

REPRODUCTIVE HEALTH ASSOCIATION OF CAMBODIA (RHAC)

# End of the Project Report

Cooperative Agreement #: 442-A-00-08-00007-00  
**Together for Good Health (ToGoH) Project**

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Reproductive Health Association of Cambodia (RHAC)  
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Together For  
Good Health



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# GLOSSARY OF ACRONYMS

<b>AI</b>	Avian Influenza
<b>AOP</b>	Annual Operational Plan
<b>AMTSL</b>	Active Management of Third Stage Labor
<b>ARI</b>	Acute Respiratory Infection
<b>BEmONC</b>	Basic Emergency Obstetric and Newborn Care
<b>CBD</b>	Community Based Distribution of Contraceptives
<b>CC</b>	Commune Council
<b>CCWC</b>	Commune Committee for Women and Children
<b>C-DOTS</b>	Community DOTS
<b>CEmONC</b>	Comprehensive Emergency Obstetric and Newborn Care
<b>CHS</b>	Community Health Specialist
<b>CIP</b>	Commune Investment Plan
<b>COP</b>	Chief of Party
<b>CPHSP</b>	Community and Public Health Support Program
<b>DOTS</b>	Directly Observed Treatment Short Course
<b>DPT3</b>	Diphtheria, Pertussis, Tetanus vaccine-3 doses
<b>EmONC</b>	Emergency Obstetric and Newborn Care
<b>FP</b>	Family Planning
<b>HBB</b>	Helping Baby Breathe
<b>HC</b>	Health Center
<b>HIS</b>	Health Information System
<b>HIV</b>	Human Immunodeficiency Virus
<b>IDU</b>	Intravenous Drug User
<b>ILI</b>	Influenza-Like Illness
<b>IMCI</b>	Integrated Management of Childhood Illness
<b>IUD</b>	Intrauterine Device
<b>IYCF</b>	Infant and Young Child Feeding
<b>LAPM</b>	Long-Acting and Permanent Methods
<b>LR</b>	Linked Response
<b>MCAT</b>	Midwifery Coordination Alliance Team
<b>MMR</b>	Maternal Mortality Rate
<b>MNCHN</b>	Maternal Newborn Child Health and Nutrition
<b>MoH</b>	Ministry of Health
<b>MSM</b>	Men who have Sex with Men
<b>NCHADS</b>	National Centre for HIV/AIDS, Dermatology and STD Control
<b>NRHP</b>	National Reproductive Health Program
<b>NNP</b>	National Nutrition Program

<b>OD</b>	Operational District
<b>PE</b>	Peer Educator
<b>PEP</b>	Post Exposure Prophylaxis
<b>PHD</b>	Provincial Health Department
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission of HIV
<b>QoC</b>	Quality of Care
<b>RH</b>	Reproductive Health
<b>RH</b>	Referral Hospital
<b>RTI</b>	Reproductive Tracts Infection
<b>STD</b>	Sexually Transmitted Disease
<b>STI</b>	Sexually Transmitted Infection
<b>TB</b>	Tuberculosis
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>VCCT</b>	Voluntary Confidential Counseling and Testing
<b>WRA</b>	Women in Reproductive Age
<b>YFS</b>	Youth Friendly Services



# I. INTRODUCTION

The Reproductive Health Association of Cambodia (RHAC) has been implementing the Together for Good Health (ToGoH), a five year Cooperative Agreement awarded by the United States Agency for International Development (USAID)/Cambodia, for the past five and a half years. The implementation of the ToGoH project by RHAC began on October 1, 2008 and ended on September 30, 2013 with a six month cost extension at a reduced level of effort until March 31, 2014.



*RHAC-ToGoH field staff conducting IEC session in village as part of our TA in the presence of village women, HC staff and village health volunteers*

USAID-Together for Good Health (ToGoH), managed and implemented by RHAC, was a comprehensive public health program with primary focus in providing technical assistance (TA) to improve and strengthen key reproductive health, family planning, maternal, newborn, child health, along with HIV/AIDS, TB and overall health systems strengthening, particularly at the community and Health Center level of the Ministry of Health (MoH). Our strategies and approaches included comprehensive information and services with a set of technical assistance tools.

While we worked both at the national and periphery level, ToGoH TA activities were mainly concentrated at the OD and Health Center level to improve, expand, consolidate and sustain the availability of and access to essential quality health services at the community level.

In addition to supporting public sector counterparts, ToGoH also supported the provision of comprehensive reproductive health services through RHAC's network of 18 non-profit clinics in the country (RHAC closed 3 clinics in 2011 due to enhanced capacity of public health centers in providing health services in the areas).

ToGoH also supported a modest effort in promoting “Good Governance in Health” whereby we worked closely with non-health actors such as Commune Councils to advance the concepts and practices of governance and accountability of local authorities in supporting community level health services and the rights of the community people to receive decent health services.

ToGoH activities were implemented in 31 Operational Districts in 9 provinces of Phnom Penh, Preah Sihanouk, Battambang, Takeo, Kampong Cham, Kampong Speu, Siem Reap, Svay Rieng, and Pailin, which has a combined population of approximately 6.5 million people. ToGoH phased out from 5 ODs in Takeo province in October 2011 and Preah Sihanouk province in October 2013.

This “End of the Project Report” (EPR) captures the main achievements of the project for the five full years from October 2008 to September 2013 made by Clinic Services Component, Youth Health Program Component, Vulnerable Groups and Workplace Health Component and the achievements of the Community and Public Health Support Component for five and half year from October 2008 to March 2014 regarding RHAC/ToGoH support to PHDs, ODs and health center.



*USAID official on field visit with mothers and newborns at a ToGoH supported coverage area*

The report has five main parts. The INTRODUCTION part explains the structure of the report and how this report is organized. The second BACKGROUND section provides how the ToGoH project was conceptualized in our original proposal, some of the underlying implementation principles, how the RHAC project approach was organized. In this section, we provide a summary of our intervention approaches which is important in understanding how the various activities were planned, the process of implementation and how we worked with our counterparts in the public sector. Though there were obvious variations in the specifics of each activity in the field the overall approach –

principles, planning process, capacity building, counterpart accountability, monitoring and supervision et al were fairly uniform in its application across all the activities.

The rest of the report focuses on the RESULTS of each of the main components of the program which is the bulk of the report and constitutes the essence of the report. We provide a brief summary of the key results as it becomes unnecessarily repetitive to explain the details of each activity. We thought it is best to capture the main results of the five year effort in a more tangible fashion with data through graphs and tables. This section includes the RHAC Clinic activities, technical assistance to the public sector, youth health activities and vulnerable groups.

The final part of this reports attempts to capture some of the lessons we learned from our experiences. Some of the lessons from the five and a half year effort may have some bearing on future USAID health and development programming strategies but some of the lessons learned are specific to our experiences in field implementation. Equally important, the future USAID programming will be vital in achieving greater pro-

grammatic sustainability and to ensure tangible returns on USAID's decade long investments for better health status of the Cambodians.

**Note:** For illustrative purposes, we cited the 2012 figures which we think represent a much more accurate picture of the ToGoH's outcomes and outputs. Though the achievements were substantial in all the years the project implementation was at different stages of development, with focus in developing and rolling out interventions in the first year, implementing and making adjustments in the second year and a greater focus on expansion in the third year. The fourth year of the project, i.e. 2012 saw more of a normal implementation of all the interventions and achieved relative stability in the way the health systems strengthening was envisaged in the ToGoH conceptual framework. As such 2012 figures provide a more balanced indication of the project's performance. Though the final year of the five year effort shows greater outputs, ToGoH was more focused in winding down the activities as the project close-out plans called for, in accordance with the terms of the Cooperative Agreement.

**RHAC Data Sources:** As detailed in numerous reports, including the original ToGoH proposal, RHAC maintains a very robust and comprehensive data collection, maintenance and analysis system as part of our performance monitoring system. Each program such as the Clinic, Youth Health Component, Community and Public Health Support Component, Vulnerable Group and Work Place Health components collects and reports on the specific individual program which is reported to and collated by the Data Management Unit of the Monitoring and Evaluation Team at the RHAC headquarters. These data sets are analyzed and used for program monitoring in meeting our established performance indicators, donor reporting, capacity building of RHAC staff and our public sector counterparts. Data from the field activities is further supplemented, corroborated with MoH routine service statistics.

One of the important activities by the Monitoring and Evaluation Team is the methodical and scientifically designed annual health survey. This is a population based survey with similar sampling methodology as the Cambodia Demographic and Health Survey, though by necessity, our annual health survey is confined to our target provinces and focused on our main program areas. The RHAC Annual Health Survey generates greater accuracy and we believe it provides a much more robust independent picture of our program's performance on the ground. All together, these various data sources supports RHAC/ToGoH in making needed adjustments in field implementation, fine tuning interventions to achieve greater programmatic sustainability and helps the RHAC/ToGoH staff, Ministry of Health counterparts at all levels and our USAID and development partner colleagues in understanding and gaining a clearer picture of what it takes to achieving results on the ground, hopefully, for longer term sustainability in the health status of Cambodians.



# II.

# BACKGROUND

Together for Good Health (ToGoH) is a five year Cooperative Agreement awarded by the United States Agency for International Development (USAID)/Cambodia to the Reproductive Health Association of Cambodia (RHAC). The implementation of the ToGoH project by RHAC began on October 1, 2008 and ended on September 30, 2013 with a six month cost extension at a reduced level of effort until March 31, 2014. This end of the project report captures the achievements of the project for the five full years and six months from October 2008 to March 2014.

The main purpose and the primary focus of this report will be on the tangible results the project has achieved during the five and half year period, based on the indicators and results the project was mandated to work towards the Cooperative Agreement (CA). As such, the report will not repeat and dwell on the details of each and every activity carried out during the five year period. The details of the approaches, specific activities, planning, coordination, strategies, implementation details etc. for the multitude of activities under the **ToGoH** have been detailed in the past annual and semi-annual reports. Thus, we will not repeat them here to have better and clearer focus on the results. However, a summary of the basic strategy and approaches of the ToGoH activities is provided here to understand the context and better frame our activities and results for this end of the project report.

## I. Cooperative Agreement (CA) Mandated Program Focus Areas

The Table below shows the main program focus components as stipulated in the USAID Cooperative Agreement awarded to RHAC in 2008. Community Public Health Support Program (CPHSP), commonly referred to as the community health program constitutes the bulk of the USAID awarded program, aside from the Clinic, Youth Health, Vulnerable Group and Work Place Health components.

RHAC Program Components	Focus of the ToGoH/USAID Project
<b>Community Public Health Support Program</b>	<ul style="list-style-type: none"> <li>■ Comp 1: Nationwide technical assistance in FP/RH</li> <li>■ Comp 3: Community-based sales of contraceptives</li> <li>■ Comp 5: Community health promotion</li> <li>■ Comp 6: Ta and capacity building to operations district.</li> </ul>
<b>Clinic Services</b>	<ul style="list-style-type: none"> <li>■ Comp 2: Clinic-based service delivery</li> </ul>
<b>Youth Health Program</b>	<ul style="list-style-type: none"> <li>■ Comp 4: BCC in HIV/STI for Youth</li> </ul>
<b>Vulnerable Groups and Work Place Base Program</b>	<ul style="list-style-type: none"> <li>■ Comp 4: BCC in HIV/STI for Migrant Workers, and Young Entertainers</li> </ul>

**ToGoH's** agenda was substantial in terms of size and scope of its activities. It is a fairly comprehensive public health program which include a wide range of technical areas such as maternal, newborn and child health (MNCH), reproductive health, family planning, nutrition/micronutrient, HIV/AIDS, TB, health systems strengthening, capacity building, health governance as well as population specific focus on youth groups, construction workers, garment factory workers, vulnerable groups such as men who have sex with men, fishermen, young entertainment workers et al.

Fundamentally, the **ToGoH** is a technical assistance activity to improve the performance of the public sector service providers in order to improve access to and availability of basic health services to communities for better health status outcomes of mothers and children and vulnerable populations. With this fundamental mission in the backdrop, **ToGoH** embarked on mapping out the target areas/populations and began formulating strategies and approaches for specific interventions. Early on, ToGoH sought the partnership/collaboration of our MoH counterparts at all levels, especially at the OD/HC level where the specific activities were carried out.

## 2. CA Mandated Indicators/Outcomes

The following were the main Indicators and numerical targets the ToGoH project was to have achieved at the end of the five year effort. For the most part, ToGoH has achieved all the targets and often exceeding the established targets as illustrated in the tables and graphs under the specific focus areas in the following pages of this report.

1. % married women using a modern method of FP: 35%
2. % of ANC client tested for HIV and received results: 90%
3. % men & women of reproductive age tested for HIV: 30%
4. % of HIV+ women using a modern form of FP: 50%
5. # of known HIV+ pregnant women who received ARV prophylaxis during 5 years: 960
6. % males 20-24 years old reporting high risk sex decreased to 20%
7. % sexually active unmarried males 20-24 years reporting condom use with last partner increased to 95%
8. % of deliveries preceded by more than or equal to 4 ANC visits increased to 60%
9. % of births attended by a trained provider increased to 75%
10. % of children aged 0-5 months exclusively breastfed increased to 65%
11. % of births received PNC/Newborn care within 24 hours increased to 70%
12. % of births with BF initiated within 1 hour of delivery increased to 60%
13. % of children with diarrhea treated with ORT and Zinc increased to 70%
14. % of children aged 12-23 months fully immunized increased to 70%
15. % of TB case detection increased to >70%
16. % of children who received Vitamin A increased to 85%

Aside from these quantitative indicators, a great deal of the activities was qualitative in nature and process oriented. Many of the capacity building activities and health systems strengthening interventions are by nature very qualitative and driven by processes which are often reflected in quantitative outcomes as part of the overall approach in improving the quality of services at the community level.

## 3. CA ToGoH Implementation Principles

**ToGoH** implementation was framed under certain basic operational principles as we articulated in our original proposal submission in 2008. These principles are vital because it defines our approach in the way we strategize, plan and implement our interventions.

We will briefly recapitulate here some of those key operational principles in order to have the proper perspective in the way ToGoH was implemented and hence the results shown in this report in the following pages.

**Underlying Operational Principles of the ToGoH Implementation:** Our original response to the RFA described our approach to three areas of emphasis in the RFA which pervades across all the six components as well as in specific technical focus areas. These areas of emphasis included sustainability of interventions, capacity building of the public and private sector providers and institutions, visible and enhanced technical leadership of the awardees and coordination among implementing partners, not only to avoid duplication but more importantly to achieve scale, share and apply best practices and achieve synergies in program interventions and efficiency in resource use.

### 3.1. MoH Stewardship and Sustainability

**Enabling Role:** The stewardship of the Ministry of Health - effective leadership, responsibility, accountability and transparency - in health governance for the health sector was an important starting principle to ensure a cohesive and standardized service delivery system. In all our technical assistance activities, RHAC has positioned itself in the background as an enabler of ministry-owned initiatives—whether at the provincial, OD, or Health Center (HC) level. Consistent involvement of relevant government officials in all program activities was a vital part this operational rule. We tried to put our MoH counterparts at the front and center in activities to the extent that they are able and willing (whether as actor or at first as mere functionary). Enabling, coaching, mentoring and in some cases prodding was one of the capacity building strategies of the **ToGoH** project.



*HE Dr. Mam Bun Heng, Minister of Health, presiding over a function to distribute bicycles to Village Health Support Group, village based health volunteers*

**Partnering and Linkages:** This “enabling” role was to have engendered greater trust and acceptance of the program by other NGOs and both public and private entities. The commitment of many participating organizations has brought access and improvement in services to a large proportion of Cambodian communities. As an indigenous organization with a strong reputation, RHAC had built credibility and trust with government partners and in the communities. Our team sought to strengthen and expand existing linkages under a new paradigm that replaces fragmentation with cohesion and ministry-led direction.

RHAC had strong linkages with all the national programs which helped to cement government’s stewardship role and enhanced capacity building and sustainability of interventions, especially at the community level. Much effort was exerted to foster meaningful linkages among USAID partners to learn, share and apply best practices and innovative approaches to scale from pilot phases. RHAC pursued these link-

ages as much as feasible throughout the life of the ToGoH project.

RHAC's experiences show that achieving impact at the community level requires linkages beyond the health sector. RHAC worked at the community level with schools to reach adolescents, and through factories in order to reach vulnerable populations. Broad-based collaboration with civil society partners is essential to mobilize communities during immunization campaigns and vitamin A distribution. Our work logically crosses several sectors, involving work with the Ministry of Education, Youth and Sports, the Ministry of Women's Affairs and others.



*ToGoH - RHAC staff conducting training in the proper use of Partograph to midwives attending MCAT meeting*

**Enabling of Community Assets:** Involving the community itself in strengthening services – as well as adopting positive health practices on an individual and family basis—is a fundamental principle of effective public health programs and particularly critical in fragile societies where community support can make the difference in maintaining a cold chain or timely referral of pregnancy complications. Improving



*HE Professor Eng Hout, Secretary of State, MoH, delivering his opening remarks at the MCAT National Workshop, held on March 1, 2013 under the aegis of the National Center for Maternal & Child Health Center/MoH*

outreach, mobilizing communities, creating demand generation and motivating participation has been important strengthens of RHAC which we tried to apply in the implementation of the **ToGoH** project activities. RHAC made concerted efforts to stimulate genuine energy at community level to capitalize on all available community level assets, be it religious assets such as the pagodas or political assets such as the Commune Councils. RHAC leveraged these assets to strengthen government systems, institutions to spur community led actions to achieve better health outcomes.

### 3.2. Capacity Building and Coordination

During the ToGoH implementation process, we addressed the capacity building and coordination issues linked to the principle of “three ones:” one strategy, one implementation mechanism, one evaluation/reporting framework. Harmonization requires strong coordination. It also requires systems and tools, and personnel who are trained and committed to using them. RHAC therefore attempted to position its role of enabling coordination by the Provincial Health Departments, and building capacity at multiple levels, to be closely connected with the overall project implementation activities.

Our approach to capacity building was focused on all six components of the original RFA with emphasis on impact at the community level. While standardization, synergy and harmonization in these areas is the goal, we stimulated greater participatory processes to encourage sharing of innovations and flexibility to meet local needs. As described below, we followed a systematic process of assessment, consensus, dissemination and training, follow up, and sharing/publicizing results with a government led approach within the constraints of limited capacity and absorptive capacity and genuine commitment of our public sector counterparts.

**Systems to Improve Resource Base and Financial Management:** Lack of adequate resources for health—by the government systems and by families and communities—is a seemingly intractable problem in Cambodia and is the reality in all our coverage provinces at all levels. However, in recent years there have been several approaches to address this problem, and incorporating elements of performance management. Though not directly funded by the USAID CA, RHAC has helped establish and implement health equity fund activities which invariably helped removing financial barriers in accessing essential services whereby ToGoH project infrastructure and assets were leveraged in selective areas of our coverage provinces. We also introduced and implemented Voucher schemes to promote long term family planning methods, Vouchers for maternal and newborn health services towards reducing maternal mortality and improving newborn survival. These voucher schemes enabled communities to access birth spacing methods and maternal and newborn health services at government service delivery points without having to worry about their ability to pay. Such social health enabling schemes strengthen the ties between Health Centers and communities as well as the broader health service delivery system.



