0	1	1

Annex 4_B
Hospital Profiles

	Provinces and Operational Districts	Number					Year most recent level 1 QA			URC focus activities	
		2ndary midwives	MD	MW trained AMTSL	MW trained HBB	MW trained IUD	RH-full Level 1 tool	Most Recent Assessment Year	Level 1 for Maternity section only	MNH Support	HIP support
		(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)	(t)	(u)
	RACHA supported										
5	SIEM REAP										
	OD Siem Reap	7	3	6	6	0	1	External 2009. URC	0	1	1
	OD Angkor Chum	3	5	5	5	3	1	URC 2010	0	2 ¹⁰	2
	OD Soth Nikum	3	6	3	3	1	1	External 2009 RACHA/URC	0		
	OD Kralanh	3	4	3	3	0	1	External 2009. URC	0		
	Total District Hospitals										
	Total Provincial RH										
	Total Numbers	95	144	81	81	21	12			9 ¹⁰	7
	Percent of Hospitals (PRH+DH)						60%				

Annex 4_B
Hospital Profiles

	Provinces and Operational Districts	Number					Year most recent level 1 QA			URC focus activities	
		2ndary midwives	MD	MW trained AMTSL	MW trained HBB	MW trained IUD	RH-full Level 1 tool	Most Recent Assessment Year	Level 1 for Maternity section only	MNH Support	HIP support
		(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)	(t)	(u)
	RHAC supported										
1	BATTAMBANG										
	OD Battambang	25	6	14	0	5	1	2010	0	1	1
	OD Sangke	0	0	0	0	0	0	None	0		
	OD Thmar Koul	6	0	4	4	3	0	None	0	1	
	OD Mong Russey	7	3	7	0	5	1	2010	0	1	
	OD Sampov Luon ¹¹	8	1	2	2	0	1	2010	0	1	
2	KAMPONG CHAM										
	OD Kampong Cham	33	47	12	30	2	0	None	0		
	OD Prey Chhor	2	4	4	2	0	1	2009	0		
	OD Cheung Prey	4	9	4	4	0	1	2009 ⁷	0		
	OD Chamkar Leu	3	4	6	3	1	1	2009	0		
	OD Kroch Chhmar	1	1	2	1	0	0	None	0		
	OD Tbong Khmum	2	6	3	2	0	0	None	0		
	OD Ponhea Krek	6	3	1	6	1	1	2009	0		
	OD O Reang Ov ¹²										
	OD Memut	6	4	4	5	3	1	2009	0		
	OD Srey Santhor	3	3	3	4	3	1	2009	0		
3	KAMPONG SPEU										
	OD Kampong Speu	14	29	14	0	14	1	2009	0		
	OD Oudong	4	14	3	1	0	1	2009	0		
	OD Kong Pisey	3	12	2	2	1	1	2009	0		

Annex 4_B
Hospital Profiles

	Provinces and Operational Districts	Number					Year most recent level 1 QA			URC focus activities	
		2ndary midwives	MD	MW trained AMTSL	MW trained HBB	MW trained IUD	RH-full Level 1 tool	Most Recent Assessment Year	Level 1 for Maternity section only	MNH Support	HIP support
		(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)	(t)	(u)
	RHAC supported										
4	SIHANOUK PROVINCE										
	OD Sihanouk Ville	27	22	8	3	5	1	2009	0		
5	PAILIN										
	OD Pailin	7	4	7	0	0	1	2009	0		
	Total District Hospitals										
	Total Provincial RH										
	Total Numbers	161	172	100	69	43	14			4	1
	Percent of Hospitals (PRH+RH)						74%				

Footnotes for hospital profiles

- 1: Broken
- 2: Funded by Health Net International and implemented by RACHA
- 3: Prakas 809 (MOH pays 50,000 riels/case)
- 4: RH nurses insert IUDs in private clinics but reported for HC statistics. RH has capacity
- 5: Kampong Trabek 2 MD plus 3 MW
- 6: 3 have not yet shown to work
- 7: Reported by OD Director
- 8: Smach mean Chey: 2 PMW; Sre Ambel 4 PMW
- 9: Has operating theater but reported no C-sections past year
- 10: Pourk is a HC that is in the process of becoming a District Hospital. MNH support is in the start-up stage now.
- 11: URC supports MNCH services. RHAC does not work in this OD as it was not a part of the original proposal.
- 12: SCA responsible for OD--URC and RACHA not working here

Annex 5

Reducing financial barriers to access

Despite considerable improvement in the health sector, access to quality health services remains a major problem for Cambodian population, especially the poor and vulnerable. Numerous supply-side and demand-side barriers, especially financial barriers, limit access to essential health services, including professional maternal health services [1].

More than two thirds of the relatively high total health expenditure (US\$35/capita in 2007) was direct out-of-pocket payments. A body of evidence shows that direct payments, in any form, prevent the poor from accessing essential health services they need and cause financial hardship or impoverishment for those who obtain the services [2-4]. As highlighted in the Health Strategic Plan 2008-2015 [5], a major challenge for Cambodia is to reduce these direct payments through extending the coverage of prepayment and risk pooling mechanisms under a unified Social Health Protection (SHP) system, which has been widely recommended [6]. Several SHP mechanisms have been developed in Cambodia. These include Health Equity Fund (HEF), Community-Based Health Insurance (CBHI), vouchers and very recently conditional cash transfers. The USAID health program partners have directly or indirectly involved in development and implementation of these schemes or similar ones.

