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MIDTERM EVALUATION OF USAID HEALTH PROJECT AND IMPLEMENTATION ACTIVITIES IN CAMBODIA

August 2016

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by William Jansen, Deborah Thomas, Srey Mony, Pam Putney, Ros Bandeth, Nhu-An Tran and Mao Bunsoth.

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Cover Photo by: Mr. Yong Lyheng, Nurse at Snam Preah Health Center, Operational District, Pursat Province

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ANNEXES

FIGURES

ACRONYMS

BCC	Behavior change communication
CAF	Community accountability facilitator
CBD	Community-based distribution
CC	Commune Council
CCWC	Commune Committee for Women and Children
CDHS	Cambodia Demographic and Health Survey
C-DOT	Community directly observed treatment
CENAT	National Center for Tuberculosis
CIP	Commune investment plan
CPG	Clinical practice guidelines
CMHEF	Community-Managed Health Equity Fund
CSO	Civil society organization
D&D	Deconcentration and decentralization
DPHI	Department of Planning and Health Information (MOH)
ECH	Empowering Communities for Health
FHI 360	Family Health International 360
GH Pro	Global Health Program Cycle Improvement Project
HCMC	Health Center Management Committee
HCQI	Health Center Quality Improvement
HEF	Health Equity Fund
H-EQIP	Health Equity and Quality Improvement Program
HMIS	Health management information system
HSP3	Third Health Strategic Plan
HSSP2	Second Health Systems Strengthening Program
I-SAF	Implementation of Social Accountability Framework
IT	Information technology
IUD	Intrauterine device
LAPM	Long-acting and permanent method
M&E	Monitoring and evaluation
MCAT	Midwifery coordination alliance team
MCH	Maternal and child health
MEF	Ministry of Economy and Finance
MNCH	Maternal, newborn and child health

MNH	Maternal and newborn health
MOH	Ministry of Health
NCDD	National Committee for Democratic Development (sub-national)
NMCHC	National Maternal and Child Health Center
NOURISH	USAID-funded nutrition project launched in August 2014
PAE	Public Administrative Establishment/Entity
PCA	Purchase Certification Authority
PCAT	Pediatric coordination alliance team
P/DHFSC	Provincial/District Health Financing Steering Committee
PLHIV	People living with HIV
PMRS	Patient Management and Registration System
PNC	Postnatal care
QHS	Quality Health Services
RACHA	Reproductive and Child Health Alliance
RCRS	RACHA Central Reporting System
RGC	Royal Government of Cambodia
SHP	Social Health Protection
TB	Tuberculosis
TBC	Targeted Benefit Contracts
URC	University Research Company
USAID	United States Agency for International Development
VHSG	Village Health Support Group
WHO	World Health Organization

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND QUESTIONS

The purpose of this evaluation was two-fold: (1) to identify lessons learned from USAID/Cambodia's current health office portfolio and inform the future portfolio currently in design, given the Ministry of Health's (MOH) strategic direction; and (2) to measure the progress of specific activities on their performance, namely: Quality Health Services (QHS), Empowering Communities for Health (ECH), and Social Health Protection (SHP), and identify the potential synergies among these activities to improve outcomes for the health project.

The questions that the evaluation addressed are grouped in four categories (listed with the findings). Three of the four categories have specific questions related to each of the three separate implementation mechanisms. The fourth (for the health portfolio) has questions relevant to issues above the level of individual mechanisms and that pertain to USAID/Cambodia's future assistance planning for the health sector.

PROJECT BACKGROUND

The mechanisms that are the focus of this evaluation are working to achieve improvements in three of the main building blocks of a better health care system in Cambodia: (1) quality health services that are widely available; (2) sufficient community-level participation and support; and (3) reduction of financial barriers to health care. For example, the QHS mechanism works to improve basic neonatal health competences related to the major causes of newborn mortality at all levels in the public sector. The ECH mechanism is working to build the capacity of Commune Councils (CC) to manage and support the health system functions delegated to communities in Cambodia. Implementation activities within the SHP mechanism are assisting the Royal Government of Cambodia (RGC) to expand the coverage of the health equity fund (HEF) so that more poor individuals can access health care services. SHP implementation helps to ensure the quality and efficiency of HEF operations and provides international technical assistance to various parts of the RGC as it institutionalizes and scales up the HEF.

EVALUATION DESIGN AND METHODS

The evaluation team's approach facilitated the pursuit of specific information relevant to the scope-of-work questions for each mechanism while also providing sufficient information to answer the broader, crosscutting questions related to development assistance to the health sector. The evaluators used a variety of data collection methods that yielded both qualitative and quantitative data. These included key informant and focus group interviews and reviews of existing data sets and documents. The use of focus groups was largely limited to the community or health facility level. The combination of these information-gathering methods allowed a consistent triangulation of quantitative and qualitative data, which helped ensure that findings were drawn from quality data and facilitated the identification of patterns or trends.

Choices of sampling techniques largely applied to the selection of geographic areas or specific sites within the three focus provinces for the evaluation. After reviewing information on the three mechanisms' implementation locations, the team adopted a purposive sampling approach, which was better suited to the evaluation parameters and could generate sufficient information to answer the evaluation questions. Since the focus of the evaluation was on three provinces, the selection of geographic areas within those provinces to visit was done with a view to those locations where implementation efforts are or have been active.

FINDINGS AND CONCLUSIONS

Health portfolio

Question 1: How can QHS, ECH and SHP interventions that are being implemented in the same target areas reduce potential overlap and develop synergies and align better to improve the quality of health services and health outcomes that are targeted by the USAID/Cambodia health project?

Although each mechanism had been implementing activities in some of the same provinces, the evaluation found no areas of current overlap between them. Key reasons for the absence of overlap include the fact that each mechanism is addressing different causal factors for improvements in health care, and the mechanisms' complementary design. Opportunities for increased synergies between the mechanisms include: all three (through their respective implementing partners) working collectively on aspects of health client satisfaction; SHP and ECH collaborating for HEF accountability at the CC level to build capacity to create demand for quality health services; and SHP and ECH jointly addressing the funding of transportation from remote areas to referral sites for emergency or urgent health care cases.

Question 2: What are the potential milestones for the USAID/Cambodia health portfolio to transition from discrete activity implementation/projects to more consolidated mechanisms with other donors (such as a World Bank single-donor trust fund or other consolidated mechanisms) that would improve health quality and the financial sustainability of the MOH?

As USAID/Cambodia considers options for future health sector assistance formats, consolidated mechanisms with other donors may offer some advantages or increased efficiencies. Most of the three mechanisms' activities potentially could be undertaken through a single, consolidated funding source (such as a multi-donor trust fund). Within a consolidated funding mechanism, performance-based financing options may offer advantages for incentivizing the achievement of specific intermediate implementation goals that are identified as being critical to overall progress. Consolidated, multi-donor funding also provides an opportunity for the participating donors to collectively address health sector issues in a united and coordinated manner. Nevertheless, even if more consolidated funding mechanisms are pursued, USAID/Cambodia may still need to consider separately funding technical assistance deemed important for the overall success of jointly funded efforts. Possible milestones in any transition from discrete activities to consolidated mechanisms include: assessing the merits of consolidation (which may not always be the best option); exploring mechanism options (different consolidation formats exist); developing common sets of indicators and complementary targets for use across all activities (indicators and targets could be mapped across a range of intervention areas to show where complementarities exist and where a consolidated approach would be advantageous); building upon the existing experience base; and exploring and defining appropriate roles for civil society in support of decentralization, quality assurance and accountability in the health sector.

Question 3: What are the potential challenges and opportunities for USAID/Cambodia's health portfolio, given current RGC strategic direction in its third Health Strategic Plan (HSP3)?

The strategic direction of Cambodia's health sector is affected not only by the HSP3 but also by the establishment of the national social health protection system and the deconcentration and decentralization (D&D) initiative. All three will continue to affect strategic directions in the health sector and the following challenges and opportunities:

Challenge 1–The process of decentralizing government functions involves a number of ministries and is multisectoral, affecting more than health services.

Challenge 2–Decentralization in Cambodia is an ongoing process that is still being defined and will take several years, changing further over time.

Challenge 3–The transformation of the relationships between health service delivery and health financing systems could take 10 or more years and contain changes in direction.

Challenge 4–The absence within the HSP3 of a clear and detailed approach to promoting optimal health care behaviors and addressing non-clinic-based issues affecting the demand for and use of health services creates challenges for applying consistent approaches for reaching or serving potential health clients well.

Opportunity 1–Recent development assistance experience within the health sector has generated a wealth of information about interventions that yield positive changes in the country, which can help improve designs for future assistance.

Opportunity 2–Lessons learned and best practices identified within USAID/Cambodia's portfolio of health sector assistance mechanisms can be transferred and applied within new mechanisms that provide support for the HSP3 in the future.

Opportunity 3–With decentralization still evolving, donors can help define how the overall process may unfold and affect health care.

Opportunity 4–Donors can help explore new funding avenues for expanding HEF coverage to additional vulnerable populations within the changing health financing arena.

Question 4: To what extent have QHS, ECH and SHP achieved their objectives and expected results at this time?

Given where the three mechanisms are in their implementation, all three are near to or exceeding the achievement of proportional life-of-project targets for most progress indicators. As of the end of March 2016, for example, QHS had completed about 45 percent of its implementation period and achieved more than 45 percent of total life-of-project targets for the majority of its indicators. At 30 percent of its implementation, ECH is nearing the achievement of 30 percent of life-of-project targets for several indicators and is exceeding 30 percent for a few others. At 47 percent of implementation, SHP has achieved more than 47 percent of its targets for most indicators. All three mechanisms, therefore, have the potential to achieve their objectives and expected results by the scheduled completion of implementation. Some are on track to exceed targets in several indicator areas.

QHS Mechanism

Question 5a: Which QHS components appear to be most effective to change health providers' services and practices and improve the quality of health services?

The three components implemented in combination that appear to be most effective are: on-site skills coaching and team building for coaching and clinical skills practice at health facilities; simple, inexpensive job aids and innovative tools for enhancing quality; and inputs to improve the provincial referral system.

Question 5b: What are strengths and weaknesses of QHS's team-based learning approaches, including team-based learning approaches meant to complement the MOH's in-service training strategies, and QHS's coaching and mentoring efforts?

No significant weaknesses were found in the learning approaches used by QHS. Strengths of its team-based and on-site approaches include: Training and materials used are high-quality, and the topics meet providers' needs (life-saving skills, competency based); all trainings are conducted as or systematically followed up with on-site skills building and coaching, which reinforces new knowledge, skills and best practices. When staff turnover occurs or new staff arrive, they are oriented by MOH trainers and other facility staff who have been supported by QHS.

Question 5c: Are the current monitoring tools and systems sufficient for measuring activity results?

QHS has developed and implemented a comprehensive set of monitoring tools and systems to measure activity results. Most of its monitoring indicators are based on the latest internationally recognized standards for measuring service effectiveness and quality. QHS also uses an effective technique to measure the quality of services at facilities (a composite checklist applied and scored by quality assurance teams composed of health personnel). These systems and tools measure both implementation progress and the achievement of results. Also, checklist scores for a health facility can improve or decline over time, prompting opportunities for management intervention for quality assurance. Data generated by these systems are used in implementation management, contributing to QHS' ability to achieve its objectives and expected results.

ECH Mechanism

Question 6a: Are the approaches of the behavior change campaign, including a comedy show and interpersonal communication, effective for disseminating messages to people? If not, why not?

ECH uses a variety of approaches to disseminate messages to communities, ranging from interpersonal communication and group announcements by community-based workers to awareness-raising at Comedy for Health shows. The approaches are effective in reaching substantial numbers of residents in the communities where activities occur, and the monitoring system uses recognized methods for estimating audience size for the shows. However, no data are available that indicate if audience members have actually changed their behaviors based upon the information received through the communication efforts.

The package of ECH behavior change communication (BCC) approaches is conceptually sound, but stronger coherence between them is required to achieve and demonstrate their effect on behaviors. Additionally, the Comedy for Health shows need to be shortened and include fewer, more focused messages on priority topics, with information booths added throughout the viewing area to provide information for specific audiences or target populations.

The use of Village Health Support Group (VHSG) members to disseminate information and mobilize village people is appropriate for the social and institutional Cambodian context and is the government-endorsed method of linking health centers with catchment populations and disseminating information. ECH support to VHSGs has multiple purposes: It strengthens their awareness-raising and behavior-change functions and participation in Health Center Management Committees and is part of the process of institutionalizing community health into CCs' responsibility. However, given their gender, age and tendency to be village leaders, there are limitations to the use of male VHSG members, and alternative methods need to be considered for disseminating messages that are at odds with their social position and gender, including reproductive health information for women and adolescent girls. The low compensation of VHSGs and other community-based volunteers (including community accountability facilitators) also leads to low motivation and high turnover.

The logic of how the various awareness-raising and behavior change activities connect, amplify and lead to changes in knowledge, attitudes and practices needs to be better articulated and to drive BCC programming. Therefore, it is recommended that a more coherent and mechanism-wide BCC strategy and plan be developed that includes monitoring of BCC processes and evaluation of behavior change outcomes; at the moment, this is a weakness in the evaluation framework. As part of this proposed planning process, the package of BCC health topics delivered by the mechanism needs to be reconsidered to fit good practice around the continuum of care, including adolescents' reproductive and sexual health, pre-pregnancy

nutrition, infant and young child feeding, and the practical realities of behavior change programming. Evidence-based methods that have demonstrated appropriateness in Cambodia or similar contexts and existing community platforms, such as women's saving groups and Wat grannies, need to be leveraged.

Question 6b: Are the current monitoring tools and systems sufficient for measuring the results of these project activities?

The ECH team has invested considerable effort in developing indicators that measure local governance of community health for which there are no standard global indicators. A new e-based monitoring information system has been introduced and generally appears to be working well. The monitoring and evaluation (M&E) team reports that it has improved data quality, timeliness and reliability. Overall, the monitoring tools and systems are sufficient for results measurement. However, further improvements are possible and include: reducing narrative reporting to lessen work burdens on field staff, amending a few current indicators (numbers 1 and 20), and adding some monitoring elements for capacity development of institutional change at the community level (such as the functionality and effectiveness of health center management committees).

SHP Mechanism

Question 7a: How do contextual changes in the political and socioeconomic environment in Cambodia affect the project in achieving its objectives?

The prospect of elections in Cambodia (for CCs in 2017 and Parliament in 2018) means no major policy decisions on social protection or universal health care are being made until after the elections and has slowed some aspects of implementation. In addition, the Ministry of Economics and Finance (MEF) is developing a comprehensive social protection framework that envisions a merging of all social health protection schemes under the National Social Security Fund at the Ministry of Labor. Uncertainty exists as to which ministry will take the lead in implementation of the social protection and universal health care strategy.

The transition from the donor pool-funded Second Health Systems Strengthening Program (HSSP2) to the new Health Equity and Quality Improvement Program (H-EQIP) has also resulted in some substantial changes regarding the operations of the HEF and how it will be governed in the longer term. Under the new H-EQIP agreement, the MOH is now expected to establish an independent Purchase Certification Authority (PCA) as a Public Administrative Establishment (PAE), to which the University Research Company (URC)/SHP would transfer its monitoring role. However, at the time of the evaluation team's visit, the date for PCA establishment had not yet been decided, and there is still some debate over where it should be located. The new H-EQIP also proposed a change of the HEF operator into an HEF promoter, with the health facility taking on the responsibility for distributing transportation reimbursements and caretaker food allowances, while the HEF promoter's primary role will be patient advocacy, awareness-raising and promotion.

Question 7b: How can the HEF monitoring system be institutionalized in a cost-effective manner?

The cost of the HEF monitoring function is estimated to be less than 6 percent of the overall system. Although there are no international or best-practice standards that are currently widely accepted, this cost ratio appears to be reasonable and could be absorbed by the PCA. To ensure that the cost expended for the HEF monitoring system will result in the same outcomes (i.e., fraud prevention, financial transparency and client protection), the institutionalization process should maintain the principle of third-party monitoring, ensure continuity in processes and staffing and build civic and community engagement to strengthen accountability.

Question 7c: What should be the future roles of SHP in the HEF expansion system and broader social health protection schemes?

SHP has played a critical role in HEF implementation to date. Continuing World Bank support for the HEF is counting on SHP for future contributions to the institutionalization and expansion of the HEF. Future SHP roles could include help to: (1) advocate for continued improvement in the quality and coverage of health care for all clients regardless of socioeconomic status, (2) increase the sustainability of health centers, (3) expand the use of the community-managed health equity fund (CMHEF) as a complementary structure for expanded social health protection, and (4) work with national programs to encourage the use of Targeted Benefit Contracts (TBCs) for better integration of potentially underserved populations (such as people living with HIV (PLHIV)).

CONCLUSIONS

The three mechanisms evaluated are contributing significantly to three of nine components in USAID/Cambodia's current health project: maternal, newborn and child health (MNCH) quality improvement; strengthening community health systems and CC capacity; and support to social health protection mechanisms. Overall, continued implementation within each mechanism, along the pathways defined, should allow achievement of objectives and expected results. A slow start-up of implementation and internal managerial issues have affected ECH's rate of progress. However, the pace of implementation is increasing, and revisions to certain management practices (described in Section IV B) can help improve managerial efficiencies.

A substantial implementation challenge facing all three mechanisms is the issue of inconsistent levels of per diems in use across mechanisms within the health sector. Resolving this issue fully is beyond the capacity of any one mechanism. The team recommends that implementing partners use a common system of per diems and that USAID/Cambodia, perhaps in concert with other donors, engage the MOH to present and explain a harmonized practice of per diem practices across all USAID-funded activities. A harmonized per diem system should address current disincentives for participating in activities at any level. Dialogue with the MOH over a unified per diem practice within USAID-funded mechanisms may also help build broader understanding of the administrative environment for in-country implementation.

OBSERVATIONS ON MULTI-MECHANISM EVALUATION

During the evaluation effort, the team explored appropriate methodologies for a combined-mechanism evaluation and learned about the nature of analysis that is possible when examining multiple distinct mechanisms at the same time. Combining multiple mechanisms into a single evaluation creates an analytical environment that elevates the possible level of analysis to a higher level of abstraction than that commonly found in an evaluation of a single mechanism. This characteristic facilitates the identification of cross-mechanism patterns or trends that can affect general assistance patterns to a given sector. Multiple-mechanism evaluations require more complicated evaluative methodologies, resulting in the need for increased upfront planning and may involve the development and use of a wider range of information-collection tools. Such evaluations are more labor intensive and require a broad range of subject-matter expertise. Potential limitations include reduction in the capacity to examine any one mechanism in depth or lessened methodological rigor in the analysis of issues or factors affecting a single mechanism.

I. INTRODUCTION

This midterm evaluation is different from many past evaluations in that it examines progress and what has been learned during the initial period of implementation in not a single activity, but rather in three complementary, but independently operated and distinct, implementation mechanisms that contribute to USAID/Cambodia's current health project (see the evaluation scope of work in Annex I). The health project has nine components; however, the evaluated mechanisms address only three of them: maternal, newborn and child health (MNCH) quality improvement; strengthening community health systems and Commune Council (CC) capacity; and support to social health protection mechanisms.

In addition to examining the status of implementation within each of the three different mechanisms, the evaluation looks across all three, at a higher level of abstraction, to explore what knowledge has been gained through implementation that can help with planning for new health sector assistance. With the Royal Government of Cambodia (RGC) finalizing the third *Health Strategic Plan* (HSP3) that covers 2016–2020, experience gained in the three activities can also help inform how future development assistance efforts can better support Cambodia's strategic directions for the health sector.

The evaluation team consisted of seven individuals: Dr. William Jansen, Ms. Pamela Putney, Ms. Ros Bandeth, Ms. Deborah Thomas, Dr. Srey Mony, Ms. Nhu-An Tran, and Dr. Bunsoth Mao. During May and June of 2016, the team conducted in-country evaluation work and data collection. To examine three distinct implementation mechanisms in a single evaluation exercise, the team developed an approach and information-collection tools that could assess individual mechanism progress as well as identify patterns or trends emerging across all three mechanisms.

Although the three mechanisms were active in a variety of provinces across the country, the evaluation examined field activities in only three: Battambang, Banteay Meanchey, and Siem Reap, as specified in the evaluation scope of work developed by USAID/Cambodia.

EVALUATION PURPOSE

The purpose of this evaluation was two-fold: (1) to identify lessons learned in USAID/Cambodia's current health office portfolio and inform the future portfolio currently in design, given the Ministry of Health's (MOH) strategic direction; and (2) to measure the progress of specific activities on their performance, namely: Quality Health Services (QHS), Empowering Communities for Health (ECH) and Social Health Protection (SHP), and identify the potential synergies among these activities to improve outcomes for the health project.

The findings, conclusions and recommendations of this midterm evaluation, therefore, can be used to inform future plans and portfolio designs for assisting the health sector. They also offer possible opportunities for adjustments in the efforts of current health project activities.

EVALUATION QUESTIONS

The evaluation questions are grouped in four categories. Three of the four have questions related to each of the three separate implementation mechanisms. The fourth (for the health portfolio) has questions relevant to issues above the level of any one of the three mechanisms and that pertain to future assistance planning for the health sector.

HEALTH PORTFOLIO

Question 1: How can QHS, ECH and SHP interventions that are being implemented in the same target areas reduce potential overlap and develop synergies and align better to improve the quality of health services and health outcomes targeted by the USAID/Cambodia health project?

Question 2: What are the potential milestones for the USAID/Cambodia health portfolio to transition from discrete activity implementation/projects to more consolidated mechanisms with other donors (such as a World Bank single-donor trust fund or other consolidated mechanisms) that would improve health quality and the financial sustainability of the MOH?

Question 3: What are the potential challenges and opportunities for the USAID/Cambodia health portfolio, given the RGC's current strategic direction in HSP3?

Question 4: To what extent have QHS, ECH and SHP achieved their objectives and expected results at this time?

QHS

Question 5a: Which QHS components appear to be most effective to change health providers' services and practices and improve the quality of health services?

Question 5b: What are strengths and weaknesses of QHS's team-based learning approaches, including those meant to complement the MOH's in-service training strategies, and QHS's coaching and mentoring efforts?

Question 5c: Are the current monitoring tools and systems sufficient for measuring activity results?

ECH

Question 6a: Are the various approaches of the behavior change campaign, including a comedy show and interpersonal communication, effective for disseminating messages to people? If not, why not?

Question 6b: Are the current monitoring tools and systems sufficient for measuring the results of these project activities?

SHP

Question 7a: How do contextual changes in the political and socioeconomic environment in Cambodia affect the project in achieving its objectives?

Question 7b: How can the HEF monitoring system be institutionalized in a cost-effective manner?

Question 7c: What should be the future roles of SHP in the HEF expansion system and broader social health protection schemes?

II. PROJECT BACKGROUND

Although Cambodia has made substantial progress in improving health outcomes in recent years, the country still has maternal and child mortality rates that are among the highest in the region. Cambodian women and children continue to die each year from preventable and treatable causes, including pneumonia, diarrhea and labor complications. To meet these and other challenges, the public health system has expanded rapidly in recent years. However, limited skills of health providers and limited institutional capacity contribute to fragmented and insufficient service delivery in some areas. Many Cambodians prefer to seek care in the private sector, although quality is questionable and private practices are not routinely regulated.

The RGC has demonstrated significant commitment to realizing improvements in the health sector and has set goals for better health care. Health financing, however, remains problematic; public health funding flows are uneven and difficult to track. This situation contributes to significant geographic variations in the accessibility and quality of services. Consequently, health financing reforms are at the center of efforts to strengthen and extend the health system.

In addition, Cambodia has embarked upon a program of government decentralization and deconcentration (D&D) that is affecting the role of sub-national and local administrative authorities in health services and government-provided health care. D&D reforms are also influencing how resources and administrative responsibilities are applied to the activities of Village Health Support Groups (VHSG), an important community resource for local health initiatives. While MOH managers have a voice on provincial and district councils, sub-national and local administrative bodies (which include locally elected officials) will have an increasing decision-making role in how public sector health services are offered in communities. Therefore, the capacity of local administrative bodies to play this new role needs strengthening.

The mechanisms that are the focus of this evaluation are working to achieve improvements in three of the main building blocks of a better health care system in Cambodia: (1) quality health services that are widely available, (2) sufficient community-level participation and support, and (3) adequate financing systems for health care.

The QHS mechanism works to improve basic neonatal health competencies at all levels of the public sector related to the major causes of newborn mortality. Implementation is oriented to reducing maternal mortality and improved newborn and child outcomes during the critical first 1,000 days of life. Another element of QHS is strengthening the provision of a full range of family planning services.

The ECH mechanism is working to build the capacity of CCs to manage and support the health system functions delegated to communities. ECH supports community agents to promote appropriate home health and nutrition behaviors, optimal health care-seeking, and improving community-based provision of tuberculosis (TB) treatment and contraceptive services. Additionally, it is working to improve community awareness of the rights of health care consumers (as set forth in the MOH's *Client Rights Charter*), strengthen social accountability and assist CCs to fully exert the health care stewardship role envisioned for them in the MOH's *Guidelines for Operational Districts*.

In support of health care financing systems, activities within the SHP mechanism are assisting the RGC to expand the coverage of the health equity fund (HEF) so that more poor individuals are able to access health services. SHP helps to ensure the quality and efficiency of HEF operations and provides international technical assistance to various parts of the RGC as it institutionalizes and scales up the HEF. In doing so, the mechanism is designed to facilitate the development of a broader system of social health protection within the country.

III. EVALUATION METHODS AND LIMITATIONS

EVALUATION APPROACH

In the development of an appropriate evaluation protocol and data collection tools, the evaluation team considered a range of possible approaches and methods to select those that could be best aligned to the evaluation purpose and questions. Among the design factors facing the team in developing the details of an effective information-gathering approach was choosing between greater geographic coverage with less detailed probing or less geographic coverage with more in-depth probing from any single data source or site.

The approach selected by the team facilitated the pursuit of mechanism-specific information relevant to the questions for each mechanism while also providing sufficient information to answer the broader, crosscutting questions related to health sector development assistance. The evaluation used a variety of qualitative and quantitative data collection methods. These included key informant and focus group interviews and reviews of existing data sets and documents. The use of focus groups was largely limited to the community or health facility levels. The combination of these information-gathering methods allowed a consistent triangulation of quantitative and qualitative data, which helped ensure that findings were drawn from quality data and facilitated the identification of patterns or trends.

Choices of sampling techniques largely related to selection of geographic areas or specific sites within the evaluation's three focus provinces. Given that outreach and coverage areas vary widely across the three mechanisms and that substantial differences exist in duration of implementation within geographic areas, a random sampling approach to site selection was not practicable. After reviewing information on the mechanisms' range of implementation locations, the team adopted a purposive sampling approach, which was better suited to the evaluation parameters and could generate sufficient information to answer the questions.

Since the evaluation focused on three provinces, the team selected geographic areas within those provinces to visit based on where implementation efforts are or have been active. The site selection criteria are included in the evaluation matrix (see below and Annex II). Site selection or sampling precepts included a variety of purposive elements; criteria included such factors as: high- and low-performing sites, hard- and easy-to-reach locations, low- and higher-income areas, established and recently commenced implementation areas, and areas with stronger and weaker network support.

The field work schedule allowed the evaluation sub-teams, and the information-gathering process in general, to achieve a balance between greater geographic coverage with less detailed probing and less geographic coverage with more in-depth probing. Sites visited in each province are listed in Annex III.

EVALUATION MATRIX

In the development of an evaluation approach and information-collection tools, the team used a version of GH Pro's evaluation matrix. This matrix (similar to the one in the scope of work) helped to align methods and tools to specific questions. A combination of methods was used to obtain information to answer each question. For each evaluation question (going from right to left in the matrix), the matrix lists the types of information-collection tools envisioned for use, source selection or site sampling preferences, and sources of data or information. The team developed a separate matrix for each of the three mechanisms and another for the more macro-level, crosscutting questions. All matrices are included in Annex II.