*VHSG providing IEC service to a village mother on family planning and reproductive health*

**Incorporating Evidenced-base Behavior Change and Communication:** RHAC under the ToGoH helped deliver systematic health promotion programs with a rigorous focus on changing behavior—not only knowledge and awareness. Developments of the BCC strategies were guided by formative research and the audience's perspective. “Health education” is usually the lowest priority and the least systematized process in the health system. In the past, materials were often developed in an ad hoc way and core behaviors and messages were seldom harmonized. Building on national efforts, ToGoH team streamlined certain core behaviors across our technical focus areas in close coordination with relevant national programs. In collaboration with relevant provincial/OD offices, we conducted numerous capacity building workshops, focusing in each wave of focal health areas, starting with RH/FP, often under the leadership of the PHD/OD/HC colleagues. ToGoH took every opportunity to strengthen and utilize existing forums and settings such as the MCAT, Health Center Management Committee, and Commune Council meetings to undertake capacity building and health information and promotion activities.

## 4. CA ToGoH Implementation Design & Approaches

**On the Ground Implementation Approach:** With these operational principles and practices in the backdrop, each and every RHAC/ToGoH intervention undertook the following basic approach in a systematic manner under the leadership and technical guidance of the Chief of Party of the USAID-RHAC ToGoH project. The implementation approach for any specific intervention/activity with a results target essentially involved a three stage process – initial understanding and consensus building, actual planning and development of the strategy such as the activities, key persons involved, geographical focus, time frame, indicators, results/outcomes/outputs to be achieved et al, and finally, the actual implementation on the ground. In between these processes are multitude of other activities such as training, consultations with partners, organizing, mobilization, monitoring of interventions, review of results, adjustments to activities, further in-house review and consultations with stakeholders et al.

**Assessment/Mapping:** Based on our overall strategy and the work plans, ToGoH conducted a thorough review of the issue to ensure that the issue is understood well within the project and among the staff at all levels. This review exercise involved literature review and extensive consultation with other implementing NGOs, relevant government agencies and technical experts, including those in the field at the PHD/OD/HC level. The review and mapping exercise also involved consultations with communities and local authorities and on the ground study of the community health needs and health seeking behaviors.



*RHAC-ToGoH Senior Technical Staff conducting training for HC/IOD midwives for MNCH skills improvement*

This initial in-house review is critical to ensure that all the project staff and our counterpart partners in the public sector are on the same page and agree on the issue, avoid possible duplication and maximize synergy of inputs by other partners in the same geographic areas in the same technical focus areas.

Prior to the identification of the issues based on the overall agenda of the USAID awarded Cooperative Agreement, ToGoH has designated senior technical experts (Community Health Specialists) with responsibility to be the lead person in our focus technical areas as well as supervisory responsibility for specific provinces. For example, if the project has “increasing the acceptance and utilization of IUD FP method in Kampong Cham Province (KPC)” as one of the focused interventions, CHS who is the designated expert in FP/Maternal Health will lead this intervention and coordinate closely with CHS who is in charge of the KPC province along with the KPC Provincial Program Coordinator (PPC) in a team effort.

**Design the Intervention/Planning for Activity Details:** This phase involved detailed activity planning, identification of MoH counterparts at the leadership level as well as at the HCs, geographic coverage areas, training of the staff and MoH counterparts, detailed implementation schedule, PHD/OD supervisory visits and monitoring activities, consultations within field staff and local authority’s et al. In short, this phase involves working out all the details of what, where, how and who of the specific implementation activities on the ground.

In between and particularly during the implementation phase, there are other on-going activities which must be attended to by the CHS, PPC and the COP as needed. These included training, capacity building activities, monitoring, review, readjustment of planned approaches, consultations with MoH counterparts, continuing discussions and brainstorming within the project, sharing information and providing updates to RHAC management and technical groups within RHAC, Provincial and national level sub-technical working groups as well as providing strategic updates to USAID and other development partners. This short narrative essentially describes RHAC's implementation approach which we had applied to in working towards improving health services and achieving results in terms of improving the health status of our target communities in the past five years of the USAID-RHAC ToGoH Project.



*RHAC annual survey interviewer with a respondent in the field*

## 5- Key Focus Areas, Activities and Results Achieved

ToGoH supported five main activities of long standing RHAC programs as noted below. The six components of the USAID mandated activities were organized into these main five program areas as they provided the best and most efficient platform for implementation. With support of other donors, we were able to leverage the main support from USAID in achieving much greater scale and reach in 9 provinces covering 31 Operational Districts (ODs) and 435 Health Centers (HCs) with about 6.5 million population, though the USAID alone support with a comprehensive MNCH/RH/FP, HIV/AIDS, TB and health systems strengthening was implemented in five provinces.

**Note:** The coverage numbers such as the number of provinces, number of ODs and Health Centers, number of specific target populations such as factory workers, MSMs et al, cited in this report represents the most comprehensive and directly under the support of the ToGoH for the duration of the project period. In any given year, there will be some variation in the coverage numbers. For example, ToGoH supported CBD and IUD activities from 2009 – 2011 in Takeo province. However, following the approved Cooperative Agreement and in consultation with USAID COTR, RHAC/ToGoH phased out from Takeo province in October 2011 given the interest and commitment by Takeo PHD to take over activities support by ToGoH. Similarly, ToGoH coverage included 18 Clinics initially but 3 district clinics (Phaav, Chamkaleu and Pourk) were closed given enhanced capacity of public health centers to provide primary health care and reproductive health services similar to RHAC clinics and the present of health equity fund that support poor and vulnerable population in these particular ODs as found by the 2011 USAID Mid-Term Evaluation of the ToGoH project.

- ❖ Clinic Services
- ❖ Community and Public Health Support Program
- ❖ Youth Health Program
- ❖ Vulnerable Group Program
- ❖ Workplace Health Program



# III.

## RHAC CLINIC SERVICE ACTIVITIES

### Selective RHAC Clinic Results

- ❖ More than 1.8 million clients were served by RHAC Clinics during the ToGoH project period (October 2008 to September 2013)
- ❖ Fully 25% of the clients were high risk vulnerable groups (VG)
- ❖ Over 20% of the clients received part or full fee exemption
- ❖ Majority of the STI services for VGs in Cambodia were provided by RHAC Clinics:
  - 81% of low risk women
  - 17% of high risk women (entertainment workers)
  - 51% of male clients
  - 30% of MSM (NCHADS report 2012).
- ❖ 19% of total VCCT services in the country were provided by RHAC Clinics (NCHADS report 2012)
- ❖ 30% of all the Clinics clients were under 25 years of age
- ❖ 94% of the total cervical cancer screened in Cambodia was done by RHAC Clinics (MoH report 2012)

RHAC operated 15 clinics in 9 provinces (we closed 3 clinics in 2011 given the improved service delivery by public health facilities). Our comprehensive services included the full range of FP methods, antenatal care, post-natal care, post-abortion care, cervical cancer screening, premarital counseling, rape victim support, menopause and infertility, STI diagnosis and treatment, voluntary HIV counseling and testing (VCCT), prevention of mother to child transmission (PMTCT) services and other primary health care services.

Clinics provided services to both specific target groups (most of them are high-risk, marginalized or vulnerable groups) and the general population. The specific target groups served by RHAC clinics included entertainment workers, MSM, factory workers, rubber plantation, construction workers, fishermen, and youth. More than 20% of our clients came from the specific target groups. Close to 40% of RHAC clinic beneficiaries were young people under 25 years of age; and 58% of the clients were factory workers especially for RHAC clinics located near factory zones.



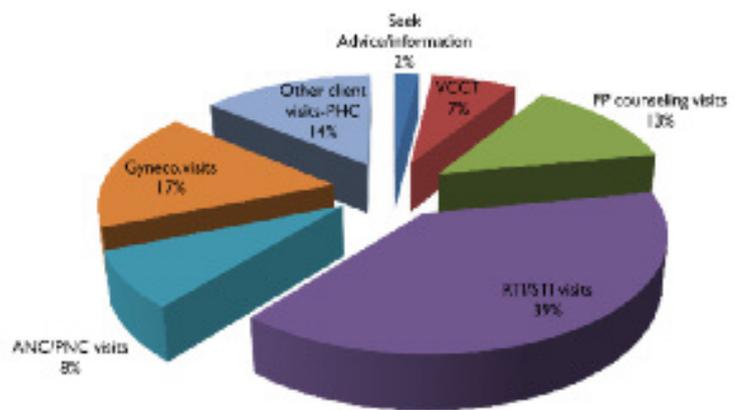
*Health education session for young factory and entertainment workers at RHAC clinic site*

### ToGoH Supported 15 RHAC Clinic Service Package

- ❖ RTI services
- ❖ Counseling and HIV testing
- ❖ Ante natal care and PNC
- ❖ Family Planning Services
- ❖ Cervical cancer screening
- ❖ Post abortion care
- ❖ Premarital counseling
- ❖ Support rape victims
- ❖ Menopause and infertility management
- ❖ Other primary health care services

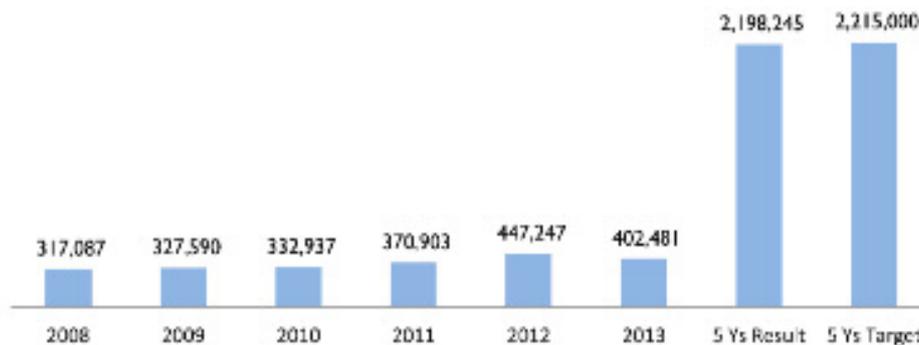
In terms of types of health services available at RHAC clinics, 39% received RTI services, 7% (including pregnant women) received VCCT, 17% received gynecological services, 8% received ANC and PNC services, 13% received family planning methods and counseling, 2% received healthcare advice on various health related issues, and another 14% received other primary health care services such as ARI, Diarrhea, minor injury, headache, referral to other service providers et al.

**Profiles of Service Types by RHAC Clinics**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

**Total Visits of Clients Served by RHAC Clinics**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

During the five year ToGoH project period (October 2008 – September 2013 noted that the Clinic Component does not cover in the extension period of ToGoH from October 2013 to March 2014), RHAC Clinics served a total of 2,198,245 clients, with an average annual increase of 10% in client visits with the exception of 2013 where total client visits decline slightly as shown in the graph above. The total client visit to RHAC Clinics during the 5 year period is about the approved 5 year target.

### I-Voluntary Confidential Counseling and Testing (VCCT)

VCCT services were provided through 15 RHAC clinics in accordance with NCHADS protocols and guidelines. VCCT is integrated with other services provided by RHAC clinics such as ANC, RTI, FP etc., as appropriate. Providers are trained to be aware and provide appropriate counseling and refer patients or clients who may have other related conditions such as TB or risky behaviors for HIV exposure. We routinely advise them to do HIV testing but at client’s choosing with consent.

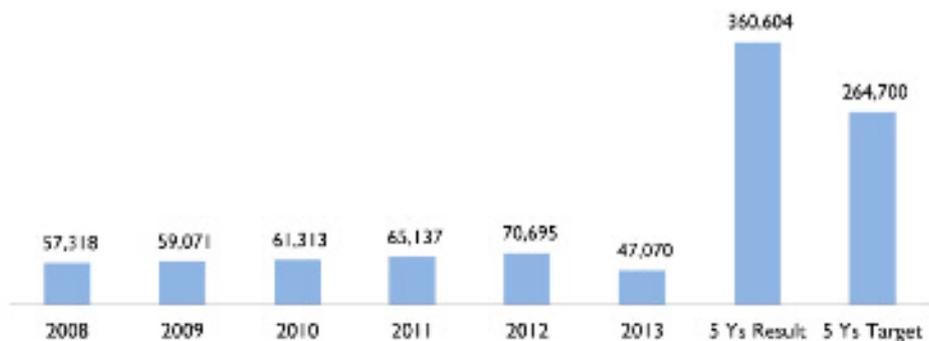


*Voluntary Confidential Counseling and Testing for HIV in RHAC Clinic*



*Laboratory activities in RHAC Clinic*

#### Trend of VCCT Service Served by RHAC Clinics



*Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report*

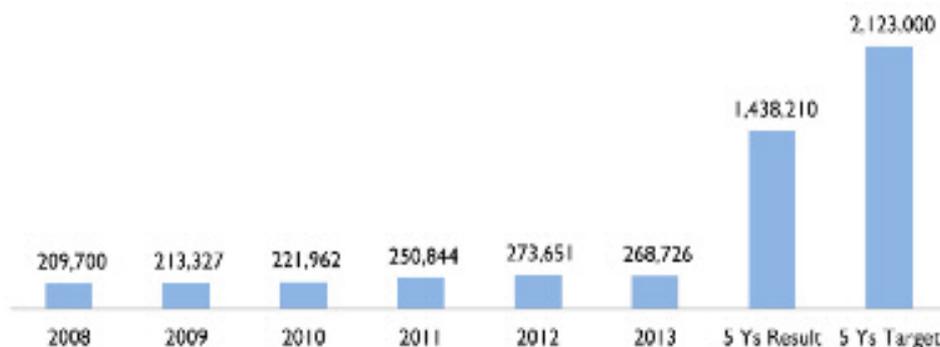
**Note:** In 2013, RHAC had to phase out the C/PITC (Community-Peer Initiated HIV Testing and Counseling) due to shortage of HIV test kits which resulted in only 47,070 cases of VCCT services at RHAC Clinics compared to 2012 figures which stood at 70,695 VCCT service outputs. C/PITC is the approach where RHAC Clinic teams go to Entertainment Establishment to provide education and counseling about HIV/AIDS and conduct HIV testing on-site for entertainment workers. In so doing, the clinic teams can effectively reach entertainment workers with HIV counseling and testing service.

VCCT service is one of the most successful services provided through RHAC Clinics. As in the case of total client visits, clients received VCCT service from RHAC clinics is increasing on average 5% annually with the exception of the 5th year while total 5 year performance result exceed the approved target by 36%. As mentioned in the selective results list, 15 RHAC Clinics provided a good proportion of the VCCT services in the country. There is substantial demand for VCCT services and our experience suggests that with proper counseling and effective information and outreach, most clients seeking reproductive health services are amenable in taking voluntary HIV status testing. Given the mostly younger population age group seeking reproductive health services, and with recent studies suggesting that the HIV/AIDS situation is undergoing certain shift in the mode of transmission to certain segment of the heterosexual population as well as greater concentration of the transmission occurring among particular high risk groups such as Entertainment Workers, MSMs and IDU, the effort to reach the widest possible audience/clients with VCCT service is imperative in achieving further reduction in HIV prevalence in Cambodia.

## 2. Diagnosis and Treatment of STDs/RTIs:

RTI, which includes STI diagnosis and treatment, was one of the most sought after services at all RHAC clinics. According to NCHADS STI report in 2012, out of a total of 58 STI clinics around the country under NCHADS, the STI treatment contributed by RHAC clinics constituted 81% of total intake for low risk woman, 17% for high risk women and 51% of all male clients were seen at RHAC clinics. This is a remarkable number given that RHAC operated only 15 clinics where as more than 70% of the rest of the facilities are operated by the public sector and yet, RHAC clinics are contributing more than half of the case loads of STIs in the country.

**Total number of RTI Clients Served by RHAC Clinics**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report



*RHAC Clinic doctor attending a male client as part of RTI services*



*RHAC Lab technician performing STI test*

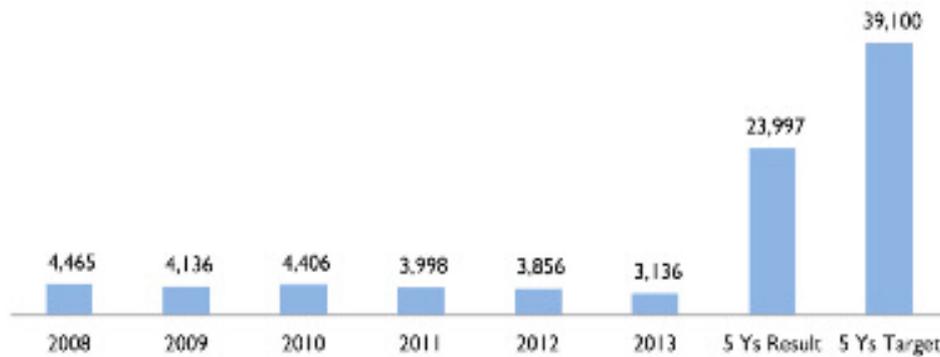
RHAC Clinics provided over 1.2 million RTI/STI cases for treatment during the five year ToGoH project period. Male clients accounted for 5% of the total RTI/STI case load.

Although RHAC Clinics made substantial contribution in providing RTI/STI services in the country, we believe the reason for the lower performance for RTI/STI services at RHAC Clinics was to some extent the fact that RHAC has closed 3 district clinics as indicated elsewhere in this report which would otherwise have certainly contributed to greater service outputs. Our 5 year achievements for RTI/STI services for the ToGoH were substantially lower to meet the numerical goal, which clearly suggests the target setting was unrealistic at the inception of the project. After all, the 5 year targets were set during the proposal development in 2008 which were not thoroughly revised and adapted in accordance with changes and revision that occurred in the course of the ToGoH implementation. One of the lessons here for RHAC and any implementing partner is the need to be judicious in setting realistic targets and systematic revision of numerical targets in line with programmatic changes in the course of a multi-year program such as the USAID-RHAC Together for Good Health.

### **3. Premarital Counseling and Screening**

RHAC clinics provided pre-marital counseling services consisting of VCCT, family planning information and counseling, counseling on gender issues and HIV/STI prevention information. The pre-marital counseling was tailored to meet the needs of new couples, focusing on male responsibility, being faithful, family planning information, and the importance of seeking early ante-natal care, birth preparation, importance of seeking timely post natal care et al.

### Number of Clients Received Premarital Counseling Service at RHAC Clinics



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

Premarital counseling services at RHAC clinics provides both an important opportunity to reach younger populations with essential reproductive health information and we believe in some ways, these counseling sessions help young women and men entering into life experiences vital aspects of mutual support and shared responsibilities of family life. Often, elements of women's empowerment messages gets through young men who are still accustomed to women's role solely confined to domesticated chores such as child rearing, household chores rather than shared responsibility of both women and men. RHAC counselors emphasize the importance of men's role in family planning decisions and method choices et al.