Health Equity Funds

Health Equity Funds (HEFs) are a SHP mechanism to complement other health financing schemes addressing financial barriers to accessing public health services for the poor and preventing poor households from financial hardship or impoverishment due to health care costs (iatrogenic impoverishment). The management of the fund is entrusted to a third party, usually a national NGO, which is closely monitored and given technical support by a HEF implementer. HEF beneficiaries are identified according to eligibility criteria, either at the community before health care demand –pre-identification –or at the health facilities through interviews –post-identification. At the health facilities, the eligible poor patients get full or partial support from HEFs for the cost of user fees (mainly hospital user fees), transport cost and other costs during hospitalization.

Since the first pilots in 2000, the number of HEFs has increased considerably. By February 2011, there are 57 HEF schemes, including 15 government subsidy schemes,¹ being implemented in 56 of the 77 operational health districts (ODs) in Cambodia. HEFs cover all referral hospitals in the 56 ODs and 172 health centers in some of these ODs only. Available evidence from several studies suggests that HEFs effectively improve access to public hospital services for the poor and hold potential for protecting poor households from iatrogenic impoverishment through reducing their out-of-pocket payments and health care-related debts [7-10].

URC has been supporting the implementation of HEFs since 2003, as part of the “Health System Strengthening in Cambodia” (USAID-HSSC, 2002-2008). URC plays mainly the role of HEF implementer –selecting and subcontracting national NGOs to operate HEFs and providing them necessary technical assistance and monitoring their work. In addition, URC

¹ Unlike standard HEFs, the government subsidy schemes are directly operated by the participating health facilities without a third party operator and fully financed by the government fund. The benefit package is limited to user fees only. The participating health facilities get reimbursed by the government for the user fees foregone according to the number of exempted cases and on a flat rate per case (ranging from US\$0.25 for an outpatient at health centre to US\$20 for an inpatient at national hospital). For more detail on the government subsidy schemes, please refer to the inter-ministerial *Prakas* 809.

also uses its staff expertise and lessons learned from the field to contribute to HEF policy and institutional development, through various forums, including support the development of the Health Equity Fund Implementation and Monitoring Framework in 2005 and participated in organization of National HEF Forum in 2006.

An evaluation of the USAID funded HEF schemes in 7 ODs conducted in late 2008 and early 2009 confirmed the HEF impact on increased hospital utilization by the poor, especially for deliveries. In addition, the extension of the HEF to cover health center services also saw an increase in their utilization by the poor. Assessment of clinical indication for admission in two HEF supported hospitals showed that about 90% was correct. The findings also suggested that HEFs reduced health care related debts among poor households.²

In the life of the “Better Health Services” (URC-BHS, 2009-2013), URC continues the efforts began by the HSSC to support the implementation and expansion of HEFs with a clear strategy to promote greater responsibility by the Ministry of Health (MOH) and reducing dependence on donor inputs, in order to improve the efficiency and sustainability of HEFs rather than expansion, which does not rely on URC, but on MOH and the partners of Health Sector Support Project phase 2 (HSSP2). As a result, the number of URC-implemented HEF schemes has not increased much (22 schemes in 25 ODs at the end of the HSSC to 24 schemes in 28 ODs, covering about 1.5 million poorest people in Cambodia). For 14 of these HEF schemes, URC is subcontracted by the MOH-HSSP2 as a HEF implementer and all the costs for these schemes are born with the Royal Government of Cambodia (RGoC) counterpart and HSSP2 pooled funds. As a result from efforts to sustain the existing HEF schemes, URC has managed to get RGoC counterpart and other donor pooled funds to finance the direct benefit costs (50% from the RGoC and 50% from HSSP2 pooled fund) for other 9 HEF schemes, whereas USAID fund pays for NGO operating costs. Only one HEF scheme in Phnom Penh is fully financed with USAID fund.

According to available data, the 24 HEF schemes implemented by URC supported 4,948 facility deliveries (including 454 C-sections) and 10,799 facility deliveries (526 C-sections) respectively in 2009 and 2010. Analysis of available HEF and HIS data in some selected provinces and ODs showed that the overall C-section rates among the poor (HEFB) are comparable (even higher in some places) to those among the non-poor (non-HEFB), suggesting some impact of HEF on improved access to C-section for the poor (Table 1).

In addition, URC has also recently contributed more to HEF institutional development through innovating new implementation arrangements to improve HEF efficiency. These include the introduction of output-based contracting with HEF operators; the standardization of price structures and performance-based payment mechanisms for HEF operators to strategically purchase services from the contracted hospitals and health centers for the poor; development of new HEF/CBHI operational database; innovation of ways to link HEFs to other SHP schemes such as CBHI and government subsidy schemes; and establish a pilot “SHP Agency” in support to the Master Plan for SHP. Moreover, feedback from MOH policy makers and donor agencies were very positive about URC role as HEF implementer in Cambodia. They appreciated URC expertise and inputs in this field. URC seems to have been considered as a referral agency for HEF data.