DIVISION OF LABOR WITHIN THE EVALUATION TEAM

Given the need to cover three different implementation mechanisms and the limited time available for in-country work, the team divided into three sub-teams to accomplish the evaluation tasks. Each sub-team focused on the specific evaluation questions posed for one of the mechanisms. For QHS, the sub-team was composed of Pamela Putney and Ros Bandeth; for ECH, Deborah Thomas and Srey Mony; and for SHP, Nhu-An Tran and Bunsoth Mao.

The team leader, William Jansen, focused on reviewing and working with the quantitative data sets contained within each of the mechanisms' management information systems (MIS). All team members worked on identifying patterns and trends from the collected data. Similarly, the entire team worked on answering the questions related to the health portfolio.

LIMITATIONS

The fact that the evaluation scope covers three different mechanisms, each operating in distinct causal pathways to achievement of results, made the development of a common protocol and set of data-collection tools more difficult. Additionally, the limited time available for in-country information-gathering presented some challenges for selection of feasible data-collection methods. An approach had to be identified that could be accomplished within the time available.

INFORMATION-GATHERING TOOLS

As represented in the evaluation matrices, the evaluation team developed several information-gathering tools. Some were oriented to gather information from a specific mechanism. The tools vary somewhat, depending on the source type or category of informant. Most were designed for the collection of qualitative data.

The standardized collection tool for quantitative data was a generic data table, designed to be populated from the data sets available from the MIS used by each evaluated mechanism. The table was adapted (and expanded) to correspond to the types of relevant data available. When available, relevant baseline data also were added to the basic data table.

Given the brief amount of time available for in-country information gathering, field-testing of the tools prior to the start of full-scale data collection was not possible. The tools developed by the team, therefore, were modified as needed during the actual information collection process to best capture the information present or perceptions offered by informants.

The tools developed and used by the team are included in Annex IV. Since the tools were guides for the evaluators to use, they are only in English. In practice, each sub-team conducted interviews in the local language (Khmer) to facilitate communication, using interpreters where needed for further clarifications and probing.

ANALYSIS PLAN

As mentioned above, the analytical process involved a triangulation of the data from the three main source categories. Qualitative information was related to and compared with the available quantitative data from each of the three mechanisms' MIS databases. Analyses were oriented to identify repeating patterns or trends. The focus of analysis was first upon each of the three evaluated mechanisms independently. Then, the analytical review determined if any patterns identified within one mechanism appeared in another or all of the mechanisms. The final stage determined what trends or patterns identified from the data collected are relevant for answering the evaluation's health portfolio or crosscutting questions.

A thematic analysis of qualitative interview data and information was used in determining patterns or trends. Analytic techniques allowed for comparisons in trends among beneficiaries or mechanism participation by sex. Similarly, the patterns identified were checked to see if they appear at national, sub-national or local levels (if relevant).

The secondary analysis of the mechanism data sets examined general rates of progress over time, looking at yearly and quarterly increments. Rates of progress were compared against life-of-mechanism timelines. The analysis looked at variations in progression rates across geographic areas (provinces as well as operational districts) and allowed a comparison between results that have been achieved to date with overall mechanism targets.

Data trends or patterns, particularly those discerned from the mechanisms' databases, were verified with relevant implementation partners and stakeholders. This verification step represented an opportunity to check data quality and to compare identified patterns with other related trends affecting the health sector in Cambodia.

IV. FINDINGS

Answers to evaluation questions 4 through 7 needed to be determined before answering questions 1 through 3, with their higher-level dimensions. The findings related to questions 4–7 contributed important perspectives in answering questions 1–3. Therefore, the findings, conclusions and recommendations begin with the mechanism-specific questions, and those pertaining to questions 1–3 (and a summary for question 4) appear at the end of this section.

A. QUALITY HEALTH SERVICES (QHS)

Additional background and context for the QHS mechanism is included in Annex V. That information illustrates how QHS components are grouped and relate to its overall activity objectives.

FINDINGS

Question 5a: Which QHS components appear to be most effective to change health providers' services and practices and improve the quality of health services?

> "Under QHS, health center quality has improved from 32–65 percent since the baseline in 2014."
>
> *–URC: Statistical data, 2016*

Three components implemented in combination appear to be the most effective in strengthening provider services and practices and improving health service quality. One is the combination of on-site skills-coaching and team-building efforts for: health center quality improvement (HCQI); midwifery coordination alliance teams (MCAT); pediatric coordination alliance teams (PCAT); coaching/clinical skills practice at referral hospitals [which includes clinical skills practice on maternity and gynecology wards, clinical practice guidelines[1] (CPG) for severe acute malnutrition on pediatric wards and in outpatient departments, and neonatal CPG on pediatric and maternity wards]. The other two are the series of simple, inexpensive innovations and job aids and the efforts for improving the provincial referral system.

HCQI, coaching and clinical skills-practice approaches at referral hospitals, and MCAT and PCAT on-site skills- and relationship-building approaches have strengthened teamwork and collaboration and improved referrals: On-site skills coaching and relationship building have resulted in the staff from different levels and facilities (health centers, referral hospitals, operational districts and provincial health departments) meeting regularly to discuss routine and complicated cases and resolve problems together for the first time. The results are significantly stronger networks (community, health center, referral hospital, provincial hospital, operational district, provincial health department) with strengthened and improved relationships between the levels; a team approach to care and managing complications both within and between facilities; improved communication, mutual respect, understanding and a shared sense of responsibility; and more timely, appropriate and efficient referrals for life-threatening maternal and newborn complications.

> "MCAT has changed the behavior of midwives and we are getting fewer complaints from the communities now."
>
> *–Provincial health department staff member*

Staff midwives and nurses at health centers and referral hospitals, as well as health center, referral hospital, operational district and provincial health department managers consistently stated that HCQI, clinical skills practice, severe acute malnutrition CPG (and more recently neonatal sepsis CPG), MCAT and PCAT have significantly improved their clinical skills and quality of care, including their capacity to detect, manage and refer complications. According to staff and managers, counseling has improved, care

[1] CPG–Clinical Practice Guideline (Cambodian guidelines for hospital care)

is more client-centered and the team approach to care and managing complications has improved confidence and decreased the stress and anxiety levels of midwives, nurses and physicians at all levels when life-threatening complications occur.

> "The confidence of my staff has increased a lot and their capacity and skills have really improved. They are charting and keeping records better now and know how to examine patients head to toe."
>
> *–Referral hospital director*

For the first time, staff at the different levels are conducting regular joint case reviews to discuss how to improve care and solve problems, resulting in greater transparency, peer pressure and healthy competition between facilities. Referrals have improved due to a combination of skills improvement (e.g., midwives and nurses now follow criteria for referrals, and their ability to detect complications and their confidence in their capacity to manage and stabilize mothers and newborns at risk have improved), relationship building (e.g., midwives and nurses now know who to call and have a working relationship with referral hospital staff) and the QHS-designed provincial referral hotlines and standard, MOH-approved referral slip.

Simple, inexpensive innovations and job aids developed and implemented by QHS have improved the quality, efficiency and effectiveness of care: QHS, in collaboration with the MOH, has developed and implemented simple, inexpensive innovations and job aids for health center and referral hospital staff to improve the quality, efficiency and effectiveness of care for mothers, newborns and children. Staff at every level repeatedly stated these innovations had made a significant difference in their ability to provide quality care.

QHS Innovations/Job Aids	
Clinical posters (postpartum hemorrhage, immediate newborn care, eclampsia, postnatal care, family planning, handwashing, postpartum practices to avoid including roasting, new posters in process for growth monitoring and promotion and integrated management of childhood illness) MCH Book Severe acute malnutrition screening stamp for referral hospitals Stamps for active management of the third stage of labor and immediate newborn care for referral hospitals and health centers Referral slip and feedback form User-friendly recording terms	Provincial hotline poster Growth-monitoring scale with basket Length/height measurement board Laminated weight-for-height standard deviation card for identifying severe acute malnutrition Non-pneumatic anti-shock garment (postpartum hemorrhage) Emergency boxes (postpartum hemorrhage, immediate newborn care/newborn asphyxia and eclampsia)

QHS developed the *Maternal and Child Health (MCH) Book* ("Pink Book") with the active collaboration and support of the National Maternal and Child Health Center (NMCHC) and other donors. The book is helping midwives and nurses to effectively teach key health messages to mothers and families and to involve fathers.[2] It is also helping providers to provide and document services and care. In an interview, the NMCHC director acknowledged the positive impact the book has had with service-providers and clients.

The basket scales have made weighing babies easier and much safer (they can't fall out). The wooden length/height measurement boards are sturdy, light and easy to use; health center staff use them in services for the integrated management of childhood illness in outpatient departments and Expanded Program on Immunization rooms at facilities, and they carry them to communities to conduct severe acute malnutrition screening. The active management of the third stage of labor and immediate newborn care stamps are routinely used in charting during deliveries and act as a reminder of important steps that save women's and newborns' lives during birth and postpartum. Severe acute malnutrition

[2] It also costs less to print than the current MOH book, which has no illustrations or designs and far less information.

stamps are used at referral hospitals to screen incoming pediatric (under 5 years old) patients. Clinical posters are placed on the walls of every exam and delivery room in the health centers and referral hospitals; they guide staff during emergencies and routine care, reinforce knowledge and skills, and increase efficiency. Posters and stamps decrease stress and anxiety ("We know what to do now and don't forget."). The "emergency boxes" for postpartum hemorrhage, eclampsia and immediate newborn care/newborn asphyxia improve the management of routine care and emergencies. Midwives and nurses stated that QHS helped them chart more efficiently and effectively using simple terminology. The referral slip for complications and emergencies has four copies: one that the referring facility keeps, one the referral hospital keeps with the patient record, one for the referral box on one of three wards receiving referrals (maternity, pediatrics or emergency); and the last for the HEF. Referral hospital staff fill out a separate referral feedback form for the patient's family to take home, which includes the treatment so the referring facility can follow up effectively.

Question 5b: What are strengths and weaknesses of QHS's team-based learning approaches, including those meant to complement the MOH's in-service training strategies, and QHS's coaching and mentoring efforts?

Team-based and on-site skills-building and learning approaches effectively improve skills and capacity and follow national guidelines: The strengths of QHS's team-based and on-site learning approaches include: The training and materials used are of high quality, and the topics meet providers' needs (life-saving skills, competency-based); all trainings are conducted as (or systematically followed up with) on-site skills building and coaching, which reinforces new knowledge, skills and best practices. The approach to training consistently follows both international adult learning best practices and national guidelines and protocols. The trainers demonstrate, coach and support, rather than criticize and humiliate, which is particularly important in the Cambodian context.

> "Our relationships have improved between the nurses and the midwives, the community and the patients. Our reputation has improved and we have a lot more patients coming to the HC [health center]. The number of patients has doubled, and the community trusts the midwives now."
>
> *–Health center manager (referring to one center's experience)*

On-site training decreases feelings of jealousy between the staff because they are all trained, instead of one or two being sent to another facility or training center and receiving per diem. Operational district, provincial health department, and national program staff co-facilitate or lead all capacity-building activities alongside QHS staff, to build their capacity and support them in their roles as key managers and supervisors in the health system. The QHS approach increases transparency and accountability because complicated cases and deaths are now routinely reviewed as a team between levels, and staff now work together to improve care and solve problems.

> "Team-based learning is helping us find solutions. We now talk to each other and find the gaps and share experiences."
>
> *–Health center staff*

These training approaches are becoming standard practices in MOH in-service training. They incorporate standard MOH service-delivery guidelines, and the MOH is involved in the development of all training materials. With such integration in MOH in-service training procedures, the likelihood of sustained continuity of the training capacity developed is high.

The community has responded to improved quality of care in health centers and referral hospitals: Health center and referral hospital staff at a number of facilities visited reported that utilization at their facilities has increased–and doubled or tripled in some cases (when compared to their recollection of the time before the mechanism was implemented). The reported increase in facility utilization, however, is the perception of the informants (the evaluation team did not collect utilization

data from facility records to verify or further quantify utilization over time). Health facility staff also reported that they believe communities now have more confidence/trust in the care they receive. Several health center managers and referral hospital directors stated private practice utilization has decreased significantly in their coverage areas. The fact that the number of deliveries has increased at public health facilities is another indicator that clients are more frequently opting for services there.

> "In 31 years of practicing this is the most effective method of training. I've been waiting a long time for this. Now the results of the training are seen by everyone, even the patients."
>
> *–Health center manager/nurse*

Staff repeatedly stated the communities have an increased knowledge of danger signs and harmful traditional practices, such as roasting postpartum, have decreased. A frequent comment from staff at all levels was the positive impact of the *MCH Book* on mothers and families, who like and use it (including fathers, who often read it to the mothers, especially when their wives are illiterate).

Support for the QHS approach is strong at all levels and is largely seen as an MOH policy: MOH support was consistently cited as strong for QHS approaches such as MCAT, PCAT, clinical skills practice, severe acute malnutrition and neonatal sepsis CPG at referral hospitals, family planning and HCQI at all levels (NMCHC, provincial health department, operational district, referral hospital and health center). Some exceptions exist at higher levels due to anger about lack of per diems and no direct budget support for operational districts and provincial health departments. An important part of the mechanism's approach is building the capacity of operational district, provincial health department, and national staff and managers to support facility-based quality improvement and to ensure sustainability of successful mechanism-supported approaches. Capacity-building efforts include: application of international best practices, active engagement of MOH staff in developing materials, coaching and mentoring, and an integrated approach to improving quality that includes clinical skills, management principles, supply chain, data collection, and use of data for decision-making.

> "The change in the training approach to coaching and mentoring on site is working. HCQI addresses all components of improving quality. It is not just clinical skills but management and supply chain and record keeping."
>
> *–Director, NMCHC*

Most operational district and provincial health department staff felt included, empowered and better able to support facilities to improve quality as a result of the mechanism. The evaluation team also found strong evidence that relationships and trust between operational district, provincial health department and national staff and facility-based providers at health centers and referral hospitals (midwives, nurses and physicians) have been improved and strengthened greatly by the mechanism. Providers at health centers and referral hospitals stated that they now feel more supported by operational districts, provincial health departments and national levels.

Challenges do exist. For example, with the increase in the number of health facilities in the nine provinces since QHS began, expanding coverage to all facilities within a province places increased demands on the existing budgetary levels. The QHS mechanism is currently exploring ways to cover all facilities and operational districts in each province. This situation also contributes to challenges in managing expectations of counterparts, partners and others in terms of how rapidly the mechanism can expand implementation.

Question 5c: Are the current monitoring tools and systems sufficient for measuring activity results?

QHS has comprehensive and effective systems for measuring mechanism results: QHS has developed and implemented a comprehensive set of monitoring tools and systems for measuring mechanism activities results that includes:

- A database system with dashboards to monitor competencies, facility performance, training data, performance indicators, and component and team capacity assessments and monitoring tools
- Level 2 quality assessment in nine USAID-supported provinces (2014-2015)
- Level 2 quality assessment adopted nationwide by the MOH and partners, to be continued every two years and included in Health Equity and Quality Improvement Program (H-EQIP) [pooled fund partners after the Second Health Systems Strengthening Program (HSSP2)]
- A maternal and newborn health (MNH) survey of delivery/post-delivery care practices in referral hospitals (2014 and 2015)
- Technical assistance for health information system improvement and linkages to the MOH and other implementing partners.[3]

Measurement of improved quality tied to competency-based training and coaching is a part of regular QHS on-site follow-up in referral hospitals and health centers (see figures 1, 2 and 4), and results are routinely fed back to facilities, operational districts, provincial health departments and the national level.

QHS routinely uses data for decision-making: QHS monitors progress of mechanism inputs closely and rapidly adjusts focus as necessary to achieve the expected results. Two examples of this are in the referral system and in permanent methods of family planning. When monitoring showed a delay in achieving indicator targets in late 2015, QHS assessed the reasons and refocused efforts in those two areas. The referral systems in the nine provinces have improved, with significant progress noted in the three provinces visited by the evaluation team. Long-acting and permanent family planning methods (LAPM) are on track. However, supply and demand for voluntary surgical contraception require extensive and long-term investments.[4]

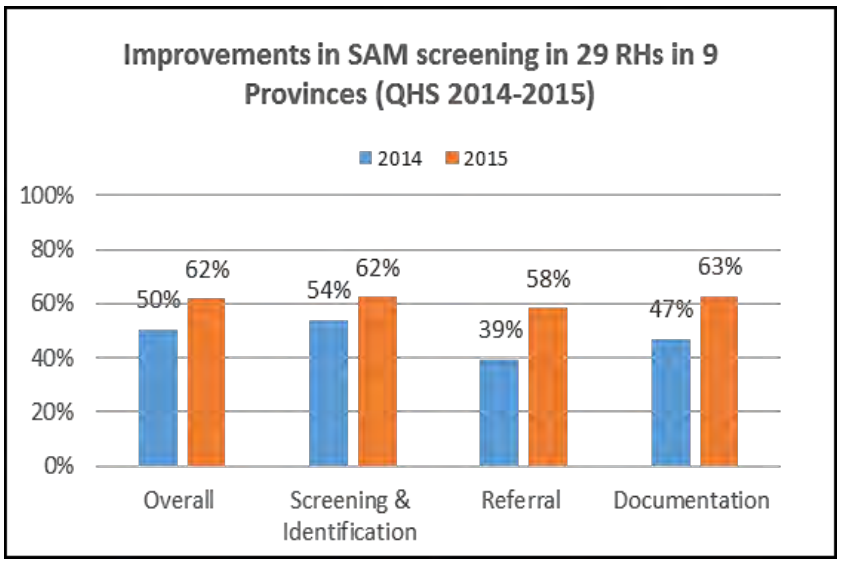


Figure 1. Improvements in severe acute malnutrition screening in 29 referral hospitals in nine provinces (QHS 2014-2015)

International standard indicators are present and effectively monitored: QHS uses and effectively monitors international standard indictors, as illustrated in the chart for QHS mechanism indicator #3 a.1, number of women giving birth who received uterotonics in the third stage of labor (Figure 3).

[3] See Annex VII for charts of key indicators.

[4] A recent study of 30 developing countries found that, among users of contraception, wealthier women were more likely than poorer women to use LAPM. In only two countries (Bangladesh and India) were poorer women more likely to use LAPM than wealthier women. *Global Health: Science and Practice*, June 2016.

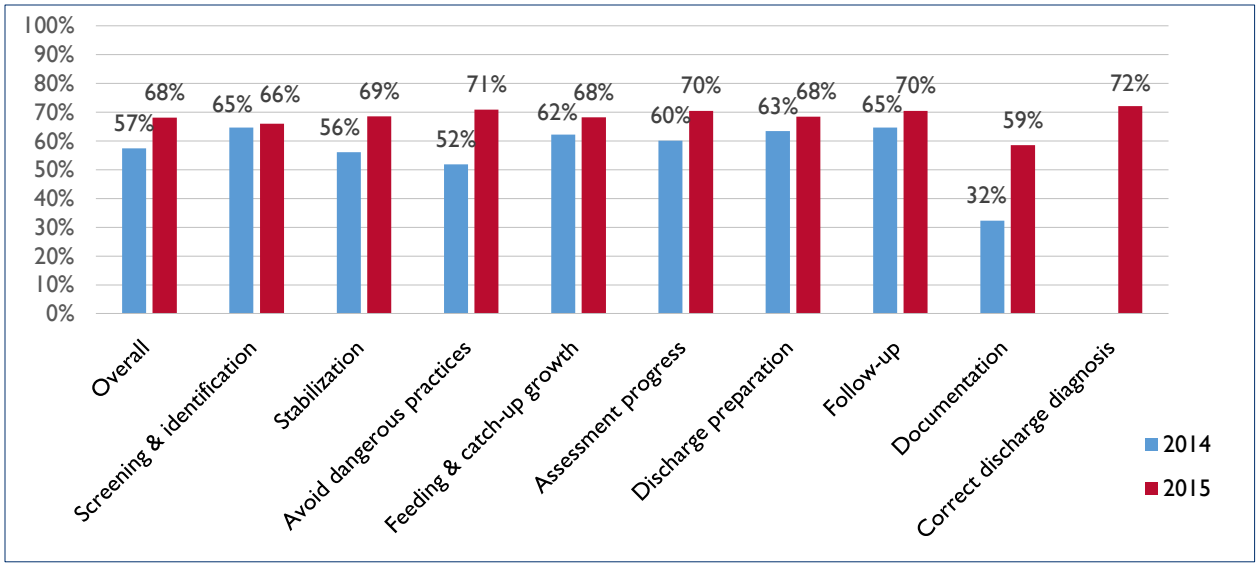


Figure 3. Improvements in severe acute malnutrition treatment according to severe acute malnutrition CPG in 17 referral hospitals in nine provinces (QHS 2014-2015)

Question 4 (part 1): To what extent has QHS achieved its objectives and expected results at this time?

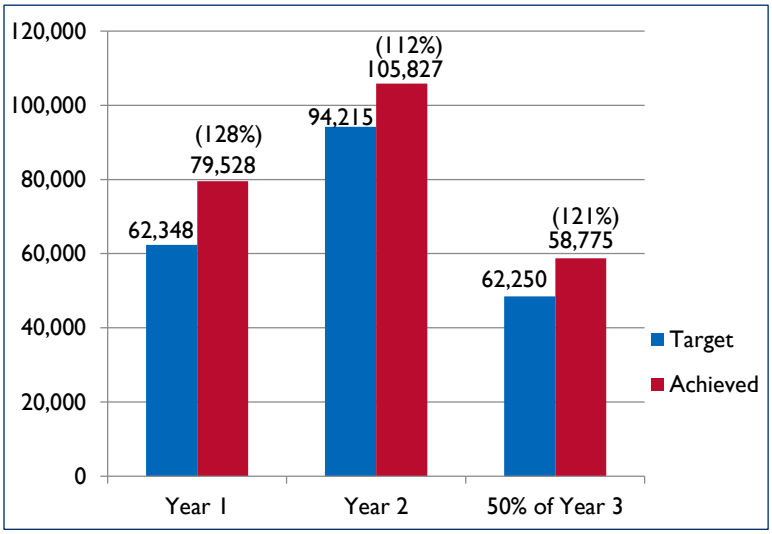


Figure 2. Number of women giving birth who received uterotonics in the third stage of labor

Monitoring and evaluation (M&E)–including baseline data and routine monitoring of improvements in the quality of reproductive, maternal, newborn and child health care at the health facility, operational district and provincial levels–has been a high priority for QHS since the project's inception. QHS uses M&E data for project management and capacity building, as well as for improving quality of care in the health facilities. M&E data are systematically and routinely collected, analyzed and shared both within the project and with MOH staff at all levels of the system. Progress in the achievement of most progress indicators for QHS are on or ahead of schedule in terms of overall life-of-mechanism targets. Graphs showing the progress of specific sample indicators are contained in Annex VII.

Overall, the QHS mechanism has achieved its objectives and expected results at this time. QHS did experience a slight delay in making certain permanent methods [not intrauterine devices (IUDs) and implants] more widely available; but this delay was due to circumstances beyond the mechanism's control. Provincial referral system improvements are at this point functional in fewer provinces than planned but are catching up. Current efforts to refocus have proven effective and useful, and the expansion of provincial referral system improvements to additional provinces is expected to show similar results in the remaining provinces moving forward.

Quality improvements are occurring in facilities supported by QHS, with substantial progress. Illustrative quality improvement interventions in health centers supported by the mechanism through December 2015 are shown in Figure 4. Such interventions have helped facilities achieve higher standards of quality in service delivery. Quality-improvement measurement within the QHS MIS includes eight separate indicators directly related to quality-improvement index scoring at the facility level: level 2 quality assessment scores for discharge (PNC1), overall quality of care, PNC2, family planning, outpatient/pediatric and well child (health center only); MNH survey (delivery/post-delivery) quality index; national level 2 quality assessment implemented annually in all referral hospitals and health centers in the nine targeted provinces; and MNH (delivery/post-delivery) quality survey implemented annually for the first two years (see Annex VII graph: Life of Project Target Achievement by Selected Indicators as of 3/31/2016: QHS–1). Other MIS indicators track additional service-delivery factors related to quality of care. All quality-related indicators show progress that is on track with mechanism targets or that exceeds objectives for the current point in the life of implementation.

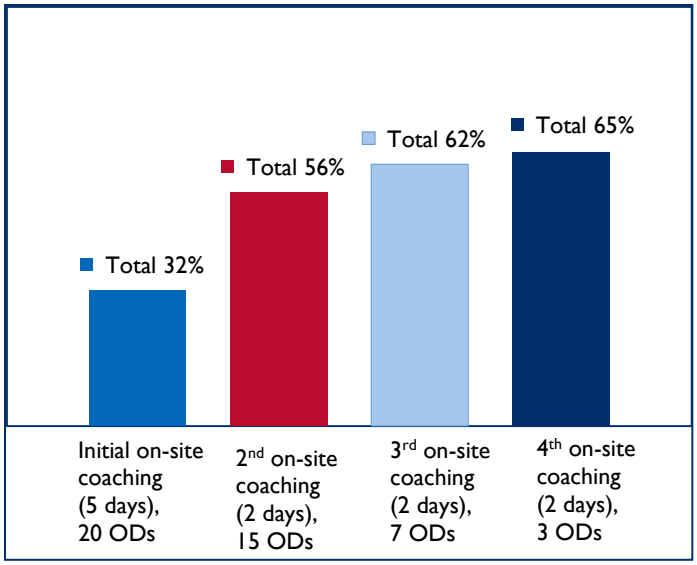


Figure 4. Overall quality improvement interventions in health centers covered by HCQI in eight provinces (QHS 2014-2015)

Most QHS activities are on track or ahead of schedule: QHS has 26 project indicators, 15 of which come from the health information system. Reproductive, maternal, newborn and child health service core competencies (currently there are 18, and infection control is crosscutting) are assessed at baseline and each follow-up session, using competency checklists for health centers and referral hospitals. Feedback on gaps and improvement over time is provided to the staff at baseline and in each follow-up session, and the results are shared with health center, operational district and provincial health department staff to strengthen supportive supervision and improve the quality of care.

Health facilities in nine provinces providing IUD services (cumulative total)			
2013 (Baseline)	By end PY1	By end PY2	By end Q2, PY3 (March 2016)
10 referral hospitals	13 referral hospitals	25 referral hospitals	35 referral hospitals (92 percent of target)
424 health centers	438 health centers	451 health centers	470 health centers (85 percent of health centers at baseline)
Health facilities in nine provinces providing implant services (cumulative total)			
2013 (Baseline)	By end PY1	By end PY2	By end Q2, PY3 (March 2016)
8 referral hospitals	13 referral hospitals	21 referral hospitals	34 referral hospitals (90 percent of target)
259 health centers	282 health centers	298 health centers	319 health centers (60 percent of health centers at baseline)

Figure 5. Health facilities in nine provinces providing IUD and implant services

Voluntary surgical contraception is slightly behind schedule; however, increased efforts over the past six months are expected to improve progress. Demand for voluntary surgical contraception remains very low in Cambodia, despite considerable investments in this area by donors, including USAID, over the past 20 years. An additional factor is an issue with implants: The MOH recently switched from Implanon Classic to NXT (both one rod) and there have been stock-outs of implants in facilities. Additionally, the MOH is requesting that all providers be retrained for three days on the insertion, use and removal of the new implant–which would require resources beyond the capacity of QHS and other donors–instead of a short refresher training. As noted above, the referral system improvements were behind schedule; however, mechanism inputs were adjusted and significant improvements noted in the three provinces during field visits, and the indicator is getting back on track.