Relative to the overall number of people availing RHAC clinic services year to year, the number of couples seeking premarital counseling is relatively small but this population group is significant in reaching with all the essential life tools with respect to reproductive health, family planning, pregnancy and post delivery information and services, which will impact on the health of the mothers, newborns, children and family as a whole in the long run.

#### 4. Family Planning Services

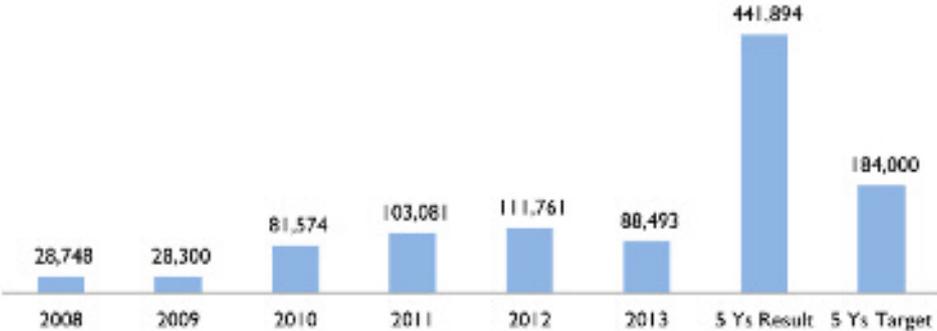
RHAC has a long history of providing quality family planning services as part of its original mission at the very inception of RHAC in its early days. Early on RHAC developed a robust outreach program with its Community Based Distributors (CBDs) who were trained in basic family planning concepts, practices, methods, informed choices, RHAC clinic services in family planning et al. The RHAC trained CBD volunteers carried out its outreach and family planning promotion services from door to door in selective Phnom Penh neighborhoods and in Sihanoukville where RHAC had established basic clinic facilities. Over the years, RHAC clinics expanded its service package to include other needed services such as cervical cancer screening et al. The clinic service package was complemented with a very strong demand creation program such as CBDs, long-term method promotion vouchers which entitled the clients free services and reimbursement of transportation costs with an equally strong focus on quality of care.

In the current RHAC clinic operation during the ToGoH project period, RHAC continued to provide comprehensive family planning services at all 15 RHAC clinics. RHAC provided both short and long term modern contraceptive methods with widest possible choice of methods. RHAC upgraded selected clinics to enable RHAC to provide vasectomy services.

Periodically, RHAC organized and extensively undertook special promotion of IUD and VSC services by providing these methods free of charge and reimbursed transportation cost to those who use the services during the promotion period. We know from our experience over the years that provision of health services, whether it is birth spacing methods, child immunization services, prenatal care or HIV status testing of at risk groups, access to good quality services is an important determinant of service utilization but it is equally important to address the issue of ability to pay for services.

RHAC caters to a wide spectrum of clients in terms of socio-economic status. From our client surveys and profile of clinic visitors availing RHAC clinic services, over a quarter of the clients received reduced service fee or were fully exempt from fees, which suggests that ability to pay for services remains a significant barrier in accessing needed reproductive and health services for a large proportion of the population. Interventions such as free provision of birth spacing methods greatly improves the ability of the poor to receive services that they may otherwise choose to forego.

**Number of Clients Received FP Counseling through RHAC Clinics**

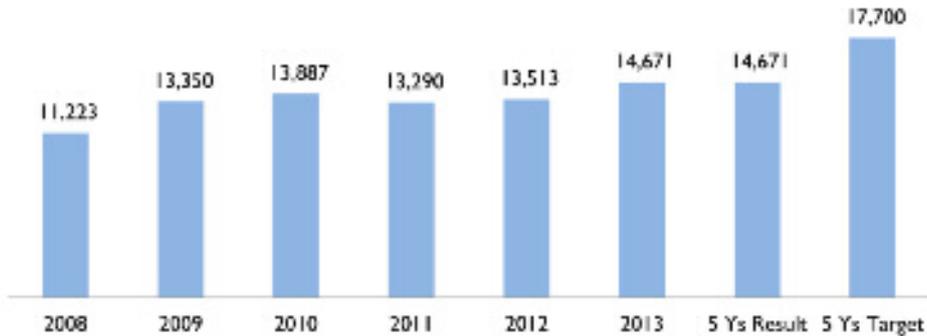


Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

In 2012 alone, RHAC clinics provided 175,854 condoms, 14,893 cycles of pills, 3,554 injections of Depo Provera, 2,295 IUD insertions, 1,045 sets of implant and performed 79 vasectomies, which translated to a total of 15,725 CYP, to illustrate the level of output in one year.

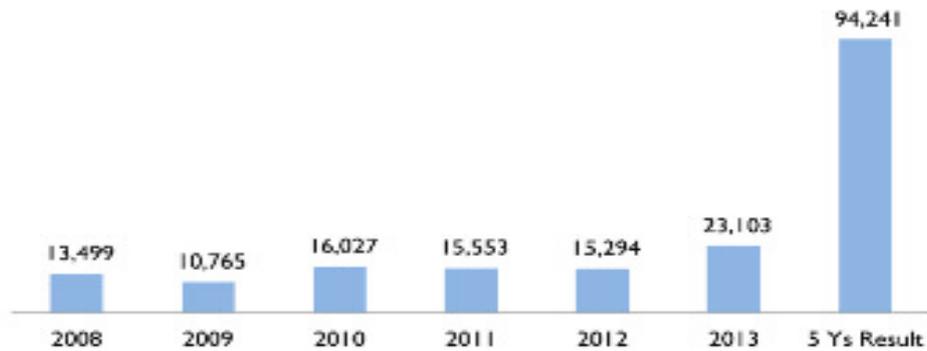
The overall 5 year achievement far exceeded the approved target established in 2008. RHAC, in coordination with the National Reproductive Health Program, made concerted efforts, in the aftermath of the MoH's Fast Track initiative in late 2010 to address the high levels of maternal mortality in Cambodia, to ramp up family planning services across the entire RHAC program. And RHAC Clinics are at the forefront of the renewed focus in strengthening and expanding family planning and reproductive health services which certainly added in the increased utilization of FP services as reflected in the above graph. Promotion of birth spacing methods, especially long term methods remains a key strategy in meeting the ambitious goal of the Fast Track Initiative.

### Number of Clients Currently Use FP Methods at RHAC Clinics



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

### Trend of Couple Year of Protection Served by RHAC Clinics

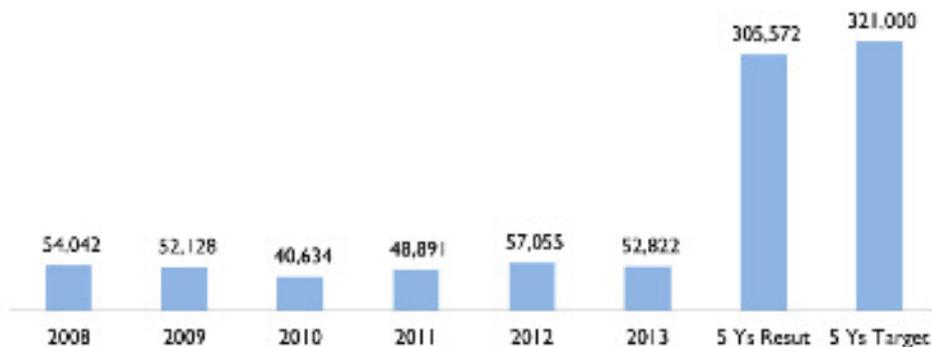


Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

## 5. Ante-Natal & Post Natal Care Services

The package of ANC & PNC services included iron/folate, tetanus immunization, counseling HIV, screening for syphilis and STI treatment, urine check, and hemoglobin check for anemia. In addition, the clinics provided counseling on birth preparedness, importance of delivery at health facilities, immediate, early and exclusive breastfeeding, family planning counseling and follow up for post partum visits.

### Total Number of ANC Visits to RHAC Clinics

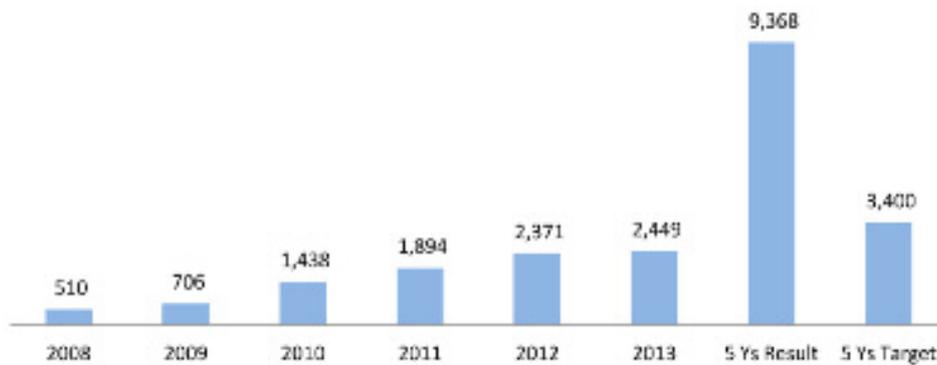


Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report



*RHAC Clinic midwife conducting ANC session on proper newborn care*

**Total Number of PNC Visits to RHAC Clinics**



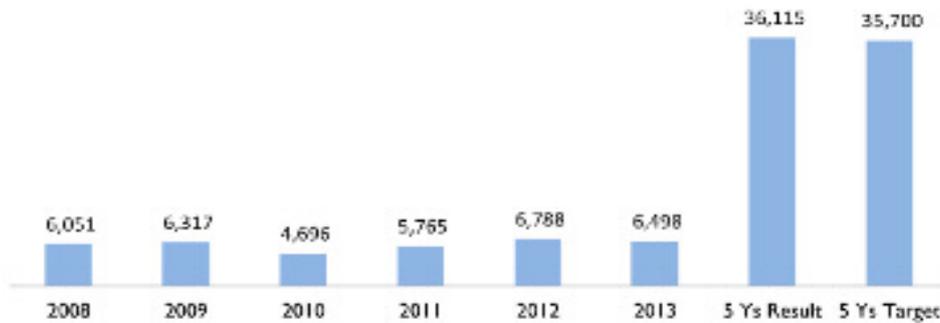
*Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report*

In 2012, RHAC clinics provided a total of 57,055 ANC visits to 15,974 pregnant women. Of this total, 38% of the women availed at least four ANC visits and 13,041 pregnant women received HIV test and received their results, to illustrate the level of Clinic service output for one year.



*Antenatal care at RHAC Clinic site*

### Total Number of Clients Received ANC4 Visits by RHAC Clinics

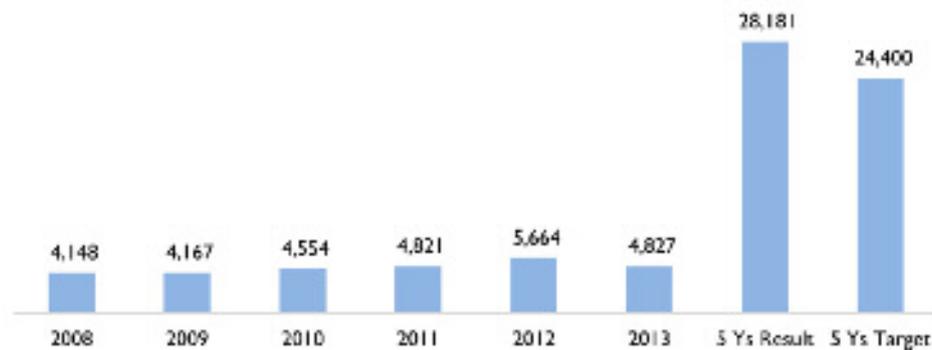


Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

## 6. Post-Abortion Care (PAC)

Services were available in all 15 RHAC clinics. RHAC witnessed increased demand for PAC services, especially at urban clinics and clinics around the manufacturing zones. RHAC clinics provided a package of PAC services which included counseling about family planning, STI, HIV testing, treatment of infections, MVA in cases of incomplete abortion and referral as needed to other appropriate services and facilities.

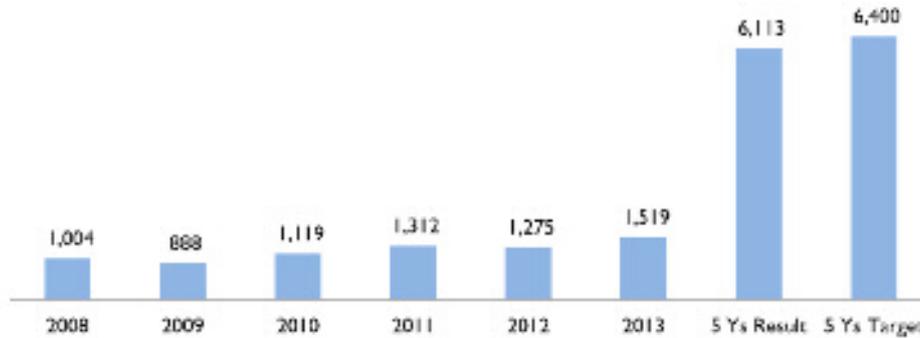
### Total Number of Post Abortion Care Visits to RHAC Clinics



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

In 2012 alone, a total 5,664 clients sought PAC services at RHAC clinics. Among these clients, 986 cases were factory workers and 1,275 clients sought services for incomplete abortion, which required MVA procedure.

### Total Number of Clients Served with MVA Procedure



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

Overall results for ANC, PNC and post abortion care services are somewhat mixed, again reflective of the ambitious target setting prior to the implementation of these activities and perhaps some oversight on the part of RHAC technical staff in not adjusting the target numbers in line with experiences on the ground. However, it is encouraging to note that RHAC clinics witnessed consistent improvements in the number of clients following up on the minimum recommended number of ANC visits in the course of the pregnancy life cycle at intervals recommended by the MoH and WHO guidelines.

Demand for PAC services continue to increase over the years and we see a corresponding increase in the number of MVA procedures performed in RHAC clinics. RHAC clinic shows that a vast majority of the PAC services and MVA procedures were availed by clients in clinics located in manufacturing zones in Phnom Penh and adjoining provinces. Most of the workers in these factories are young women with limited education and life skills who come from rural areas. They are at risk of many health (and social) problems such as STIs, unintended pregnancy and its complications et al.

While RHAC clinics have undertaken vigorous outreach and IEC/BCC activities with factory focused peer educators as well as more traditional approaches through CBDs and special promotional activities, the need for RH and basic health information and services, including effective referral for non-health services is vital for young female factory workers who are as vulnerable to exploitative practices and behaviors by men as other vulnerable groups such as entertainment workers.

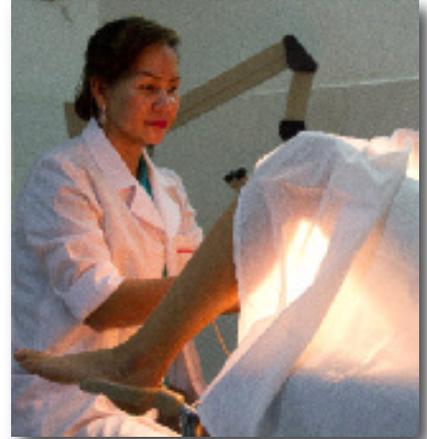
## 7. Cervical Cancer Screening

RHAC clinics offered two cervical cancer screening techniques: PAP smear and VIA. Clients were provided with comprehensive information on the two methods and were given the option to choose their preferred method. VIA was available in all RHAC clinics, while the PAP smear method required the smear to be sent to the main Phnom Penh clinic for reading by RHAC's central laboratory.

**Total Number of Clients Received Cervical Cancer Screening by RHAC Clinics**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report



Cervical cancer screening at RHAC Clinic

In 2012 alone, 47,431 women received VIA and 9,933 PAP smear screening. According to MoH report for 2012, 94% of the total cervical cancer screening in the country was done by RHAC clinics in Cambodia.

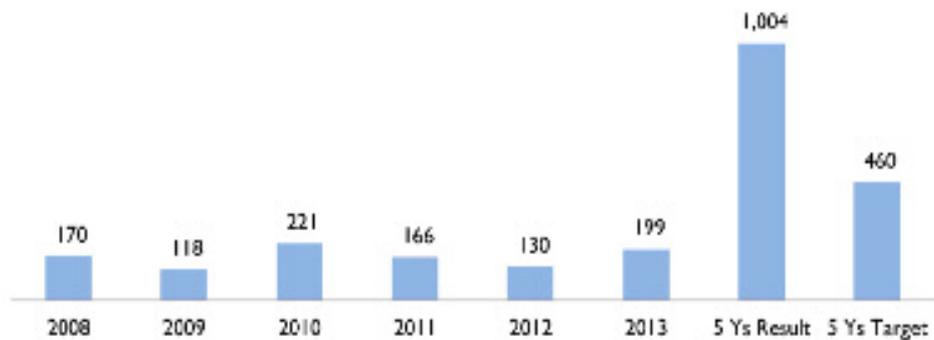
As the above graph shows, there has been substantial increase in demand for cervical cancer screening services at RHAC clinics in the past 5 years, especially in clinics located in urban areas and main provincial towns such as Battambang. RHAC counselors routinely encourage women to take cervical cancer screening.

The risk for cervical cancer is high among women in Cambodia and early screening provides the best options for prevention and treatment of this highly prevalent and life threatening condition. RHAC experience in the past 5 years of the ToGoH implementation clearly shows the need to strengthen cervical cancer screening for women to meet the demand and undertake greater outreach and awareness raising activities as part of early diagnosis and cervical cancer prevention measures.

**8. Rape Victim Services**

RHAC provided comprehensive medical and psycho-social care for rape victims at all the 15 clinic sites during the ToGoH implementation period. The services included mental assessment, physical examination, pregnancy assessment, emergency contraception, STI management, and HIV counseling and testing. ARV prophylaxis for HIV was available in all RHAC clinics, and given to clients, if they meet the established criteria. RHAC collaborated with other NGOs working in social services and human rights to refer rape victims for medical assistance or refer them back to partner NGOs for legal assistance.

### Total Number of Clients Received Post Rape Services RHAC Clinics



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

In 2012, RHAC clinics provided services to 130 post rape victims. RHAC also provided ARV prophylaxis to post rape victims, and a total of 366 cases received PEP services at RHAC clinics.

RHAC staff from clinics and other programs such as the Youth and Vulnerable Group have been trained in handling rape victims with sensitivity and confidentiality. We maintain close contact and good working collaboration with local NGOs and civil society organizations (CSOs) that provides psycho-social, legal and other life skills services to enable RHAC staff to follow up with appropriate services.

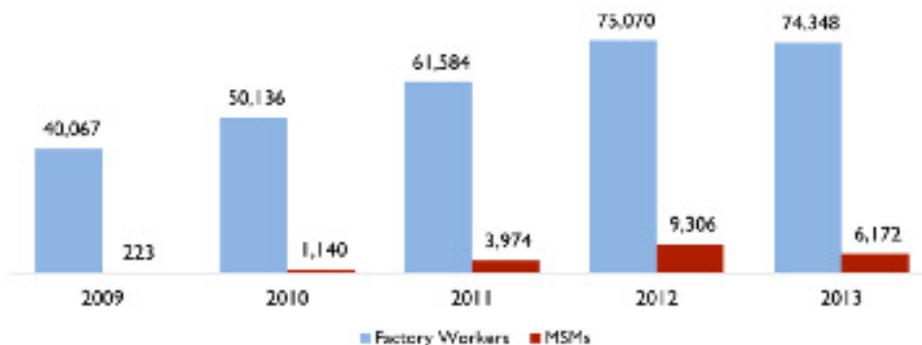
By the nature of our work and focus, RHAC is limited to attending to the immediate health and medical needs of rape victims. However, rape victims and other vulnerable groups' needs far more than health and medical support. As such, it is imperative that the work and support of other organizations that caters to the needs of rape victims for psycho-social, legal and livelihood support continue to be supported by donor communities as there is hardly any responsive and effective government support at the national or local authority level.