However, along with these strengths, there are also weaknesses and challenges around the HEF implementation and expansion. Although the government is contributing to financing HEFs and commits to increasing its commitment overtime, this has been less clear in practice and is subject to availability of budgets for this purpose. Moreover, the current HSSP2

² For further detail, please refer to the “Evaluation Report: Health Equity Funds Implemented by URC and Supported by USAID, September 2009

funding source of financing HEFs encounters a number of problems, including disbursement delays, poor monitoring, especially monitoring of quality, and under consideration of the role of third party NGO HEF operators. HEF expansion, which relies on HSSP2 funding, is beyond the control of URC. Currently, HEFs do not exist in many ODs in some provinces (Kampong Speu, Prey Veng and Kampong Cham) where RHAC and RACHA are working. This seems to undermine the effectiveness of many program activities of the two partners, especially referrals for emergency obstetric and newborn care. It was reported that the output-based contracting with HEF operators initiated by URC was turned down by an MOH policy maker for the reason of risk of collusion between HEF operators and providers, despite evidence that it was not the case and its effect on reduced operating cost. This suggests the lack of consultations and communications with MOH policy makers prior to the introduction of the idea.

Besides URC, RHAC has also implemented some five HEF schemes in Kampong Chhnang and Kampong Cham province (Tbong Khmom), co-funded by UNFPA and the RGoC (HSSP2). The schemes in Kampong Chhnang were initially for reproductive and maternal and child health services only. In 2011, they were all converted to be standard HEF schemes, covering all service user fees and associated costs at hospitals and health centers.

Table 1: Comparison of C-section rates among HEF beneficiaries (the poor) and the non-HEF beneficiaries in four selected provinces

Province or OD	Population			Expected Births (CBR 26)		2010 C-Sections				
	Total	HEFB	non-HEFB	HEFB	non-HEFB	# total	# HEFB	# Non- HEFB	% HEFB	% Non- HEFB
Pursat + BTB + BMC	2,173,586	538,010	1,635,576	13,988	42,525	869	264	605	1.9%	1.4%
Koh Kong + SHV	355,026	108,160	246,866	2,812	6,419	209	58	151	2.1%	2.4%
Memut + Ponhea Krek	351,151	89,095	262,056	2,316	6,813	41	29	12	1.3%	0.2%
note: only have data for these2 ODs.										
Pearaing	167,066	43,413	123,653	1,129	3,215	99	15	84	1.3%	2.6%
All the above	3,046,829	778,678	2,268,151	20,246	58,972	1,218	366	852	1.8%	1.4%

30% of all C-S performed in these facilities in 2010 were paid for by HEF.

Notes:

Assumes CBR of 26

Assumes equal CBR among HEFB and non-HEFB, actually may be a bit higher among HEFB, but probably not by much
C-S rate for HEFB probably represents actual, while for non-HEFB will be some underestimation in that it does not include C-S done in private

facility, VN, Thailand. K.Cham data may also miss some done in PRH.

Denominator for HEFB is pre-ID while some of the HEF C-S might have been post-ID, effect would increase the percentage

Vouchers

Vouchers are a demand-side financing mechanism to stimulate demand for under-used services/products, through which subsidies go directly to the consumer in the form of a voucher or token that the consumer redeems when demanding the services/products from a provider [11]. Health vouchers are considered a potentially effective means to address demand-side barriers to access to specific health services/products for specific population groups, usually the poor and disadvantaged [12]. Vouchers have also been increasingly used for promoting access to and utilization of reproductive health services in many low-income countries in Latin America, Africa and Asia. Some of these schemes have been extensively evaluated in recent years and have showed positive results [13,14].

In Cambodia, vouchers have been introduced since early 2007 by BTC in three rural ODs in Kampong Cham province –namely Cheung Prey, Chamkar Leu and Prey Chhor –as an extension of HEFs targeting poor pregnant women for delivery and associated services, including support for transport and referral services in case of complications. In-depth evaluation of the voucher scheme suggested vouchers together with HEFs improved access to safe deliveries for poor pregnant women [15]. Since early 2011, a similar voucher scheme for reproductive and maternal health services funded by KFW has been launched in 9 ODs in three provinces of Kampot (Chhouk, Angkor Chey and Kampong Trach), Kampong Thom (Kampong Thom, Baray Santok and Stong) and Prey Veng (Pearaing, Preah Sdach and Kampong Trabek). EPOS, a consulting firm, and Action for Health (local NGO) are subcontracted by KFW to jointly implement these voucher schemes.