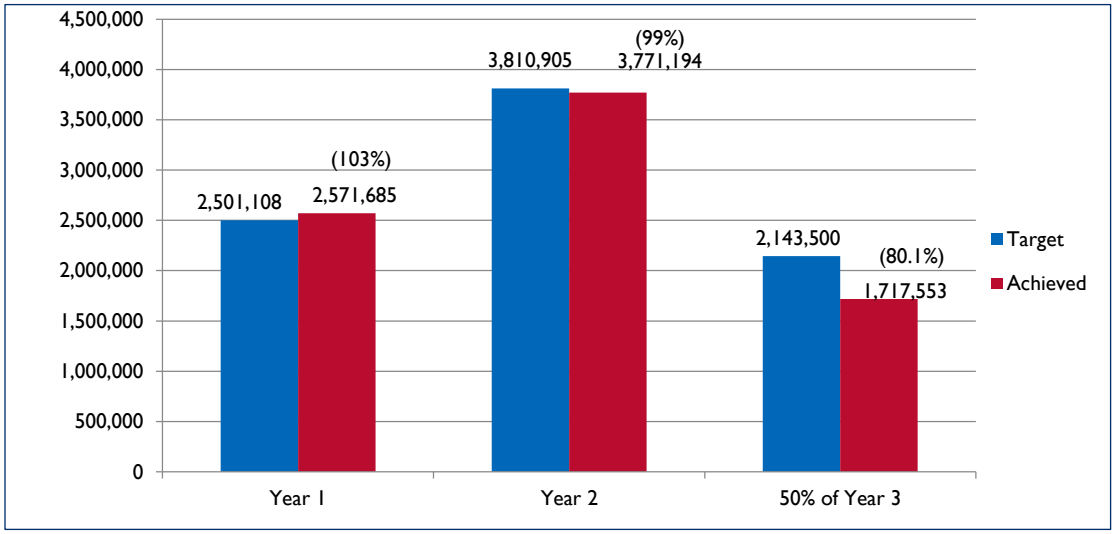


Figure 6. QHS project indicator #4.1: Family planning couple-years of protection

CONCLUSIONS, BEST PRACTICES AND LESSONS LEARNED

Training staff at all levels together and on-site coaching are effective, improve quality of care, build teams, foster positive and collaborative relationships and change behavior.

There is a team approach to care as a result of the mechanism's on-site and team-based approaches to capacity building. Midwives, nurses and physicians are more motivated, and care is more client-centered. A midwife at a health center in Battambang stated they now manage complications together. When there is a postpartum hemorrhage, she calls the team and everyone helps and manages the emergency together, and they all know what to do. At her health center, emergencies are managed more effectively, and the team approach to care lessens the fear and stress of doing something wrong. Many key informants stated that they regularly practiced the skills they learned during the QHS trainings and coachings together with other facility staff.

> "The project has changed the behavior of the staff. They are more motivated. Staff who were good before are even better now and those who were lazy before have improved a lot."
>
> *–Operational district manager*
>
> "Midwives don't use bad words with patients anymore."
>
> *–Key informant interview*

Small, low-cost innovations can make a big impact.

Small innovations such as the *MCH Book*, stamps, clinical posters, emergency boxes, and growth monitoring tools reinforce new knowledge and skills learned in training and coaching, remind staff of the important steps in providing quality care and increase the efficiency of work.

Demonstration and coaching on-site is more effective than teaching off-site.

> "Now our HC [health center] is clean. Before we didn't know how to clean and organize but now we do. The community has noticed how clean it is now, and we got feedback from the VHSGs that we have improved, and we have a lot more people coming to the HC now. We used to have only 1-2 births a month and now we have 20-30."
>
> *– Health center manager*

Learning on the job is practical, tangible and effective. Demonstration of skills and quality care on-site shows staff how to provide quality care in their setting using the resources they have and is a supportive and flexible approach. Midwives, nurses and physicians develop confidence in their capacity to detect, manage and refer life-threatening complications. QHS staff are effective role models, while meeting the needs of operational districts, provincial health departments, facility managers and staff in improving care and outcomes. Facility staff did not know what organized and clean health centers or hospitals looked like prior to QHS showing them infection prevention, organization and good hygiene on-site.

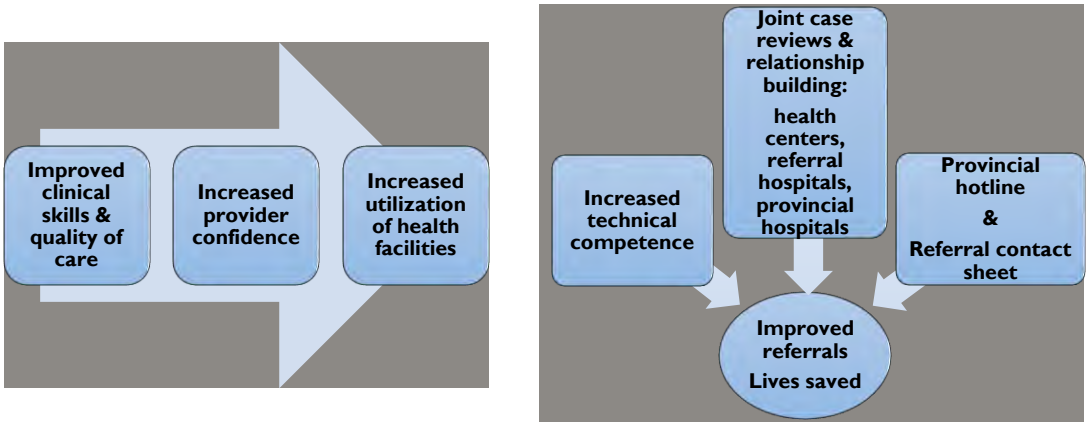


Figure 7. Dynamic: Improved skills and quality of care, and Dynamic: Improved referrals

Challenges, obstacles and issues

The main challenges, obstacles and issues for QHS include: the substantial recent MOH increase in per diems; the expectation of some operational districts and provincial health departments for direct funds; the availability of implants and the request that all providers be given a three-day training course in the new implant; infection prevention and hygiene, which have improved significantly but remain a challenge; the inadequate number of cases for emergency obstetric and newborn care skill practices in some areas; and the fact that national safe motherhood protocols have not been approved yet (but are expected soon), which has led to a delay in increased collaboration with ECH (e.g., needed for VHSG training in MNH by health center midwives). Infection prevention is a challenge even in developed countries. A difficult infection prevention practice to improve is handwashing by doctors and other clinical staff, especially in settings where clean water, soap and disinfectant solutions are often not available.

The RGC significantly increased government per diem rates (from an overnight rate of $20 to $34, effective September 2015) without an increase in budgets at all levels (facility, operational district, provincial health department and national), resulting in decreased funds for all field activities. This affected MCATs most acutely, since QHS does not provide any per diem support for them because they are a national standard. However, this also affects other QHS activities and its overall budget. In addition, some operational district and provincial health department staff want their own budget from QHS that they can manage directly, and they tend to withhold support for implementation efforts if independent budgets are not provided for activities in their areas. Additional per diem increases that are under discussion between USAID and other donors will also affect QHS. These include an increase in

the non-overnight per diem rate to $14 (QHS is currently paying $8 as per the MOH outreach policy) and decreasing the distance criteria for per diem eligibility from 30 kilometers (current USAID policy) to 20 kilometers.

RECOMMENDATIONS

The recommendations for QHS to overcome current obstacles and barriers to future roles include:

- Continue on track with current mechanism approaches and inputs.
- Allow QHS to cover all facilities and operational districts in the nine focus provinces and to use flexible implementation approaches to achieve wider geographic coverage.
- Withdraw plans for a national call center. Provincial referral systems are improving and are more appropriate and effective. Resources conserved can be used to cover additional facilities and operational districts in the nine focus provinces.
- Implant training for the new one-rod Implanon NXT should be a short (half-day or maximum one day) refresher course, not a three-day training, for which there is no technical rationale, according to international best practices.
- Assess the factors at operational districts in Battambang that may have contributed to the reportedly high demand for implants there, to determine if key elements can be replicated in areas with low demand.
- USAID should assist QHS to resolve per diem issues with the MOH and other partners by establishing a common per diem standard across all USAID-funded mechanisms.
- QHS should develop a common strategy with ECH and SHP for future collaboration and joint operational planning.
- Given that some provincial health departments and operational districts lack sufficient training materials, resources permitting, QHS should purchase and provide sets of training materials and supplies (mannequins, dolls, etc.) to all provincial health departments, operational districts (for health centers) and provincial referral hospitals (for their training units). This would build further capacity at each location for in-service training. Additional Complementary Package of Activities 1 & 2 referral hospitals in the nine provinces could also receive these supplies, if possible. The provision of such materials does not guarantee continued or sustained use over time. Longer-term sustainability for training and other quality-assurance measures may depend upon the extent to which they are adopted and incorporated within host-country systems.

B. EMPOWERING COMMUNITIES FOR HEALTH (ECH)

FINDINGS

ECH is a community health systems-building mechanism that works through community and government actors, mechanisms and institutions. It works through three demand-side pillars: improving health behaviors, increasing demand for health services and strengthening demand-side governance and social accountability of health services. As shown in Figure 8, these actions in turn mobilize short and long routes of accountability to improve the quality of health services through pressure on health providers and by informing policymakers.[5]

[5] See World Bank, 2004. *Making Services Work for Poor People*. World Development Report 2004.

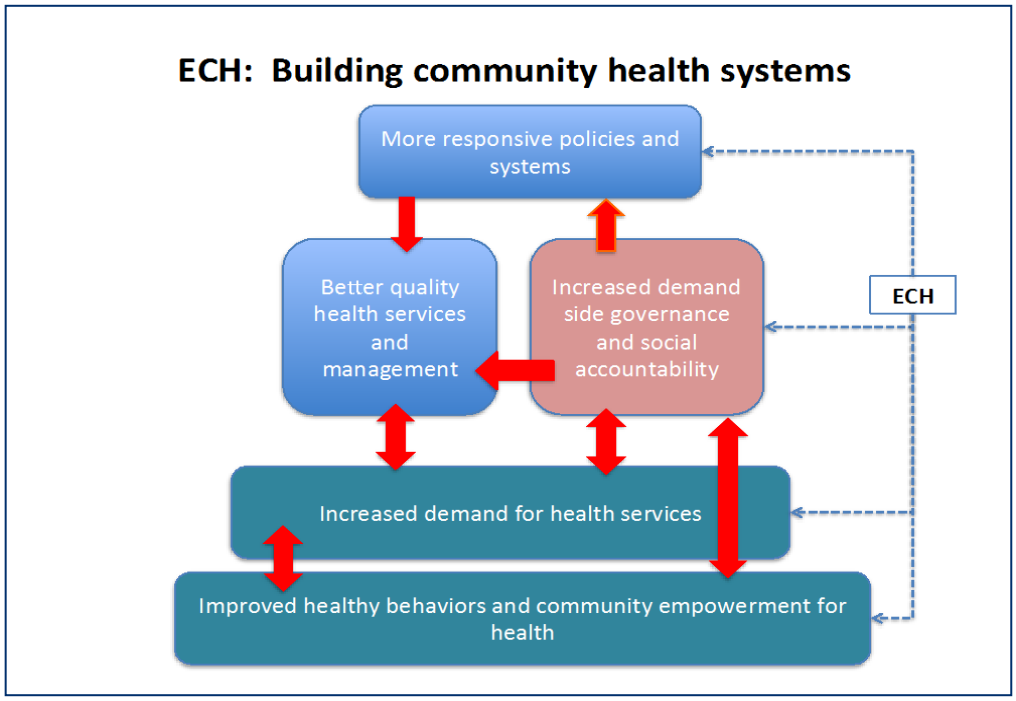


Figure 8. ECH strengthening of community health systems

The mechanism's objectives are to strengthen health systems and governance, improve maternal and child health practices in communities and improve effectiveness and efficiency of infectious disease programs (TB).

Reproductive and Child Health Alliance (RACHA) was awarded the cooperative agreement for implementing ECH in September 2014. At the time of the evaluation, the mechanism had been implemented for 19 months, of which the first 11 had been funded on a cost-reimbursement basis and the remainder as advance funding (September 2015). Delays in the approval of the annual work plan and budget (March 2015) and M&E plan (April 2015), as well as the constraints faced by RACHA to fund implementation during the cost-reimbursement period, slowed the pace of implementation in year 1 (see Figure 9).

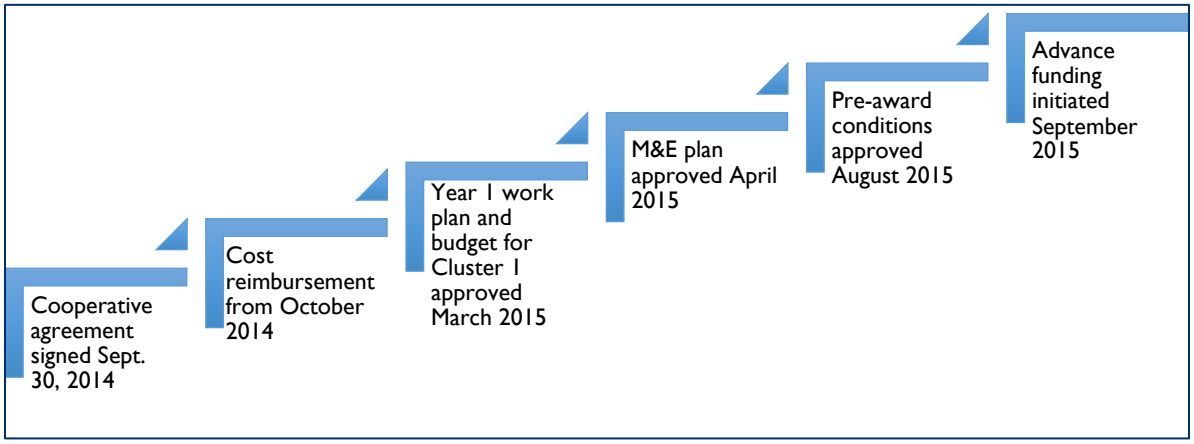


Figure 9. ECH start-up timeline

ECH covers nine provinces that are divided among three clusters. As expected for a community-based program, coverage is being gradually rolled out across the focal provinces (see Figure 10 and Annex VI). Implementation started in Cluster 1, consisting of Siem Reap and Banteay Meanchey provinces, and has rolled out to one new cluster in each subsequent year. Given the early timing of the evaluation in the mechanism's life, the evaluation focuses on Cluster 1 performance.

	Year 1	Year 2	Year 3	Year 4	Year 5
Cluster 1	x	x	x	exit	
Cluster 2		x	x	x	exit
Cluster 3			x	x	x

Figure 10. ECH roll-out plan

Question 4 (part 2): To what extent has ECH achieved its objectives and expected results at this time?

The following section reviews progress and constraints of each of the mechanism's three components and analyzes management and organizational issues affecting implementation.

Component 1: Health Systems and Governance

Sub-components:

1. Institutionalization of VHSGs under CC
2. Creation of sustainable technical linkages and coordination mechanisms between VHSG, CCs and the health system
3. Strengthened health center governance

Context: Component 1 of the mechanism aims to strengthen community health systems and local governance of health services and responds to the opportunities and new institutional arrangements being introduced through the RGC's D&D program. So far, decentralization in the health sector has involved shifting the institutional home of VHSGs from the MOH to CCs.[6] This is to be followed by the transfer of health centers to CCs.

The ECH mechanism is facilitating the transfer of ownership of community health to CCs by building the capacity of VHSGs, Health Center Management Committees (HCMC), and CC members, particularly the Commune Committee for Women and Children (CCWC). ECH is also partnering with the National Committee for Sub-Democratic Development (NCDD) at the national level in piloting the implementation of social accountability at the ground level. The pilot, known as Implementation of Social Accountability Framework (I-SAF), is fostering new values of citizen voice, community engagement and social accountability of health, education and commune services. The decentralization reforms and social accountability mechanisms provide the institutional and policy backdrop for the mechanism and the structures for evolving community health systems.

Progress: Reasonable progress has been made in implementing Component 1 activities, despite the delays experienced at the beginning of the mechanism (see Figures 11 and 12). The pace of activities has picked up in year 2. The figures below illustrate levels of achievement of a selection of component indicators (other progress indicators are included in Annex VI). Overall progress appears to be good.

[6] See Annex VI for background information on VHSGs and HCMCs.

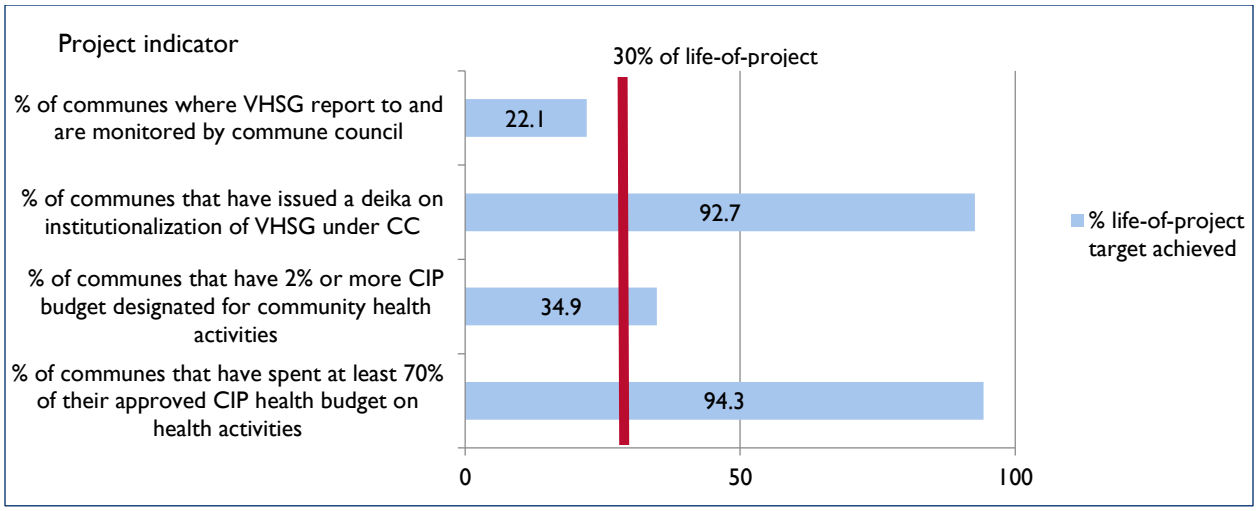


Figure 11. Life-of-project target achievement by selected indicators as of March 31, 2016: ECH Cluster 1

From interviews with a wide range of government and community stakeholders, the evaluation found widespread support for social accountability and recognition of how it is improving service delivery.

Provincial government staff in Banteay Meanchey and Siem Reap noted how complaint boxes introduced under I-SAF that are unlocked and addressed by a multisectoral provincial steering committee are changing bad health staff behavior. All 14 CC members interviewed in the five communes visited endorsed the importance of health for their communities and recognized their responsibility for VHSGs. The shifting of VHSGs from the MOH to CCs was reported by the CCs interviewed to have increased the direct interaction between health center and commune chiefs.

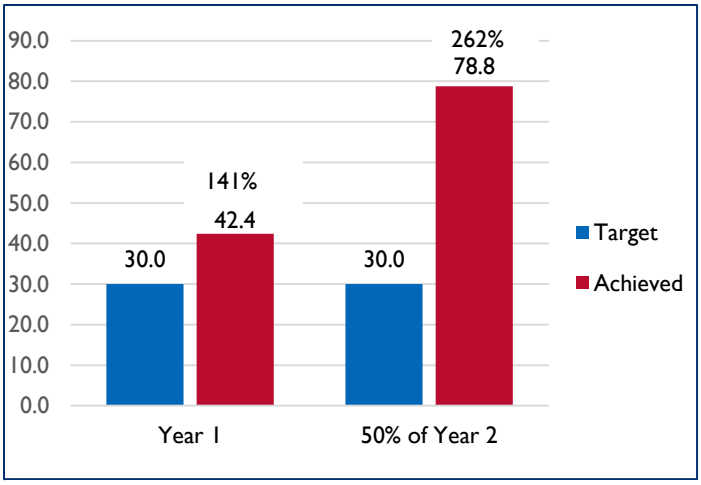


Figure 12. Percentage of communes that have issued *deika* on institutionalization of VHSG under CC (Cluster 1)

> "Community Scorecards have improved staff attendance, improved provider behavior and increased community outreach activities."
>
> *–Operational district director*

Implementation challenges:

Decentralization: The RGC is taking an incremental approach to D&D, experimenting through pilot projects and scaling up based on lessons learned. While this makes good sense, there is uncertainty among health providers as to the impact that decentralization of health services will have on their roles and responsibilities. In Cambodia's hierarchical environment, service providers, health center managers and CCs are hesitant to initiate new working practices without direction from above. While the mechanism is making progress in forging relationships between the community health system and CC, and building CC capacity to take greater ownership of health, institutionalization of VHSGs and broader community health into the CC will greatly depend on the issuance of supporting policy directives.

Low government ownership: The community nature of ECH, compounded with low per diems provided to government officials engaged in mechanism activities, is constraining provincial health department and operational district ownership of the mechanism. There is a common perception among provincial and district health sector managers that because ECH is working with communities, it has limited benefit to health sector stakeholders. However, on further probing, we found that the conceptual linkages between ECH activities and health outcome targets are well understood by health managers and that the main barrier to provincial health department and operational district ownership is the low monetary rewards from the mechanism. In Banteay Meanchey, the low per diems severely affected engagement of government officials in mechanism activities in year 1, though this has eased in year 2.

Commune Council capacity: CC capacity is generally low and contributes to their uneven knowledge of and reluctance to deploy their full powers of delegation. For example, in the five CCs visited, members reported that they needed guidance from above to allocate funds to specific health activities. ECH does not build the capacity of CCs, which is a broader undertaking but also an enabling condition for institutionalizing community health into the CC. ECH includes monitoring indicators that are indicative of increasing CC capacity related to community health. While cognizant of the need to avoid overtaxing the program, qualitative monitoring of CC capacity more broadly would have the advantage of tracking the enabling environment for community health institutionalization and contributing this experience to relevant policy circles.

Low budget allocations to CCs per year generally limit their potential to fund health or other social sector activities. In 2015, Cluster 1 commune investment plans (CIPs) allocated an average of $520.52 for community health activities, which was approximately 0.87 percent of the total commune budget. By the end of the year, an average of $482.82–or 89.36 percent–of the planned budget for health was spent. The 2016 CIPs in Cluster 1 have allocated an average of 1.5 percent for community health activities, which, though an increase, is still below the 2 percent target. Continuing advocacy of the importance of community health activities through direct ECH staff interaction with CCs, particularly CCWC, and via VHSGs, of which many members hold village leadership positions, is building local commitment. However, the CIP budget is limited, and securing the 2 percent target at scale will require a national policy mandate. Stronger advocacy at the national level from ECH, USAID and other implementing partners working on decentralization will support this move.

The political motivation of CCs, and the patronage networks through which they select village leaders (who also can be VHSG members), is an important factor to bear in mind. Circumstances where the political affiliation of the commune chief differs from that of CC members can create operational or functional challenges for a CC.

I-SAF is a government pilot program that promotes citizen and provider participation in social accountability processes. It was designed with activities targeted to providers (supply side), funded by RGC, and to communities (demand side), funded by development partners and implemented by civil society organizations (CSOs). A shortfall in government funding of the program has left 14 of ECH's 21 administrative districts earmarked for I-SAF in Cluster 1 and 2 areas without funding from government for supply-side activities. ECH therefore absorbed activities for both citizens and providers. This development has pros and cons. On one hand, this simplifies coordination of demand- and supply-side activities; on the other, it is difficult for a CSO to mobilize government systems to deliver supporting activities, such as compilation of government services and budget data for public dissemination. Field visits and discussions with NCDD, World Bank, and the CSO I-SAF coordinator (who represents all participating CSOs) show that health is a key subject in I-SAF activities at the community level and in learning being drawn from the pilot program.

High turnover of community facilitators: At the operational level, the low compensation provided to VHSGs and community accountability facilitators (CAF)[7] leads to low motivation and high turnover of both. VHSG members receive $4 for a full day of participation in training and meetings; they are not compensated for time spent on other health-related tasks. CAFs, who are better educated than VHSG members, receive $5 per day. Both VHSGs and CAFs are compensated more favorably by other non-governmental organizations: $8 per day for VHSG members under USAID's NOURISH project, and $10 per day for CAFs by World Vision Cambodia. RACHA staff in Poipet District estimated a 40-50 percent turnover of CAF staff within the past year due to low compensation and high work migration to Thailand. World Vision Cambodia reported a similar level of CAF turnover.

Component 2: Community MCH practices

Sub-components:

1. Creating sustainable technical linkages and coordination mechanisms between VHSG, CCs and the health system
2. Increasing VHSG capacity in family planning and newborn care
3. Developing sustainable community-to-health facility referral mechanisms in remote communities

Context: Cambodia has achieved impressive gains in maternal and child health (see Figure 13), with significant declines in maternal, infant and child mortality over the past 15 years. Neonatal mortality has been slower to decline, and child undernutrition is a continuing problem. Unmet need for family planning also remains a challenge. Within this health context, ECH aims to further improve MCH practices and build on RACHA's core area of MCH expertise and the achievements of earlier USAID MCH funding.

Progress: Activities under Component 2 complement those of the other two components and share common bottlenecks. As with Component 1, Component 2 experienced delays in the first year related to start-up and the disinterest of government in engaging in ECH activities due to low per diems. From the mechanism's April 2016 semiannual report, momentum appears to have increased around training and continuing education of VHSGs and community-based distribution (CBD) agents,[8] which is consistent with field findings (see Figure 14). However, the number of new clients served by CBD agents remains considerably lower than expected for Cluster 1 in the first half of year 2, though this is expected to increase now that all operational districts are cooperating with the project

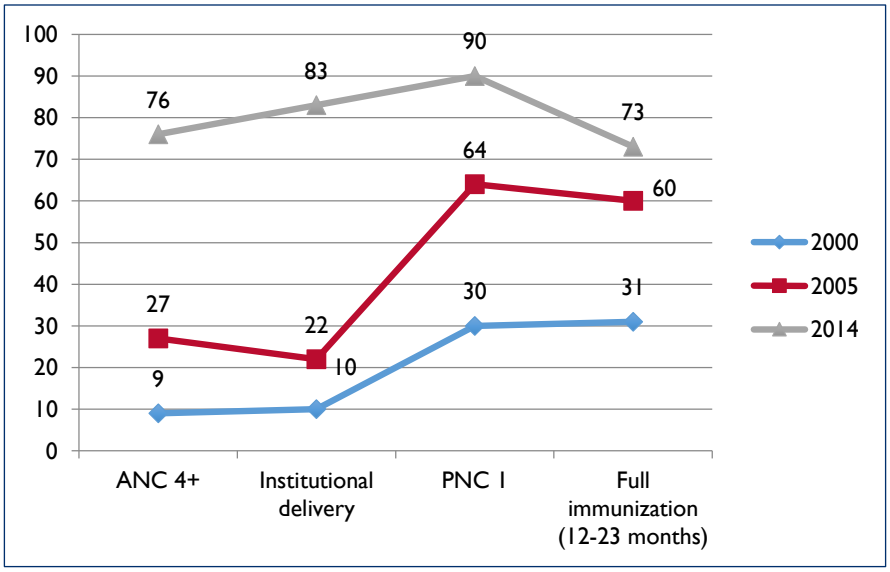


Figure 13. Changes in maternal and child health in Cambodia in the past 15 years

[7] CAFs facilitate the social accountability process.

[8] CBD agents sell oral pills and condoms and are also often VHSGs.

and continuing education of CBD agents is being rolled out (see Annex VI for analysis of additional indicators).