*RHAC MSM counselor is providing counseling to MSM group about prevention of HIV/AIDS transmission*

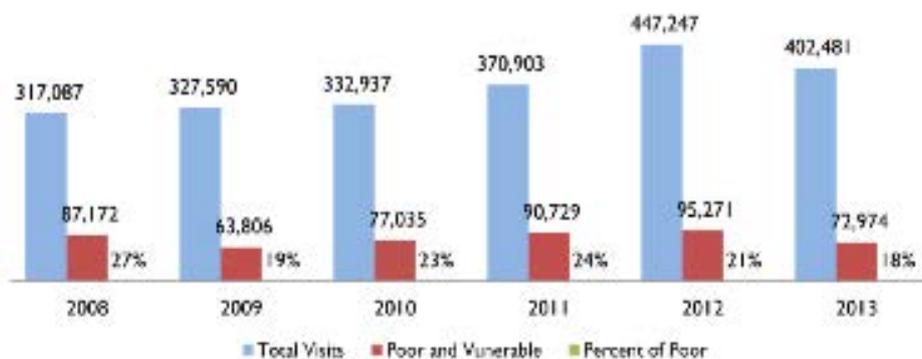
RHAC's Peer Educator network of the Youth and Vulnerable Group health programs disseminated educational and health information, raised awareness about the availability of services, and provided referral to those in need of clinical services to RHAC Clinics (Please see the Youth Health Program section for more detail). Following graphs provides a snapshot of the services provided by RHAC clinics for specific target groups with comprehensive reproduction health services tailored to the needs of at risk populations.

**Number of Factory Workers and MSMs Served by RHAC Clinics**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

**Percentage of RHAC Clinic's Visits Provide to Poor and Vulnerable Groups Clients**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

On average, RHAC provided free or heavily discounted services to about 10,000 clients a year which amounted to close to 25% of the total client load of the RHAC Clinics in a given year. Poor and vulnerable groups who received discounted or free services included youth population, entertainment and factory workers, slum populations and MSMs. Though our clinic service delivery does not target the poor per se but as a matter of government policy, no one is refused service on account of a client's inability to pay the service fees. In order to achieve greater financial sustainability of the RHAC Clinic operations, we focused on quality of services and reasonable payment for the services. However, RHAC continued to meet the health needs of a large proportion of poor Cambodians regardless of their ability to pay.

## 9. Quality Improvement

RHAC clinics conducted quality improvement annually by a multidisciplinary team composed of medical professional, managers and research staff. Using RHAC's Quality of Care (QoC) assessment tools, the QoC system resulted in improvements to RHAC's clinical services and has contributed to an overall increase in utilization of clinic services. The favorable factors for client satisfaction with RHAC clinic services included: professionalism, excellent counseling skills, and friendliness, facilitation with decision making, affordable price, good hygiene, convenience, and accessibility. According to the assessment results for 2012, the overall score reached 95.2%, which included 97% for professional skills, 94% for good management of clinics and 90.3% for overall client satisfaction. None of the clinics were under the 85% cutoff point for quality standards.



# IV.

## Community and Public Health Support Program (CPHSP)

Community and Public Health Support Program (CPHSP) which constituted the bulk of the RHAC activities of the USAID/ToGoH project, aside from its Clinics, had its primary focus in providing technical assistance in the areas of maternal, newborn and child health and nutrition, RH/FP, HIV/AIDS, TB and overall health systems strengthening of the public sector, especially at the Health Center level. Through the CPHSP Component, ToGoH extended our technical assistant role for the period of 6 months from October 2013 through March 2014.

Following focus areas were undertaken in 6 Provinces, 23 ODs by the CPHSP/ToGoH in addition to our role as technical assistant in reproductive health and family planning (RH/FP) at the national level

- Technical Assistance and capacity building for OD/PHD
- Maternal and newborn health
- Health Center outreach services
- Community based Vitamin A
- CBD and FP services at HC including Long Acting and Permanent Method (LAPM)
- Facility IMCI and Community IMCI
- PMTCT/Linked Response
- Community-DOTS
- Strengthening Health Information System
- Community ILI/AI/ARI
- Community mobilization, education and community events
- Community participation, and good governance

CPHSP package of interventions covered 337 HCs in 23 ODs of six provinces: Battambang (4 ODs), Kampong Cham (9 ODs), Kampong Speu (3 ODs), Preah Sihanouk (1 OD), Pailin (1 OD) and Takeo (5 ODs). In addition, the CPHSP worked with community, village volunteers and local authorities to improve health of people in the community, to promote role of local authorities to foster greater accountability in health governance. CPHSP activities covered a population of approximately 4.7 million people.

**Note:** Following the Cooperative Agreement and in consultation with USAID, coverage for Takeo province ceased at the end of FY 2011 under the ToGoH support.

### Selective Results in Maternal and Newborn Health Outcomes

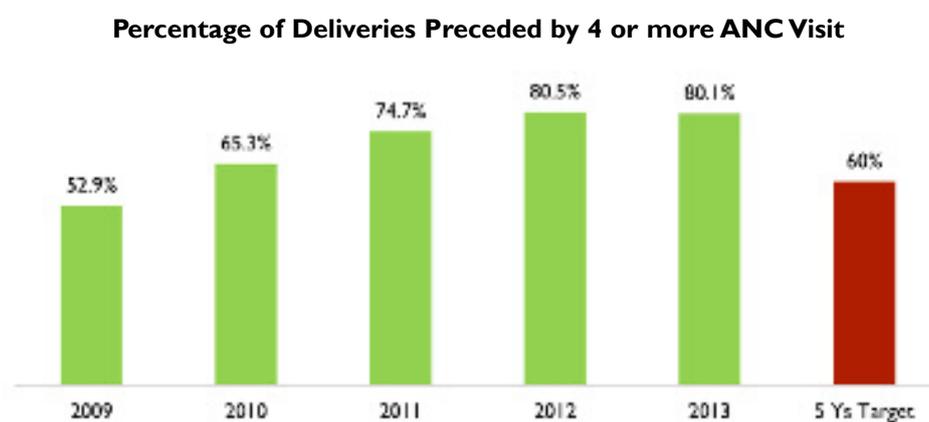
- ❖ Increased delivery at health facilities from 44% in 2005 to 88% in 2012
- ❖ On average, 30,000 deliveries a year were done at HC with ToGoH support
- ❖ Increased ANC4 visits from 46% (2007) to 81% by 2012
- ❖ Over 700 HC/RH Midwives were trained on Key Interventions, emergency obstetric care and other key reproductive health subjects in improving their skills to reduce maternal mortality and saving the lives of newborns
- ❖ Renovated Maternity Wards in more than half of our coverage HCs
- ❖ Water supply system was renovated and upgraded in a number of HCs in our coverage areas
- ❖ Provided equipment to HCs (EmONC kits, IUD kits, delivery kits etc.) to Health Centers

- ❖ Established community level referral system in 1,546 villages among 3,904 villages in 18 ODs.
- ❖ Trained 7,800 VHSGs in 3,904 villages to strengthen community awareness of MNCH/RH including birth preparedness, HIV, TB and other infectious diseases.
- ❖ 68 communes have budgeted in community health in CIP 2014.

Aside from the Clinic activities, CPHSP was the heart of the ToGoH focus which was fundamentally aimed at improving and strengthening service delivery of the public sector, i.e. the Ministry of Health, performance across the board of health system strengthening and health governance as well as specific service areas such as family planning, emergency obstetric care, newborn care, vitamin A supplementation, immunization coverage et al. Where possible, ToGoH assiduously avoided any vertical approach for the sake of achieving quick and discreet results. It is vital that in order to promote long term sustainability of provision of essential health services and a functioning health system, a more comprehensive and integrated approach must be the modus operandi in any effort to improve health outcomes and achieve impact in the long run. CPHSP made the utmost effort with such an integrated and government led approach in all our interventions during the USAID supported ToGoH project period.

## I. Maternal and Newborn Health

The decrease in MMR from 462 to 206 per 100,000 live births (Cambodia Census, 2008 & CDHS, 2010) shows a marked progress in reducing maternal deaths. We also witnessed similar progress in key indicators which contributes to MMR reduction in RHAC's coverage areas such as the increase in antenatal care visit, facility based delivery, and increased contraceptive prevalence rates.



*Source: Joint Annual Evaluation Survey, 2009 - 2013*

As shown in the selective graphs here, RHAC made excellent progress in achieving its targets in MNCH indicators of the ToGoH project. We improved delivery at health facilities and assisted delivery by trained Health Center Midwives who provided key maternal and newborn Key Intervention package of services, and assisted certain selected HCs to work towards meeting Basic-Emergency Obstetric and Newborn Care (BEmONC) standards as designated by MoH.

**Percentage of Deliveries Attended by a Trained Provider**



Source: Joint Annual Evaluation Survey, 2009 - 2013

Through the HIS data analysis by comparing the results of ANC4, delivery and PNC at HCs, the three indicators achieved much higher results in RHAC than non-RHAC supported areas. For example, ANC4 visits in ToGoH/RHAC support coverage increased by 33% points compared to 17.4% points in the rest of the country, which translated a change of 70.9% over the baseline in 2009.

RHAC trained VHSGs on birth preparedness, proper registration of all pregnant women in their villages. We also supported VHSGs to provide the pregnant women with information on self care during pregnancy and recognizing danger signs during pregnancy and delivery, helped pregnant women to develop birth preparedness plans, and encouraged them to seek at least 4 ANC visits and deliver at a public health facility especially health center.

In order to address financial barriers in seeking health care, RHAC implemented MNH voucher scheme with HCs. With a voucher, a pregnant woman was entitled to receive a package of services free of charge, namely: 4 ANC visits, delivery at the HC, and PNC. The MNH vouchers were distributed to VHSGs who then passed the voucher on to the pregnant women whom they met. VHSGs were trained during the bi-monthly meetings in the use of the vouchers to encourage pregnant women in their respective coverage villages to seek services and to ensure that the burden of service fees do not impede a pregnant women's ability to seek the essential RH services at government health facilities.

RHAC reimbursed the Health Centers USD 10 for a completed verified voucher. The 2012 RHAC Population Based Joint Annual Survey also showed the increase in ANC4, delivery and PNC at HCs in RHAC coverage areas. These results are largely contributed by the MNH Voucher scheme.



A RHAC - ToGoH field staff and a VHSG jointly conducting health education in the community



Romork used for LAPM promotion at community

## 2. Key Intervention (KI) Package

RHAC implemented Key Intervention package of activities in our coverage areas which focused on addressing AMTSL, management of pre-eclampsia and eclampsia, newborn resuscitation (HBB - Helping Baby Breath), and post partum hemorrhage management, the key leading causes of maternal and newborn deaths.

**Trend of No. of Delivery at HCs and ANC 4 Visit in RHAC/ToGoH areas**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report & MoH HIS

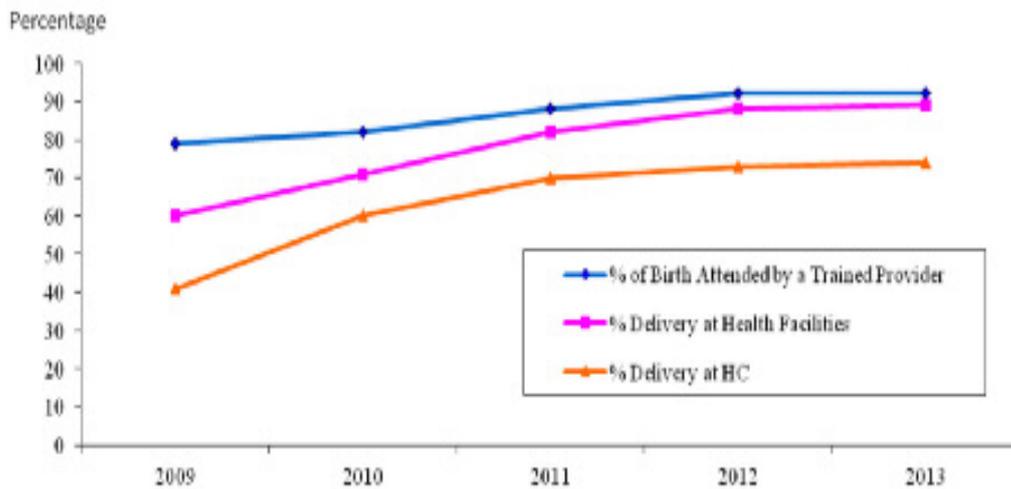
The Key Intervention improvement plan focused on four areas: (1) Improving staff capacity through training in Key Intervention services; (2) Ensuring availability of needed equipment and drugs in each health center; (3) Distribution and posting of job aids/posters/IEC materials on Key Intervention services with in easy access of midwives; and (4) Other targeted specific activities to ensure that the Key Intervention package of services are fully and effectively implemented with high quality standards at HCs.

RHAC improved the HC MW skills through MCAT (Midwifery Coordination Alliance Team) and monitor the application of skills of MW through supportive supervision and coaching to ensure that the Key Intervention package is implemented with quality outcome. MCAT forum provided an effective mechanism to improve the skills of key service providers and strengthen communication and coordination between HCs and referral hospitals. RHAC made a great deal of effort in planning these quarterly MCAT meetings with support and participation of the PHD and OD leadership.

By the end of 2012, out of the total of 255 HCs in the plan to be upgraded, 236 HCs have fulfilled with all the requirements to be able to provide Key Intervention services; 251 HCs have consistent stock of MgSO4, one of the persistent problems we encountered earlier in health facilities. Skill of health center midwives in administering MgSO4 has been greatly strengthened.

We believe consistent application of Key Intervention package with high quality in service provision is an important approach towards reducing maternal death and improving the chances of greater survival of newborns as the Key Intervention package addresses the underlying causes of poor pregnancy and newborn health outcomes. However, the success of the Key Intervention approach depends a great deal on the commitment, support and participation of the PHD, OD and HC leadership and the designated midwives. The adequately trained service providers such as the midwives with necessary professional ethics must be in place, along with leadership support. Mainstreaming the Key Intervention approach in HCs needs to be a priority and accordingly, reflected in the Annual Operational Plan of the respective PHDs, ODs and HCs to achieve sustained improvements maternal and newborn health outcomes.

### Steady Progress in Delivery at Health Facilities & Delivery by Trained Birth Attendants



Source: Joint Annual Evaluation Survey, 2009 - 2013

HC deliveries in RHAC areas increased by 32% in 2012 compared to the 2009 baseline while in non-RHAC areas, it increased by 21.8% for the same period and baseline. This is one of the encouraging signs of increased utilization of health facilities in the past several years as opposed to earlier times where the use and demand for existing government facilities was severely limited.

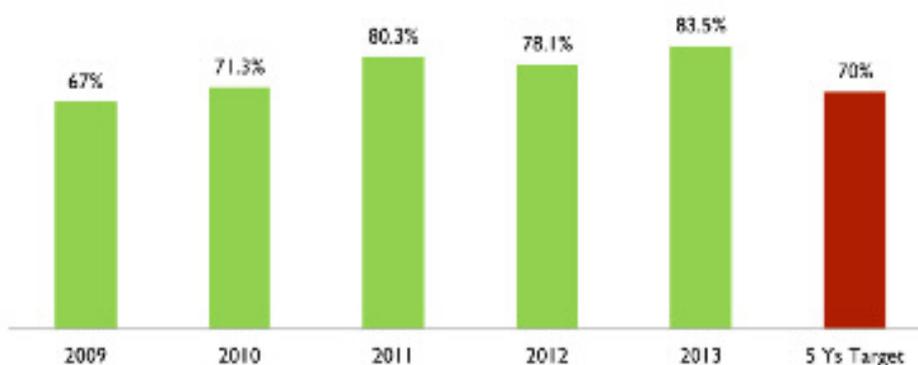
### 3. Basic Emergency Obstetric and Newborn Care (BEmONC)

RHAC made good progress in helping HCs designated by MoH to become BEmNOC in four provinces within RHAC/ToGoH coverage areas. RHAC, in collaboration with PHD and OD MCH officers, identified the gaps in each site, and developed improvement plans so that they have the needed infrastructure, human resources and technical skills to perform all the required seven signal functions (injectable antibiotic, injectable uterotonic, MgSO<sub>4</sub>, newborn resuscitation, manual removal of placenta, MVA and assisted delivery).



*Safe delivery at HC with healthy newborn*

#### Percentage of Births Received PNC within 24 Hours from Trained Providers



*Source: Joint Annual Evaluation Survey, RHAC & PHD*

Deliveries referred from health center to Referral Hospital in RHAC areas in 2012 increased by 4.8%, a change of 154.8% from the 2009 baseline. In non-RHAC areas, the increase was 1.3%, a change of 41.9% from the same baseline. Timely referral is a critical activity to help prevent complications and maternal death.

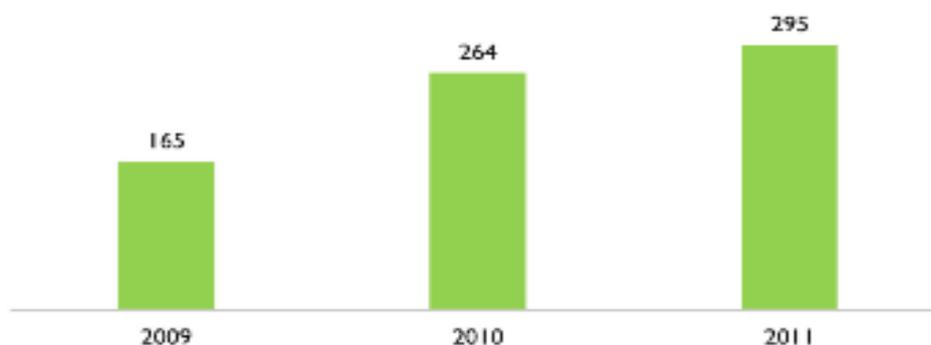
## 4. Family Planning Services

Under the ToGoH initiative, RHAC supported FP activities in five provinces covering 18 ODs (excluding 5 ODs of Takeo province which ToGoH phased-out in October 2011). In collaboration with PHDs/ODs/HC staff we worked to promote access to FP services especially long term methods by improving the availability and quality of service provision at the government health facilities and in the communities by using the results of mapping of FP service availability to expand FP service coverage and monitor its progress. In collaboration with PHD/OD, we conducted mapping of IUD insertion service by health center, conducted training for health center staff on IUD competency and provision of IUD kits to enable HC to provide IUD service. Through these efforts, the number of health center capable to provide IUD service increase exponentially from 165 HCs in 2009 to 295 HCs in 2011.