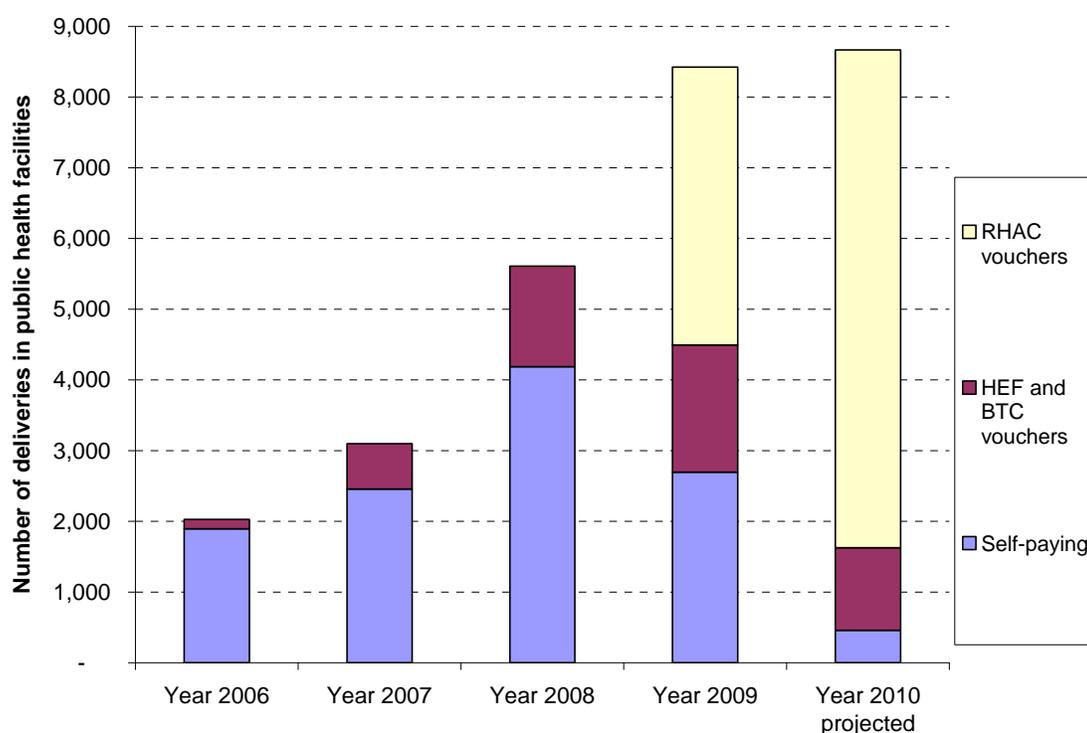
RHAC has implemented vouchers (the so-called Purchase Maternal and Newborn Health Services) aimed at promoting safe deliveries in 18 ODs in the five target provinces (including the three ODs where BTC vouchers are implemented), RHAC purchases services (4 ANC, delivery, 24h PNC) from all health centers (at US\$10 per case of completed use of all recommended services) through "health card" (pink color). Unlike BTC and KFW voucher schemes, RHAC vouchers target all pregnant women regardless their socio-economic status and do not provide support for transportation cost and referral service fees at the hospital, which have to be paid for by the women. The cards are distributed to pregnant women through Village Health Support Group (VHSG) and/or health center staff. In principle, women holding the card will get the recommended services for free. In case of an obstetric complication and appropriately referred to hospital, the health center will also receive USD10 from RHAC. Although no in-depth performance and impact assessment of the voucher scheme has been conducted so far, some available data showed encouraging results. Analysis of data from 3 ODs supported by RHAC vouchers in Kampong Cham suggests contribution of this scheme to increasing number of deliveries in public health facilities (Figure 1). However, it seems that almost half of the voucher scheme beneficiaries replace the former self-paying women.

Since output-based financing schemes like vouchers are prone to over-reporting for the remunerated outputs, one could question the reliability of the reported voucher beneficiaries. According to key informants and RHAC reports, RHAC has regularly carried out systematic spot checks to health centers, picking up about 20% of the reported cases to check in the community. The results showed no evidence of over-reporting, but did reveal some operational limitations such as incomplete ANCs and PNC less than 24h and extra payments. All ANC visits are supposed to be free of charge for pregnant women, but in practice, most health centers charge fee from pregnant women with promise to return the money to them when they came for delivery at the health centers, which in some cases is forgotten. Moreover,

many pregnant women still paid some money to health centre staff for the delivery services, mainly as an act of gratitude and/or for some extra services such as injections. According to RHAC population-based survey conducted between July-August 2010, 82% of births were attended by trained providers; 65% of deliveries were preceded by more than 4 ANC visits; and 65% of births received PNC/newborn care within 24 hours.

However, according to BTC and other key informants, overlapping in voucher distribution (one woman receives 2 vouchers) and unnecessary competition between RHAC and BTC vouchers were evident, although no double payments were found. Their recent discussions may have found solution to this problem. It was also reported that overlap could also happen to health centers having HEFs. RHAC has discussed this issue with URC and other related partners to avoid overlapping. Although RHAC claims that practical lessons learned from its vouchers have contributed to highlighting the need for such mechanism to address financial barriers and be part of Fast Track Initiative (FTI) road map, we believe that there is a need for an in-depth assessment of the RHAC vouchers and others to draw lessons useful for their improvement and scaling up in Cambodia.

Figure 1: Deliveries in public health facilities by type of financing in 3 ODs supported by RHAC vouchers



Community-Based Health Insurance

Based on the principles of risk pooling and prepayment, the first voluntary and not-for-profit Community-Based Health Insurance (CBHI) scheme was piloted in 1999. As of 2009, there were 12 CBHI schemes, covering 120,000 people in 12 ODs in Cambodia [16]. Varying results have been reported. A number of studies on CBHI are ongoing, but there is no empirical evidence on its impact to date.

In 2006, RACHA began piloting a voluntary CBHI in some villages in one health center catchment area and later expanded to cover the referral hospital and 8 health centers catchment areas in Sampov Meas OD in Pursat province. The overall coverage in 2010 was about 5% of the total OD population. With a relatively low premium, the scheme is subsidized by the USAID. The benefit package includes user fees for all services available at participating health centers and the referral hospital and transportation cost for emergency referrals from health centers to the hospital. The costs for poor clients who hold a HEF card are paid for by the money saved from micro-credit interests.