Implementation and design challenges

VHSG model: The RGC's VHSG model was defined in the 2003 *Community Participation Policy for Health* and then revised in 2008 to better align with the *Second Health Sector Strategic Plan* (2008-2015)[9]–although this revised version has not yet been formally approved by the RGC. VHSG members are volunteers who aim to build trust between the health center and community, with the goal of increasing health center referrals and improving community health knowledge and awareness. VHSGs are not paid community health workers but are expected to carry out a large number of responsibilities, including regular information sharing, data collection and community mobilization, and to represent the village in HCMCs. They also perform activities specific to MNCH conditions and projects, such as referral of sick newborns and children. There are several other volunteer community-level health workers who support various vertical programs, such as distributing contraceptives (CBD agents), case-finding and treatment of malaria (village malaria workers), and case-finding and observation of TB treatment (C-DOT watchers). VHSGs may take on several of these vertical program functions; however, data on the percent of VHSGs taking on parallel voluntary health roles are not available. Under the ECH mechanism, VHSG members receive compensation for their participation in training and in HCMC meetings; no other payments are made to them.[10] VHSG members are typically village leaders, deputy village leaders, village committee members, or the wives of these officials. In some areas, the norm of one woman and one man per village is not adhered to, partly due to the low literacy levels of women and the education requirement. The low compensation of $4 per day, when a laborer can expect to earn $8-12 per day, reinforces the selection of village elites as VHSG members because they are more able to absorb the loss of earnings.

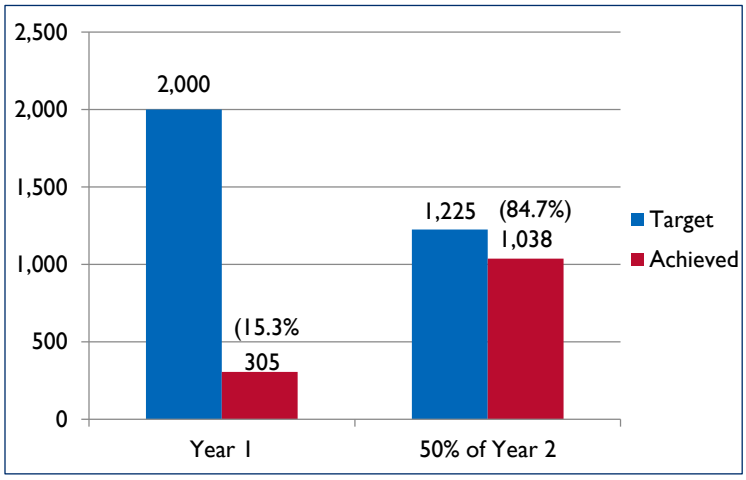


Figure 14. Number of postpartum/newborn pairs visited by VHSG within one week after birth
(Cluster 1 only)

The selection of village authorities, who tend to be older people, as VHSG members has positive and negative implications. Village authorities have influence, are respected members of the community and are appropriate community representatives to engage in HCMCs and to share non-sensitive information to people in the community. However, due to their social and often official position, they are unlikely to question the power structure, and so are not appropriate facilitators of social accountability. They are also less appropriate as providers of participatory behavior change communication (BCC) on topics that challenge cultural norms, such as adolescents' access to contraceptives.

[9] Ministry of Health, July 2008. *Community Participation Policy*.

[10] The MOH entitles VHSGs to free health care at health centers and referral hospitals, in recognition of the functions and support they provide to community health.

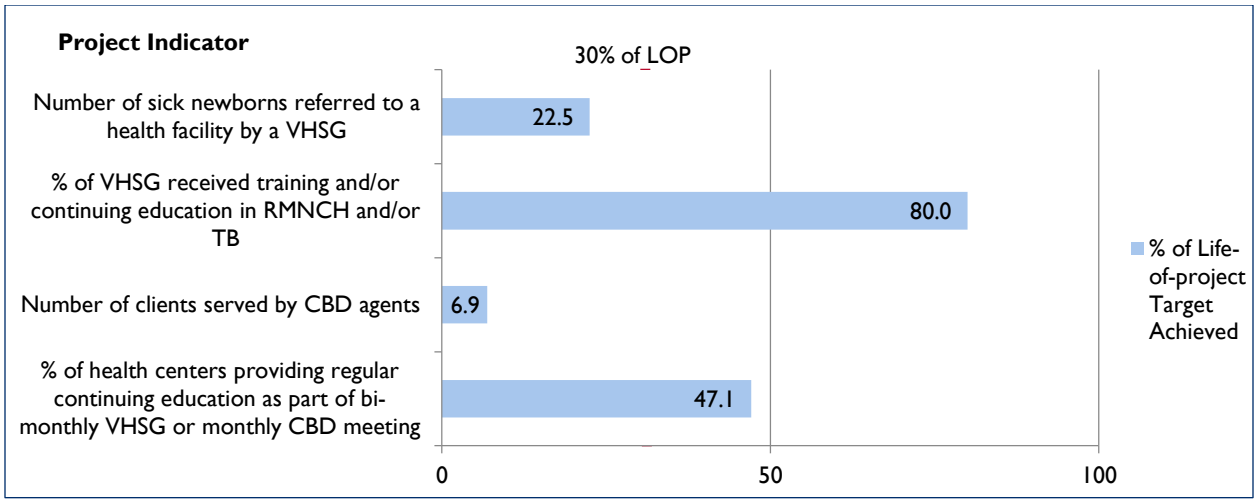


Figure 15. ECH life-of-project target achievement by selected indicators
(as of March 31, 2016, Cluster 1)

VHSG performance: Low compensation translates into low motivation, low activity levels and high turnover of VHSGs. Since VHSGs represent a valued and government-recognized resource for promoting community health, projects and initiatives compete for their time. During a group discussion, VHSGs ranked BCC activities as their lowest priority because it was difficult and time-consuming. CBD sales were also reported to cover less than 10 percent of their monthly expenses and not be a significant income earner.

VHSG priority ranking exercise

During a focus group with 18 VHSGs, they gave the following priority order of their activities:

1: CBD sales

2: NOURISH nutrition activities ($8 per day)

3: VHSG meetings ($4 per day)

4: BCC activities (no compensation)

Barriers to access: The Cambodia Demographic and Health Survey (CDHS) 2014 found that 16 percent of daily pill users sourced supplies from community distributors, 34 percent from health centers and 35 percent from pharmacies and shops. CBD agents that sell pills and condoms reported they do not sell contraceptives to unmarried young people. The social norm that equates sex with marriage inhibits adolescents' access to reproductive and sexual health information, products and services. The high drop-out of young people from secondary education, especially in poorer and more remote areas where access to secondary schools is itself difficult, also closes off schools as a source of reliable adolescent health information.

The pill is by far the most common method of contraception in Cambodia, representing 18 percent of current methods used (CDHS, 2014), and is the most popular modern method among women who are spacing births and those who have completed their family size. ECH aims to increase awareness of and access to LAPM through CBD agents. However, these agents report low demand for LAPMs.

Narrow behavior change focus: The mechanism's behavior change activities focus on family planning, antenatal care, facility-based delivery, postnatal care and newborn care and only partially cover the reproductive, maternal, newborn, child and adolescent health continuum of care and life-cycle approach.[11] The selection of BCC messages has been affected by the division of labor between ECH and USAID's NOURISH project and the perception among ECH staff that the ECH mechanism is restricted to maternal and newborn health, with infant and child health off-limits. ECH includes elements of the

[11] The Partnership for Maternal, Newborn & Child Health. 2011. *A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH).* Geneva, Switzerland: PMNCH.

1,000-days approach in the health information it provides to the community (such as early initiation of breastfeeding), but behavior change activities are not designed in coordination with nutrition initiatives (such as NOURISH), and synergies and shared methods are not leveraged. This is a missed opportunity to reinforce child nutrition information via ECH's strengthening of VHSGs and other influencers. USAID-led cluster meetings with implementing partners provide a forum for sharing information, and this could be used to initiate closer coordination between the two projects. Agreement to share existing materials and collaborate at the grassroots level will likely require formal agreement between partners and facilitation from USAID. No special focus is given to the pre-pregnancy health of adolescents, despite the importance of this for maternal and newborn outcomes. The mechanism also has no explicit BCC strategy to engage men and other family influencers, such as women's mothers or mothers-in-law, to support behavior change.

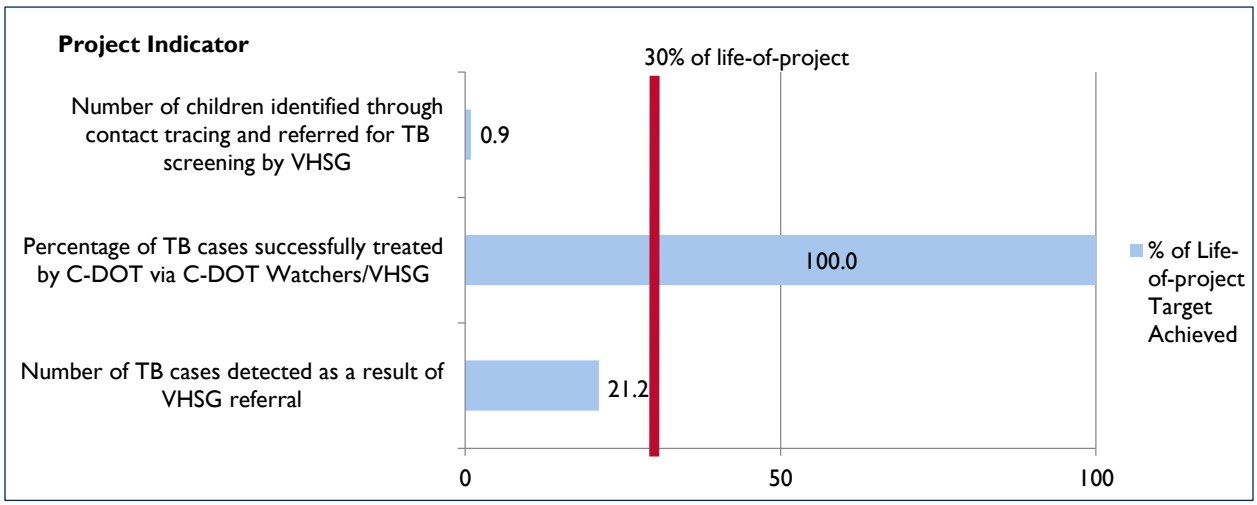


Figure 16. ECH life-of-project target achievement by selected indicators

Component 3: Community support systems for tuberculosis (TB)

Sub-components

1. Increasing VHSG capacity to recognize and refer suspected pediatric TB cases
2. Ensuring the sustainability of C-DOT

Context: Community-based directly observed treatment (C-DOT) is an important approach of the RGC's TB control strategy and enjoys a high level of commitment from the MOH, provincial health departments and operational districts. The National Center for TB (CENAT) considers RACHA and the ECH mechanism as a core partner in the fight against TB, with the flexibility to resolve demand-side constraints that are beyond the means of government.

Progress: As with other components, progress with Component 3 was slow in the first year, but is improving in year 2. Poor cooperation from Banteay Meanchey Provincial Health Department and some operational districts within the province prevented C-DOT training in some places. In addition, delays were reported in clarifying the division of labor between FHI 360's Challenge TB and ECH, although this has now been resolved. In Cluster 1 districts where FHI 360's Challenge TB is not present, ECH is facilitating the capacity building of health staff in addition to strengthening community TB support

systems.[12] This has helped to resolve some of the supply-side bottlenecks to identifying TB cases, although gaps in the availability of TB screening and testing resources continue to be an issue. CENAT is aware of the challenges, and ECH is working in close coordination with them.

Progress in indicator number 20, the number of children identified through contact tracing and referred for TB screening by VHSG (as shown in Figure 17), is very low. Contact tracing only started in year 2, and the low performance is due in part to gaps in the supply of equipment and testing kits from CENAT to operational district referral hospitals, as well as low knowledge levels of VHSGs/C-DOT and ECH field staff about pediatric TB. Performance in this indicator is expected to improve over the next six months. Contact investigation and semi-active case finding are a relatively new component of the national TB strategy and is being implemented with VHSG/C-DOT community mobilization (these are also handover activities from Challenge TB to ECH). This activity is not currently captured by the M&E plan and needs to be included, preferably with the same indicators as used by Challenge TB and the MOH.

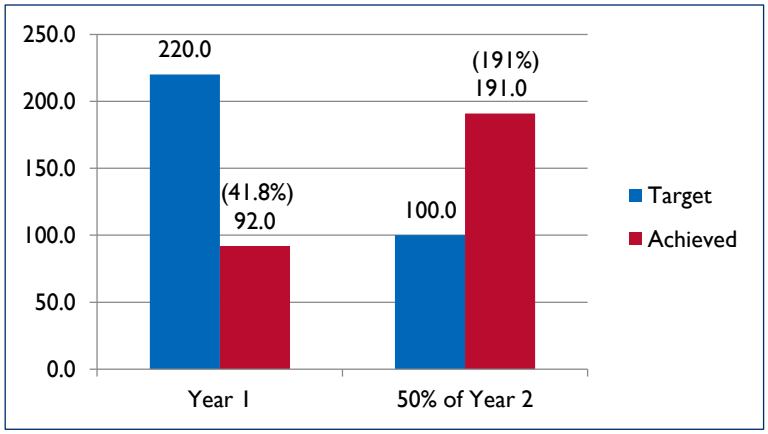


Figure 17. Number of TB cases detected as a result of VHSG referral (Cluster 1 only)

Implementation challenges:

Transportation: Semi-active case-finding events and contact tracing to identify children at risk of TB are significantly increasing the number of people referred to a referral hospital for TB testing. These new approaches were reported to be stretching the referral hospital's capacity to manage the reimbursement of transportation costs under the HEF. ECH, FHI 360, SHP, CENAT and USAID have agreed that, as a temporary measure, ECH and FHI 360 will cover the costs of transporting suspected TB cases identified through semi-active or active case finding to the referral hospital for TB testing. Institutionalizing coverage of these costs into the HEF is the more sustainable and intended path of the stakeholders. It will be important that the mechanism's related short-term measures do not create incentives that discourage institutionalizing transportation costs to referral hospitals related to TB testing into the HEF.

Low compensation of C-DOT watchers: C-DOT watchers receive $4 for a day of training and semi-active case-finding outreach events, but no additional incentive for directly observing treatment or referral; this impacts their motivation levels. Further research is required to understand the time invested and performance of C-DOT watchers and other community health volunteers, the financial and social incentives they receive and levels of motivation. This will contribute to the MOH's future plans around community health systems and the use of volunteers.

Mechanism management and organizational structure:

The evaluation team interviewed a wide range of ECH staff, from headquarters to the field level, and spoke to two members of the RACHA Board of Directors to understand the mechanism management systems and organizational structure. Documentation of USAID's limited financial reviews and discussions with external stakeholders also contributed to the team's findings.

[12] Where FHI 360 Challenge TB is operational, ECH will focus only on community support systems.

Financial management and control: The current financial management system used by ECH has evolved to satisfy what RACHA perceives to be donor requirements. RACHA has embraced recommendations from various financial reviews in its effort to assure USAID of its financial integrity and compliance. However, the resulting financial system is too complicated and time-consuming for the operating context and is a bottleneck to implementation. Furthermore, the USAID/Cambodia agreement with RACHA may provide the organization financial-management flexibility that it is not utilizing currently.

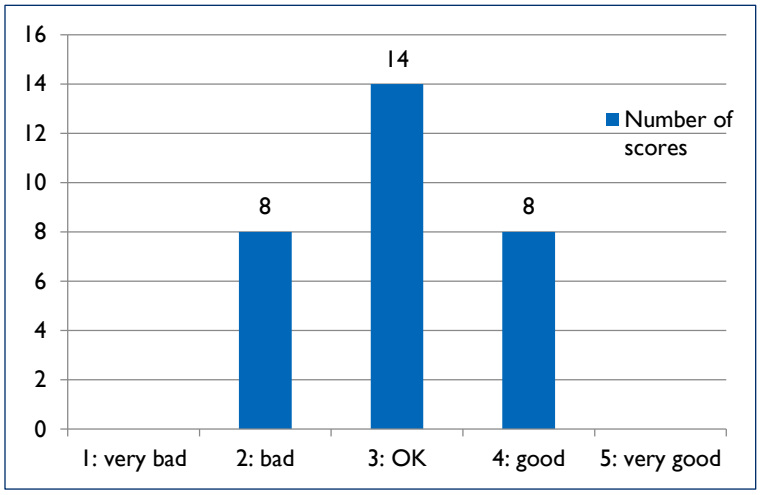


Figure 18. ECH team's scoring of overall ECH project management

The centralization of financial decisions in Phnom Penh hinders active management of field operations and requires an excessive amount of field staff time to complete funding proposals to carry out field activities and settlement processes. Transportation of hard copies of funding proposals from district towns to the capital is also time-consuming and therefore costly. The tendency for finance, rather than program rationale, to drive decisions is undermining the mechanism's flexibility, responsiveness and innovation; this includes addressing programming gaps, such as in BCC as discussed under evaluation question 6a. Similarly, decisions on how to respond to local programming challenges and opportunities need to be taken by local program managers, who are informed of the budget envelope and are working to program objectives and strategies, rather than by centrally based finance staff rigidly following line items in budget allocations without the breadth of view or position to manage the program. Finance needs to play a more supporting role to mechanism management, with leadership of ECH firmly driven by the chief of party in line with the goals and objectives of the ECH agreement with USAID.

The current system of spot-checking on whether government staff have participated in activities for which they receive a per diem is overzealous and is undermining the mechanism's relationships with government; a more diplomatic approach is needed. The financial management system urgently needs to be made more efficient and simplified in order to increase the pace of implementation. For example, decentralizing financial authority (at a reasonable level) to provincial managers so that they are able to effectively manage activities could reduce the complexity of documentation (possibly through an e-based accounting and approval system) and make fund management more efficient and transparent.

Standard operating procedures are reported to be complicated and not understood or accessible to all staff, and some of them are not available in Khmer. Some standard operating procedures have been developed through rounds of externally funded technical assistance that have created overly complicated procedures that are not fit for the operating environment.

Staffing and workload: Difficulties faced in recruiting appropriately qualified staff for management and field positions has led to staffing gaps that have hindered implementation, relationships with government partners and communities. This has resulted in high workload for some staff. Staff working in operational districts with a large number of health centers and communes also have a high workload and need extra support. The excessive administrative burden on field staff due to the financial management system and excessive reporting requirements is leading to significant levels of frustration.

Communication: The structure and flow of communication needs to be reviewed and enhanced to expedite the timely translation of decisions into action and strengthen communication between the field and central management.

Question 6a: Are the various approaches of the behavior change campaign, including a comedy show and interpersonal communication, effective for disseminating messages to people? If not, why not?[13]

ECH uses a variety of approaches to disseminate messages to people in the community, ranging from interpersonal communication and group announcements by VHSGs/CBD agents/C-DOT watchers/CCWC to awareness-raising at Comedy for Health shows. As found by other studies, women reported to prefer receiving health information from other women at home. In contrast, men reported to prefer receiving health information in informal social settings. Reaching men is difficult, given their work patterns and lack of interest in health matters, which are often considered women's domain. One of the strengths of the Comedy for Health shows, which are held in the evening, is that they attract large numbers of men.

Comedy for Health shows are a medium that RACHA has been using since 2002. An evaluation in 2012 found them an effective awareness-raising method.[14] The evaluation team observed a show in Mongkul Borey District, Banteay Meanchey Province that attracted more than 300 people, including large numbers of adolescent boys and girls and men and women. Given the lack of access to other forms of entertainment in rural areas, the evaluators believe that the approach remains a relevant and appropriate awareness-raising event for rural communities. There is, however, scope for improving their effectiveness:

1. Shows are held in the evening in a central village location, often at the pagoda. The show that the evaluation team observed started at 7:30 p.m., and by 9 p.m. the majority of the audience was leaving, although the show had not finished. It was reported that 7:30 p.m. was a good start time because families have generally eaten and completed domestic chores by this time. After 9 p.m., it is difficult to retain a rural audience because people sleep early in preparation for work early in the morning. The current show is too long and needs to be reduced to approximately 90 minutes because it is difficult to retain the attention of a rural audience much beyond that duration.
2. The number and prioritization of messages needs attention. The evaluators recommend coverage of fewer messages that are woven into the drama, rather than reading a list of messages out loud.
3. The BCC team needs to lead the design of the script and ensure coherence and comprehension of the messaging through field testing.
4. In addition to the comedy show performed on the main stage, the mechanism could explore the opportunity to disseminate messages through information booths located around the pagoda and via IEC materials targeted to different audience segments. Information booths could be styled for specific audiences or themes, such as young people or "everything you want to know about I-SAF."

[13] USAID explained at the evaluation in-briefing that the focus of this question was on whether BCC methods were appropriate and reaching audiences, rather than a cost-effectiveness inquiry, which would require a different and more robust analytical approach.

[14] Chhea Chhorvann and Chea Chhordaphea. September 2012. *Evaluation of the Effectiveness of the Comedy for Health Program of the Reproductive and Child Health Alliance (RACHA).*

The comedy show provides health messages for VHSGs and other actors to draw on in their interaction with target groups in the community; however, this will require stronger linkages across the different BCC approaches being used. Monitoring of shows captures the number of people attending events but does not measure awareness raised at the event or the pathway from awareness to behavior change (this issue is discussed further below).

VHSGs/CBD agents/C-DOT watchers/CCWCs disseminate information opportunistically in group settings and through interpersonal communication. As they are influential and trusted members of the community, such interaction is important for awareness-raising, mobilizing community support for health and triggering behavior change. However, it is important to recognize the limitations of older male community actors to demonstrate and catalyze new behaviors that may cross gender boundaries, such as breastfeeding and female contraception. The coverage and volume of this interaction is not measured.

The mechanism is strengthening VHSG linkages with health centers and regular VHSG and HCMC meetings; as part of this, the evaluators recommend that practical, easy-to-use reminders and job aids be developed for health staff to guide VHSGs in their BCC activities. These could include reminders for health center staff to make weekly phone calls to inform VHSGs of recently delivered women so they can follow up. Similarly, VHSGs need compact BCC materials that they can easily carry around to remind them of key messages. Such materials can be developed from existing BCC message content.

SMS and social media: There is limited reach of social media in rural areas, and most rural people are not able to read English language messages carried by phone companies. However, ownership of smartphones capable of carrying Khmer script is increasing in rural areas. A recent study by Phong and Sola (2015) found that 34 percent of rural residents own a smartphone, including 32.3 percent of women and 46.8 percent of men.[15] Ownership increases with education; only 15.2 percent of people with no formal education own a smartphone. The increasing penetration of smartphones in rural Cambodia, especially among young people, is opening up opportunities for messaging via SMS and social media. However, given current capacity within the ECH communication team, this is not a priority area at this stage.

Active and participatory BCC is not currently implemented under the mechanism, though there is potential to build on existing women's groups, such as RACHA's savings groups and mother's groups. Such platforms could be used for participatory learning and action, which has been shown to be an effective method for reducing maternal and neonatal mortality in high-mortality settings.[16] RACHA's past positive experience with nuns and Wat grannies providing breastfeeding guidance to new mothers is not implemented under ECH, and this seems a missed opportunity to scale up a successful approach. Quasi-experimental research (2007) undertaken by RACHA found that the nun and Wat granny intervention increased the early initiation of breastfeeding from 24.8 percent to 84.2 percent, and exclusive breastfeeding from 38.4 percent to 72.5 percent after a one-year intervention; gains in control sites were significantly less.[17]

Internal BCC capacity within the mechanism needs strengthening, and the ECH communication unit needs to be empowered to lead the design of BCC methods and tools. In January 2016, an external consultant assessed communication needs to inform the development of a communication strategy. While this is a

[15] Phong, K., & Solá, J. November 2015. *Mobile Phones and Internet in Cambodia 2015*. Retrieved from https://asiafoundation.org/resources/pdfs/MobilePhonesinCB2015.pdf

[16] WHO. 2014. WHO recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health. http://apps.who.int/iris/bitstream/10665/127939/1/9789241507271_eng.pdf?ua=1

[17] RACHA with Brigham Young University. 2005. *Changing lives in Cambodia: Do Nuns and Wat Grannies Improve Breastfeeding Practices?*

good starting point, further work is needed to develop this into a more coherent BCC strategy and plan that identifies target behaviors, audiences, influencers, key messages, choice of BCC approach and medium, and methods for evaluating effectiveness. A mechanism-wide BCC strategy and plan will draw linkages across BCC methods, articulate how awareness-raising activities are expected to translate into behavior change, and identify the synergies between ECH nutrition-related BCC activities and those of NOURISH. The draft strategy document can be strengthened in several of these areas.

Question 6b: Are the current monitoring tools and systems sufficient for measuring the results of these project activities?

Progress

Online MIS: RACHA has invested in the development of a custom-built online MIS for the mechanism, known as the RACHA Central Reporting System (RCRS). The RCRS measures mechanism activities and their outputs and most indicators in the M&E plan; the remainder of the M&E indicators are to be measured via special studies. The ECH team has invested considerable effort in developing indicators that measure local governance of community health, for which there are no standard global indicators. Field staff have been trained to use the RCRS, and, although some geographical areas suffer from unstable internet, generally the system appears to be working well. The M&E team reports that it has improved data quality, timeliness and reliability. Similarly, a March 2016 data quality assessment by USAID found significant improvements in data collection, reporting, security and data quality compared to a November 2015 assessment.

Areas for strengthening

Review field reporting needs: Field staff complete weekly and monthly reports and enter daily activity data in the RCRS. The weekly report template is a basic activity table and does not include narrative reporting. From the weekly reports, the ODM creates a monthly report for the district. The PMs compile all of the ODM reports for a provincial monthly report. There is a perception among some staff that the reporting requirements place a high labor burden on field staff. The evaluation team suggests that headquarters staff review the reporting requirements, frequency and uses of reported data with field personnel to ensure an appropriate balance of labor efficiency with data needs.

Amendment of indicators: A few monitoring indicators in the M&E plan need modifying to better capture intent, including indicators #1, "percentage of communes where VHSG (including CBD/C-DOT watchers) report to and are monitored by Commune Council," and #20, "number of children identified through contact tracing and referred for TB screening by VHSG." Indicator #1 is a complicated composite indicator that incorporates several actions and would be better streamlined. Indicator #20 only focuses on children, while contact tracing activities also include adults. The three indicators linked to Component 3 do not currently capture semi-active case-finding activities, which is a gap. Therefore, it is suggested that the three TB-related indicators be reviewed and modifications made to include adults referred for TB screening as a result of either contact tracing or semi-active case finding. These points were discussed with the M&E team, who will propose modifications to USAID.

Balance between process, output and outcome indicators: The indicators in the M&E plan measure the processes and outputs of the project's three components, which include changes in community health systems and governance, capacity building of VHSGs and CBD agents, and delivery and use of select MCH, family planning and TB services at the commune and health center levels. The indicators carefully measure the process of building community health systems and the relationship between VHSGs/CBD agents and users, but they do not seek to comprehensively measure changes in individuals' knowledge or practices in the areas of MCH, family planning or TB. For example, for newborn care, the indicators include #17 (number of postpartum/newborn pairs visited by VHSG within one week after birth), and #18 (number of sick newborns referred to a health facility by a VHSG). These indicators measure VHSG performance in providing postpartum newborn care visits and referral, but no indicator measures

mothers' knowledge of the newborn danger signs or use of postnatal care visits for the baby and/or mother (PNC2 and PNC3). Given the focus of the project on community health systems, the balance between systems versus individual practice indicators in the M&E plan seems reasonable. However, as noted below, further work is required to develop a higher-order evaluation plan that includes measurement of changes in individuals' behavior; this will also provide direction to the BCC strategy.