### Selective Outcomes in FP Services under the ToGoH Program

- ❖ Increased CPR from 27% (2005) to 32% (2010) to 46% (2012)
- ❖ Increased coverage of CBD program from 10 ODs (2008) to 14 ODs (2009) to 19 ODs (2010)
- ❖ Increased coverage of HC with IUD services from 165 HCs (2009) to 264 HCs (2010) to 295 HCs (2011) or 90% of the coverage
- ❖ Trained 321 Midwives in IUD insertion procedures to achieve full competency in 167 HCs
- ❖ 180 IUD Insertion Kits were distributed to Health Centers
- ❖ Extensively promoted FP awareness in communities through HCs, VHSGs and local authorities
- ❖ Improved the use of long term FP methods with Voucher schemes to remove financial barriers

**Increased Number of Health Center Providing IUD Service**



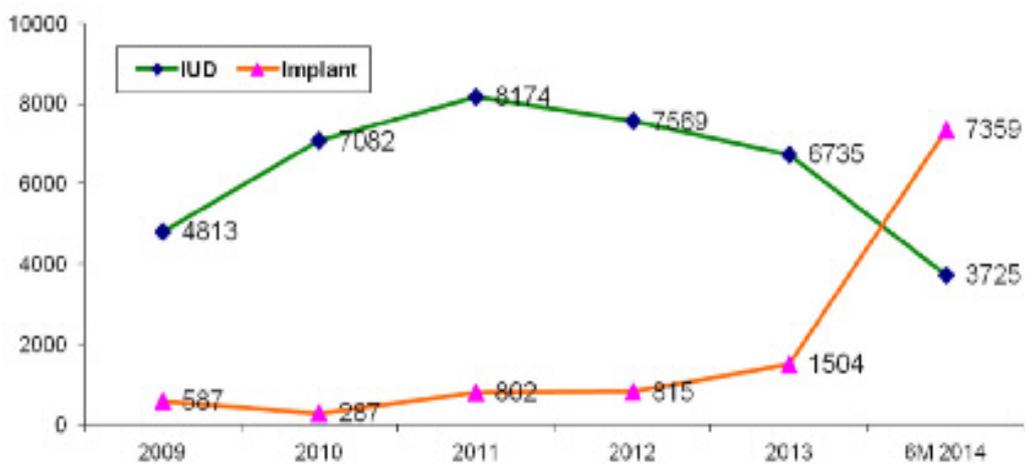
Under the ToGoH, we designed a Voucher system to promote long-term FP methods and to increase access to such FP methods especially IUD by WRA. The LAPM Vouchers were given to all the VHSGs/CBDs for free distribution to women of reproductive age (WRA) who intended to use FP service. The VHSGs/CBDs were given clear guidance in promoting the benefits of the voucher during monthly meetings as well as during supervisory visits. Voucher users were entitled to receive free IUD services at HCs and permanent methods at RHAC clinics with reimbursement of transportation costs. In the extension period from October 2013 to March 2014, we conducted intensive promotion for long acting and permanent methods (LAPM) and extending support fee of Implant service by LAPM Voucher to

promote use of FP services for the short run and changing behavior therefore generating long lasting demand for FP services for long term. The graph below reflects the substantial demand for longer term methods as there has been steady increase in uptake of IUD service when use of Implant method elevate significantly in ToGoH coverage areas perhaps contributing by our promotion efforts. RHAC-ToGoH undertook targeted activities to promote IUD, Implant and VSC services, both in government Health Centers as well as in RHAC managed USAID supported 15 clinics in the country.



HC midwife counseling on FP and postpartum nutrition

**Trend of IUD Acceptors and Implant Clients Served by HCs with ToGoH Support**

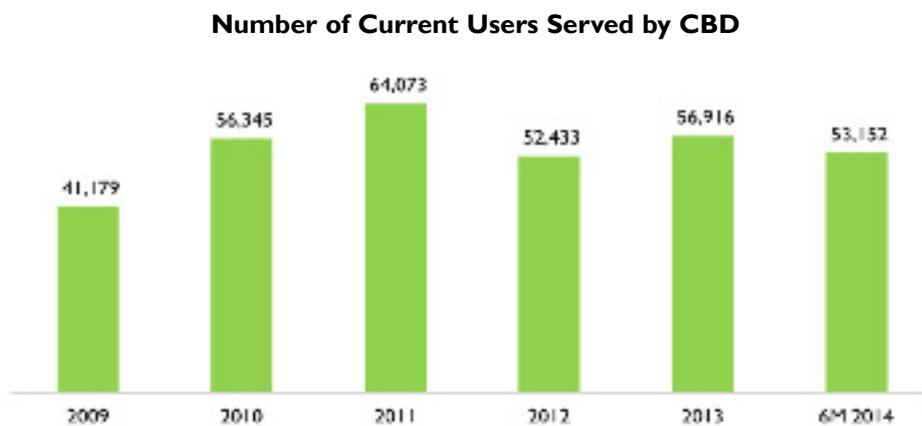


Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

Despite the fact that Oral pill remains the most popular method among the range of FP methods available in government facilities and through the CBDs, our field experience and survey data show increase preference for long term methods particularly IUD and Implant, partly for its availability at HCs. Other permanent methods such as vasectomy are not readily available in HCs and the number of referral hospital upgraded to be able to provide such methods are limited. Given the demand for longer acting methods, it is clear that there needs to be continued and more robust efforts to promote and provide long term and permanent FP methods as widely as possible in the government health service delivery infrastructure.

### 5. Community Based Distribution (CBD) of FP Activities

CBD is a globally recognized and MoH approved strategy that is widely used in Cambodia to improve access to and expand the use of FP services at the community level. RHAC followed a consistent strategy for initiation of CBD activities which included: training HC staff about the CBD program (including training of trainers), working with HC staff to recruit CBD agents from the existing group of VHSGs, training the new CBDs to provide a limited set of modern FP methods (oral pill and condom) in their villages (door to door) and to provide comprehensive information and counseling on comprehensive method of FP, follow-up of FP clients , referral for other FP methods available at health facilities, management of side effects and Informed Choice principles and guidelines in the promotion of FP methods and services.

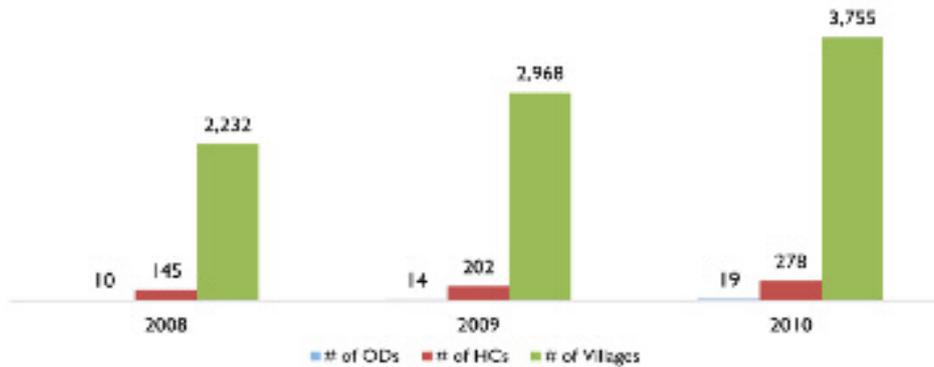


*Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report*

**Note:** The decline in number of current users of FP served by CBDs as well as number of CBD agents from 2012 onward because RHAC/ToGoH withdrew from 5 ODs in Takeo province in October 2011.

Through ToGoH support, CBD coverage notably increase from only 10 ODs in 2008 to 19 ODs in 2010 especially in Kampong Cham province from only 2 OD prior to the start of ToGoH support to all 9 ODs within year of ToGoH implementation. By 2012, we were able to increase the coverage of CBD program from 57% of eligible villages to 90% of the total eligible villages. By the end of March 2014, there were 2,600 CBDs providing family planning methods (pills and condoms) in the community, and there were 53,152 current users of FP methods served by CBDs in the five provinces under the ToGoH/RHAC coverage areas.

### Expansion of Coverage of FP Service by CBD



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

Often CBDs are the VHSGs in the villages but the designation of these VHSGs as CBDs entails additional and specific responsibilities directly related to family planning services. As a designated CBD, they will be trained in family planning concepts, methods and practices. Each CBD is supplied with a set of educational/promotional materials related to family planning. Most important and the one that is easily visible and which often draws the interest of the VHSGs and perhaps the community is the supply of family planning methods, principally pills and condoms which the CBDs receive from respective Health Centers which they can sell to clients in their villages. CBDs also maintain prescribed service records such as the Registration book for women of reproductive age in their coverage area.

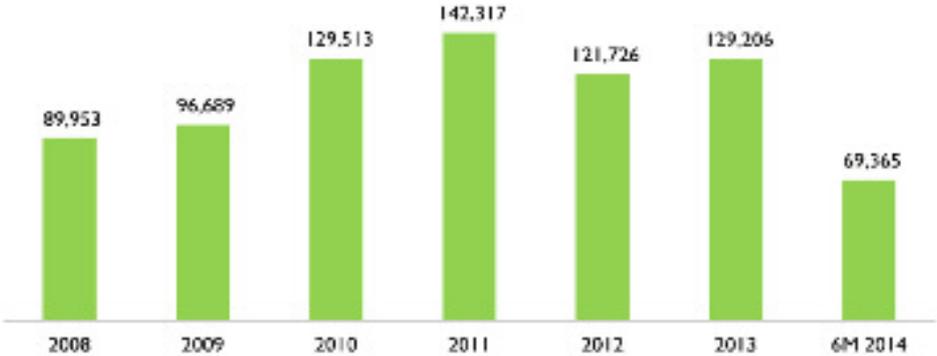
As the data here shows the overall contribution towards Cambodia's improved contraceptive prevalence rates in the successive CDHS with large CYP results and the coverage by CBDs, RHAC-ToGoH experience has clearly demonstrated the important role CBDs play in meeting the family planning needs of the women and men of reproductive age as well as in creating needed demand for family planning needs through their outreach and door to door services. Like other aspects of the public sector health



A RHAC trained CBD conducting education activity on family planning

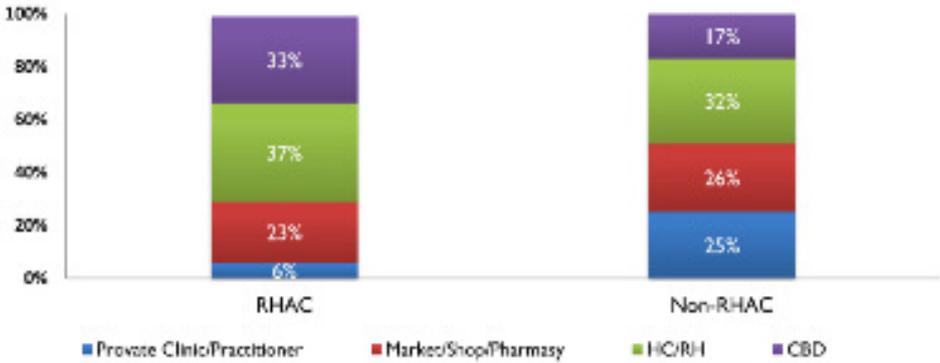
service delivery system, CBDs do not receive the level of consistent and sustained support it needs to mainstream the role, and the responsibilities of the CBDs as a regular part of the service delivery infrastructure. Often, CBDs are well trained, organized and delivery results where there is active and competent technical assistance and supportive supervision and training by NGOs such as the USAID supported RHAC ToGoH initiative for the past 5 and half years.

**CYP Supported by RHAC-ToGoH/USAID**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

**Contraceptive Pill Users in RHAC & Non-RHAC Supported CBD**

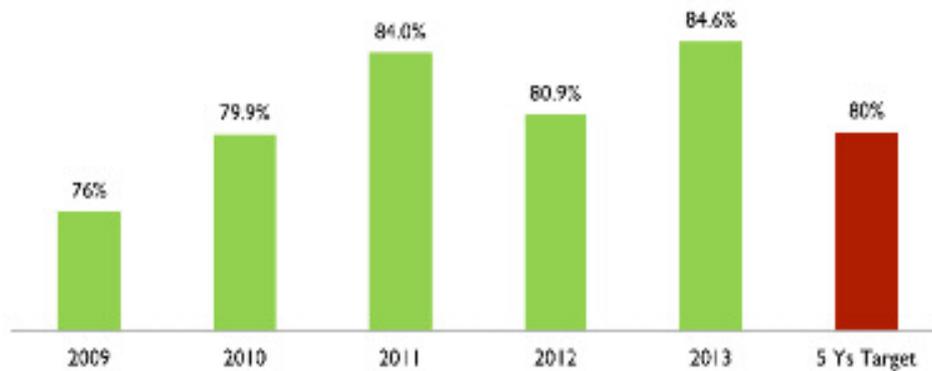


Source: Joint Annual Evaluation Survey, 2012

**6. Child Survival Activities**

RHAC supported the government HC’s outreach program by forging closer working relationships between VHSGs and HC staff and through frequent technical consultations, training and collaboration between RHAC, HC staff, and relevant national programs.

### Percentage of Children Aged 12-23 Months Who Were Fully Immunized



Source: Joint Annual Evaluation Survey

By 2012, RHAC supported HCs in 12 ODs to conduct outreach activities in key child survival services. A total of 61,445 children received immunizations against measles and 60,727 received full immunization coverage, and 62,568 children received DPT3, surpassing the five year ToGoH project target of 80% immunization coverage.

### Percentage of Children Under 5 with ARI Treated by Trained Provider

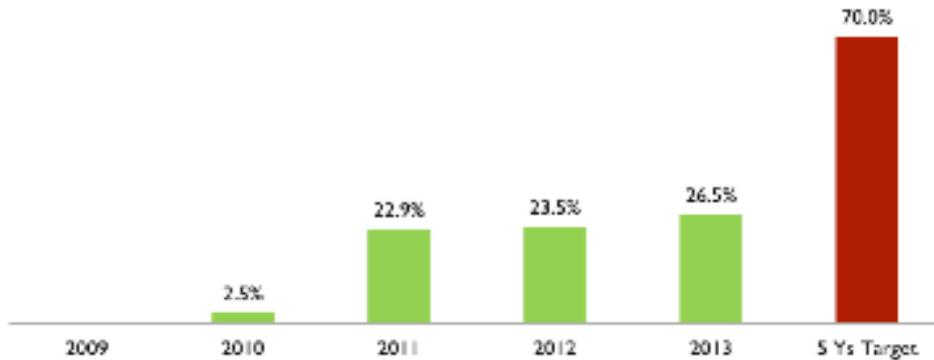


Source: Joint Annual Evaluation Survey

## 7. Management of Childhood Illnesses: IMCI & C-IMCI

RHAC supported activities to improve the capacity and skills of health workers at Health Centers in the management of childhood illnesses to enable them to provide appropriate treatment for sick children. The MoH's strategy to combat childhood illnesses focuses on facility and community-based IMCI approaches. RHAC supported facility IMCI in 5 provinces in 11 ODs, covering 153 HCs during the ToGoH implementation. We support training for health center staff on IMCI following guidelines of the MoH and support IMCI supervision by OD-MCH focal point. In community, we trained VHSGs on community IMCI to enable them to provide education to mother/caretaker about childhood illnesses and refer sick children to health facilities.

### % of Children with Diarrhea Treated with ORT & Zinc



Source: Joint Annual Evaluation Survey

One of the key challenges in the provision of essential health services, be it child health, family planning, or ARI et al, at the community level which essentially takes place at the Health Center level and during outreach services by key service providers such as the midwives invariably has to do with the professional commitment and skill levels of the providers. While there is obvious progress in the performance of the health service delivery system as well as in the skills and knowledge of the providers, largely due to countless technical assistance and training undertaken by the government and the collaborating NGOs such as RHAC, given the fundamental weakness of the health sector and low skill levels of the providers, the only way to sustain the incremental progress achieved thus far will depend largely on continued training of the public sector providers and sustained technical assistance support to the public sector service delivery system in the foreseeable future.

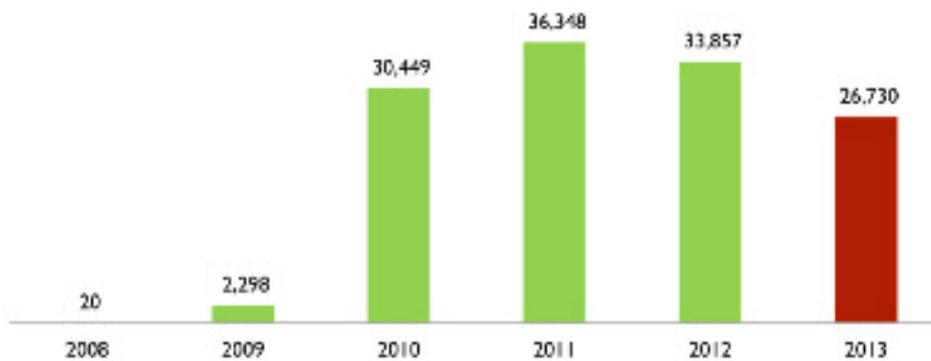


A HC staff providing counseling to a mother of an under 5 years old child sick with diarrhea

## 8. Linked Response (LR)

RHAC supported government HCs in the provision of counseling and testing on HIV/AIDS and promote counseling and testing especially for pregnant women attending ANC service and other clients including TB patients through support Linked Response approach in 6 ODs. In collaboration with NCHADS, RHAC/ToGoH conducted assessment and mapping of health centers feasible to function as Linked HC or Satellite site, support training for counselor and lab technician on Linked Response approaches, provision of basic equipment and office supply, support transportation cost for refer blood sample from Linked HC to satellite for testing, support supervision by OD supervisor and other support for pregnant women identified with HIV etc. Trained staff at 69 designated Linked Response HCs and 19 satellite sites promoted VCCT service during routine consultation services, especially to those who displayed high risk symptoms such as TB or STI patients and pregnant women. PEs who worked with youth and migrant workers were active in referring their peers to receive VCCT services at RHAC clinics or referral hospitals or HCs where VCCT services were available.

**Total Number of Clients Received VCCT at ToGoH Support LR HCs**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

For example, in 2012, 18,851 pregnant women received pre and post test counseling on HIV from RHAC supported LR sites. Thirty one of these pregnant women were identified as HIV positive and referred for further testing (CD4 count); prophylaxis to prevent MTCT, and appropriate care and treatment. In addition, 15,011 non pregnant clients were tested for HIV at the six LR sites, including their partners.

## 9. Nutrition Activities

**Note:** We are providing more detailed information on nutrition related activities carried out under the USAID ToGoH project because of the increasing attention given to nutrition and food security by the development community in recent years. Without exception, nutrition related activities have been subsumed under maternal, newborn and child health and seldom receives the level of attention other areas receive such as HIV/AIDS, TB, malaria et al. As shown here, RHAC undertook substantial nutrition related activities during the ToGoH project period and many of the key nutrition related activities such as the promotion of exclusive breastfeeding are thoroughly embedded into the routine maternal and child health key interventions.