An official evaluation by the USAID in 2009 showed that CBHI has had some positive impact on health seeking behavior among its members as indicated by an increasing percentage of health center clients who are CBHI members and high utilization rates among members. However, there is no evidence indicating that CBHI has by itself improved quality of the public services. It also revealed that RACHA has insufficient capacity to run CBHI and make it sustainable. Since the scheme was launched, no further trainings to increase capacity of managers in the implementation and monitoring of the CBHI were done and the close relationship between RACHA and public health services make it difficult to effectively play the role of purchaser. Different from the original proposal, there are insufficient linkages with other schemes, such as HEF, risking inefficiencies caused by overlaps and gaps, and also insufficient participation of the community in the CBHI. An efficient feedback mechanism to voice the needs, complaints and wants of members has not been established.

Following the evaluation, RACHA was asked to develop a business plan for the future development of the CBHI scheme within 6 months. After the receipt of the plan, USAID requested URC to assume the management of the scheme in April 2010. Since then, URC developed a contract with the existing HEF operator (PfD) to continue management of the scheme until a long-term community-based structure could be developed. However, RACHA managers still believe that RACHA can manage and further expand the scheme to become a sustainable health financing mechanism. Before the evaluation, RACHA did receive some technical assistance from URC in data analysis, which allowed drawing some useful operational recommendations. Currently, RACHA is still operating another CBHI in Pearang OD funded by HealthNet International.

Community-Based Health Cooperative

As part of efforts to achieve the goal of increasing equitable access to quality health services for the poor, URC recently initiated a “Community-Based Health Cooperative” (CBHC) in Angkor Chum OD, where there is strong ownership and commitment by the OD director, local authorities, including commune councils, and strong community participation. Thanks to this strength, the public health facilities in this OD are performing reasonably well and illegal private practices are not allowed. It is the first locally registered community-based health financing scheme officially approved by the MOH, and allows incorporating elements of CBHI and HEF as well as Pay-for-Performance, Conditional Cash Transfers (CCT) and Health Promotion.

The CBHC is operated by a newly-created Community-Based Organization (CBO), accountable to a board of directors composed of representatives from the district administrative authorities, commune councils, and Angkor Chum OD. Contracted health service providers are the public health centers and referral hospitals in Angkor Chum, Siem Reap provincial hospital and Khmer-Soviet National Hospital in Phnom Penh which will be

paid for their services rendered to CBHC members on a case payment basis, which is further adjusted by the most recent quality assessment scores.³

Commune councils are responsible for scheme promotion and registration of households. In exchange, they receive a flat service fee to cover administrative and logistical costs, according to the length of the enrolment. They receive 6,000 Riels (US\$1.5) for a 12 month enrolment of a poor household and from 1,500 Riels to 12,000 Riels for a 3 month to 12 month enrolment of a non-poor household. Poor households identified by the commune councils through the standard Ministry of Planning national poverty identification process are registered to the scheme at no charge to household, whereas non-poor households have to pay 2,000 Riels per person per month as premium contribution. The enrolment must be done for all members of the household. Depending on the length of the enrolment (6, 9, 12 months), a discount rate (5%, 7.5%, 10%) is provided according.

All scheme members –poor and non-poor –are entitled to free health services at all contracted health facilities and cost for transportation of distance more than 5 km. Referrals to Siem Reap provincial hospital and national hospital require a referral letter from Angkor Chum referral hospital. In addition to this benefit package, CBHC member households with a pregnant woman or newborn child will be eligible for a schedule of CCT following documented completion of scheduled appointments: after 4th ANC, at birth, 6 weeks, 6 months, 12 months, 18 months and 24 months. For each completed schedule, the household will receive cash of 20,000 Riels (US\$5). Funding of CBHC activities come from two initial sources: premium contribution by the non-poor households and sub-grant from BHS, which will cover all scheme costs, including cost for CBO, for which premiums are not sufficient.

The successful pilot in 6 communes covered by 3 health centers since July 2010 has led to an expansion to 12 communes in 7 health centers by January 2011. During this period, the CBHC has enrolled 4,791 households (18,560 individuals) of which 77% are poor households. Although the proportion of non-poor enrolment remains low as compared with the poor, severe adverse selection (as confirmed by commune councils and OD people) may raise a concern about the future scheme financial stability. It is, however, too early to make any judgment on the success of this scheme at this stage. The adverse selection may not necessarily be negative at this stage as it benefits scheme marketing. According to commune councils, enrolling the ones with obvious health care needs (pregnant women and those with preexisting diseases) will make them happy and help promote the scheme. Moreover, the innovative design of this scheme, the enthusiasm and commitment of all stakeholders to the scheme, and strong support from the MOH policy makers enhance the likelihood for its success and scaling up.

This CBHC is an important and very useful experiment. There is a general consensus around the problems it is intended to address in current HEF implementation arrangements. However, it remains a challenge to make this scheme become a successful and sustainable community-based health financing model for Cambodia. It seems that URC has made considerable efforts and investment to create the CBO (which did not exist before) and make it operational. The large proportion of poor households that cannot contribute and the difficulty to convince those better-off to enroll (because they may not want the public health services even free) may continue to make the scheme subsidies (for both premiums and incentives for CCT) dependent on external funding. Last but not least, the particularly conducive context in Angkor Chum may make this scheme unique and limit its replicability in other places. This requires careful comparison of its results with other CBHC pilots being implemented in other

³ For more detail, refer to the scheme document: Community-Based Health Cooperative in Angkor Chum OD, Siem Reap. Description of Services.

contexts, such as Pursat and Phnom Penh, to reveal more about the pre-conditions needed for successful replication and expansion. Experience and lessons learned need careful documentation and publicity.