Process monitoring: Empowerment and institutional change (such as CC ownership of community health) are at the heart of the mechanism and require a more nuanced approach to measurement than is currently in the M&E plan, such as through qualitative process M&E tools. This could include tracking capacity development of key community agents through self-assessment processes woven into capacity-building activities. Qualitative measures such as ladders of change could be developed to measure the functionality and effectiveness of HCMCs, against which HCMCs could review their progress biannually. Tools also need to be developed to support CCs to discharge their oversight of health centers and enable them to monitor health center budgets, spending and performance.

Evaluation plan: A comprehensive evaluation plan and methodology needs developing, with clearly defined intermediate and end-of-program outcomes. This needs to build on the outcome indicators in the M&E plan and include composite measures of community empowerment, commune ownership of community health and behavior change goals. The joint impact evaluation of I-SAF with NCDD, World Bank and the consortium of CSOs implementing I-SAF will contribute to the mechanism's evidence footprint. Intervention-specific evaluations to capture promising good practices for wider dissemination also need to be factored into evaluation planning.

Evidence, learning and influencing policy

ECH is engaged in change processes central to the decentralization of health services and empowering communities for health. To date, the focus of the mechanism has been on implementing activities at a pace to catch up on lost time at the beginning, and the M&E unit's focus has rightly been on designing and rolling out the RCRS. Now that sufficient momentum has been achieved, greater focus needs to be given to the evidence and analytical agenda in order for the mechanism to perform its learning and policy-influencing objectives.

Greater analysis is needed of the appropriateness and effectiveness of interventions, the identification of gaps and the design of creative programmatic solutions. A more efficient financial management system that is positioned to support mechanism management will enable the mechanism to be more flexible and responsive. More attention is needed to tailor interventions to better fit the context, testing different packages and approaches for different environments, such as remote and very poor communities, and developing methodologies to reach underserved groups, such as adolescents. A stronger focus on documenting and disseminating evidence to inform policymakers and development partners needs nurturing. The rich database of CIP budget allocations to community health is an example of data collected by the mechanism that could be developed into a series of briefing papers.

Other observations

Per diems: ECH complies with the harmonized per diem guidelines disseminated by USAID in February 2015. However, there is a widespread perception among government stakeholders that ECH provides lower per diems than other USAID implementing partners. This perception is aggravated by the fact that ECH activities generally take place at the health center and commune levels, which are compensated at a rate of $3.75, while the equivalent participation at the provincial level is $10.50 per day.[18] USAID involvement is needed to level per diems across implementing partners and address the in-

[18] These are rates for a "day return," i.e., the officer goes to the training/meeting and returns to their place of work in one day.

built disincentive for government provincial and operational district staff to visit lower levels of the system.

Compensation for loss of earnings: ECH rates for compensating the loss of earnings that VHSG/CBD agents/C-DOT/CAF incur through their participation in the mechanism are very low, out of line with market conditions, and not competitive with other USAID projects or CSOs. This results in high turnover, concentrates participation among elites and makes it difficult to attract younger, better-educated people.

Crosscutting themes of sustainability and gender[19]

The ECH mechanism is designed with the intention of supporting the institutional and financial sustainability of VHSGs through building CCs' ownership of VHSGs and budget allocations for VHSGs under CIPs. While this objective remains appropriate, the low funding of CIPs means that the budget space for absorbing VHSG costs and other potential community health interventions is very limited. This external constraint is beyond the capacity of the mechanism to influence and means that VHSGs may require continuing external support, even if the mechanism achieves the buy-in of CCs. Advocacy at the national level to position community health structures as important vehicles for achieving HSP3 goals, especially those around behavior change, local governance and accountability and in the effective decentralization of health services, will be important to enhance policy attention to this area.

Gender is a social determinant of health that affects access to health services and the social norms that have an impact on health risks, behaviors and outcomes. While ECH captures sex-disaggregated data and promotes maternal health, the focus on gender beyond this across the mechanism is shallow. There is scope to better integrate gender into the design of interventions (e.g., in an analysis of which BCC approaches are better suited to meeting women's and adolescent girl's information needs), organizational ways of working (how to encourage more women into field management positions), analysis of who is participating in mechanism activities and who is left out (e.g., how to build the confidence of female VHSGs to speak out in HCMC meetings) and evidence and learning strategies (how women can be empowered to actively engage in I-SAF). At the organizational level, this will require a stronger understanding of gender and how it impacts health outcomes among the ECH team, the allocation of responsibility to lead efforts to strengthen attention to gender across the mechanism, and a commitment to attract women into field positions, including in management.

CONCLUSIONS

Policy

ECH has the potential to demonstrate and learn how local governance of health services can be strengthened in the evolving decentralization environment and how social accountability contributes to community empowerment. While the I-SAF package of social accountability tools fits with global good practices, the VHSG model is outdated and in need of evidence-based review. The institutional relocation of VHSGs and the decentralization of health services present an opportunity to support the government review and revise the VHSG model to better fit the Cambodian health and institutional context and feed into the HSP3 (2016-2010) and Ministry of Interior plans for CC development. This needs to take into account the large body of global evidence on the effectiveness of community health workers and factors that contribute to their success.

Behavior change

The package of BCC health topics delivered by the mechanism needs reconsidering to fit good practice around the continuum of care and the practical realities of behavior change programming. Synergies with

[19] Linkages to national policymakers is a third crosscutting theme, but this has already been addressed.

other community health and nutrition projects need exploiting. The mechanism's targeting of adolescents needs strengthening, given increasing teenage pregnancy in the country and adolescents' poor access to information and health services. Pre-pregnancy adolescent nutrition is also important. Stronger attention needs to be given to engaging and involving men in community health, building on the appeal of the Comedy for Health shows. There is a need to re-energize BCC within the mechanism and create greater synergy between activities.

Mechanism management

Strict and conscientious interpretation of all USAID directives by RACHA has contributed to the development of complicated management systems and structures that are not fit-for-purpose. This has led to overly centralized decision-making, a complicated and inefficient financial management system and a lack of flexibility and creativity in programming.

USAID programming

Parallel design and contracting of USAID community health and nutrition projects in the same geographical areas without clear incentives or directives for coordination has not fostered coordinated programming.

RECOMMENDATIONS

ECH mechanism management

To increase the effectiveness and efficiency of mechanism management, the evaluators recommend:

- The financial management system should be made more efficient and fit-for-purpose, without compromising transparency or encouraging misuse.
  - Financial authority should be decentralized to provincial managers up to a reasonable ceiling, such as $1,000 per transaction.
  - The complexity of documentation should be reduced, possibly through an e-based accounting and approval program, to make fund management more efficient and transparent.
- Standard operating procedures should be revised by RACHA (with local assistance as needed) to make them less complicated and more accessible to staff.
- Field staff should be increased where operational districts have a high number of health centers and based on field experience of ECH provincial and regional managers.
- Decision-making and communication structures need to be clarified to expedite timely translation of decisions into action and to improve communication flow between headquarters and the field.

Per diems

- As soon as possible, RACHA should raise the per diem it provides for attending activities at the health center and commune levels, in line with rates provided by other USAID implementing partners and CSOs involved in community health programs, and seek approval from USAID. This immediate action is recommended to make RACHA rates equivalent to similar USAID-funded community programs, such as NOURISH, while USAID/Cambodia seeks to harmonize per diems across all USAID-funded health programs in consultation with the MOH, which is expected to be a more drawn-out process.

Compensation for loss of earnings

- Compensation for loss of earnings of community agents (CAF, VHSG, CCWC, CBD agents, C-DOT) needs increasing to be consistent with market conditions and rates paid by other USAID implementing partners and non-governmental organizations.

Programmatic and technical

- A coherent, mechanism-wide BCC strategy and plan needs to be developed or finalized, drawing on the early 2016 needs assessment.
  - Review priority areas of behavior change to align with the continuum of care and life cycle. In addition to the current focus on family planning, antenatal care, delivery and postnatal care and care of the newborn, include adolescent reproductive and sexual health, pre-pregnancy nutrition, complementary feeding and care of the child.
  - Include attention to adolescent reproductive and sexual health as a priority area and strengthen the engagement of men and adolescent boys in BCC programming.
  - Leverage evidence-based BCC methods that have been shown to be effective in Cambodia or similar contexts and existing community platforms, such as nuns and Wat grannies and women's saving groups.
  - Introduce complementary sources of contraceptive information to promote LAPM, such as CCWCs, nuns and Wat grannies, village leaders and women's saving groups.
  - Revamp Comedy for Health shows to reduce their length, prioritize the number of messages and deliver them through engaging drama, and test complementary information outlets at the event for specific audiences.
- Delegate financial management of small amounts of money to facilitate HCMC and VHSG meetings to CC/CCWC.

M&E

- Modify the few monitoring indicators that could be better framed to capture intent (#1 and #20), and review the TB-related indicators to include contact tracing and semi-active TB case finding of adults.
- Develop qualitative process M&E tools (such as most significant change and participatory ethnographic and evaluation research) to capture empowerment and institutional change processes.
- Develop a comprehensive evaluation plan that includes outcome indicators, composite indicators of empowerment and institutionalization, and behavior change goals.

Influencing policy

- Advocate for an evidence-based review of the VHSG model to inform government and development partners of the effectiveness of the approach.
- Contribute to MOH and Ministry of Interior policy-making on community health structures in the context of decentralization, including: disseminating evidence and learning from the program, developing briefing papers, and participating in technical working groups.

Capacity strengthening

- The BCC unit needs strengthening of its technical capacity and empowering to lead the design of BCC approaches.
- The capacity of the M&E unit needs strengthening to drive analytical work and support translation of learning into advocacy and knowledge management.
- The capacity of ECH to engage in advocacy and policy-influencing needs strengthening.

- Greater understanding of the impact of gender on health should be developed to support the better integration of gender into mechanism components, activities, ways of working, evidence, analysis and learning.

C. SOCIAL HEALTH PROTECTION (SHP)

FINDINGS

Question 4 (part 3): To what extent has SHP achieved its objectives and expected results at this time?

As of March 31, 2016, SHP has achieved most of its objectives, with some delay in the institutional strengthening component because of the evolving policy environment, upcoming elections and continuing discussion between the MOH and development partners participating in the pooled fund mechanism regarding the future of the HEF and the RGC's vision for broader social protection (see more detailed discussion in the section covering Question 7a). The following section summarizes the key achievements of SHP to date and discusses remaining challenges facing the mechanism.

SHP technical support has enabled the MOH to achieve national HEF coverage: As a continuation of the Better Health Services project, also implemented by URC, one of SHP's main objectives was to enable the expansion of the HEF to cover all public health facilities by 2018. To this end, the mechanism has exceeded its targets, covering 100 percent of operational districts, 90 percent of referral hospitals, and 100 percent of health centers at the end of March 2016 (see Figure 19).

A total of 2.98 million poor people are receiving HEF benefits, and the provider network was extended to 1,068 health centers, 72 former district hospitals, 98 referral hospitals and one national hospital, the Khmer Soviet National Friendship Hospital, which provides tertiary care.[20]

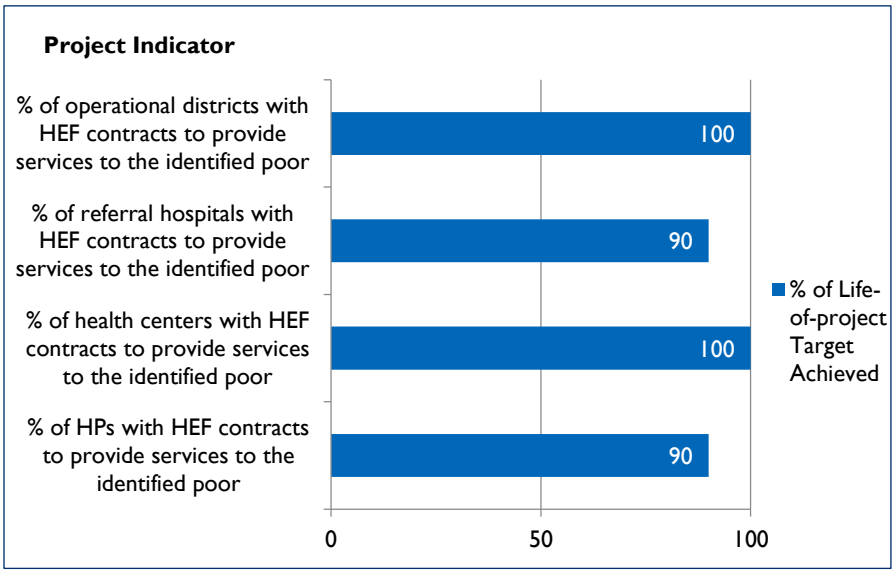


Figure 19. HEF Health Provider Coverage

Challenges: While the majority of informants interviewed agreed that the HEF has greatly expanded access to health services for the poor, there remain continuing concerns regarding community awareness and client targeting.

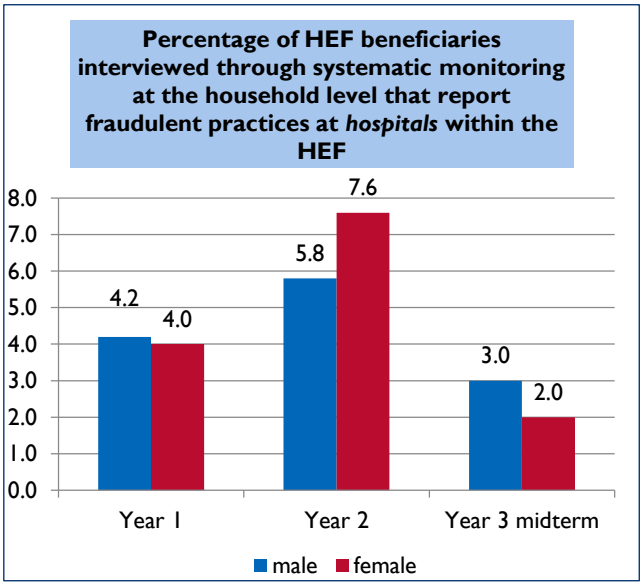
[20] At the beginning of June, three additional national hospitals were ready to sign HEF contracts, bringing the total number of national hospitals in the HEF network to four.

Health facility staff and management, especially those at referral hospitals, report that a few poor clients still lack knowledge about their HEF benefits and patient rights. Some patients either forget to bring their IDPoor/Equity Card, or fail to show the card at registration. Some are willing to pay out of pocket for the consultation fee of 1,000 riels and only show the card when presented with more elevated fees.

Local government authorities at both the provincial and district levels stated that they are hearing fewer complaints from the community regarding the HEF. Nevertheless, there remain concerns about the Ministry of Planning's IDPoor selection process and the variation in local government implementation, which risks excluding certain populations. During the evaluation team's field visit, representatives from the provincial health department, operational district, and provincial and district government authorities cited cases where poor families were not getting cards while some "non-poor" were getting them. The mobility of migrant populations in provinces such as Battambang and Bantay Meanchey meant that those who may be eligible were not being counted due to their absence during the household interview process. SHP research showed that while the IDPoor process includes a village consultation phase where these types of omissions could be corrected, this phase is not consistently implemented in all locations. The existing IDPoor process is also not suitable for targeting the urban poor population. SHP has made some initial inroads with the Ministry of Planning to develop more appropriate indicators for urban populations but had limited influence in getting the Ministry to adopt these indicators.

The third-party monitoring function played by the mechanism has strengthened HEF governance: SHP has put in place a robust independent monitoring system that not only safeguards the financial integrity and transparency of the HEF but also ensures client protection. Through a geographically well-distributed and coordinated local team of monitors and technical supervisors, the mechanism provides verification that poor clients are indeed receiving the benefits and clinical services being reported by the health facilities.

The mechanism aims to keep the percentage of irregular cases below 5 percent. In year 2, the HEF achieved national coverage, and the number of new health facilities contracted by the MOH increased exponentially. The number of flagged cases also experienced a notable spike, especially at referral hospitals, where the patient volume tends to be higher (see Figure 20). However, by the middle of year 3, the percentage of reported irregularities has decreased substantially, to 3 percent for males and 2 percent for females at referral hospitals, and 0.3 percent for males and



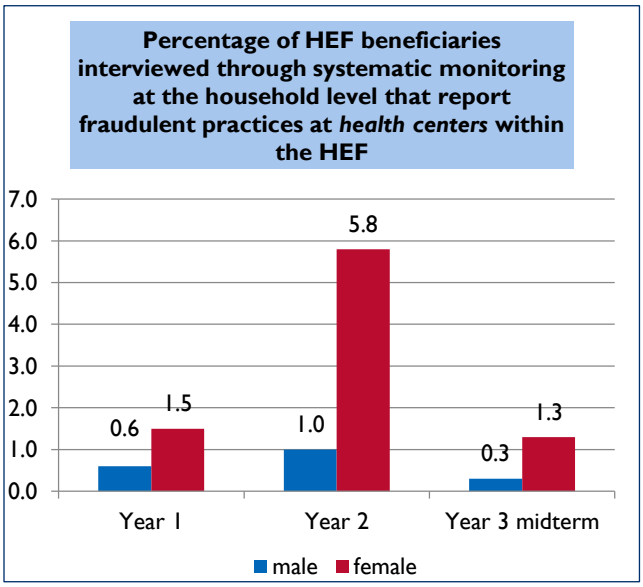


Figure 20. Percentage of reported irregularities among clients interviewed during monitoring

1.3 percent for females at health centers. These results indicate that the SHP monitoring system is effective at flagging potential fraudulent practices at health facilities.

The monthly monitoring reports prepared by SHP and submitted to the Provincial and/or District Health Financing Steering Committee (P/DHFSC) succinctly capture "sensitive" cases that were flagged during the verification process, giving the committee sufficient information upon which to resolve disputed claims. Interviews with P/DHFSC members and health providers confirm that the committee provides an indispensable and neutral forum for dispute resolution and further strengthens HEF governance. However, this governance structure cannot exist without some external budgetary support to ensure regular quarterly meetings are held to address and resolve disputed cases.

Challenges: Given the "policing" role played by SHP, there exists a natural tension between the mechanism (and as an extension URC), health facility managers and the provincial health departments. While SHP adopts a collaborative approach in gathering facts about flagged cases, the fact that these incidents are being raised to the P/DHFSC, a structure outside of the regular provincial health department reporting channel, has been a source of friction in certain provinces, such as Bantay Meanchey and Siem Reap. In Battambang, on the other hand, the level of collaboration and coordination with SHP was highly rated by the health facilities, provincial health department, and Steering Committee members.

The mechanism has successfully integrated the Patient Management and Registration System (PMRS) at HEF facilities: At the end of March 2016, SHP had exceeded its targets for the number of HEF-contracted public health facilities that are using the MOH PMRS for full patient registration (Figure 21), with an actual realization of the system at 37 facilities, compared to the original target of 42 for the project's third year. The accelerated level of implementation for this component is mainly due to the policy and operational changes that are part of the transition from the HSSP2 to the H-EQIP, which will be discussed in more detail under Question 7a.

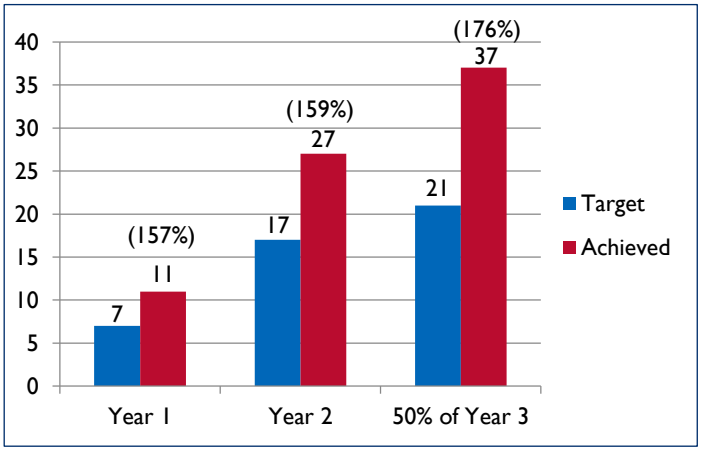


Figure 21. Public health facilities covered by a social health protection mechanism using the MOH PMRS for full patient registration

By automating the patient registration process and giving each patient a unique ID number, the PMRS enables more comprehensive documentation and a historical record of a patient's medical treatment. The system also contains built-in checks and balances to improve monitoring of HEF benefits and payments.

Implementation of this activity went beyond the simple installation of a management information system. It also entailed reorganizing the physical flow of patients through a centralized point of entry and moving them from triage to registration to treatment in a sequential manner. Each health facility made a commitment to redefining not only their internal processes but also their physical spaces to accommodate this process. The end result is a more orderly and efficient patient intake process with clear separation of administrative, financial and clinical functions.

During the evaluation team's visits of referral hospitals with the full PMRS, facility managers and staff unanimously agreed that the PMRS has been helpful in finding information about a client's history. The head of the Preah Net Preah Referral Hospital in Bantay Meanchey stated that the PMRS records all

income, which makes it easy for him to "see the hospital's financial situation, which results in improved management and better control of staff."

Challenges: Facilities still face challenges, such as the low IT skills of hospital staff, which necessitate the hiring of contractors to handle administrative functions, and inconsistent and erroneous entry of diagnosis. The PMRS clerk in Thmar Kol Referral Hospital remarked that the diagnosis code in the system sometimes does not match the patient intake form, so he sometimes has problems identifying the right code to enter into the system.

Another common challenge observed by the evaluation team relates to the limited availability of physical space for patient files. In high-volume provincial referral hospitals, rooms are overflowing with files, sometimes placed in bound bundles on the floor, making it nearly impossible to find a patient file. While the medical record and history are available online, access to patient files is limited as a safeguard against health staff changing diagnosis codes after the fact, so the physical patient file remains the primary source of information.

The Community-Managed Health Equity Fund (CMHEF) provides a complementary structure for expanded health benefits: At the mechanism's midpoint, 217 CMHEFs have been established in 16 operational districts in six of the nine USAID-targeted provinces. Currently, 163 CMHEF committees are purchasing services from health centers covering 2,759 villages in 282 communes and working with 961 pagodas and 205 other faith-based organizations.[21] The rate of CMHEF establishment has been below target due to the lack of buy-in from provincial health departments and operational districts in certain provinces. Upcoming CC elections in 2017 may also be a factor in the delayed implementation. The slowdown in CMHEF expansion is not necessarily negative, because the project can focus its resources on strengthening the existing group structures and building the evidence base on the structure's impact, which can be used to advocate for future expansion into non-participating provinces.

Visits to CMHEFs in three provinces confirm that these commune-level structures are indeed providing complementary coverage to the national HEF by covering costs of transportation to health centers and

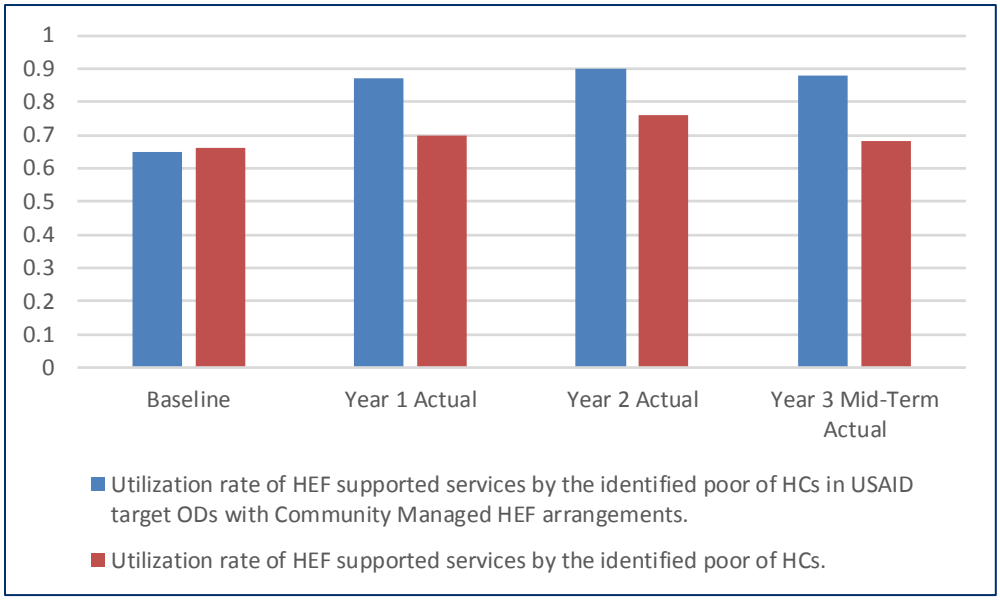


Figure 22. Health center utilization rate by the poor in operational districts with CMHEF compared to national utilization rate

[21] SHP presentation to GH Pro midterm evaluation team on May 12, 2016.

targeting other vulnerable groups such as the elderly, disabled and orphans. This is reinforced by mechanism data (Figure 22) showing that the utilization rate of health centers by the poor is higher in operational districts with CMHEFs than at the national level.

Challenges: One of the primary roles of the CMHEF is to mobilize local financial resources to strengthen the health system at the community level. All CMHEFs are locally funded through donation boxes and other community fundraising events such as Khmer New Year celebration, Phchum Ben ceremonies, etc. SHP, through its sub-agreement with Buddhism for Health, has provided training on planning, budgeting and record-keeping to ensure that funds being raised are properly managed and accounted for. In visits to CMHEF committees in Battambang and Bantay Meanchey, the evaluation team found that records are well kept and, in general, members are aware of the level of available funds. However, capacity for financial planning and analysis still needs strengthening; members struggled to respond to the team's question about budgeted versus actual funds raised and spent. Moreover, knowledge about finances tends to be concentrated in one or two people, which increases the risk for potential misuse of funds.

Another key role for the CMHEF is to promote community outreach and engagement regarding HEF benefits and IDPoor selection and to receive community feedback regarding quality of service and barriers to accessing health services. To date, the mechanism's focus around the CMHEF has been primarily on establishment of the structure and on fundraising. SHP has developed a training module that details how CMHEFs can intervene at each stage of the IDPoor process–from the commune-level working group to village consultation when the list of households to visit is prepared. In interviews with CMHEF members, this aspect was not mentioned when members were asked to describe the role of the CMHEF. During the meetings, there was less focus on this role and more discussion of fundraising and management of benefits. In addition, there is no formal mechanism for collecting feedback from the community, though SHP has started to develop some tools to facilitate this task. During the field visit interviews, CMHEF members indicated that more can be done to collect feedback from the community.

CMHEFs are also supposed to be self-managed, with major policy decisions made at the annual general assembly and based on consensus. The evaluation team was not able to observe the general assembly; however, through the field visits of CMHEF meetings and focus group discussions held with members in the two provinces, the team observed that a few individuals tended to be the most vocal–usually the CC chief, head monk or village chief–and influenced the flow of the meetings. The head of the health center usually attends quarterly leadership meetings and also seems quite vocal relative to other committee members. The engagement of these traditional authority figures lends the structure more credibility and trust within the community; however, it also raises the question of whether all members genuinely have an equal voice in decision-making about target beneficiaries, types of benefits, and fundraising. This situation is exacerbated by the differing level of engagement and commitment by members. Since participation is voluntary and no per diem is paid to attend the quarterly meetings, the motivation for regular attendance is not there.

While SHP has made efforts to encourage female participation, there is still a notable gender imbalance both at the leadership level and in the general membership. According to the mechanism's FY 2015 annual report, women comprise only 19 percent of total memberships and 16 percent of leaders. On the finance or feedback subcommittees, the results are only slightly better, with women comprising 22 percent of the former and 57 percent of the latter.

Question 7a: How do contextual changes in the political and socioeconomic environment in Cambodia affect the project in achieving its objectives?

As a health systems strengthening mechanism that works in concert with the government at the policy level on social health protection, SHP is particularly reliant on the MOH counterpart, as well as the

actions of other development partners, to move forward with its own project objectives and work plan activities. Several developments in the external operating environment have had significant impact on the pace and substance of mechanism implementation.