Cambodia has one of the highest malnutrition and under-nutrition prevalence in the Asia Pacific Region. Results from the successive Cambodia Demographic and Health Surveys (CDHS) on nutrition indicate little or no change in nutrition and growth indicators since 2000.

### 9.1. USAID ToGoH/RHAC Approach

Nutrition is a complex issue which involves many factors such as food availability, food security, household purchasing powers, food related behaviors and feeding practices, water, sanitation and hygiene practices, diarrhea, parasites et al.

Based on our decade long of experience in working at the community level and strong partnership with public sector, USAID ToGoH nutrition activities are largely focused on IEC/BCC in our coverage communities in 18 ODs and 270 Health Centers for demand creation in communities and capacity building of service providers. Our focus in improving health services in MNCHN (Maternal, newborn, child health & nutrition) essentially entails an integrated approach in implementing MPA module 10 which includes nutrition and nutrition related activities.

Our activities/indicators and strategic objectives are aligned with USAID, National Nutrition Program Strategy (2009-2015) and Cambodia MDGs.

Our work in nutrition under the USAID ToGoH Project is summarized below:

RHAC/ToGoH included three key nutrition indicators as end of project targets in maternal, newborn and child health and nutrition:

❖ Percent of births with BF initiated within 1 hour of delivery:	60%
❖ Percent of children aged 0-5 months exclusively breastfed:	65%
❖ Percent of children who received Vitamin A:	> 85%

### Selective Nutrition Related Results in 2012

❖ Total participants received health education on Nutrition (C-IMCI) from VHSGs and RHAC Staff	167,202
❖ Total PW received 90 Iron Folic Acid tablets at 2nd ANC visit to HC and/or during HC Outreach	86,533
❖ Total Post Partum Women who Received 42 Iron Folic Acid tablets during 1st PNC visit to HC	49,719
❖ Total Newborns who Received Immediate Breastfeeding (within one hour of delivery) at HCs	43,168
❖ Total # of children aged 6 - 59 months who received Vitamin A capsules at HCs (Nov 2012 distribution)	281,009
❖ Total PW who received 90 Iron Folic Acid tablets at 2nd ANC visit during visit to RHAC Clinics	10,935

As of 2012, RHAC is on track in meeting all its nutrition related end of the project performance indicators. The above indicators are aligned with key results of the National Nutrition Program Strategy 2009 – 2015.

### 9.2. Promoting Breastfeeding, IYCF & Supporting VHSGs in IEC/BCC for MNCHN

ToGoH/RHAC's focus primarily aimed at strengthening the capacity of the VHSGs in our coverage areas. Approximately 8,000 trained VHSGs in 18 ODs provided education messages related to nutrition which included the importance of breastfeeding, benefits of exclusive breastfeeding and appropriate complementary feeding practices, Vitamin A, ORS and Zinc to family members in rural areas. For example, VHSGs provided such IEC services in nutrition to a total of 167,202 participants from October 2011 – September 2012.

**Percentage of Births with BF Initiated Within 1 Hour of Delivery**



Source: Joint Annual Evaluation Survey, 2009-2013

Breastfeeding, complementary feeding, nutrition during pregnancy and postpartum nutrition were regularly featured in the MCAT Meetings with the special emphasis on the role of the HC midwives in counseling of expectant mothers and post partum women. ToGoH provided technical and financial support for the Quarterly MCAT Meetings in 18 ODs of five provinces under ToGoH coverage.

**Percentage of Children 0-5 Months Exclusively Breastfed (2009-2013)**



Source: Joint Annual Evaluation Survey, 2009-2013

ToGoH/RHAC supported the Bi-Monthly meeting of the VHSGs (7,799 VHSGs in 2012) in 273 Health Centers in 18 ODs under our coverage in five provinces. Aside from supporting the modest travel and per diem expense of the VHSGs to enable them to attend this important bi-monthly gathering of all the VHSGs under the respective HC jurisdictions, ToGoH/RHAC team provided technical assistance to the concerned ODs/HCs by assisting them in planning the meetings, review of the progress and challenges since the last meeting and setting the agenda for the current meeting etc. One of the main focuses of the gathering was to improve the knowledge and skills of the VHSGs in targeted key MNCHN messages, refresher training about breastfeeding, exclusive breastfeeding, complimentary feeding and motivating the VHSGs to undertake outreach health education in using ORS/ Zinc to re-hydrate children with diarrhea episodes, Water Sanitation and Hygiene and MNCHN/RH/FP in their respective villages.

### 9.3. Community-Based Vitamin A Distribution

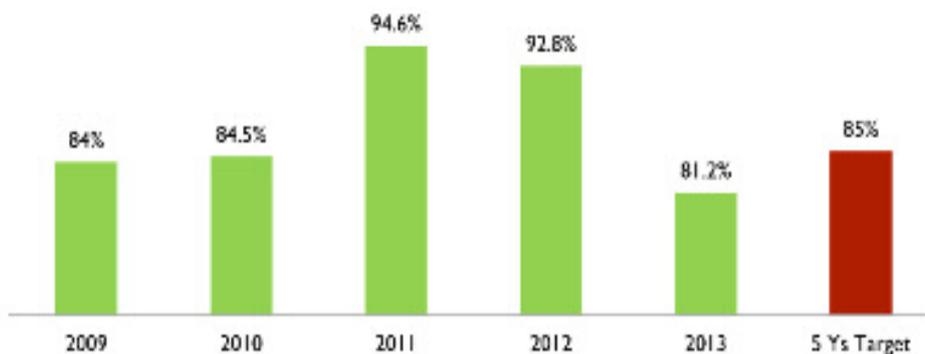
Community based Vitamin A distribution for children under 5 continued to be a key child survival intervention and a high priority of the Ministry of Health. Our Vitamin A supplementation approach continued to demonstrate proven effectiveness, with 93% coverage of Vitamin A (RHAC Annual Survey, 2012) in our coverage areas, reaching 281,009 children 6-59 months of age in 2012.



A government Health Center staff giving Vitamin A capsule to children during Vitamin A distribution in November 2012

With handover of Vitamin A & deworming activities to respective PHDs/ODs as of October 2012 for full

#### Percentage of Children (6-59 Months) Who Received Vitamin A (2009-2013)



Source: Joint Annual Evaluation Survey, 2009-2013

ownership and execution, ToGoH/RHAC continued to monitor and provide programmatic technical assistance to ensure that planning, distribution, community mobilization, monitoring, inter-sectorial coordination, follow-up etc. are all implemented with proper quality and adherence to established national guidelines.

**ToGoH/RHAC Technical Assistance for Vitamin A support included:** Volunteer Recruitment: Assisted Health Centers in recruiting VHSGs and Vitamin A specific volunteers called Community Support Group (CSG) members (these groups include village chiefs, school teachers, monks, and participants from other sectors who can support VHSGs in their work) in their respective villages.

**Training of HC Staff & Volunteers:** In collaboration with National Nutrition Program (NNP) and PHD, we played a supportive role in planning a series of cascade training and developed the promotion/distribution plan with HCs, HCMC, local authorities;

**IEC & Mobilization:** Supported the IEC and community mobilization/outreach activities of CSGs/VHSGs with intensive training and education in villages before each distribution cycle (May and November). Refresher training for the volunteers about Vitamin A occurred a few months prior to the Vitamin A Distribution month (May & November);

**Community Outreach:** On the distribution day, RHAC staff supported the HCs to conduct outreach sessions in designated villages/ locations where Vitamin A supplementation was carried out. VHSGs and CSGs mobilized communities to bring their children to the location with display of colorful big banners posted in strategic location and accompanied by loudspeaker announcements in the villages.

**Follow-Up:** RHAC staff assisted with follow-up by reviewing the list of the registered children to determine if any children who were on the list missed coming to the designated location for the Vitamin A capsules. Based on the review, additional Vitamin A capsules were given to the VHSGs to administer to registered children who missed the distribution day.

**Post-mortem & Forward on the Next Round:** ToGoH/RHAC assisted the HCs in collecting the Vitamin A distribution results and help them to analyze to learn what went right, what went wrong, what needs to be improved and discuss ways to improve. Under respective OD leadership, we assisted in organizing a planning meeting with participation of all the HC chiefs in each OD to share the results of the last completed Vitamin A distribution and map out the activities each HC needs to gear up for the next round. Results of the distribution, lessons learned, improvement plans and plans for the coming year were shared with other stakeholders and participants such as HCMC, Village Chiefs, Commune Councils, District governors and other local authorities during the Annual Review Health Workshop at OD or Provincial level.

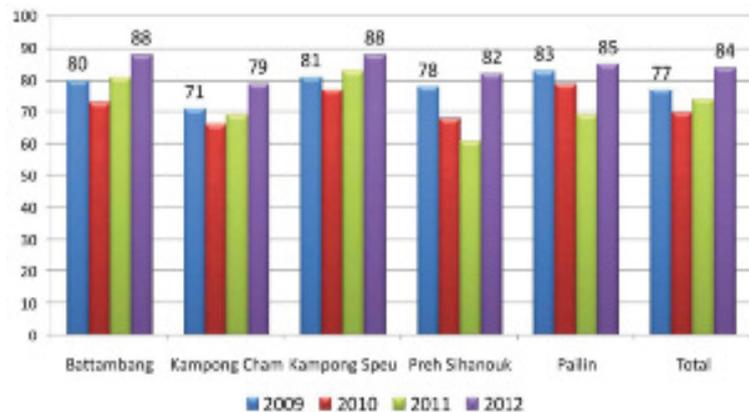


*A RHAC trained VHSG conducting Vitamin A outreach session in the village*

### 9.4. Iron Folic Acid Distribution during ANC and PNC Visits

Maternal and newborn health continues to pose major challenges for the health sector. Based on RHAC's past experience, key areas of need and thus the focus of our activities in MNCHN were to: strengthen delivery care by trained health personnel by improving the competencies and skills of providers, establish minimum standards of service delivery at HCs, and reduce financial barriers for care for pregnant women and families. RHAC's approach continued to focus on ANC, birth preparedness, safe delivery, and post natal care. RHAC/ToGoH team worked with HC staff to provide comprehensive services that included counseling, health education about how to stay healthy while pregnant, eating nutritious food while pregnant, consuming a variety of food each day, using iodized salt, food for post partum women, breast feeding, exclusive breast feeding, providing 90 Iron Folic Acid tablet (84% of pregnant women took all 90 tablets during ANC in 2012), weighing, PMTCT and other para-clinic services as needed during ANC visits, and 42 Iron Folic Acid during PNC visits (84.8% of postpartum women received Iron-folate acid, and 56% of post partum women took Iron-folate acid in 2012).

**Trend in % of mothers who took all 90 tablets of iron-folate during the last pregnancy (2009-2012)**

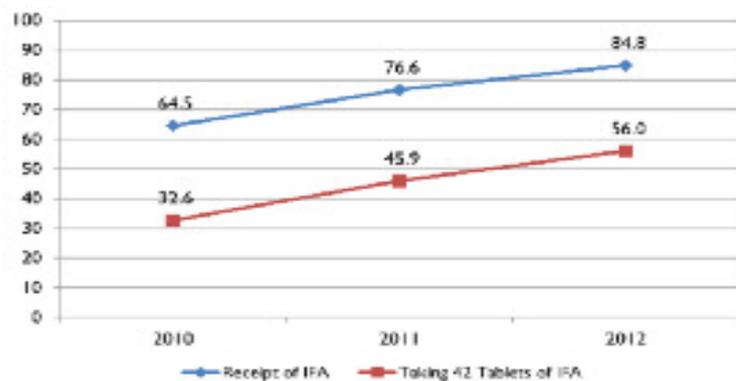


Source: Joint Annual Evaluation Survey, 2009-2013



Health Center Midwife giving Iron tablet to a pregnant woman after counselling

**Trend in receipt and intake of 42 tablets of IFA among postpartum women (2010-2012)**



Source: Joint Annual Evaluation Survey, 2010-2012

## 9.5. Nutrition Services in RHAC Clinics

Comprehensive nutrition counseling to pregnant women, postpartum clients was provided in all the 15 RHAC clinics in the country. As can be seen from the total number of monthly client visits, RHAC clinics reached substantial number of pregnant and postpartum women in the country. RHAC clinics provided blood test to diagnose anemia and prescribe Iron Tablet for anemia prevention or treatment. The clinics provided youth friendly services and services to factory workers which included information about nutrition and RHAC clinic staff provided extensive nutrition counseling.



*Nutrition counselling by RHAC clinic staff during ANC service*

## 10. Good Governance for Community Health

Targeting sustainability of community health services in communes and improved health governance, RHAC worked with commune councils, Health Center Management Committees (HCMC) to promote clients' rights, effective referral system, and demand for quality services. We especially promote institutionalization of community health promotion through building and strengthening capacity of CC/CCWC on management of VHSG and budgeting for health in Commune Investment Plan (CIP), including HCMC and VHSG meetings.



*CCWC training in Mean Commune of Prey Chhor OD, Kampong Cham province, Photo by RHAC/ToGoH*

We started our work by co-organizing a consultative provincial workshop in each province with Governor's Office and Provincial Health Department, and CC/CCWC to review and discuss their roles.

Toward the end of 2010, RHAC started implementing good governance activity in 18 ODs of five provinces. We installed suggestion boxes in all the 272 HCs, trained 4,709 CCWC/CC members in 345 communes on community health promotion, and established referral system in 1,545 villages (70% of all the eligible villages), among others. To date, 104 newly trained CCWC/CC members in 104 communes of the total 345 participated in VHSG meetings that were conducted by HC staff with assistance of RHAC staff in order to get exposed in real setting to practically learn how to conduct meeting and enable them to lead VHSGs meeting in the future. Moreover, during the six-month extension period, 68 of the total 345 communes have allocated budget for at least three health activities, including HCMC/VHSG meetings and support for referral of pregnant women in the CIP 2014. Toward the end of the ToGoH project, 65 bi-monthly HCMC meetings were held without RHAC/ToGoH financial support. Through these meetings, RHAC together with the HC and HCMC members have also monitored the use of suggestion box and the village-HC referral system. In 2012, for example, a total of 11,198 suggestion letters were collected, and 246 pregnant women and other 327 villagers used the referral system.

Despite our effort and commitment from CC/CCWC, integrated education on client rights in community education to raise awareness and encourage the communities to give comments/suggestions, the suggestion box system had not been fully utilized since some people prefer to give verbal rather than written feedback in the suggestion box, some cannot read or write, and some are afraid to write complaints and put them in the suggestion box. Given this setback, this approach is most likely to be a key potential to contribute to strengthening health sector to be better through empowering villagers/clients to use their right/voice to improve health services at all level. For sustainability, the approach requires a few more years for the community to change their behavior.



CCWC training in Prey Svay Commune of Maung Reusey OD, Battambang province, Photo by RHAC/ToGoH



Suggestion box installed in front of each HC under ToGoH coverage, Photo by RHAC/ToGoH project

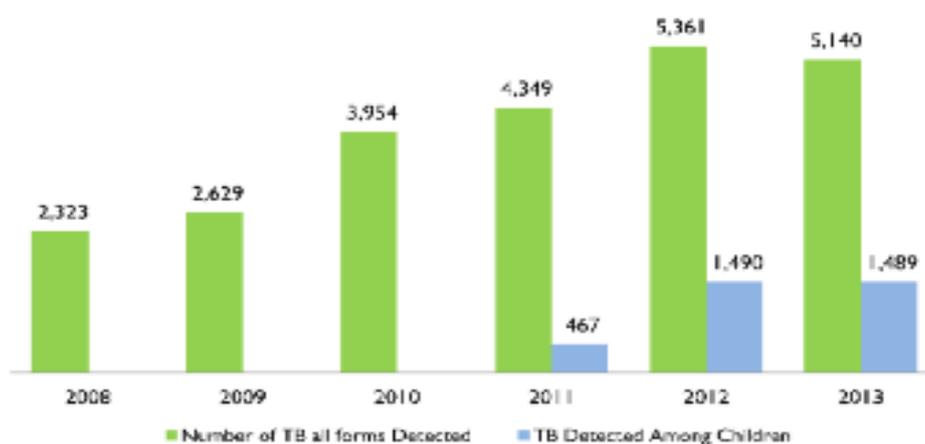
## II. Community DOTS for TB

RHAC, in collaboration with HCs and ODs and in line with the National Center for Tuberculosis and Leprosy Control Program, supported community DOTS in 8 ODs, covering 1,810 villages and 134 HCs.

### Selective TB Case Detection Results

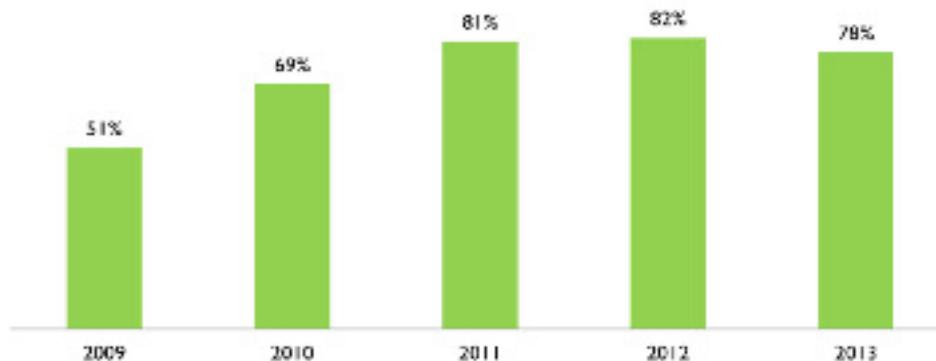
- ❖ Increased number of all forms of TB detection
- ❖ Increased TB case detection for children by more than 3 times compared with base line (2011: 467, 2012: 1,490), contributed 26% of TB children nationwide
- ❖ TB-HIV Co-Infection: 81% of TB patients tested for HIV/AIDS
- ❖ Initiated detection of TB among elderly people and referral of TB smear negative for screening at RH

**Number of TB Cases Detected**



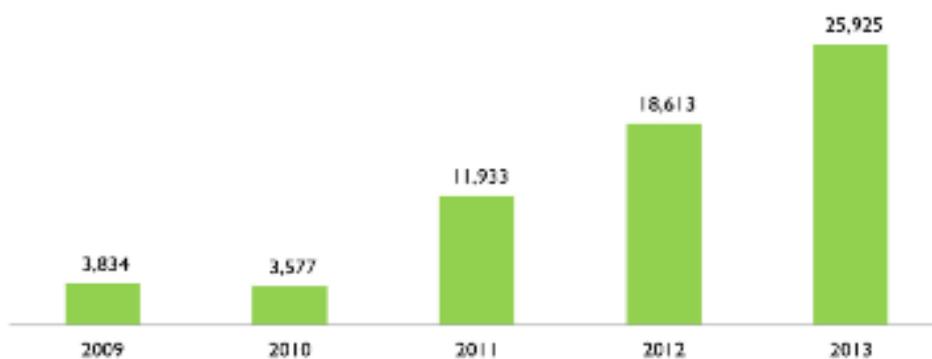
Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

**% of TB Patients Tested for HIV/AIDS**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

### Number of Suspected TB Referred for TB Screening



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

## 12. Integrated Community Health, Education & Information

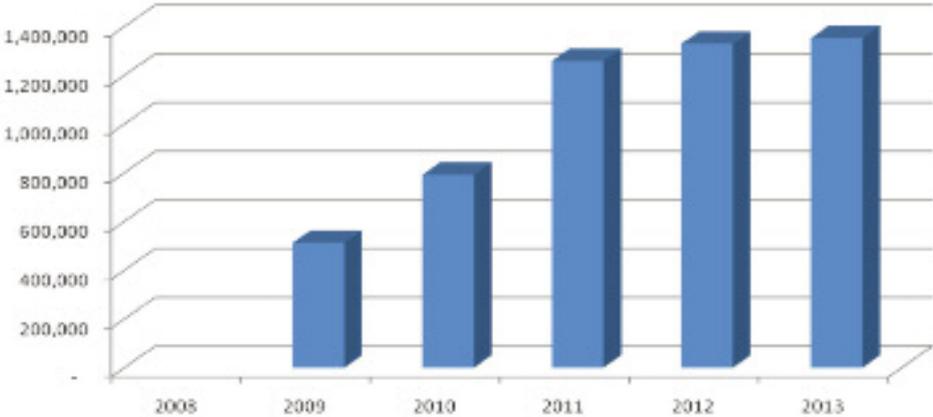
ToGoH/RHAC worked with HCs to support and ensure that each HC has two VHSGs to support community based health outreach activities. A total of 7,799 VHSG were working with HCs in the 18 ODs. VHSGs were trained on various health subjects to provide education to people in their villages. Their knowledge was also refreshed through regular bi-monthly meetings organized at the HCs. Education materials were provided to them such as flipcharts, flyers, posters and booklets to support their outreach health promotion and education activities.