Other health financing initiatives

RACHA is the only USAID partner implementing micro-credit –the so-called “Credit-for-Health” –first in Pursat and Siem Reap provinces and later extended to Banteay Meanchey province. The main objective of the scheme is to improve health of the rural population through raising their economic situation and generating funding for health promotion activities. RACHA collaborates with PHDs for oversight and monitoring, whereas the credit organization fully relies on a partnership with Provincial Rural Development and/or Women Affairs Department and local communities through Village Credit Committees. The principal funds are provided by RACHA but small projects are financed through funds generated by the interest earned on the bank accounts. The evaluation of this scheme in Pursat and Siem Reap in 2005 revealed that although this scheme was implemented in a very competitive environment, RACHA succeeded to reach a very high repayment rate. Similar findings were obtained from a joint evaluation of micro-credit and CBHI in Pursat in 2009. According to RACHA, these activities include health education and promotion in the villages, transportation costs for emergency referral, incentives for women to attend ANC, funding of Village Health Support Groups (VHSG), per diem for health center staffs attending village meetings, drilling wells in health centers, health education contests in the village, paying health care costs for the poor, buying and installing solar panels and building pre and post-delivery rooms for health centers, etc.

In addition to micro-credit, the partners are planning or implementing other health financing initiatives such as payments for referrals of complicated deliveries (US\$15 per case) to replace the loss of midwifery incentives⁴ and prevent unnecessary delays of referrals of complicated deliveries. According to URC, the early assessment of this initiative showed encouraging results. It is not only the incentive, but also the participatory process, including the supervision and monitoring the appropriateness of referrals as a condition for payment, that also contributes to change. For contributing to future policy development, the partners should continue to document the lessons learned and forward them to policy makers. The monitoring system introduced by URC for this could also be useful for others.

CCTs are cash payments to targeted eligible households, usually the poor and vulnerable groups, conditional on certain measurable behaviors such as utilization of preventive health services, aimed at improving health and poverty alleviation. CCTs have been increasingly implemented in low- and middle-income countries, mainly in Latin America, and a body of evidence of their impact on access to preventive care is available [17,18]. Besides the CCT introduced by URC as part of the CBHC in Angkor Chum, RHAC plans to institute CCTs tied to utilization of specific MCH services in its target areas.

In general, there are issues in need of further consideration with regard to any incentivization of health service utilization, such as: (1) targeting relative to the presence of HEFs and the relative cost barrier of different services; (2) targeting in terms of behaviors (paying for services for which demand is already strong may prove counter-productive in the long run), and (3) sustainability and congruence with long-term national strategies for social protection.

⁴ Since late 2007, the RGoC has launched nationwide a midwifery incentive scheme which provides midwives and other qualified birth attendants an incentive of US\$10 and USD15 for a live birth attended respectively at referral hospitals and health centers. Attendants will not receive this incentive if the delivery is complicated and the woman is referred. This is seen as a disincentive and factor for delays of referrals

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Annex 6 Notes on M&E for RACHA

1. RACHA Community-based survey

Comments relate to the following:

- Bias in the methodology for sampling and for identifying respondents.
- Ways to harmonize the RACHA and RHAC community-based surveys so that they are more useful to the MOH and donors for providing information on progress toward achieving objectives and potentially for cross-checking performance in SOA ODs for SDGs.

A. Selection of Primary Sampling Unit (PSU) for sampling

RACHA explained that they select 75% of all HCs within an OD by lottery. They then select four villages under each HC, also by lottery. This is based on a planned sample size of 600 different respondents for each category of respondent per village.

➤ Observations

- Since HCs are distributed roughly on a population basis, the proportion of the sample does roughly follow the proportional population representation, but not completely (see Table 1 provided by RACHA). There is no weighting applied to the national-level results to compensate for disproportionate representation.
- Since this is a population-based survey, it is better to base the PSU selection on population distribution rather than HC distribution.

- **Recommendation:** Stratify population numbers by province, OD, and HC, and then systematically select the village where your sampling interval falls. This will ensure that the sample selection is proportional to population representation (PPR).

B. Selection of starting point within PSU for identifying respondents

RACHA explained that they go to the center of the village and then spin a bottle, moving in the direction of the bottle, always following a “right” hand direction when decisions are needed, moving house to house until they achieve their sample. If the appropriate respondents are not identified in the selected village (sometimes happens particularly with identifying HH with 0-3m old children) they move to the next village and restart the same process until they identify the needed respondents.

➤ Observations

- There is no process for randomly selecting where, along the line from the center of the village to the most distant household (HH) in that line, the first HH for seeking respondents. This biases results (particularly for the most common categories of respondents—married women of reproductive age; HH with children 0-12m) toward persons who live in the center of the village.

➤ Recommendation:

- For small villages, count the number of HH from the center to the edge and randomly select the initial HH where respondents will be identified.
- For large villages/towns, divide the town into sections of roughly equal population (ask the village chief to help draw a rough map and make sure that boundaries for each section are very clearly delineated). The number of sections will depend on the size of the village/town. You need to be able to roughly count the HH from your

central point to the edge of the sector to identify a random starting point. Then randomly select the section where the sampling will start and use the process in bullet one to identify which HH will first be approached for a respondent. When one section is completed and you still have not identified the correct number of respondents randomly select a second section and continue the same methodology.