At the national level, upcoming elections—CC in 2017 and Parliament in 2018—mean that no major policy decisions on social protection or universal health care would be made. A draft health financing law was prepared in 2015, which outlined a path for the RGC toward the adoption of universal health care, but was never finalized and its fate is currently unknown. In addition, the Ministry of Economics and Finance (MEF) is developing a comprehensive framework for social protection that envisions a merging of all social health protection schemes under the National Social Security Fund at the Ministry of Labor. To date, this framework remains on paper only, and there is no expectation of any formal decree to be issued until after the election cycle has been completed. Uncertainty exists as to which ministry will take the lead in implementing the social protection and universal health care strategy, though there seems to be a preference among development partners toward the MEF as the lead actor. The CC elections have also affected the expansion of the CMHEF into additional operational districts because local authorities are loath to start new activities that may be perceived as an effort to influence voters' decisions.

The transition from the donor pool-funded project HSSP2 to the new H-EQIP has also resulted in some substantial changes with regard to the operations of the HEF and how it will be governed in the longer term. In SHP's original program description, the mechanism was slated to hand over its role as an HEF Implementer to the National Social Health Protection Fund under the MOH by December 2016. However, under the H-EQIP agreement, the MOH is now expected to establish an independent Purchase Certification Authority (PCA) as a Public Administrative Establishment (PAE), to which URC/SHP would transfer its monitoring role. At the time of the evaluation's team visit, the date for the establishment of the PCA has not yet been decided, and there is still some debate, both internally within the RGC and externally with development partners, concerning where the PCA should be located—as an arm of the MOH but governed by an independent multisectoral board, or as an arm of the MEF. Development partners and SHP are hoping that the disbursement-linked indicator under H-EQIP, where the formal establishment of the PCA would trigger a $500,000 payment, would be sufficient incentive for some concrete action on the part of the RGC before the end of 2016.

HSSP2 was supposed to end in December 2015 but was extended for six months while H-EQIP was being designed and negotiated. This had two major consequences. First, since development partners still fund 60 percent of HEF direct benefits, the delayed funding disrupted cash flow for HEF Operators and health facilities. HEF Operators are also responsible for organizing the quarterly P/DHFSC meetings, so when faced with a funding shortfall, this activity was among the first to be dropped. Many of the health facilities interviewed by the evaluation team mistakenly viewed the tardy payment as URC's doing in response to the sensitive cases reported by the HEF monitors. Second, the late launch of H-EQIP and the uncertain timing of the PCA establishment mean that SHP will have to extend its monitoring role beyond December 2016, an added cost that was not originally anticipated in its budget. This issue was raised to USAID in SHP's FY 2016 work plan.

The new H-EQIP also proposed a change of the HEF Operator into an HEF Promoter, with the health facility taking on the responsibility for distributing transportation reimbursements and caretaker food allowances while the HEF Promoter's primary role will be patient advocacy, awareness-raising and promotion. This required that SHP carry out an accelerated roll-out of the PMRS in order to facilitate the transition. While the transfer of client registration and payment to the health facility streamlines the process, it also reduces a layer of external monitoring. Similarly, H-EQIP failed to take into account the funding for the quarterly meetings of the P/DHFSC, which was previously included into the HEF Operator contract with the MOH. The failure to fund this multisectoral governance structure would remove not only another layer of supervision but also an important forum for dispute resolution.

Question 7b: How can the HEF monitoring system be institutionalized in a cost-effective manner?

According to data from the MOH and URC, the mechanism's total monitoring costs are less than 6 percent of the total cost of the system (Figure 23). While there is no international standard by which to assess this ratio, the cost appears to be reasonable and could be absorbed by the PCA. To ensure that the cost expended for the HEF monitoring system will result in the same outcome (i.e., fraud prevention, financial transparency and client protection), the institutionalization process should take into account the issues outlined below.

Item	2014		2015		2016 (est.)	
	Amount (US$ million)	Percent	Amount (US$ million)	Percent	Amount (US$ million)	Percent
Total cost of system (direct benefits)	8.96	100	11.6	100	17.0	100
HEFI verification and technical assistance	.62	5.4	.85	5.7	.94	5.5

Source: MOH HMIS, SHP mechanism, and World Bank H-EQIP PAD

Figure 23. Total HEF expenditures 2014-2016

Maintaining the principle of third-party monitoring: Separation of the provider-purchaser roles is sacrosanct to HEF governance. According to the deputy chair of the DHFSC in Siem Reap, HEF monitors need to be independent in order to avoid external pressure and to "tell it like it is." Likewise, patients would be less likely to report irregularities if they perceived the monitors to be prejudiced or beholden to the health facility in any way. Having an independent monitor ensures client confidentiality and helps to avoid intimidation and fear of retribution by health facility staff. SHP staff members reported incidents where the provincial health department or operational district would ask a patient to change her answer on the household visit questionnaire.

SHP's approach of using a mix of monitoring methods—documentation review, bedside interviews and random household visits—is more labor-intensive but provides an appropriate level of rigor. Over time, with the PMRS being fully operational for a longer period, there could be a shift toward more documentation review based on clinical protocols and fewer household visits. Getting patients' feedback after they leave the health facility should be maintained, even at a reduced level, since some individuals may not feel comfortable giving their honest opinion in front of health staff or other patients.

Ensuring continuity in processes as well as in staffing: Having the right processes alone is not sufficient; a good monitoring system also requires the right kind of staff. The transfer of current monitors to the new PCA is important to ensure continuity, for both technical reasons and for institutional knowledge. The HEF monitors have deep knowledge about the health system, the management and operational procedure of the health facilities and the working dynamics among stakeholders at the provincial and district levels. The main challenge for the PCA is to find a way to offer a commensurate level of compensation in order to encourage retention while still adhering to the salary scale of a civil servant. One option may be a cost-sharing arrangement between the PCA and the facility. Another is for the MOH to contract directly with Partners for Better Health through a performance-based contract, allowing Partners for Better Health to decide on the optimal staff level and allocation.

Building civic and community engagement to strengthen accountability: SHP's engagement of non-governmental organizations such as Partners for Better Health and Buddhism for Health as sub-partners has helped to strengthen institutional capacity at the grassroots level. Nevertheless, the CMHEF structure can be further leveraged to inform, educate and engage the community to advocate for accountability and transparency not only at the local level, but also up the chain to the national level of the HEF. At the moment, the CMHEF community feedback mechanism is informal and not systematic. The linkage and coordination with the CC and the HCMC appear to be shallow and coincidental rather than strategic; strengthening these relationships can validate CMHEFs' role as a viable intermediary between the community and the public health facilities.

Question 7c: What should be the future roles of SHP in the HEF expansion system and broader social health protection schemes?

The majority of key stakeholders interviewed stated that SHP has played an important role in HEF implementation. In fact, the World Bank representative stated that without the support of URC/SHP and USAID, it would not have continued to fund the HEF under H-EQIP. Even those informants who have disagreements with URC's monitoring approach admit that the mechanism has effectively carried out its functions and responsibilities.

Role 1: Advocate for continued improvement in quality of care for all clients regardless of socioeconomic status: Stakeholders agree that the HEF has changed the attitude among health care workers to one of "Treat first, pay later." According to staff of the provincial referral hospital in Battambang, "HEF implementation helps to improve quality of care as the providers have no more concerns about the payment. Our health staff only focus on the care of patients." Bedside interviews conducted by the evaluation team confirmed that patients were all treated in the same manner, poor or not. Through SHP's monitoring, the mechanism has reinforced the concept of accountability and quality, encouraging a more respectful and less hostile provider-patient relationship—patients cite fewer incidents of under-the-table payments and report better customer service by health staff.

Role 2: Increase sustainability of health centers: The HEF has contributed to the increased use of public health facilities, especially the use of health centers as the first point of care. According to the MOH PMRS, 70 percent of identified poor have benefited from HEF-supported services at health centers and referral hospitals. The referral hospital in Sampov Luon also cited that "more than 90 percent of the pregnant women went to use the HC [health center] for antenatal care (ANC) and delivery since the HEF implementation."

Financially, HEF payments have provided health centers with a steady and predictable source of cash flow. All health center managers interviewed estimated that HEF payments comprise approximately 60 to 70 percent of their total revenue. For referral hospitals, the installation of the PMRS has helped managers to have a better picture of their financial situation. The manager of the Preah Net Preah Hospital in Bantay Meanchey mentioned that he has used the extra revenue from the HEF payment to invest in new equipment to modernize the facility.

Role 3: Use the CMHEF as a complementary structure for expanded social health protection: Through SHP, there are now established community-level structures for social health protection to serve the poor and other vulnerable populations, such as the elderly, orphans and disabled. While it is still early to gauge the overall impact of the CMHEF (most committees have been in place only one year), there exists great potential for building upon these local structures and creating linkages with other community-level projects, such as ECH, to further serve the health needs of more vulnerable populations (see Section D below for more discussion on cross-project synergies). At present, the CMHEF's use of funds remains conservative relative to the amount of funds raised as they are very conscious and conscientious about running out of funds. Moreover, the process for selecting target groups and benefits can be improved to link more explicitly to health needs and barriers to access

by poor and vulnerable households. Coordinating fundraising efforts with other existing projects and putting in place a more systematic community feedback mechanism would enable the CMHEF to refine its target beneficiaries and alleviate financial barriers for health services to those most in need.

Role 4: Collaborate with national programs to encourage the use of Targeted Benefit Contracts (TBCs) to integrate most-at-risk populations, PLHIV, etc.: TBCs are a demand-side financing mechanism, where a health provider receives payment for delivering a specific set of services to specified clients at an agreed level of quality. In essence, the HEF can be considered a type of TBC. Since year 2, SHP has been advocating for the provision of a dedicated budget that works alongside and in harmony with the national HEF system to deliver additional benefits, such as TB, and to serve PLHIV and most-at-risk populations. To date, implementation of TBCs has been opportunistic, based on pre-existing funding (e.g., the methadone maintenance therapy program at the Khmer-Soviet National Friendship Hospital in Phnom Penh and the coverage of transportation benefits for PLHIV at the Pursat Provincial Referral Hospital). The TBCs represent an opportunity to unify and streamline the various funding streams managed by the MOH and build on the policies and processes that exist under the national HEF. However, several issues need to be resolved before these opportunities can be realized. Foremost, the cost implications will need to be clarified and funding sources identified and negotiated. The addition of new benefits, target clients and payment schemes will require that the PMRS module interface seamlessly with the other modules of the MOH Health Management Information System (HMIS), e.g., those managed by CENAT and the National Center for HIV/AIDS, Dermatology and STDs.

CONCLUSIONS AND LESSONS LEARNED

With USAID's support through the SHP mechanism, the HEF has become an indispensable national platform for social health protection and health systems strengthening. The long-term sustainability of the HEF system will depend on the following key elements that comprise the building blocks of the system.

Policy: The MOH's commitment to maintain the provider-purchaser separation by establishing an independent PCA/PAE is a key prerequisite for the continuing financial integrity of the system. Likewise, the MEF's commitment to fund HEF as a core element of the RGC's health financing and universal health care strategy would influence not only the system's funding level but also which population segments and health services will be covered. Among the approaches used by low-resource developing countries, tax financing through expanded fiscal space is considered to be the most stable and sustainable long-term way to health financing.[22] Granted, the government's ability to expand its fiscal space will depend on its ability to sustain economic growth and enlarge its tax base. As Cambodia transitions into a middle-income country, the government also has at its disposal other resource mobilization strategies, including a mix of public and private (non-profit and for profit) financing in the health sector.

Health systems and service delivery: Efforts by SHP (jointly with QHS) to improve efficiency, transparency and service quality need to be maintained. The PMRS provides the technical backbone for the HEF, enabling the linkage of service quality to payment, among other features, and hence should become more integrated with other modules within the overall HMIS. This would ensure that the MOH assumes more ownership of the PMRS module so that it is not seen as just a SHP-led initiative that would be replaced once the mechanism ends. Given the limited IT skills and low capacity for outsourcing IT at the MOH, targeted technical assistance in this area will be essential to ensure that the transfer will be executed in a way that will maintain the basic architecture of the system and protect patient confidentiality while still allowing for flexibility for interfacing with other systems being used by the MOH and potentially other ministries.

[22] Varatharajan Duraijaj and David B. Evans. 2010. "Fiscal space for health in resource-poor countries." World Health Report Background Paper No. 41. World Health Organization (WHO), Department of Health Systems Financing.

Secondly, efforts to tweak the payment mechanism to HEF-supported facilities will provide positive incentives for health providers who strive for increased quality, while discouraging those who are providing unnecessary or inappropriate treatment. The next step is to formulate the right algorithm for linking HEF (and service delivery grant) payments to the level 2 quality assessments, which are done every two years, as well as to treatment outcomes based on existing clinical protocols, rather than on the number of patient visits.

Community engagement: In addition to the top-down monitoring and verification system that has been put in place by SHP, grassroots-level systems and structures to advocate for government accountability would add another layer of external oversight. This can be done through existing structures such as the CC, HCMC, CMHEF or others. The main objective is to leverage existing decentralized, multisectoral, and multi-stakeholder platforms, both for community outreach ("push" of health information, HEF rights and benefits, IDPoor process, etc.) and feedback ("pull" of information on customer satisfaction, complaints and claims dispute). Decentralization of the monitoring system also dovetails nicely with the implementation of the I-SAF and the D&D process, closing a gap in the current feedback loop and moving from a mechanism-led to a fully community-led process.

RECOMMENDATIONS

The recommendations are categorized according to the three building blocks of policy, health system and service delivery, and community engagement. Within each category, recommendations are listed in order of priority.

Policy

Work in concert with other H-EQIP donors to ensure the establishment of the PAE/PCA and eventual transfer of HEF role. The mechanism should ensure that continued funding for third-party monitoring is available until the PAE is fully staffed and trained. The current URC work plan anticipated funding for the HEF monitors to go through December 2016. However, even if the PAE is set up by then, it would not be fully operational, and the monitoring will need to be funded by USAID. The team recommends that URC analyze its current budget and make proposals to USAID and H-EQIP on the feasibility of funding the monitoring based on existing obligations. There should be a plan for a gradual decrease in USAID monitoring support over the remainder of the mechanism. If needed, a budget realignment and cooperative agreement modification should be considered to minimize disruption of activities. SHP should also review and update planned PAE capacity-building activities to reflect evolving context and needs. This may also have potential budgetary implications on the mechanism and should be taken into account in the aforementioned budget analysis. In addition, SHP should continue to work with the MOH and H-EQIP development partners to identify a viable funding mechanism for supporting the P/DHFSC. The funding should be considered under H-EQIP and thus would have no budget implications on SHP.

Increase the level of interface with the MEF for continued central budgetary support of the HEF. With the MEF playing a more central role in the broader social protection and social health protection strategy, and given its budget authority, it is an opportune time for SHP and USAID to broaden their support and pivot some of their activities toward the MEF. Research and knowledge-sharing would be a good starting point; it is important and timely for SHP to start documenting and sharing the lessons learned from HEF implementation to inform the RGC's social protection policy and the MEF's reflections around this topic. Increased sharing of SHP lessons learned with the MEF will also help USAID to identify potential capacity-building needs for future programming.

Advocate and support the review and update of IDPoor selection criteria to reflect current conditions and include other vulnerable populations. While URC has limited influence over the Ministry of Planning's final decision regarding the selection criteria and the implementation of the

IDPoor process, the mechanism can assess whether the CMHEF could play an increased role by collecting feedback from the communes where future rounds of IDPoor selection will be rolled out.

Health systems and service delivery

Continue to support the MOH's Department of Planning and Health Information (DPHI) on the development of HEF operating guidelines and benefits package. SHP should work with the MOH to develop a formula for linking HEF payment to level 2 quality assessment and the clinical protocols detailed in the new benefit package. In addition, to help the decision-making process regarding future HEF expansion, the mechanism should prepare detailed cost projections and analyze the feasibility for including non-poor and targeted benefit contracts for vertical programs into the HEF.

Develop a plan for the eventual handover of the PMRS to the HEF PCA. In the short term, SHP should clarify with the MOH/DPHI which institution (PCA or DPHI) will take over management roles of PMRS and provide technical assistance, as needed, to the MOH/DPHI on PMRS troubleshooting. In the medium term, SHP should work with the MOH/DPHI to prepare a transition plan for transferring ownership of the module to the PCA, outlining eventual capacity-building needs at the PCA (and the MOH) to properly integrate the module into the overall MOH HMIS. The transition plan should also include cost projections for regular software updates, data storage and security, and staffing needs, as well as potential funding mechanisms for these costs (e.g., cost-share with health facilities through annual subscription fee, monthly deduction of HEF payments, etc.).

Community engagement

Strengthen CMHEF's community feedback mechanism and develop concrete processes for working with current commune structures. With the transition to H-EQIP, there is some confusion and misunderstanding at the community level that the HEF will be discontinued. It is thus more important than ever for the mechanism to increase its outreach to community members regarding HEF functions and benefits, patient rights and the dispute resolution process. Further, the CMHEF's feedback committee should start to gather information, either through the VHSG or in collaboration with other projects or mechanisms (like ECH), regarding community health needs and barriers (financial and non-financial) to accessing health services so that CMHEF benefits can be more explicitly linked to community health risks and vulnerabilities. In addition, the mechanism should consider whether and how the CMHEF can play a role in increasing community participation in the IDPoor selection process.

Mechanism management

Amend the SHP program description to reflect the evolving policy environment. As a result of the transition to the new H-EQIP project and the evolving nature of the government's thinking about broader social protection, URC has had to adapt and adjust its activities to reflect the needs and priorities of the MOH and ensure that USAID funding was in concert with what other development partners were proposing. Consequently, there is some variation between what the implementing partner originally proposed in the program description and what is currently being rolled out. While the "spirit" and overarching objectives of SHP remain consistent with the original intent of the mechanism at the time of award–i.e., phasing out and transferring of the HEF Implementer role–the implementing partner should document and present these deviations to the Agreement Officer's Representative so that appropriate revisions to the cooperative agreement can be made.

D. HEALTH PORTFOLIO

FINDINGS

Question 1: How can QHS, ECH and SHP interventions that are being implemented in the same target areas reduce potential overlap and develop synergies/align better to improve the quality health services and health outcomes targeted by the USAID/Cambodia health project?

All three implementation mechanisms were active in the three provinces visited during the evaluation. Although each had been implementing within these provinces for different periods of time, the evaluation found no areas of current overlap between them.

The main reasons for the absence of overlap include the fact that each mechanism is addressing different causal factors for health care improvements, and the complimentary design of the three mechanisms (see Figure 24). For example, the QHS mechanism works to improve the availability of quality health services within the public-sector service-delivery network, while the SHP mechanism strengthens parts of the health financing system that helps to fund health services. The ECH mechanism, on the other hand, works at the community level to strengthen health behaviors and local support to increase demand for and use of health services. With the three mechanisms working in very distinct arenas of variables that affect longer-term improvements in health outcomes, the possibilities for overlap or duplication of effort is greatly reduced.

However, there are opportunities for increased synergies between the three mechanisms. One such opportunity is in the area of health client satisfaction and how this affects communities' accessing of health services, perceptions of service quality and the effectiveness of health financing approaches. Currently, a variety of definitions of client satisfaction and variations in which aspects of client satisfaction are addressed exist across mechanisms. Developing a common definition across the mechanisms may promote greater complementarity of efforts undertaken within each. Aligning expected results so that the desired result within each mechanism is commonly held could also increase synergistic efforts. More complete sharing across mechanisms of the client-satisfaction information gained through implementation would also increase options for coordinated work in this area.

Another opportunity for increased synergy between the SHP and ECH mechanisms is in the area of HEF accountability. Both mechanisms could work more collaboratively at the CC level to build capacity for demand-creation for quality and accountable health services. In particular, the two mechanisms could jointly address improvements in the process of identifying potential HEF beneficiaries and operationalizing client satisfaction variables within the administration of the HEF at the community level. Identifying and adopting a common indicator (used within both mechanisms) for this aspect of HEF-

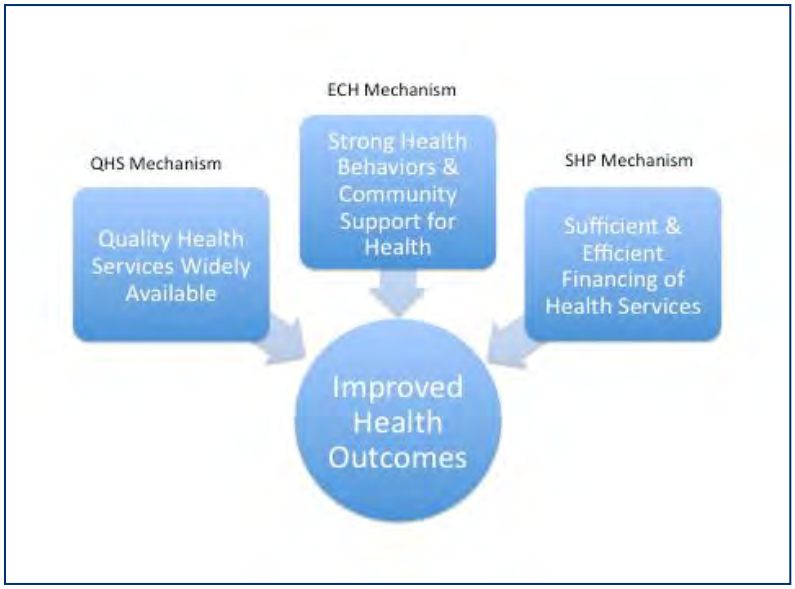


Figure 24. Complimentary dynamic of the three mechanisms

related capacity building at the commune level may help incentivize greater collaboration in this area.

Opportunities also exist between the SHP and ECH mechanisms for additional synergies around the funding of transportation from remote areas to referral sites for emergency or urgent health care cases. Co-funding options may exist for transport that link ECH health center funds and CMHEF resources. The two mechanisms can also work collaboratively on the processes for community feedback so that any expansion in the types and levels of benefits being covered by CMHEFs will truly reflect the needs and vulnerabilities of communities.

Given how the three mechanisms complement one another in addressing different sets of factors that are building blocks for improvements in health care, there are attractive opportunities for joint analyses of best practices and lessons learned through implementation. The data each mechanism is gathering may provide even greater insights for further health care advances in Cambodia when examined collectively.

The current implementation environment also contains some factors that may be hindering synergies or complicating the possibilities for closer collaboration. For example, the inconsistent per diem or daily compensation rates paid by the mechanisms to host-country counterparts for in-country travel or work at the community level create significant tensions around sub-national implementation choices. The per diem structure that rewards travel to the provincial level significantly more than travel to the health center or commune also tends to disproportionately limit attention at these lower levels. Variations between mechanisms also exist in the manner in which provincial or sub-provincial officials are informed about or involved in activities. A common protocol across all mechanisms for involving provincial or district officials in the implementation planning and execution process may improve opportunities for synergistic sub-national efforts.

Question 2: What are the potential milestones for the USAID/Cambodia health portfolio to transition from discrete activity implementation/projects to more consolidated mechanisms with other donors (such as a World Bank single-donor trust fund or other consolidated mechanisms) that would improve health quality and financial sustainability of the MOH?

Several donors are providing health sector assistance in Cambodia, and consolidated assistance mechanisms already exist. As USAID/Cambodia considers future options for assistance formats for the health sector, consolidated mechanisms with other donors may offer some advantages or increased efficiencies in development assistance.

Most of the three mechanisms' activities potentially could be undertaken through a single, consolidated funding source (such as one multi-donor trust fund). However, implementation would still need to be oriented around the three intervention levels: social protection/health financing, service-delivery quality and community engagement. Within a consolidated funding mechanism, performance-based financing options may offer advantages for incentivizing the achievement of specific intermediate implementation goals that are identified as being critical to overall progress. Such a format also provides an opportunity for the participating donors to collectively address health sector issues in a united and coordinated manner. Nevertheless, even if more consolidated funding mechanisms are pursued, USAID/Cambodia may still need to consider separately funding technical assistance deemed important to the overall success of the jointly funded efforts. For example, it may be advantageous for USAID/Cambodia to directly finance specific technical assistance positions (such as a long-term technical advisor within the PCA or the MEF to help build internal capacity) or a set of technical assistance services through an organization (such as a local IT firm to help manage and support the PMRS).

The evaluation team recommends that the following milestones be considered in any transition from discrete activities to consolidated mechanisms:

- **Assess the merits of a consolidated mechanism.** Such mechanisms can offer some advantages; however, these may not outweigh the strengths of discrete projects or implementation mechanisms. The pros and cons of using a consolidated versus a specific mechanism should be reviewed.
- **Explore various consolidated mechanism options.** Combined assistance approaches with other donors can be undertaken in a variety of ways and using different formats. For example, consolidated mechanisms are not limited to those that combine multi-donor funding within a single mechanism. Consolidation can also take the form of a concert of actions in which implementation plans and efforts are consolidated but independently funded by a variety of donors.
- **Identify and develop common sets of indicators and complementary targets for use across all implementation activities within a consolidated approach.** A unified system of objectives and methods for measuring progress will be an important part of any successful consolidated assistance format. Using common targets and indicators also will help promote greater implementation synergies. Common indicators and targets could be mapped across a range of intervention areas to show where complementarities exist and where consolidation would be advantageous.
- **Build upon the existing experience base.** QHS, ECH and SHP are already working in concert with national policies and building capacity of host-country health systems. Their experience and that of others can help identify the most appropriate interventions that should be supported within a future consolidated mechanism or assistance format.
- **Explore and define appropriate roles for civil society in support of decentralization, quality assurance and accountability in the health sector.** Within future assistance approaches that involve the use of consolidated or discrete implementation mechanisms, CSO roles need to be better defined (even if CSOs are not directly supported by the development assistance). It is clear that, as Cambodia's D&D initiative matures and evolves, civil society will play a larger role in realizing stronger health care for the country.

Question 3: What are the potential challenges and opportunities for the USAID/Cambodia health portfolio given current RGC strategic direction in HSP3?

The strategic direction within Cambodia's health sector is affected not only by what is contained within the HSP3 but also by the establishment of the national social health protection system, as well as the D&D initiative. All three will continue to affect the potential for strategic directions for the health sector in the future. Therefore, the evaluation team considered the three together when identifying the following challenges and opportunities:

- *Challenge 1*–The process of decentralizing government functions involves a number of ministries and is multisectoral. It is a larger phenomenon that also affects how health services are provided sub-nationally. With decentralization practices being developed across such a broad cross-government arena, developing appropriate development assistance approaches for a specific sector is more complex. Addressing common decentralization factors that affect one or more specific sectors may require development partners or donors to use more multisectoral approaches.
- *Challenge 2*–Decentralization in Cambodia is an ongoing process that is still being defined. The whole process will take several years, and the forms that decentralization may take could evolve

further, changing over time. The context of decentralization in Cambodia, consequently, will need to be monitored for changes and newly emerging trends. Development assistance approaches should be flexible, with frequent options for revision or modification as the decentralization environment evolves.