A RHAC - ToGoH field staff and a VHSG jointly conducting health education in the community

The primary responsibilities of VHSGs/CBDs included providing reproductive and family health education and information, registering pregnant women and women of reproductive ages, mobilizing people to receive HC outreach services and other campaigns, referring patients to government HCs or RHAC clinics, distributing and selling contraceptives (condoms and pills), serving as DOT Watchers in the coverage areas where RHAC supported C-DOTS, and providing feedback from community to HCs. The VHSGs were encouraged with set schedules to provide different educational topics based on health issues in their community. These topics included FP, RH, MNH, Nutrition, Hygiene, water and sanitation, TB, AI, and other health related issues in their community.

**Number Men and Women Received Health Education  
(Group + Talk Education)**



*Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report*

The number of people who received health information through the ToGoH project in the last 5 years is staggering, though exposure to information alone do not necessarily translate into action and change in behavior conducive to better health. However, access to correct and right type of basic information about health concerns of communities with low literacy levels and where “good” public service oriented mass media penetration is severely lacking, is the first and a necessary step in generating demand for services. Under the ToGoH, we employed every available platform and setting through all the existing mechanisms to reach with basic health information in as many villages and communities as was feasible. The various settings and mechanisms we used included the frontline health workers at the community level such as the VHSGs, CBDs, C-DOTS Watchers, population specific peer educators such as in the Youth and Vulnerable groups and the public sector service providers such as the midwives, including community wide focused QUIZ shows and community theatre performances by locally recruited and trained artists.



# V.

## Youth Health Program (YHP)

RHAC implemented youth related health activities in 8 provinces: Phnom Penh, Kampong Cham, Battambang, Preah Sihanouk, Siem Reap, Kampong Speu, Monduliri, and Pailin, covering a total of 1,281 villages and 38 schools. ToGoH covered 6 of these provinces and the results reported here through the following graphs reflect the ToGoH covered provinces.

### Youth Health Program Coverage areas under ToGoH

Village/Year	2009	2010	2011	2012	2013
Ever covered	671	951	1,129	1,129	1,129
Dropped from last year	0	196	78	0	0
Replaced	0	196	78	0	0
New	0	84	100	0	0
Currently covered	671	755	856	856	856
School/Year	2009	2010	2011	2012	2013
Ever covered	38	38	42	42	42
Dropped from last year	0	0	4	4	4
Replaced	0	0	4	4	4
Currently covered	38	38	38	38	38
YC/Year	2009	2010	2011	2012	2013
Ever covered	10	10	10	10	11
Dropped from last year	0	0	0	0	6
New	0	0	0	1	0
Currently covered	10	10	10	10	5

RHAC's Youth Health Program provided BCC activities on HIV/AIDS and RH to in-school and out-of-school youth, aged 10-24 years old. The Youth Health Program provided an integrated package of BCC on HIV/AIDS, STI/RTI and RH/FP through four pillars of BCC framework: (1) increasing knowledge through different education and information sharing approaches, (2) ensuring the availability of quality services and products, (3) building a supportive environment, and (4) providing effective referral and follow up of young people to access appropriate services.

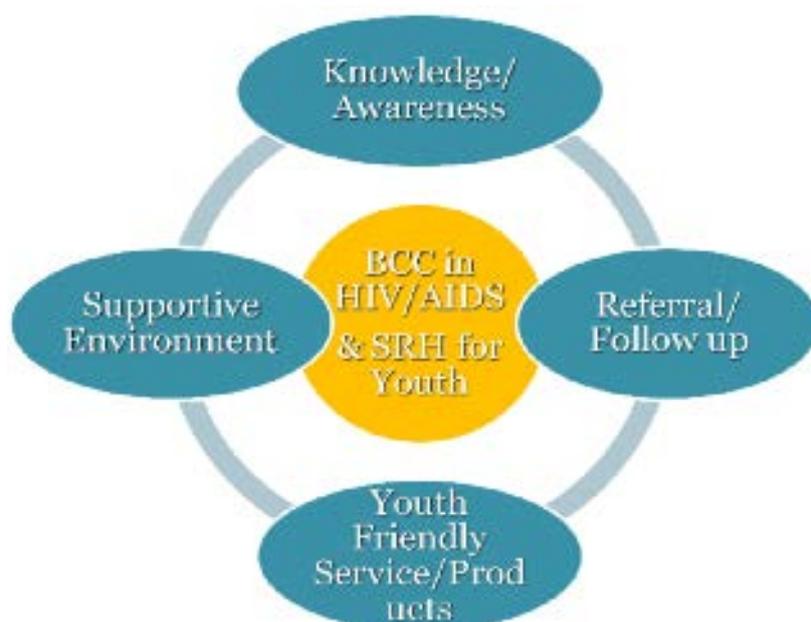
### I. HIV/AIDS, STI/RTI and RH/FP IEC for Youth

The program used a peer education approach to reach the target groups. ToGoH/RHAC worked with 2,289 Peer Group Educators (PGEs) in and out of school, who were responsible for hosting Youth Center activities, conducting peer group education and one-on-one discussion on the topics, referring their peers for further technical information or treatment services to RHAC clinics or HCs, and acting as focal persons for contacting young people in the villages and schools for special events.

In-school and out-of-school PGEs are recruited and trained on a set of comprehensive sexual education topics, such as the human reproductive tract system, risks associated with teenage pregnancy, unsafe abortion, STD/HIV/AIDS transmission, hygiene, nutrition, illicit drug use, and life skills (life skills is a cross cutting subject which is integrated in all subjects of education whenever appropriate).

ToGoH/RHAC Youth Health Program team employed this comprehensive and integrated approach in reaching the youth population with key RH, HIV/AIDS, STI messages with aim towards achieving needed behavior modification. Both project staff in the field, government counterparts and volunteers and community leaders were trained in the basic concepts of the IEC/BCC framework and taught in its implementation, along with provision of the necessary IEC materials developed by the project.

### RHAC IEC/BCC and Outreach Conceptual Framework

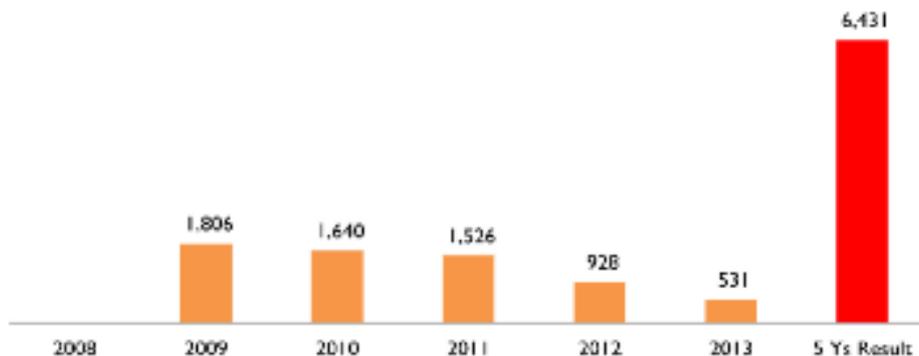


#### Key Youth Health Program Activities

- ❖ Initial Planning and Orientation Meeting
- ❖ Recruit and training Peer Educators (PEs)
- ❖ Provide/Conduct health education through one-on-one talk, Group Discussion Session, Quiz/Local drama performance.
- ❖ Referral linkage to clinical services
- ❖ Provision of good quality products and services i.e. Youth Friendly Services (YFS)
- ❖ Training service providers especially health center staff on YFS
- ❖ Planning and supporting the regular Bi-Monthly Meeting of the Peer Educators & HCs
- ❖ Supporting the CCWC, Youth Advisory Group for the Quarterly Meeting of the YHP
- ❖ Integrating YHP activities into the annual Commune Investment Plan (CIP)
- ❖ Supporting the Annual YHP Meeting under the local authority leadership
- ❖ ToGoH also supported Youth Camps, home visits for follow-up

These activities were an essential part of creating the necessary environment to reach youth population where they feel safe and self assured of the supportive environment to seek services and network with their peer groups.

### Number of Youth Peer Educators Trained by Year



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

## 2. Youth Centers

RHAC created Youth Centers in most of its clinic sites as well as in selected district town near public health centers. Each Youth Center was designed to be a “youth space”, where young people can spend time using the library and karaoke facilities as well as accessing youth-friendly counseling and clinical services. RHAC hosted a total of 20 Youth Centers in 6 provinces. The Youth Centers at the community level are important for rural youths who want and need information on sexual and reproductive health. Moreover, it is a forum for them to discuss and seek accurate information for improving the quality of their health and lives, as well as a forum for fun and peer networking. PEs were available for one-on-one discussions on a range of youth related health issues.



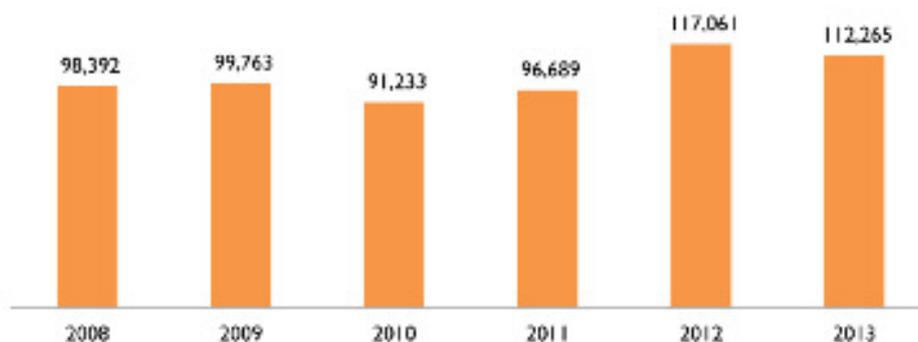
Youth friendly service in action at RHAC Clinic

### Number of Youth Received Health Education by Year



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

### Number of Young People Received Clinical Youth Friendly Services

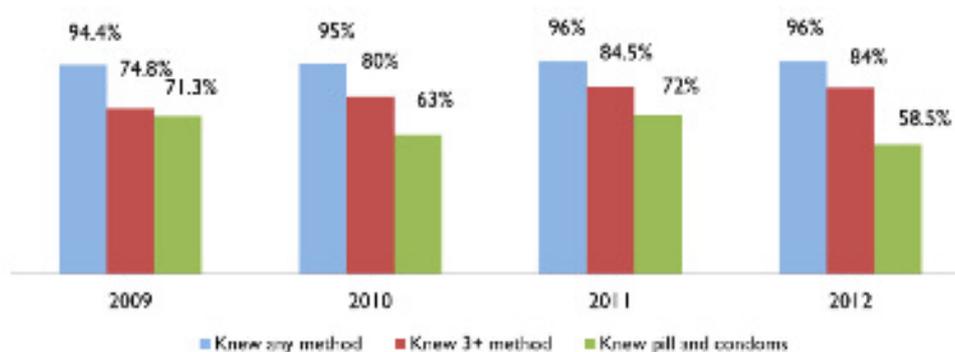


Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

### 3. Involving Stakeholders and Creating an Enabling Environment

To create a supportive environment for young people, RHAC established collaborative relationships with community stakeholders, including teachers, parents, village chiefs, Commune Council members and district authorities, through stakeholder orientation meetings at the beginning of each project cycle. The purpose of these meetings was to educate stakeholders about sexual and reproductive health needs of young people and to seek their feedback and support for the planned project activities. At the end of each year, the project organized annual review meetings with all the stakeholders at the provincial level to review the performance of the project, share experiences and challenges and find solution to addressing the challenges and to develop next year's action plans.

#### Trend of Knowledge about Family Planning Methods among Young People

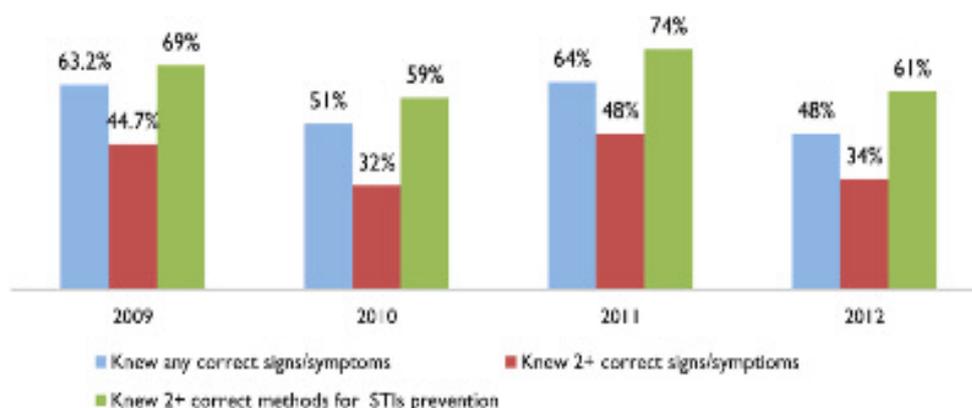


Source: Monitoring and Evaluation Survey, RHAC's Youth Health Program

#### 4. Referral and Follow up for Young People

RHAC had many years of experience in implementing effective and appropriate youth friendly services at all youth health program sites, including government Health Centers and RHAC clinics. To increase the accessibility of young people to the services, the Youth Health Program staff increased their attention to the referral of clients, through referral and follow up to ensure that each client received the services they needed.

**Trend of STI Knowledge among the Target Youth Population**

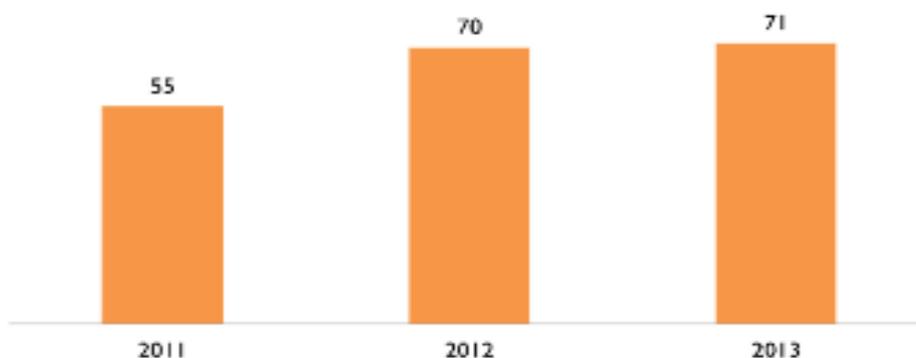


Source: Monitoring and Evaluation Survey, RHAC's Youth Health Program

#### 5. Youth Friendly Services

RHAC offered a full range of youth-friendly reproductive health services which included family planning, RTI/STI diagnosis and treatment, VCCT, emergency contraception, antenatal and postnatal care, rape victim care and support, premarital counseling and screening, Post-Abortion Care (PAC) and referral services. Youth friendly services were an integral part of all RHAC clinics where there were designated examination room and waiting areas for young people.

**Number of HCs Providing Youth Friendly Services Trained by RHAC/ToGoH**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report



# VI. Vulnerable Group Program (VGP)

The VG component implemented IEC/BCC activities on HIV/AIDS and reproductive health and family planning targeting vulnerable groups of entertainment workers, MSMs, factory workers, construction workers, and fishermen.

## Vulnerable Group Program Coverage Areas under ToGoH

Project Locations	Target Groups	# of Companies/Sites /Establishments	# of Target Groups
<b>Preah Sihanouk</b>	Construction Workers	3	1,035
	Fishermen	3	4,647
	Factory Workers	9	11,027
	MSMs	-	330
<b>Svay Reang</b>	Entertainment Workers	48	3,349
<b>Riem Reap</b>	Construction Workers	13	1,481
	Fishermen	2	5,199
	MSMs	-	1,000
<b>Battambang</b>	MSMs	-	2,304
<b>Total</b>	Construction Companies	16	2,516
	Factory Workers	9	9,846
	Entertainment Workers	48	12,027
	Fishermen	5	2,634
	MSMs	-	3,634
	Total Workers/Target Groups		30,657

Similar to the Youth Health Program, the BCC activities followed RHAC's BCC strategic framework, which focuses on four pillars of strategic intervention as depicted earlier: increasing knowledge /information, making services or products available, referral and follow up of access to services and establishing enabling environment.

RHAC's primary aim was to provide knowledge and information among these vulnerable groups by raising awareness of risks associated with HIV/AIDS and STD, benefits of family planning, the importance of consistent condom use and its dual protective value, dangers of illicit drug use, and other related health issues. RHAC used peer education approach to achieve its goals and objectives.



Project staff conducting Group Discussion with Casino workers

The PEs referred their peers for VCCT services as well as for other sexual and reproductive health services to RHAC clinics or government health facilities. With the assistance from PEs, RHAC also arranged transportation for those who could not afford to pay to go to RHAC clinics. For example, in 2012, 15,284 migrant workers were referred to RHAC clinics for various services including 5,482 cases who received VCCT service and 5,373 cases received STI services, and the rest received other reproductive health and family planning services. RHAC collaborates with other partners for referral of vulnerable groups especially entertainment workers and MSM to receive clinical services at our clinics.

RHAC clinic staff and outreach program staff have been trained to understand MSM behavior and their health needs and to provide appropriate counseling and clinical services according to their needs. RHAC also provided training to MSM peer educators from other NGOs to increase their knowledge in referring MSM for counseling and clinical services. The clinic team organized regular interactive workshop between clinic providers/MSM counselors and MSM Peer Educators to allow opportunity for them to exchange their view, expose MSM to clinic environment and strengthen relationship with providers of the clinic in order to increase access to clinical services by MSM.