C. Sample size:

RACHA explained that they calculated that they need 600 respondents for each category of respondent, for a national Confidence Limit (CL) of +/- 4%. They have decided to seek one of each type of respondent in each selected sampling unit.

- This eliminates the potential of clustering effect
- RACHA presents data by OD and then for the total working area. There is no calculation of the CL for the OD level information and the number of respondents for each questionnaire ranges from around 16 (Koh Kong ODs) to 32 or more for the other ODs.

➤ **Recommendations:**

- See recommendations under Section D: Selection of respondents.

D. Selection of respondents:

RACHA has seven different questionnaires, many of which have overlapping eligibility criteria.

- Questionnaires: 1) Women of reproductive age (WRA); 2) Woman with child 12-23m; 3) Woman with child 6-12m; 4) Woman with child 0-12m; 5) Woman with child 0-3m; 5) VHSG; 6) traditional birth attendant

They ask one questionnaire in a HH, meaning that a HH that meets the eligibility criteria for several questionnaires will be selected for only one questionnaire. I did not clearly understand how it is decided, for example, in a HH with a child 11m old whether 1st, 3rd, or 4th questionnaire was administered. One of the survey implementers was present and he explained that

- for WRA they selected every 5th HH, but it was not clear exactly when this 5th HH rule was applied.
- He also acknowledged that they sometimes ask the VHSG to identify a HH with a child 0-3m.
- I did not ask how they selected which VHSG they interviewed (there are supposed to be 2 per village).

➤ **Observations**

- The current system leaves much room for bias in deciding who gets what questionnaire.
- Asking the VHSG to identify respondents biases data toward HH the VHSG knows well—and most likely against high risk HH such as those who don't access services, who are marginalized in the village, etc. It is recognized that this was not a consistent practice, but it should never be done. Every HH along the path for selecting respondents must be interviewed for eligibility—even village chiefs often don't know the ages of children, and don't necessarily keep track of births—again, especially for more marginalized HH within a community.

- Also, although getting very current data (e.g., 0-3m for maternity questions) provides very current information, it does make sampling much more difficult.
- Following the same methodology as RHAC will increase comparability. This restricts the respondents to women who had a live-birth within the past 0-24 months.
- The RACHA survey interviews related to delivery and child care interviews only women with live births whose child is still alive.
- It is difficult to advise on how to make the RHAC and RACHA surveys more comparable, without more detailed discussion with both. There are strengths and weaknesses with both methodologies for eligibility of respondents and analyses. RHAC probably has greater recall bias because the recall time frame for practices around birth and IYCF can be up to 24 months, while RACHA limits questions to shorter intervals after birth, however, the RACHA method results in potential for much selection bias searching for a representative for each category of respondent. If proper methods were used to identify each type of respondent, it would most likely mean visiting (although not interviewing) many more HH than they currently visit. It is acknowledged that even simply visiting and screening a HH for eligibility does take time.

➤ **Recommendations:**

- An expert should consult with RACHA to revise the selection of respondents and subsequent sample size needed for meaningful results within the desired CL.
- Combine the questionnaires so that all HH get all relevant questions, and interview all HH with a birth within the past 0-24m. Then analyze according to your separate ages, perhaps expanding the ages for maternity information to 0-12m; and maintain the exclusive BF information from 6-12m. This will require interviewing more HH per village to increase the probability of getting sufficient numbers of children at the correct age for desired analyses, and potentially reduce the total number of villages once a sampling expert consults—ensure that the sample gives agreed upon CL for OD level reporting.
- Consider including women whose child born 0-24m ago was stillbirth or has died (these are included in the RHAC survey). This will provide information (not statistically significant- but definitely important) on practices among the HH where the child died. The numbers will be small enough that it should not affect the overall sample size greatly, and should provide useful information at the total working area level. Relevant questions up to the age the child died should be asked.
- **Retrain the interviewers in HH selection so that they visit every HH along the sampling path to determine eligibility and do not rely on information from the VHSG or other village person.**

E. Questionnaire

- USAID should review the RHAC, RACHA, and CDHS questionnaires for common questions related to MNCH and ensure that where relevant, the CDHS well-tested questions are used, or if modifications are needed for practicality, that RHAC and RACHA ask these questions the same way and have responses that can be mapped to each other (if they want different categories of responses) so

that for analysis they can have the same definition for “yes” or “no” or whatever the response categories are.