- *Challenge 3*–Like decentralization, the transformation of the relationships between service delivery within the health sector and the country's health financing systems is a long-term process. The overall transformation process could take 10 or more years and contain changes in direction. Since development assistance strategies or packages often cover a five-year timeframe, a development assistance approach may need to forecast a set of midpoint objectives or goals that could be achieved within the longer-term process. Even five-year strategies or packages may need considerable flexibility to adapt to changing dynamics for health sector financing in Cambodia.
- *Challenge 4*–Health promotion and behavior change currently are not strongly represented in the HSP3. However, these factors are critical elements for future long-term success in improving health outcomes in Cambodia–particularly with the increasing profile of non-communicable diseases. The absence of a clear and detailed approach to promoting optimal health care behaviors and addressing non-clinic-based issues affecting the demand for and use of health services creates greater challenges for applying consistent approaches for reaching or serving potential health clients well. Donors could help address this challenge by providing technical assistance to the MOH to develop a more detailed, nationwide approach for health promotion and behavior change.
- *Opportunity 1*–Recent development assistance experience within the health sector has generated a wealth of information about interventions that yield positive changes in the country. There are great opportunities to learn from the implementation experience in the health sector, as well as other sectors, within Cambodia. What has been learned from USAID's support of development efforts, as well as from those supported by other donors, can help to better design future assistance.
- *Opportunity 2*–Lessons learned and best practices identified in USAID/Cambodia's portfolio of health sector assistance mechanisms can be transferred and applied within new mechanisms that provide for the HSP3 in the future. For example, the lessons learned in quality improvement for MNCH within QHS could be applied to quality improvement in other health services.
- *Opportunity 3*–With decentralization still very much evolving, there are opportunities to help define how the overall process may unfold and affect health care. Donors may have opportunities to support decentralization pilots that explore how decentralization will work for health centers and how local authorities can best support the achievement of better health outcomes. Such pilots could identify options for building district administrative capacity (roles, responsibilities) and operationalizing social accountability for health (including at the commune level). The experience emerging from ECH implementation may provide relevant examples for replication in a pilot.
- *Opportunity 4*–Within the changing health financing arena, opportunities exist to explore new funding avenues for expanding HEF coverage to additional vulnerable populations. Options to explore for supporting such an expansion include examining taxation policies (i.e., progressive tax on income and profit, value-added tax and sales taxes on certain products such as alcohol or tobacco products) that could provide a more stable and equitable health care funding source.

Question 4: To what extent have QHS, ECH and SHP achieved their objectives and expected results at this time?

Answers related to specific mechanisms were provided in the sections above pertaining to each mechanism. Given where the three mechanisms are in their lives of implementation, all three are near to or exceeding the achievement of proportional life-of-project targets for most progress indicators (Annex VII).

As of the end of March 2016, for example, QHS completed about 45 percent of its implementation life and has achieved more than 45 percent of total life-of-project targets for the majority of the mechanism progress indicators. ECH completed 30 percent of its life-of-project implementation and is nearing the achievement of 30 percent of life-of-project targets for several indicators while exceeding 30 percent for a few others. SHP completed 47 percent of its implementation life and has achieved more than 47 percent of its targets for most indicators.

All three mechanisms, therefore, have the potential to achieve their objectives and expected results by the scheduled completion of implementation. Some are on track to exceed targets in several indicator areas.

V. OBSERVATIONS ON MULTI-MECHANISM EVALUATIONS

Although evaluation team members had considerable prior experience with health project or mechanism evaluations, this was the first evaluation for anyone on the team that covered multiple, independently implemented mechanisms in a single exercise. Consequently, in the conduct of the evaluation, the team explored appropriate methodologies for a combined-mechanism evaluation and learned about the nature of analysis that is possible when covering more than one mechanism.

The team found that combining multiple mechanisms into a single evaluation creates an analytical environment that elevates the possible level of analysis to a higher level of abstraction than that commonly evidenced in an evaluation of a single mechanism. This characteristic promotes or facilitates the identification of cross-mechanism patterns or trends that can affect general assistance patterns to a given sector. Similarly, with a wider range of data sources, a multi-mechanism evaluation format also facilitates a broader range of possibilities for data verification and confirmation options for the variables that may have a causal or determining role in conclusions drawn.

Multiple-mechanism evaluations require more complicated evaluative methodologies, resulting in the need for increased upfront planning, and may involve the development and use of a wider range of information-collection tools. A combination methodological approach to evaluative analysis, as well, appears to be more effective in generating the volume and various types of information or data needed to cover multiple mechanisms in a single evaluation.

Multi-mechanism evaluations are more labor intensive, with a broader range of subject-matter expertise required. Creating sub-teams or other divisions of labor to effectively complete work scopes offers time-efficiency advantages. Larger multidisciplinary evaluation teams will likely be needed to make the conduct of multi-mechanism evaluations more feasible. Similarly, multiple disciplines on the evaluation team will provide valuable perspectives and strengthen technical capacity.

Combining multiple mechanisms into a single evaluation also may introduce some limitations. For example, including a larger number of mechanisms may reduce the capacity to examine any one mechanism in depth, and the probing of issues or analysis of factors affecting a specific mechanism may not be as possible with the same rigor. Including multiple mechanisms also may broaden the geographic area of operational activities to be assessed. In such situations, work scopes may need to choose between greater geographic coverage with less detailed probing or less geographic coverage with more in-depth analytical probing.

ANNEX I: EVALUATION SCOPE OF WORK

Global Health Program Cycle Improvement Project–GH Pro
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

Date of Submission: 1/20/2016
Last update: 3/25/2016

Refer to the USAID How-To Note: Developing an Evaluation SOW and the SOW Good Practice Examples when developing your SOW.

TITLE: **Midterm Performance Evaluation of the Health Project and Implementing Activities in USAID/Cambodia**

I. Requester/Client

■ USAID Country or Regional Mission
Mission/Division: Office of Public Health and Education/USAID Cambodia

II. Performance Period

Expected Start Date (on or about): April 6, 2016

Anticipated End Date (on or about): September 16, 2016

III. Location(s) of Assignment: (Indicate where work will be performed)

Cambodia, Siem Reap, Banteay Meanchey, and Battambang (for QHS and SHP only)

IV. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

■ **Performance Evaluation** (*Check timing of data collection*)
■ Midterm ☐ Endline ☐ Other (specify):

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

☐ **Impact Evaluation** (*Check timing(s) of data collection*)
☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

☐ **Assessment**

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ **Costing and/or Economic Analysis**

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ **Other Analytic Activity** (Specify)

PEPFAR EVALUATIONS *(PEPFAR Evaluation Standards of Practice 2014)*

Note: If PEPFAR-funded, check the box for type of evaluation

☐ **Process Evaluation** (*Check timing of data collection*)

☐ Midterm ☐ Endline ☐ Other (specify): _____

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Outcome Evaluation**

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Impact Evaluation** (*Check timing(s) of data collection*)

☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

☐ **Economic Evaluation** (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

V. BACKGROUND

If an evaluation, project/program being evaluated:

Project/Activity Title	**Quality Health Services (QHS)**
Award Number	Cooperative Agreement No. AID-442-A-14-00003
Life of Project/Activity	From January 17, 2014 to January 16, 2019
Funding	US $19,789,955.00
Implementing Organization(s)	University Research Co. (URC)
USAID's Agreement Officer's Representative (AOR)	Sopheanarith Sek, Office of Public Health and Education, USAID Cambodia

Project/Activity Title	**Empowering Communities for Health (ECH)**
Award Number	Cooperative Agreement No. AID-442-A-13-00001
Life of Project/Activity	From November 14, 2012 to November 13, 2017
Funding	US $15,000,000
Implementing Organization(s)	Reproductive and Child Health Alliance (RACHA)
USAID's Agreement Officer's Representative (AOR)	Sochea Sam, Office of Public Health and Education, USAID Cambodia

Project/Activity Title	**Social Health Protection (SHP)**
Award Number	Cooperative Agreement No. AID-442-A-14-00002
Life of Project/Activity	From December 26, 2013 to Dec 25, 2018
Funding	USD $15,790,461.00
Implementing Organization(s)	University Research Co. (URC)
USAID's Agreement Officer's Representative (AOR)	Chantha Chak, Office of Public Health and Education, USAID Cambodia

Background of project/program/intervention:

Development Context

The Cambodian health system is in a period of consolidation and strengthening of proven programs and interventions. Considerable progress has been made in the past decade (2005-2014) in both improved outcomes and strengthening the health system. For example, childhood mortality has decreased by more than half, from 83 deaths among children under 5 per 1,000 live births in 2005 to 35 per 1,000 live births in 2014. Significant increases in deliveries attended by skilled health workers have contributed to dramatic reductions in maternal mortality; from 472 per 100,000 live births in 2005 to 170 per 100,000 live births in 2014. The donor concentrated investments and increased government financing for health have resulted in huge gains and successes with impressive positive changes in national indicators for health. However, the health system remains extremely fragile with the quality of care very much below par.

While Cambodia has made substantial progress to improve health outcomes in recent years, it still has among the highest maternal and child mortality rates in the region. Many Cambodian women and children die each year from preventable and treatable causes, including pneumonia, diarrhea and complications in labor. Recent survey results show that approximately one-third of children are stunted from poor nutrition and suffer from high rates of anemia (Cambodia Demographic and Health Survey 2014). The Royal Government of Cambodia recently launched a Food Security and Nutrition Strategy and has a dedicated coordinating body for nutrition with the role to interface across sectors and ministries to address the complex causes of malnutrition. Many households, particularly in rural areas, lack adequate access to clean drinking water and sanitation facilities.

While the public health system has expanded rapidly in recent years, limited skills of health providers and limited institutional capacity contribute to fragmented and poor service delivery in some areas. Most Cambodians prefer to seek care in the private sector, although quality is questionable and private practices are not routinely regulated. Health financing remains problematic as almost two-thirds (62 percent) of health expenditures are made out-of-pocket by the consumer at the time of use of services (National Health Accounts 2014). Public health funding flows are uneven and difficult to track, resulting in significant geographic variations in

the accessibility and quality of services and, consequently, of health indicators. Despite the many challenges ahead, the Royal Government of Cambodia (RGC) has made notable progress in the past decade and demonstrated significant commitment toward reaching higher goals.

Reforms in health financing are at the center of efforts to strengthen and extend the health system. The draft National Health Financing Policy (2014) outlines the establishment of a national social health protection system to expand coverage from the poor to also include the informal sector near-poor, the formal private sector and civil servants. However, the policy has not yet been approved due to the need to develop an overarching social security framework that would incorporate health insurance and pensions. Increases in the government national health budget have contributed to improvements in the health system.

Currently, the Royal Government of Cambodia is finalizing the Health Strategic Plan 3 (HSP3) 2016-2020 with a vision that "All peoples in Cambodia have better health and wellbeing, thereby contributing to sustainable socio-economic development." The policy goal of the strategic plan is the improved health outcome of the Cambodian population and financial risk protection. The plan will use five main strategies:

1. Increase coverage of and accessibility to quality health services and information for the population, especially the hard-to-reach and vulnerable population.
2. Strengthen referral system to enable client access to comprehensive package of health and health-related services based on need.
3. Provide quality services in compliance with national protocols, clinical practice guidelines and quality standards, with special emphasis on proper consultation, education and counseling, early diagnosis and provision of appropriate medical care, together with referral pathways.
4. Create a favorable environment and supportive structures for behavior change and communication of both providers and consumers of health services.
5. Develop and implement innovative approaches for effective and efficient health service delivery.

Project/Activity Information

a) History

Further reductions in maternal mortality will require improvements in how women with obstetric complications are managed once they reach the point of referral, which in turn will require sensitizing and improving the capacity of a much wider cadre of health personnel than have to date been targeted by the "Fast Track Initiative." Specifically, physicians, medical assistants and nurses in the emergency departments and ICUs of RHs will need to give the same priority to averting maternal deaths that has already been achieved among the midwifery workforce, and both skills and hospital procedures will need to be upgraded, particularly in EDs and ICUs. The considerable financial obstacles to emergency obstetric care, which still affect women in much of the country, will need to be addressed by both expanding health equity fund (HEF) coverage and ensuring that they continue to operate with a high level of efficiency and transparency.

While the main challenge to reducing maternal deaths is now the care of obstetrical emergencies, neonatal mortality reductions require both improved provision of basic essential newborn care in primary level facilities and development of the capacity to manage ill neonates at secondary/tertiary level. Attitudinal and behavioral changes in the population (i.e., more aggressive care-seeking) will also be required but must logically follow establishment of

treatment capacities that are not currently present in rural hospitals. Increasing the routine provision of essential newborn care will require the involvement of a wider cadre of staff than the overextended midwives thus far trained.

The Decentralization & Deconcentration (D&D) reforms pose significant risks and opportunities. Opportunities lie in the possibility of reducing what has been substantial leakage of government and HSSP2 resources and of obtaining both sustainable resources and an institutional home for the activities of the Village Health Support Group (VHSGs), a critical workforce that to date has been totally dependent on donor-funded NGOs for their small resource requirements. Risks lie in the possibility of slow and/or irrational resource allocation by subnational bodies that lack an understanding of health priorities and the management capacities needed to meet their new responsibilities. While Ministry of Health (MOH) managers will have a seat on the provincial and district councils, the majority of members will be local officials with no health background, and the councils are newly created bodies with no prior experience in planning or resource allocation. In addition, MOH managers at province and district levels have a limited independent grasp of health sector priorities and, although active in the gathering of health metrics, little ability to use data, as they have historically been dependent on guidance and directives from the central level. They are thus not yet positioned to use their seats on the councils to explain health needs and advocate for appropriate resource allocation.

In addition, the MOH is increasingly faced with a need to advocate with higher levels of the RGC for increased budget allocation to the health sector to offset declines in support from donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). This raises the necessity of building strong political support for programs that did not previously require it to survive. Family planning (FP) efforts are particularly vulnerable as many senior policy-makers do not understand its connection to socioeconomic development.

The transition from management of HEFs by an independent entity to management by the MOH, while fortuitous in terms of institutional sustainability, carries with it numerous risks. There is arguably an inherent conflict of interest in combining the roles of service provider and payer, and the fact that HEFs form a significant portion of public health facility revenues (which in turn serve to augment the otherwise noncompetitive salaries of public sector health providers) may make it difficult for the MOH to enforce quality standards and safeguards against fraudulent claims. Fortunately, the MOH is aware of these risks and has expressed a desire for TA in establishing an effective system of checks and balances, as well as in meeting the enormous capacity-building needs this new and sizable responsibility will place upon it. In the near term, the central MOH has neither the experience nor the sheer manpower to take over the activities of the external HEF operator at even the current scale of coverage. Transitional arrangements will need to include, in addition to international technical assistance (TA), secondment of the more than 50 local staff involved in monitoring HEF activities to the MOH until sufficient new civil service personnel can be brought on board and trained to proficiency.

In keeping with the epidemiological and sectoral analysis, the current health project seeks to improve health status by focusing on:

- maternal and neonatal mortality
- child and maternal malnutrition and undernutrition
- unmet need for FP, especially underutilization of long-acting and permanent methods (LAPM)

- further strengthening the health system and improving curative care practices in public and well-regulated private sectors, and
- strengthening TB control with an emphasis on pediatric and multidrug-resistant (MDR) TB

It does so by direct technical interventions, such as TA and training, and by addressing the following health systems issues, which directly impact on the aforementioned technical priority areas:

- The upcoming devolution of authority for allocation of the sectoral budget (government and the complementary resources provided to the public sector by the World Bank consortium), which if not properly managed will result in insufficient operating funds for maternal, newborn and child health (MNCH) programs;
- The scale-up and institutionalization of HEF operation within the MOH. The former is essential to improving access to the majority of poor women and children who live in areas not yet covered by a HEF, while the latter is on the one hand important to long-term sustainability but on the other hand may undermine HEF impact if transparency and linkages to quality indicators are not maintained; and,
- Under-regulation of the private sector, which results in ineffective and/or harmful treatment of infants and children, along with substantial out-of-pocket expenditures for health care by the poor.

The program builds particularly on USAID's past and existing strengths in Cambodia in quality improvement, health financing and health information systems, while leveraging its long experience in working at the community level. It targets key weaknesses in the delivery of MNCH services and works strategically to maximize the opportunities presented by the D&D reform and HEF expansion while simultaneously seeking to minimize their potential risks. Understanding that the funding levels of USAID support for the Cambodian health sector will likely decline in future, the program would achieve disproportional results by working in ways that maximally leverage both government and other donor resources, particularly those of the World Bank-led consortium.

b) Approach and Implementation

There are nine components to be addressed in USAID/Cambodia's current health project. Since the evaluation requires specifically looking into SHP, QHS and ECH, this section only focuses on the approach and implementation of the component that these activities are delivering.

COMPONENT #1a: MNCH Quality Improvement: Facility focus with link to community **(QHS)**

In keeping with the epidemiological and sectoral analysis presented in Section I, the new program features a substantial increase in attention to basic neonatal health competences related to the major causes of newborn mortality at all levels in the public sector, building on USAID's past successful approaches to quality improvement in basic obstetric care. Along with this will be a continuing focus on reducing maternal mortality and a new emphasis on neonatal and child nutrition during the critical first 1,000 days of life, supported by more effective behavior change interventions around feeding practices and household water/sanitation. Work begun under the current program in increasing access to LAPM of FP will be brought to scale. This component will target MOH providers at the HC and RH levels as well as the grassroots VHSGs and contains the following technical focus areas:

Technical Focus Area #1: Rapid Improvements in Newborn Care through (1) coaching/facilitation of HC and CPA 1 and 2 Referral Hospital staff in introduction of a "team approach" to newborn care and in improving the content of postnatal care to ensure that a minimum package of maternal and newborn services is delivered, and (2) competency-based on-the-job training (OJT) for essential newborn care and identification/management of the sick neonate. This will build on lessons learned from a pilot currently underway through the National MCH Program with support from World Health Organization (WHO), and will focus on ensuring providers have the competencies to implement the new Safe Motherhood Protocol, including the new CPGs for neonatal sepsis. Accompanying this will be training of VHSGs in identification/referral of sick neonates.

Technical Focus Area #2: Improved Maternal and Newborn Nutrition through training/coaching to improve anemia detection/management and monitoring of maternal weight gain in ANC, along with appropriate nutritional counseling by both providers and VHSGs. This activity will support MOH plans to introduce the measurement of hemoglobin levels at the HC level and implementation of the existing guidelines on management of anemia in pregnancy. It will also draw on lessons learned in operations research (OR) on food intake and weight gain during pregnancy currently underway under a centrally funded USAID Child Survival grant in Kampong Chhnang province.

Technical Focus Area #3: Improved Infant and Young Child Feeding (IYCF) and WASH Practices through behavior change communication (BCC) by VHSGs and health providers, drawing on lessons learned and BCC materials developed by the UNICEF COMBI initiative with regard to promotion of appropriate complementary feeding and timely referral of infants without sufficient weight gain to the health center. These messages will be tailored to both men and women (parents, providers and village leaders) and results disaggregated by gender. Routine growth monitoring at HCs will be introduced/strengthened and combined with BCC.

Technical Focus Area #4: Improved nutritional status among children through interventions that aim to address high levels of anemia among children, as well as other micronutrient deficiencies common among targeted children. In addition, this focus area will work on strengthening routine growth-monitoring practices at the HCs through training/coaching of health providers leading to institutionalization of this practice, and at the community level by introducing this practice to VHSGs. Training and coaching of providers will also be strengthened in treatment and referral for acute and severe malnutrition.

Technical Focus Area #5: Improved Management of Obstetric Complications through OJT/ coaching of providers at CPA 1, 2 and 3 RHs in implementation of the new Safe Motherhood Protocol and related CPGs with a specific focus on the maternity, ICU, emergency and surgical services. As necessary, this support will extend to address missing core competencies and systems for monitoring and responding to changes in patient condition.

Technical Focus Area #6: Increased Availability of a Full Range of FP Methods through (1) training and coaching for implant roll-out, IUD service expansion and (CPA 2 and 3 RHs only) introduction of voluntary sterilization services; (2) increased BCC through both male and female VHSGs, with the former helping to raise awareness of male responsibility for FP and male methods such as vasectomy and condoms; and (3) TA/capacity-building to RHs to provide FP information and services to post-partum and PAC clients. Since RH maternity

services have only recently been allowed to introduce FP services, support will include training/refresher training and supply chain facilitation.

The various BCC efforts detailed above will be complemented and coordinated by the program's Communications component (see p. 17), while the Private Sector Engagement component (see p.16) will ensure the availability of commodities needed to act on many of the BCC messages received. The investments in OJT quality improvement described above will be enhanced by a component to strengthen pre-service education (see page 18). Advocacy on policy and clinical guidelines through component nine will be informed by the actual experience of communities and providers in clinics and referral hospitals on newborn and maternal health, as well as women's and child nutrition.

The results anticipated from Component 1a (in synergy with the other three components mentioned above) include:

- Routine provision of essential newborn care in HC and RH deliveries.
- Identification, referral and appropriate treatment of illness in neonates.
- Close monitoring and appropriate treatment of obstetric complications in RHs.
- Routine measurement of hemoglobin in ANC with identification and treatment of anemia in pregnancy per national guidelines.
- Routine identification of anemia among children followed by provision of essential care/treatment.
- Monitoring of weight gain during ANC accompanied by appropriate nutritional counseling.
- Routine follow-up of newborns for the first week after delivery by VHSGs.
- Availability of a full range of FP methods in public facilities[1] and increased utilization of LAPMs.
- Integration of FP services into postpartum care and PAC.
- Routine growth monitoring for children under the age of 5 conducted at both HCs and communities, followed by provision of essential nutrition counseling and/or referrals when appropriate.
- Improved quantity and quality of complementary feeding and practices of children aged 6-24 months.
- Improved household water and sanitation practices.

COMPONENT #1b: Strengthening Community Health Systems and Commune Council Capacity **(ECH)**

A major feature of the new program will be building the capacity of Commune Councils (CC) to manage and support delegated community health functions. The precise functions to be taken over will be based on results of an upcoming functional review by the MOH as part of its preparation for D&D, but will certainly include institutionalizing the VHSG workforce under the CCs, a move which is critical to safeguarding USAID's long-standing investments in community health and the gains made to date in increased utilization of preventive health services. The goal of this initiative is to produce a more sustainable, better-resourced VHSG cadre whose functions in promoting appropriate home health/nutrition behaviors and health care seeking, as well as in community-based provision of TB treatment and contraceptives, are strengthened and continue to expand in response to changing health priorities. Facilitation of continued HC technical linkages will be critical to ensuring the latter.

[1] Defined as: pills, condoms, injectables, IUD and implant for HCs and CPA 1 RHs; pills, condoms, injectables, IUD, implant plus voluntary sterilization in CPA 2 and 3 RHs.

As an important adjunct, communities will be empowered with knowledge of their rights as health care consumers as set forth in the MOH Client Rights Charter, and Commune Councils will be assisted to fully exert the stewardship role envisioned for them with regard to HC activities in the MOH's *Guidelines for Operational Districts.* The largely dysfunctional Health Center Management Committees will be revitalized, possibly through integration of their functions into the Commune Council Women's and Children's Committees (WCC).[2]

The results anticipated from Component 1b include:

- VHSGs administratively report to CCs with continued technical linkages to HCs.
- CCs support VHSG training and operating expenses (e.g., monthly meeting with the HC, BCC material production, travel costs associated with C-DOTs) from their *sangkat* funds.
- VHSGs continue to actively provide BCC, C-DOTs and community-based sales of contraceptives.
- Communities are aware of their rights under the Client Right charter and demands and expectations of the health system increase accordingly.
- CCs actively investigate client complaints and ensure enforcement of the Client Rights Charter.
- CC oversight of HC activities leads to greater accountability in terms of staff attendance and adherence to official user fees.

COMPONENT #3: Support to Social Health Protection Mechanisms **(SHP)**
USAID/Cambodia is strongly positioned to assist the RGC in expanding coverage of the HEFs through the comparative advantage built during its current and previous programs. This program component will continue USAID's contribution to ensuring the quality and efficiency of HEF operations through expert TA to the RGC as it institutionalizes and scales up HEFs and, in collaboration with other ministries and development partners like GIZ, facilitate the development of a broader system of Social Health Protection.

It is anticipated that operation of the HEFs will be institutionalized in the MOH during the five years of the program and that it will take some time for the MOH to obtain the additional civil service positions necessary for this labor-intensive activity. USAID/Cambodia will capitalize on the large cadre of national staff with expertise in HEF monitoring developed under its past and current assistance to second skilled national consultants to the MOH to ensure adequate staffing in the short term and build the capacity of additional MOH staff as they are recruited. It will also provide international TA to oversee the capacity-building and, in particular, work with the MOH at various levels and with Commune and District Councils to ensure that HEF reimbursement remains linked to quality of care and that quality criteria are ramped up in a phased manner appropriate to the level of development of individual facilities. The recently developed MOH Client Satisfaction Tool may be incorporated as a measure of some aspects of quality, especially as regards client-provider interactions.

Current funding for the Global Fund remains highly uncertain as a result of questions related to country-level Fund management and international commitment to Fund replenishments. In this uncertain environment, the Cambodian government has begun to explore alternatives for covering costs of the vertical disease programs that have been until now paid for by the Global Fund. There may be a shift in the future, as has begun to be discussed, of enrolling

[2] An established advisory committee of the Commune Council with the mandate to integrate women's and children's issues into local development activities and investments.

HIV/AIDS patients into the system of HEFs. Until now, these patients have been receiving HIV/AIDS services free of charge through the Global Fund. The expansion of the HEF system to incorporate vertical disease programs, when to date they have not been, will be incorporated under this component as requested by the government.

This component will also assist/advocate with the Ministry of Labor and Vocational Training to ensure the new NSSF for the formal sector covers an appropriate range of services (including FP and other preventive care) through NGO clinics as well as public sector facilities, given the comparative advantage the former has in provision of services to factory workers. Similar assistance will be provided for the civil service component of the NSSF as it is developed.