MSMs in the privacy-enhanced waiting room at a RHAC clinic for STI testing



Group discussion with construction workers at construction site

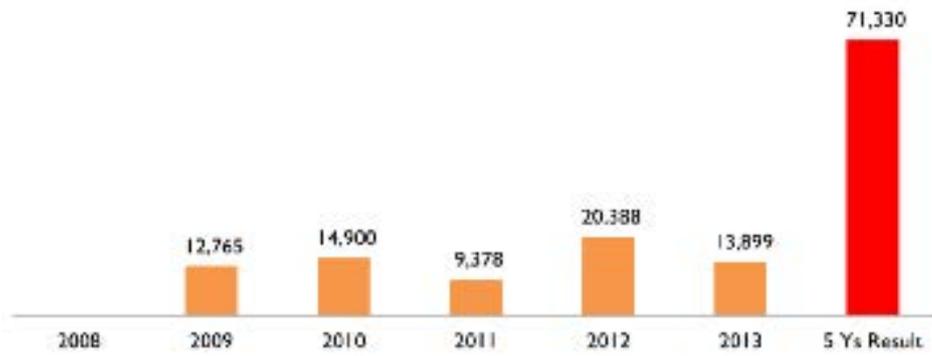
The following graphs show the reach of the services for the Vulnerable Group populations under the ToGoH project.

**Total Peer Educators Trained by Year**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

### Number of VG Reached by Year



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report



Group discussion with entertainment workers at beer garden/restaurant



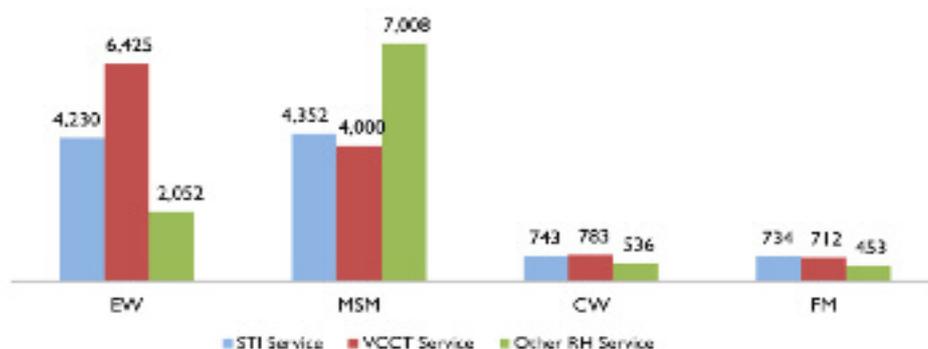
Group discussion with fishermen at fishing site



# VII. Workplace Health Program (WHP)

RHAC, over the years, developed good working relationship with the management and staff in more than 50 factories in Phnom Penh, Kampong Cham, Kampong Speu, and Preah Sihanouk Ville, which covered more than 100,000 factory workers. We used this working relationship to promote the use of clinic services among factory workers. In each factory where we work with, our work included promoting healthy behavior through interpersonal communication (peer educators), group discussions, stage performance, and distribution of IEC materials. The program promoted health service utilization at RHAC clinics and Health Centers through referral systems and vouchers.

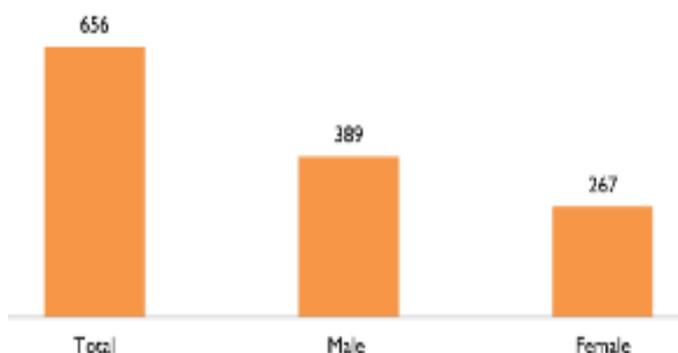
**Service-Specific Referrals to RHAC Clinics**



Source: RHAC Database, Monitoring & Evaluation Unit, Routine Monthly Report

RHAC had worked with the National Social Security Fund (NSSF) to promote injury scheme among the workers, e.g. raise awareness about the scheme; and participated with NSSF to discuss issues related to health insurance. RHAC explored insurance options with NSSF as one of the mechanisms to address financial barriers faced by the factory workers in using RHAC’s clinic services. RHAC’s workplace-based program is supported by USAID, European Commission (EC), and Marks and Spencer through Project Hope.

**Number of Workplace Health Peer Educators Trained under the ToGoH Project**



Factory workers attending education session



## VIII. Lessons Learned

In this section, we attempted to capture some of the important lessons we learned in the course of the five year USAID-ToGoH implementation in working closely with our counterparts with the Ministry of Health, particularly at the periphery level. Our work with the Provincial Health Departments, Operational Districts, Health Centers, local authorities especially the Commune Council/CCWC, and especially with communities at the village level provided many useful lessons which we tried to employ in strengthening health service delivery at the community level.

**Capacity building is long term and need to realize the fundamentally weak health sector – skills, resources, and political support – all weak in the health sector:** The long term sustainability of the health sector is an aspiration all in the development community seek out but the actual attainment of sustainability is long way off, principally due to lack of government resources and fragile health governance. Donor agencies and the implementing partners need to be realistic and appreciate the long-term nature of capacity building of competencies, skills, systems and the leadership and political will of Cambodian institutions, including the Ministry of Health. A longer term perspective of health sector strengthening will help to attain better focus rather than single-minded focus in achieving time-bound numerical targets.

**Inclusion and building bridges imperative:** As a project with a focus on improving and strengthening the performance of the public sector, we learned early on that it is vital that all the players are included, their support and participation is sought early on at the very planning stages. Depending on the nature of the activity, there may be relatively broad briefing and consultation at the higher level to inform them of the general thrust of the project and seek their “blessing” for the project. By and large, extensive consultations are needed in areas where implementation and its outcome hinges on the participation and support of the government counterparts. In such instances, it is imperative that local government counterparts are brought into the picture from the very initial stages of planning, sharing information in a transparent manner and clearly state the expectations and the mutual interest the project serves.

As important as reaching to the government counterparts across the sector, it is equally important to reach out to community based organizations and other development partners in the coverage area. Clear articulation of the project for better understanding of the project’s purpose, its implementation strategies, coverage areas et al helps to minimize unnecessary misunderstanding and reduce the sense of competition which is certainly unwanted in the development context.

Appropriate early briefings, consultations with all the players proved to be helpful in building good working relationships in the course of implementation. It certainly pays in the long run in building bridges for mutual benefit in achieving results, building public sector performance and eventually making impact in improving community health.

**Governance is fundamental to spur public action and engender accountability:** Though the ToGoH interventions were focused primarily in achieving specific health outcomes, it is abundantly clear that good governance in health is fundamental to attain long term sustainability. If there is no leadership with a sense of responsibility and accountability in improving community health, it is very difficult to carry out any meaningful activities that will have any long term impact in community health. As such, it is critical that there is greater attention and focus in improving some of the key elements of good governance in health. We found in the course of implementation that relatively simple improvement in governance practices such as the idea that elected/selected community leaders have responsibilities to care for community health by way of understanding basic community health issues, learning to do basic planning and budgeting with right “leaders” has produced tangible results such as CIP allocation for health activities, holding community forums to seek community feedback etc.

**Partnership needs to recognize self-interest and support from all:** In working with government counterparts where it is vital to form effective partnership for implementation, it is critical to understand their interest in the activity or project. Simply put, we need to address the question, “What is in it for me?”, i.e. why the Health Center will collaborate with an NGO partner which will involve time of the HC staff etc. Often it helps to understand the self-interest of the HC such as generating more income by improving service quality and creating demand for services from the community, helping them to meet service outputs demanded of them by OD, PHD, MoH et al etc. Through sustained dialogue and educating the HC staff of the benefits of the activity for the HC, partnership formation becomes much more productive and interventions tend to be much more sustainable.

**Orders from higher ups do not work unless there is genuine interest at the bottom:** While it is important to have the support of higher authorities for project activities, it is critical to have genuine interest of local authorities and Health Center staff at the lower level for the implementation to be effective. Simply having orders from the higher level authorities for activities to be implemented at the periphery level seldom works unless we can generate genuine interest and buy-in by counterparts at the lower level. It is wrong to assume that one can be effective in implementing activities at the ground level with strong support of higher authorities because there simply is no mechanism and leverage to ensure that folks on the ground will carry out what has been ordered from the top. As such, finding creative ways to generate genuine interest of people on the ground is imperative for effective implementation of community based health services.

**Staff capacity and understanding vital to have a development approach:** It goes without saying that for the technical assistance work we do with our counterparts to be effective and meaningful, the skills and knowledge of RHAC staff working with our counterparts has to be at the highest level. While RHAC staff competencies are on par with the best available in the business, we learned over the years that it is critical to have well planned and consistent periodic in-house review and training of the staff to ensure that their skills and knowledge are kept with the state of the art practices. More importantly, it is critical for the staff to be attuned with specific activities and approaches relevant to the specific intervention and not to have a cutter box approach. We learned that periodic and planned review of our approaches, strategies and activities with staff pays off in making the interventions effective and achieving more robust results in the end.

***Do not focus on task but focus on development:*** Often we are driven by getting the specific task done, especially with such a large and diverse portfolio like the ToGoH project and often lose sight of the development outcome. In the nature of the things we have to do, focus on getting specific task accomplished is unavoidable in meeting planned annual, quarterly and monthly work plans, it helps a great deal in reminding the staff the importance of focusing on development outcomes as a long term vision. Encouraging staff to focus on development perspectives also strengthens the staff's capacity in gaining better understanding of the development work in general.

***Donor advocacy for genuine government commitment critical:*** Health sector suffers from lack of Royal Cambodian Government woeful budget allocation. It is fair to say that health and the social sector in general is a low priority in the government budget allocation. While NGOs can and do vigorous advocacy for resource allocation at the periphery level, the overall pie is so small that there is not much that can be done to enlarge the overall resource base for the health sector. Vigorous and persistent pressure and advocacy by large and influential donors such as USAID is critical at the highest levels of Cambodian leadership to substantial increase real flow of resources into the health sector.

# IX.

## Conclusions/Key Accomplishments

This section will look at the broader picture of the five year effort and provide a summary of general conclusions, accomplishments and larger lessons we learned. We are taking a broad stroke in reflection of the overall project's activities for the past five years. We purposely did not dwell on the minute details of each intervention as they have been amply documented in all the semi and annual reports. Here we will attempt to tease out the take away points based on our overall activities and experiences

**Met all the indicators and achievements within the budget:** Given mandate and obligations under the Cooperative, first measurement of the ToGoH success is the obvious question: did ToGoH achieved all its objectives which is reflected in the set of indicators? Based on the evidence as amply demonstrated through this report, we are happy and proud to state that the RHAC's implementation of the ToGoH project resulted in achieving all its objectives within the allocated and sanctioned budget as approved by USAID in the September 2008 Cooperative Agreement. All the indicators achieved its target milestones and often it exceeded the targets. Approved annual work plans along with approved budget were successfully implemented in the past five years.

**Improved health sector performance in coverage areas:** The technical assistance nature and the focus areas of the ToGoH project essentially involved improving the various elements of the health sector as a whole in order to see sustainability outcomes that results improved availability, delivery and access to basic health services for communities. In order to attain better quality of services, health sector's performance has to improve in the overall scheme of the health systems. We believe the health sector performance in the ToGoH/RHAC areas has improved significantly. Such improvement in performance is reflected in our observation of greater leadership responsibility by public sector actors, huge increase in the number of clients using Health Center services, improved health service indicators across the board such as ANC, delivery, immunization coverage, improved knowledge of health issues by communities' et al.

**Strengthened skills and performance of public sector providers:** Reflective of the significant changes and improvements in key health indicators is the fact that ToGoH put major focus in improving the technical skills and performance of the public providers such as Midwives, nurses, program managers in the provision of basic health services. Aside from expanding the availability of services and improving access to these basic services, we put persistent focus on the quality of services in the entire service delivery chain from planning to specific technical areas. When we compare the baseline data, for example in just one technical area of, say Partograph, we see significant improvement after ToGoH's training and technical assistance provision.

It was a given assumption that the skills of the public sector providers were woefully low in all areas of health services. One of the key challenges in improving the overall health sector performance was to significantly strengthen the skills of the service providers. The USAID-ToGoH and RHAC's five year effort has yielded major improvements in the skills and performance of the public sector health service providers which we believe has much greater chance of sustainability, albeit the need for continued input and on-going follow-up with further technical support.

**Improved governance with CC budget commitments:** Prior to the RHAC-ToGoH interventions in our coverage areas, provision of health services was at the whim and convenience of the government staff. Communities perceived health services as a “special favor” done by the government and not as an obligation by the government to serve the communities. The basic principles of government responsibility and accountability were seldom understood by communities and providers. Local authorities such as Commune Council barely had any voice in the provision of health services and nor did they understand their responsibility in the rights of communities to receive basic health services.

Under the USAID ToGoH project, RHAC began to work with local authorities on key elements of good governance in health principles, particularly with the Commune Councils (CCs). Given the low capacity level of local authorities, both in the technical areas of basic health services as well as their role and responsibilities in good governance for communities, we extended substantial efforts in building the capacity of local authorities. Our activities included teaching the CC members in basic planning process, key community health needs, budget planning processes, accountability principles et al. Several practical steps were taken such as having suggestion boxes at Health Centers (HCs), hosting community forums for exchange, feedback between the CC/HC authorities and communities, development of follow-up mechanisms to resolve and address community feedback and issues emerging from the Health Center Management Committee (HCMC) et al.

Based on our interventions in good governance in health, there has been substantial progress in the role of the CCs health activities. For example, many CCs have committed and made specific budget provisions from the Commune Investment Fund for community health activities such as the meeting expenses for the bi-monthly meeting of VHSGs, youth health activities, community outreach for Vitamin A distribution events et al.

Overall, there has been remarkable progress in the acceptance of the health agenda by local authorities. CCs are much better informed about the importance of community health and their responsibility to support health services. Many CCs in our coverage areas have been receptive in allocating CCs own resources in supporting health activities. We believe that with further strengthening of the capacities of the local authorities and with anticipated further maturation of the local authority institutions under the on-going de-concentration and de-centralization initiative of the government, the prospect and the potential of sustained engagement of the local authorities in health activities at the community level is truly promising.

**Better understanding of health by communities with intensive IEC outreach:** There is no doubt that communities in our coverage areas are much better informed about their health than in non-RHAC areas. Successive RHAC annual surveys and other routine service data we collect reflects greater knowledge and awareness of preventive health issues among communities we have been working with under the USAID-ToGoH project. Reaching the communities with BCC/IEC activities have been a long standing activity of RHAC, especially in persistent capacity building of Village Health Support Group (VHSG) volunteers who are in the forefront of providing IEC services directly to community people. Though the eventual outcome preventive health interventions such as family planning services seeks to change behavior of clients which should result in desired health practices, in poor low literate communities, it is vital that persistent health education activities are undertaken to raise awareness and improve community's knowledge of health and actions they can take to improve their health.

**Finally better health status in coverage areas:** As shown amply in this report, the overall health status of women and children in our coverage areas has seen significant improvement as a result of the USAID-ToGoH project interventions. Health service utilization of government facilities have increased, immunization coverage has improved, family planning usage has increased, more effective referral of emergency obstetric care has saved women's lives and greater understanding and accountability by local authorities in health issues have been engendered. We believe the overall improvement in the health systems service delivery accounted for part of the improvement in the health status in the USAID-ToGoH project areas.

**Summary Table of ToGoH's 5 Year Achievements for Key Indicators**

No.	Objectively Verifiable indicators	Baseline	Data Sources	ToGoH Five Year Targets	ToGoH Five Year Achievement	Data Sources
1	% married women using a modern method of FP	27%	DHS 2005	35%	44%	RHAC Survey 2013
2	% ANC clients tested for HIV and received results	n/a	PMTCT Report	90%	96%	RHAC Survey 2014
3	% men & women of reproductive age tested for HIV	n/a		30%	Indicator was removed	
4	% HIV+ women using a modern form of FP	n/a	RHAC Database	50%	14%	Clinic Report
5	Number of known HIV+ pregnant women who received ARV prophylaxis	n/a	RHAC Annual Report	960	17500%	RHAC Routine Report
6	% males 20 – 24 year old reporting high risk sex	31%,	CDHS, 2005	20%	20%	Youth Evaluation 2011
7	% sexually active unmarried males 20-24 years reporting condom use with last partner	90%	RHAC Survey	95%	89%	Youth Evaluation 2011
8	% deliveries preceded by >4 ANC visits	27%	DHS, 2005	60%	80%	RHAC Survey 2013
9	% births attended by a trained providers	44%	DHS, 2005	75%	92%	RHAC Survey 2013
10	% children aged 0-5 months exclusively breastfed	60%	DHS, 2005	65%	65%	RHAC Survey 2013
11	% births received PNC/new-born care within 24 hours	44%	DHS, 2005	70%	84%	RHAC Survey 2013
12	% births with BF initiated within 1 hour of delivery	35%	DHS 2005	60%	80%	RHAC Survey 2013
13	% children with diarrhea treated with ORT and zinc	2.5%	RHAC Survey 2010	70%	27%	RHAC Survey 2013
14	% children aged 12-23 months fully immunized	80%,	RHAC Survey 2008	80%	85%	RHAC Survey 2013
15	TB Case Detection Rate	69%	RHAC Annual Report	70%	62%	RHAC Annual Report
16	% of children who received Vitamin A	35%	CDHS, 2005	85%	81%	RHAC Survey 2013

The Reproductive Health Association of Cambodia (RHAC) is an indigenous Cambodian non-governmental organization (NGO), which was established in 1996 with a strong determination to bring quality health services to the community, especially for the poor and vulnerable sections of the population. RHAC is an active collaborating partner and works closely with the Ministry of Health in supporting its Health Centers to improve quality, access and utilization of services. RHAC has a network of 15 non-profit clinics that provide a full range of quality services in sexual and reproductive health.

RHAC has been implementing the Together for Good Health (ToGoH), a five year Cooperative Agreement awarded by the United States Agency for International Development (USAID)/Cambodia, for the past five years. The implementation of the ToGoH project by RHAC began on October 1, 2008 and ended on September 30, 2013 with a six month cost extension at a reduced level of effort until March 31, 2014. The project covered 9 Provinces, 31 Operational Districts, and 435 Health Centers, with a total population of 6.5 million.

ToGoH's agenda was substantial in terms of size and scope of its activities. It is a fairly comprehensive public health program which include a wide range of technical areas such as maternal, newborn and child health, reproductive health, family planning, nutrition/micronutrient, HIV/AIDS, TB, health systems strengthening, capacity building, health governance as well as population specific focus on youth groups, garment factory workers, vulnerable groups such as men who have sex with men, fishermen, young entertainment workers et al.