➤ Observations:

- A quick glance shows that the respondents and potential time for recall for different sets of questions are different for RHAC and RACHA—RACHA: for breastfeeding questions immediate BF ones are asked for the mother with a child 0-3m and exclusive BF for the mother with a child 6-12m. RHAC: asks all BF questions about the most recent birth (including ones where the child has died) for a HH where there was a birth from 0-24m. The differences in recall bias will influence the responses between the two surveys, also the fact that the immediate BF question is asked of a different woman than the one for whom exclusive BF is asked. A compromise might be focusing on 0-12 months for maternity and
- Make a uniform tabulation plan for RHAC and RACHA for key indicators of interest for SDG monitoring, and other indicators important for tracking. The two can produce a very short report on the key indicators using this harmonized analysis and then analyze as per their organization’s needs
- Examples of key indicators for harmonization in methods and respondents for USAID would be full immunization, immediate breastfeeding, exclusive breast feeding, where delivery occurred, receipt of ANC and PNC, and potential care seeking behavior for the child who was sick.
- *An extra issue which may apply to RACHA and RHAC: RACHA has a question on diarrhea treatment with one response that the mother gives the child a drug. There needs to be a way to differentiate zinc tablets from antibiotics.*

Table 1

RACHA SAR#4 Random Sampling Distribution based on 2010 Population

(Multi-stage random sampling)

Name of Province	# of OD	Name of Operational District (OD)	WRA Population /OD	% of Population Distribution	Total # of Health Center/OD	# of Sampled HCs (random selection) (Sampling fraction =76%)	# of sampled Villages (random selection)	Number of respondents/ OD* (Random selection)	% of Sample Distribution
1 Siem Reap	4	Siem Reap	78,880	10	18	14	56	392	8.6
		Angkor Chum	56,911	8	17	13	52	364	8
		Kralanh	33,047	4	10	8	32	224	4.9
		Sot Nikom	76,144	10	23	17	68	476	10.5
Total				32	68	52	208	1456	32
2- Banteay Meanchey	4	O Chrov	43,451	6	11	8	32	224	5
		Preah Net Preah	34,513	5	12	9	36	252	5.6
		Mongkol Borey	63,981	8	20	15	60	420	9.3
		Thmor Pouk	63,902	8	10	8	32	224	4.9
Total			27	53	40	160	1120	24.8	
3- Pursat	2	Sampov Meas	66,265	9	22	17	68	476	10.4
		Bakan	30,374	4	10	8	32	224	4.9
Total				13	32	25	100	700	15.3
4- Prey Veng	4	Svay Antor	56,820	8	17	13	52	364	8
		Kampong Trabek	36,967	5	11	8	32	224	4.9
		Kamchay Mear	34,877	5	11	8	32	224	4.9
		Me Sang	33,728	4	10	8	32	224	4.9
Total				22	49	37	148	1036	22.7
5- Koh Kong	2	Smach Meanchey	13,817	2	7	5	20	126	2.7
		Sre Ambel	29,081	4	5	4	16	112	2.5
Total				6	12	9	34	238	5.2
Total: 5 provinces (100%)	16 ODs (100% sampled)		752,757	100%	214 HCs	163 HCs (76% of total HC)	650 villages	4550	100%

* 1 respondent per village per category

2. Clarifying/better labeling performance indicator data in progress reports

Below are two examples of where reporting is unclear. The Performance Indicators Table should be reviewed to ensure that the labeling for the data presented is clear, and that where the denominator used does not, in fact, result in the percent reported accurately reflecting what the indicator says it does, report numbers for monthly/semi-annual progress and calculate the indicator annually.

➤ Example 1:

- Reporting on data that is for annual indicators on a monthly or semi-annual basis is done without clearly labeling exactly what the data represent. Examples follow:
 - Item 9-12 in Table 2 report on indicators that reflect actions that are cumulative over a year so it is difficult to understand the criteria for being in the column. If it is the number who carried out the activity this month, that is how the label should be written (e.g., number of HC conducting peer review of HIS this month). Then the indicator should be calculated at the end of the year.

Table 2

No.	Indicators	FY3 Targets	Q1			
			Oct	Nov	Dec	Sub total
9	Number of HC involved in HIS peer assessment regularly. (12 times per year).	192/75%	232 91%	247 97%	213 84%	692 90%
10	Number/Percentage of health center with at least 85% score of quality of HIS record and report with at least 10 times/year	80%	179 70%	208 88%	182 80%	569 74%
11	Number of HIS quality management supervision done at ODs (6 times for old ODs and 12 for new OD)/year	19	6	6	10	22
12	Number of OD with at least 85% score of quality of HIS management (6 times for old ODs and 12 for new OD)/year.	15	1	2	2	5
13	Number of HC had done HIS spot check at least two times per year.	127	7	18	3	28

Example 2:

The same type of problems is present in the performance indicators table with progress reports. For example, Table 3 provides information on % of postpartum women who received a Vitamin A capsule within 6 (8) weeks after delivery has percentages reported for first 6 months and second 6 months and then these are added to give the annual percentage. Upon checking with RACHA it turns out that the denominator for each 6 months was the total expected births for that year, not the actual number of births for the 6 months. If the actual births are not being used for the denominator, the semi-annual reports should simply report numbers and then use the expected births to calculate the annual indicator result. This is the same issue for several of the indicators provided in Table 3

Table 3

Program Element		PERFORMANCE INDICATORS FOR MATERNAL AND CHILD HEALTH						
Indicator		Baseline	FY1 Achievement	FY 2 2010 Target	Indicator Value (1 st 6 months)	Indicator Value (2 nd 6 months)	Indicator Value for Full Year	
2	9.3.A	% of women who gave birth in the last 12 months who had at least 2 ANC visits with trained health personnel	84	88	90	95	96	95.5
4	9.1.2A	Number and % of postpartum women who received a Vitamin A capsule within 6 (8) weeks after delivery	19,345/ 35%	65,555/ 69%	85,506/ 90%	37,826/ 40%	33,607/ 36%	71,433/ 76%
8	9.2.B	% births with BF initiated within 1 hour of delivery*	77	71	75	75	73	74