The results anticipated from Component 3 include:

- Nationwide expansion of HEF ensures access to MNCH services for the poor.
- A system of checks and balances enables the MOH to manage the HEFs without provider bias and with a high level of accountability.
- HEF reimbursements are linked to objective measures of quality and client satisfaction.
- Develop the capacity of a cadre of civil servants within the MOH to oversee HEF operations and monitoring.
- The health benefits and modalities of the NSSF are detailed in government directives and include comprehensive preventive and curative services, including FP.
- NGO RH clinics are eligible for reimbursement under the NSSF.
- HEF expands as necessary, and as determined by government, to cover HIV/AIDS services for the poor as other donor resources decline.

c) Expected Results

IR 1: Improved maternal and child health practices in communities and facilities (QHS and ECH)

Sub-IR 1.1: Increased availability of life-saving interventions that address major killers of mothers, newborns and children

Illustrative Indicators

Impact level: Maternal, neonatal, post-neonatal and child mortality rates in the target provinces

Outcome/output level:

- Number of people trained in maternal/newborn nutrition and health (USAID Investing in People Indicator)
- Number of newborns receiving antibiotic treatment for infection from appropriate health workers (USAID Investing in People Indicator)
- Number of newborns receiving essential newborn care (USAID Investing in People Indicator)
- Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers (USAID Investing in People Indicator)
- Percent of HCs in the target provinces implementing a "team approach" to newborn care (Custom Indicator)
- Number of diarrheal and ARI treatment kits sold through social marketing (Custom Indicator)
- Percent of HCs in the target provinces measuring hemoglobin as part of ANC (Custom Indicator)

- Number of pregnant women identified with moderate or severe anemia and treated per national guidelines (Custom Indicator)
- Number of undernourished children identified and counseled/referred by HCs in the target provinces (Custom Indicator)
- Percent of children under 5 in the target provinces with watery diarrhea treated with ORS and zinc (Custom Indicator)
- Percent of CCs in the target provinces including support for VHSG activities in their Commune Investment Plans (Custom Indicator)
- Number of neonatal admissions to RHs[3] in the target provinces (Custom Indicator)
- Percent of HCs in the target provinces holding regular (monthly or bimonthly) technical meetings with VHSGs (Custom Indicator)

Sub-IR 1.2 Increased utilization of reproductive health services and LAPM of FP

Illustrative Indicators

Impact level: Modern contraceptive prevalence rate and unmet need for FP in the target provinces

Outcome/output level:

- Couple-years of protection (USAID Investing in People Indicator)
- Number of people trained in FP/RH (USAID Investing in People Indicator)
- Number of medical and para-medical practitioners trained in evidence-based clinical guidelines (USAID Investing in People Indicator)
- Number of counseling visits for FP/RH (USAID Investing in People Indicator)
- Number of people that have seen or heard a specific FP/RH message (USAID Investing in People Indicator)
- Number of service delivery points providing FP counseling or services (USAID Investing in People Indicator)
- Percent of RHs in the target provinces providing FP services to postpartum and PAC clients (Custom Indicator)
    - Percent of HCs in the target provinces providing IUD and implant services (Custom Indicator)
    - Percent of CPA2/3 RHs in the target provinces offering voluntary sterilization (Custom Indicator)
    - Number of pills, condoms, injectables and EC sold through social marketing (Custom Indicator)
    - Number of clients served in non-public sector RH clinics, disaggregated by age, sex and service type (Custom Indicator)
    - Percent of VHSGs in the target provinces selling contraceptives (pills and condoms) (Custom Indicator)

IR 2: Strengthened health systems and governance (SHP)

Sub-IR 2.1: Reduced financial barriers and increased demand for quality service

Illustrative Indicators

Impact level: Percent of persons in the lowest SES quintile who possess a HEF card

Outcome/output level:

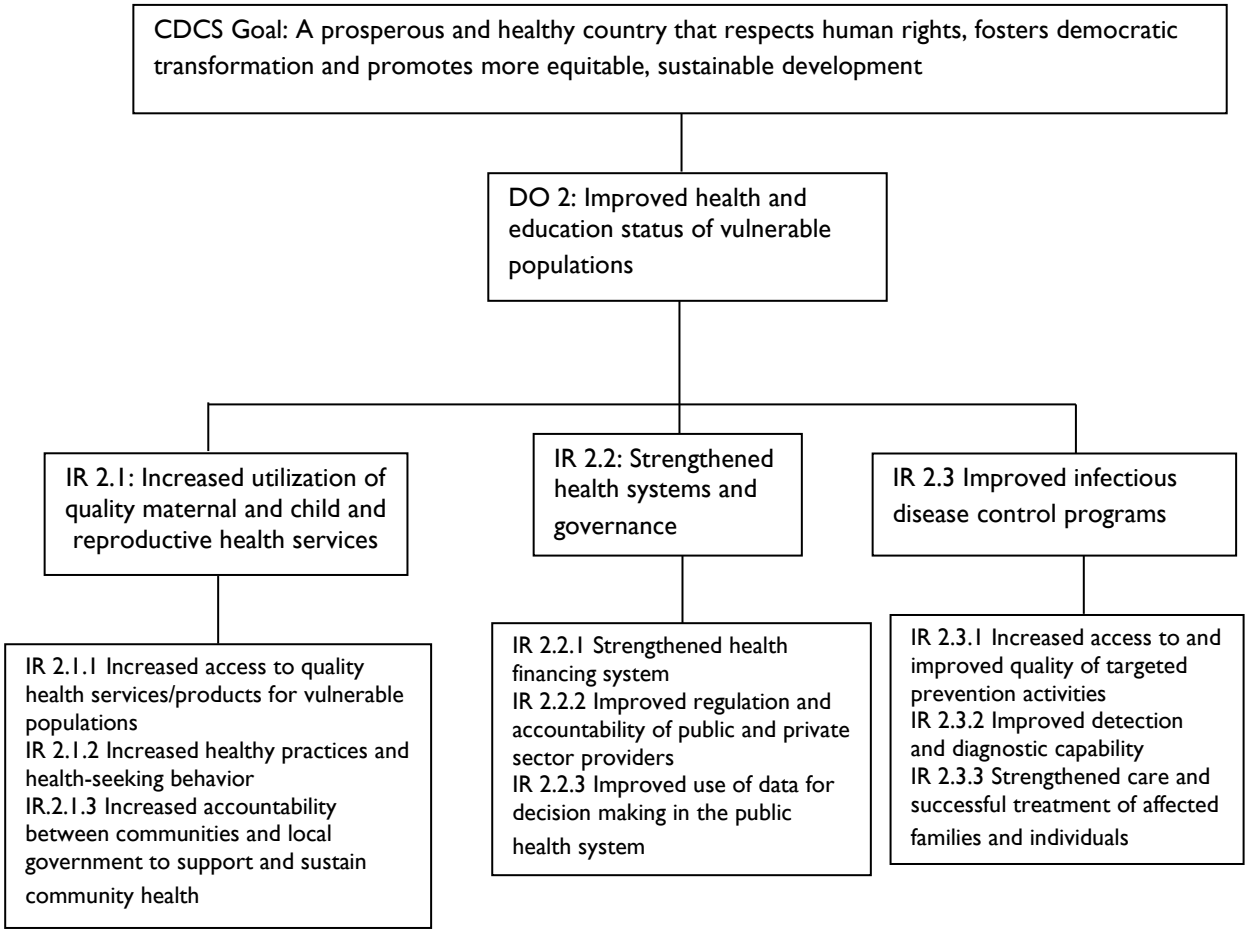
- Number of people covered by health financing arrangements (USAID Investing in People Indicator)
- Number of social protection policy reforms drafted, adopted or implemented (USAID Investing in People Indicator)

[3] This will be measurable only after planned revisions to the HIS age categories.

- MOH guidelines developed and implemented linking HEF reimbursement to client satisfaction and quality of care indicators (Custom Indicator)
- Percentage of provinces with a HEF in place in all districts (Custom Indicator)
- Percentage of expected deliveries among HEF beneficiaries taking place in a HC or RH (Custom Indicator)
- Percentage of HC and RH clients who are HEF beneficiaries (Custom Indicator)

Strategic or Results Framework for the project/program/intervention (*paste framework below*)
If project/program does not have a Strategic/Results Framework, describe the theory of change of the project/program/intervention.

Results Framework/Theory of Change
USAID/Cambodia Results Framework (Health is DO2)



What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Geographical Coverage and Targeted Beneficiaries

SHP is nationwide in scope. ECH is currently implementing in two provinces, namely Siem Reap and Banteay Meanchey. QHS focuses on eight provinces, including Siem Reap, Banteay Meanchey, Battambang, Pailin, Kampong Cham, Prey Veng and Kampong Speu.

SHP targets poor HHs to receive HEF for health service usage. QHS focuses on maternal and child care clients at health facilities, whereas ECH focuses on referring clients from community, especially maternal and child care related-service, to facility.

VI. SCOPE OF WORK

A. **Purpose**: Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of the evaluation is two-fold:

(a) to identify lessons learned of USAID/Cambodia's current health office portfolio and inform the future portfolio currently in design, given the Ministry of Health's strategic direction;

(b) to measure the progress of specific implementing activities on their performance, namely: Quality Health Services (QHS), Empowering Communities for Health (ECH) and Social Health Protection (SHP), and identify the potential synergies among these activities to improve outcomes for the health project.

B. **Audience**: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

The audience for the evaluation report will be the USAID/Cambodia Mission, USAID Asia Bureau, USAID implementing partners (IPs), the MOH, and other health key stakeholders in Cambodia.

C. **Applications and use**: How will the findings be used? What future decisions will be made based on these findings?

USAID/Cambodia OPHE will consider the evidence-based findings in refining its strategic approach to health systems strengthening. The findings, conclusions and recommendations of this midterm evaluation will primarily be used to inform the future health portfolio currently in design as well as mid-course corrections for current health project activities. It is expected that the host-country partners, the GFATM and other donors will also be able to use the report to better assist them in designing future interventions and defining their goals.

D. **Evaluation Questions & Matrix**:

a) Questions should be: (a) aligned with the evaluation/analytic purpose and the expected use of findings; (b) clearly defined to produce needed evidence and results; and (c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.); they must be incorporated into the evaluation/analytic questions. **USAID policy suggests 3 to 5 evaluation/analytic questions.**

b) List the recommended methods that will be used to collect data to be used to answer each question.

c) State the application or use of the data elements towards answering the evaluation questions; for example, (i) ratings of quality of services, (ii) magnitude of a problem, (iii) number of events/occurrences, (iv) gender differentiation, (v) etc.

For each question below, include:

- Best practices
- Lessons learned
- Recommendations for projects to overcome current obstacles and barriers
- Recommendations for future roles of the QHS, ECH and SHP projects

	Evaluation/Analytic Question
HEALTH PORTFOLIO	
1	How can QHS, ECH and SHP interventions that are being implemented in the same target areas reduce potential overlap and develop synergies/align better to improve the quality health services and health outcomes that are targeted by the USAID/Cambodia health project?
2	What are the potential milestones for the USAID/Cambodia health portfolio to transit from activity implementation to a pooled technical assistance (Pooled TA) mechanism with other donors that would improve health quality and financial sustainability of Ministry of Health?
3	What are the potential challenges and opportunities for the USAID/Cambodia health portfolio given current Royal Government of Cambodia strategic direction in Health Strategic Plan 3 (HSP3)?
4	To what extent did QHS, ECH and SHP achieve their objectives and expected results at this time? Issues to consider: • Project components that should be strengthened or modified toward achieving project objectives • Strengths and weaknesses of project implementation, management and organizational structure to support project implementation
QHS	
5	a) Which QHS components appear to be most effective to change health providers' services and practices and improve the quality of health services? b) What are strengths and weaknesses of QHS's team-based learning approaches, including QHS's team-based learning approaches meant to complement the MOH's in-service training strategies, and QHS's coaching and mentoring efforts? c) Are the current monitoring tools and systems sufficient for measuring activity results?
ECH	
6	a) Are the various approaches of the Behavioral Change Campaign, including a comedy show and interpersonal communication, effective for disseminating messages to people? If not, why not? b) Are the current monitoring tools and systems sufficient for measuring the results of these project activities?
SHP	
7	a) How do contextual changes in the political and socioeconomic environment in Cambodia affect the project in achieving its objectives? b) How can the HEF monitoring system be institutionalized in a cost-effective manner? c) What should be the future roles of SHP in HEF expansion system and broader social health protection schemes?

Note: Draft Evaluation Matrix for detailed questions is attached. This matrix will be revised by the evaluation team during the team planning meeting for the final list of evaluation questions.

Other Questions *[OPTIONAL]*
(***Note***: Use this space only if necessary. Too many questions leads to an ineffective evaluation or analysis.)

E. **Methods**: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

General comments related to methods:
This midterm performance evaluation is intended to answer the evaluation questions presented above. The suggested mixed-methods conceptual approach that will be used to answer these questions will focus on, but not be limited to, the following: desk review, key informant interviews, focus group discussions and observational site visits. Other qualitative and quantitative methods are also welcome as appropriate and applicable, including mini-surveys and other rapid appraisal methods.

Since ECH only started implementing their activities in Siem Reap and Banteay Meanchey, USAID/Cambodia requests that the evaluation team visit these two provinces only. The contractor will randomly select the field locations from a master list of all project and activity sites in each province and list these in the evaluation work plan.

The evaluation team will be required to evaluate this multifaceted portfolio in a timely manner. Data requirements, collection methods and required analyses will be determined collaboratively with USAID/Cambodia under the direction of an independent, external team leader (not affiliated with USAID or the program). Details on final datasets, collection methods and instruments (including interview questions and key informants to be interviewed), and analytical framework(s) will be approved by USAID/Cambodia as part of initial work plan approval. Data are expected to be disaggregated by sex, where relevant, and level of intervention (regional; national/country; and sub-national).

Limitations or constraints: Since the evaluation will employ mostly qualitative methods, findings will not be statistically representative and will be limited in generalizability.

To accomplish this evaluation, it is assumed that key members of the evaluation team will split up to cover each of the projects (QHS, ECH and SHP), then pool information to look across the portfolio.

■ **Document and Data Review** (*list of documents and data recommended for review)*

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

- QHS, ECH and SHP project documents:
  - Results or logical framework
  - Annual reports
  - PMP with indicator data/results
  - Technical reports
  - Agreement SOW
  - Training materials
  - IEC materials
  - Work plans
  - Other documents developed by the projects
- USAID/Cambodia Health Project PAD 2013-2018
- MOH Health Strategic Plan 3 2016-2020

- Draft national health financing policy
- Relevant national policies and guidelines
- Cambodia DHS 2014, 2010 (http://dhsprogram.com/Where-We-Work/Country-Main.cfm?ctry_id=63&c=Cambodia&Country=Cambodia&cn=&r=4)

☐ **Secondary analysis of existing data** (*This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses.*)

Data Source (*existing dataset*)	Description of data	Recommended analysis

■ **Key Informant Interviews** (*list categories of key informants and purpose of inquiry*)

The following informants will be interviewed using a semi-structured question guide:

- Project implementing partners' (IPs) staff
- USAID health staff
- MOH and other relevant government officials
- Stakeholders, including: Commune Council, Provincial Authority, World Bank, other donors, etc.
- Village health support groups (VHSG)

A list of relevant stakeholders and key partners will be provided to the evaluation team by USAID/Cambodia during the team planning meeting (TPM). The evaluation team will be responsible for expanding this list, as appropriate, and arranging all meetings.

■ **Focus Group Discussions** (*list categories of groups, and purpose of inquiry*)

Focus group discussion will be held with beneficiaries of the three projects, QHS, ECH and SHP, to gain their perceptions of access to and demand for health services and support, including:

- MNCH services
- FP/RH, including postpartum and post-abortion care (PAC)
- Community Health Systems
- Commune Council support

IPs will assist the evaluation team to identify the beneficiaries of their project during the TPM.

■ **Group Interviews** (*list categories of groups, and purpose of inquiry*)

Optional: Key informants can be grouped and interviewed together, as long as the respondents feel free to express their opinions openly.

☐ **Client/Participant Satisfaction or Exit Interviews** (*list who is to be interviewed, and purpose of inquiry*)

☐ **Facility or Service Assessment/Survey** (*list type of facility or service of interest, and purpose of inquiry*)

☐ **Cost Analysis** (*list costing factors of interest, and type of costing assessment, if known*)

☐ **Survey** (*describe content of the survey and target responders, and purpose of inquiry*)

■ **Observations** (*list types of sites or activities to be observed, and purpose of inquiry*)

Using a semi-structured observation form, the team will conduct site visits to observe activities and supported interventions implemented through QHS, ECH and SHP.

☐ **Data Abstraction** (*list and describe files or documents that contain information of interest, and purpose of inquiry*)

☐ **Case Study** (*describe the case, and issue of interest to be explored*)

☐ **Verbal Autopsy** (*list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population*)

☐ **Rapid Appraisal Methods** (ethnographic/participatory) (*list and describe methods, target participants, and purpose of inquiry*)

☐ **Other** (*list and describe other methods recommended for this evaluation/analytic, and purpose of inquiry*)

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

☐ Yes ☐ No

List or describe case and counterfactual"

Case	Counterfactual

VII. HUMAN SUBJECT PROTECTION

The evaluation team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community attendance. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

VIII. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests and what data are to be triangulated (if appropriate), for example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age and location, whenever feasible. Other statistical tests of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances, and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, DHS, HMIS data, etc.) will allow the team to triangulate findings to produce more robust evaluation results.

The evaluation report will describe analytic methods and statistical tests employed in this evaluation.

IX. ACTIVITIES

List the expected activities, such as team planning meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and deliverables may overlap. Give as much detail as possible.

Background reading–Several documents are available for review for this analytic activity. These include projects' proposals, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS). This desk review will provide background information for the evaluation team, and will also be used as data input and evidence for the evaluation.

Team planning meeting (TPM)–A four-day TPM will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID's approval

- Develop a preliminary draft outline of the team's report
- Assign drafting/writing responsibilities for the final report

Briefing and debriefing meetings–Throughout the evaluation the team leader will provide briefings to USAID. The in-briefing and debriefing are likely to include the all evaluation team experts, but will be determined in consultation with the mission. These briefings are:

- Evaluation **launch**, a call/meeting among USAID, GH Pro and the team leader to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations and agenda of the assignment. GH Pro will introduce the team leader and review the initial schedule and review other management issues.
- **In-briefing with USAID**, as part of the TPM. This briefing may be broken into two meetings: (a) at the beginning of the TPM, so the evaluation team and USAID can discuss expectations and intended plans; and (b) at the end of the TPM, when the evaluation team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-briefing will be the format and content of the evaluation report(s). The time and place for this in-briefing will be determined between the team leader and USAID prior to the TPM.
- **In-briefing with projects** to review the evaluation plans and timeline, and for the project to give an overview of the project to the evaluation team.
- The team leader (TL) will brief the USAID **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.
- A **final debriefing** between the evaluation team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting, a summary of the data will be presented, along with high-level findings and draft recommendations. For the debriefing, the evaluation team will prepare a **PowerPoint Presentation** of the key findings, issues and recommendations. The evaluation team shall incorporate comments received from USAID during the debriefing in the evaluation report. (***Note**: preliminary findings are not final, and as more data sources are developed and analyzed, these findings may change.*)
- **Stakeholders' debriefing/workshop** will be held with each project, and may include other stakeholders identified by USAID. This will occur following the final debriefing with the mission and will not include any information that may be deemed sensitive by USAID.

Fieldwork, site visits and data collection–The evaluation team will conduct site visits to for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

Evaluation/analytic report–The evaluation/analytic team, under the leadership of the team leader will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team leader will submit the draft evaluation report to GH Pro for review and formatting.
2. GH Pro will submit the draft report to USAID.
3. USAID will review the draft report in a timely manner and send its comments and edits back to GH Pro.
4. GH Pro will share USAID's comments and edits with the team leader, who will then do final edits, as needed, and resubmit to GH Pro.

5. GH Pro will review and reformat the final evaluation/analytic report, as needed, and resubmit to USAID for approval.
6. Once evaluation report is approved, GH Pro will reformat it for 508 compliance and post it to the DEC.

The evaluation report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USAID separately from the evaluation report.

X. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under "Other" in the table below. Provide timelines and deliverable deadlines for each.

Deliverable/Product	**Timelines & Deadlines (estimated)** (see LOE table below of estimated days per task)
■ Launch briefing	April 6, 2016
■ In-briefing with mission	April 18 and 22, 2016
■ Evaluation work plan with timeline	April 25, 2016
■ Evaluation protocol with data collection tools	April 25, 2016
■ In-briefing with target project/program	April 25, 2016
■ Routine briefings	Weekly
■ Out-briefing with mission with PowerPoint presentation	May 25, 2016
■ Findings review workshop with QHS, ECH and SHP with PowerPoint presentation	May 27, 2016
■ Draft report	Submitted to GH Pro: June 8, 2016 GH Pro submits to USAID: June 13, 2016
■ Final report	Submitted to GH Pro: July 6, 2016 GH Pro submits to USAID: July 13, 2016
■ Raw data (cleaned datasets in CSV or XML)	July 6, 2016
■ Report posted to the DEC	September 2, 2016
□ Other	

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 Business days

XI. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/analytic team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team leader experience and management skills, etc.
- Team leaders for evaluations/analyses must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject-matter expertise.

- Evaluations require an evaluation specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with relevant methodological expertise.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activity.
List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, as well as for the individual team members.

The evaluation team will be led by an international consultant who will be responsible for managing the whole evaluation and answering the overarching questions, as well as project-specific questions.

The evaluation team will be supervised by the evaluation Contracting Officer's Representative (COR), while working closely with all the relevant activity AORs on the OPHE team to gain in-depth information of the program activities. The evaluation COR and/or alternate COR will provide strategic direction and guidance throughout the evaluation process, including the development of the work plan, any data collection tools and the evaluation report outline, approach and content.

Edit as needed to the team leader's position description.

Key Staff 1 Title: **Team leader**

Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership, (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations.

Qualifications:

- At least an MPH or other health-related graduate degree
- Minimum of 10 years of experience of field experience managing health projects, programs and evaluations
- Extensive experience leading USAID evaluations
- Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative methods
- Advanced knowledge and skills of program performance evaluation design, methodology and processes; excellent skills in planning, facilitation, and consensus-building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners and other stakeholders
- Excellent team leadership and management skills
- Excellent organizational skills and ability to keep to a timeline
- Proficient in writing in English
- Good writing skills, with extensive report-writing experience
- Experience working in the region, and experience in Cambodia is desirable.
- Familiarity with USAID
- Familiarity with USAID policies and practices
  - Evaluation policy
  - Results frameworks
  - Performance monitoring plans

Key Staff 2 Title: **Evaluation specialist**

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, ensuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, ensuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, and data analysis to report writing.

Qualifications:

- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations
- Experience in design and implementation of evaluations
- Strong knowledge, skills and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating others to implement surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data
- Experience in data management
- Able to analyze quantitative data, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies and triangulating with quantitative data
- Ability to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- An advanced degree in public health, evaluation or research or related field
- Experience working in the region, and experience in Cambodia is desirable.
- Proficient in English
- Good writing skills, including extensive report-writing experience
- Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
- Familiarity with USAID and PEPFAR M&E policies and practices
  - Evaluation policies
  - Results frameworks
  - Performance monitoring plans

Key Staff 3 Title: **MNCH quality of care specialist [QHS lead]**

- At least 8 years' experience working in MNCH service delivery activities in low-resource settings; USAID project implementation experience preferred
- Masters of Public Health or other health-related graduate degree with strong technical expertise in MNCH and FP/RH

- Expertise in at least one of the following areas and good working knowledge/familiarity with the others: (1) obstetric care; (2) maternal, newborn, infant and young child nutrition and feeding; and (3) FP/RH
- At least 6 years of experience working in the field of health and/or NGO organizational development
- Familiar with the Cambodia MOH strategy and strategic direction, the social accountability framework, as well as a general understanding of other donors and implementing partners supporting the health systems in the country is desirable.
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Experience conducting evaluations and/or related research, including development of data collection tools
- Experience conducting qualitative data collection and analysis, such as key informant interviews, focus groups and/or observations
- Experience working in the region, including experience within the health context of Cambodia is desirable.
- Proficient in English
- Good writing skills, specifically technical and evaluation report-writing experience
- Experience in conducting USAID evaluations of health programs/activities

Key Staff 3 Title: **Community Health Specialist [ECH lead]**

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in community health, and capacity strengthening for community health. S/He will participate in planning and briefing meetings, development of data collection methods and tools, data collection, data analysis, development of evaluation presentations, and writing of the evaluation report.

Qualifications:

- At least 8 years' experience working on community health activities within primary health and/or health systems strengthening projects; USAID project implementation experience preferred
- Masters of Public Health or other health-related graduate degree with strong technical expertise in community health care
- Strong background in strengthening community-level home health practices, health seeking behaviors and health services
- At least 6 years of experience working in the field of health and/or NGO organizational development
- Demonstrated understanding of community engagement for services, demand creation and prevention
- Knowledgeable in capacity-building assessment (e.g., OCATs) and evaluation methodologies is desirable.
- Some community TB experience and knowledge is preferred.
- Experience working in organizational capacity development/strengthening among governmental and non-governmental entities in developing country settings to strengthen health programs/activities
- Familiar with the Cambodia MOH strategy and strategic direction, the social accountability framework, as well as a general understanding of other donors

and implementing partners supporting the health systems in the country is desirable.
- Experience in implementing and/or evaluating USAID community-level health programs/projects
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Experience conducting evaluations and/or related research, including development of data collection tools
- Experience conducting qualitative data collection and analysis, such as key informant interviews, focus groups and/or observations
- Experience working in the region, including experience within the health context of Cambodia, specifically on maternal and child health, is highly desirable.
- Proficient in English
- Good writing skills, specifically technical and evaluation report-writing experience
- Experience in conducting USAID evaluations of health programs/activities

Key Staff 4 Title: **Health financing & social health protection specialist [SHP lead]**

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise on health systems strengthening (HSS), with a focus on health care financing and social health protection with a focus on health insurance schemes. S/He will participate in evaluation planning, data collection, data analysis and report writing.

Qualifications:
- At least 8 years' experience working on health financing systems in developing and/or transitional country settings; USAID project implementation experience preferred
- Advanced degree in public health and/or economics with experience in health economics and/or health care financing
- Expertise working with health care financing and health system strengthening in developing countries
- Experience in assessing and/or evaluating health financing systems and capacity development related to health financing and/or payment systems
- Familiarity with health equity fund or similar systems is desirable
- Experience in stakeholder engagement
- Experience in conducting USAID evaluations of health programs/activities
- An advanced degree in health economics, health system strengthening, or related field
- Able to work well on a team
- Good interpersonal communication skills
- Good writing skills, specifically technical and evaluation report-writing experience
- Proficient in written and spoken English
- Experience in conducting USAID evaluations of health programs/activities
- Experience working in the region, including experience within the health context of Cambodia is desirable.

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Local **evaluation logistics/program assistant** will support the evaluation team with all logistics and administration to allow them to carry out this evaluation. The logistics/program assistant will have a good command of English and Khmer. S/He will have knowledge of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and ensure business center support, e.g., copying, internet and printing. S/he will work under the guidance of the team leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed.

Local evaluators (3 local consultants) to assist the evaluation team with data collection, analysis and data interpretation. They will have basic familiarity with health topics, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note-taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed. The local evaluators will have a good command of English and Khmer. They will also assist the team and the logistics coordinator, as needed. They will report to the team leader.

Local translators: Other temporary translators (three local translators, one for each team) as required, depending on the participants at meetings and interviews, as well as the demand to translate data collection tools, transcripts and other documents. Recommend translator be present during interview to translate for the consultant in real time as the local evaluators conduct the interview.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

☐ No
☐ Yes–If yes, specify who:
■ Significant involvement–If yes, specify who:

As part of the Agency's strategy to strengthen staff capacity, USAID encourages participation of USAID staff on the evaluation team when his/her participation is considered beneficial for skills development or for ensuring the use of evaluation results, and does not present a conflict of interest or a threat to validity of the evaluation. The GH Pro evaluation team may be complemented by up to two additional USAID staff team members for part or all of the evaluation time period. USAID staff participating to the evaluation must not be involved in the management of this midterm performance evaluation.

In addition, the evaluation COR and the M&E specialist of OPHE at USAID/Cambodia may accompany the evaluation team to selected sites during the field data collection to observe the field work of the evaluation team, but s/he will not be part of the team members.

Staffing Level of Effort (LOE) Matrix (Optional):
This optional LOE matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
b) Immediately below each staff title enter the anticipated number of people for each titled position.
c) Enter row labels for each activity, task and deliverable needed to implement this analytic activity.
d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
e) At the bottom of the table total the LOE days for each consultant title in the 'subtotal' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of effort in **days** for each evaluation/analytic team member

Activity/Deliverable		Evaluation/Analytic Team				
		Team Leader/ Key Staff 1	Key Staff 2, 3 & 4	Local Evaluators	Logistics/ Program Assistant	Translators
	Number of persons →	1	3	3	1	3
1	Launch briefing	0.5				
2	Desk review	5	5	2		
3	Preparation for team convening in-country				2	
4	Travel to country	2	2			
5	Team planning meeting	4	4	4	4	
6	In-briefing with mission	1	1	1	1	
7	In-briefing with project	0.5	0.5	0.5	0.5	
8	Data collection DQA workshop (protocol orientation for all involved in data collection)	2	2	2		2
9	Preparation/logistics for site visits	0.5	0.5	0.5	2	
10	Data collection/site visits (including travel to sites)	15	15	15	15	15
11	Data analysis	5	5	5	2	
12	Debriefing with mission, with preparation	1	1	1	1	1
13	Debriefing workshop with IPs, including preparation (one debriefing per project)	1	1	1	1	1
14	Depart country	2	2			
15	Draft report(s)	7	5	2	1	
16	GH Pro report QC review and formatting					
17	Submission of draft report(s) to mission					
18	USAID report review					
19	Revise report(s) per USAID comments	3	2			
20	Finalize and submit report to USAID					

Activity/Deliverable		Evaluation/Analytic Team				
		Team Leader/ Key Staff 1	Key Staff 2, 3 & 4	Local Evaluators	Logistics/ Program Assistant	Translators
Number of persons →		1	3	3	1	3
21	508 compliance review					
22	Upload evaluation report(s) to the DEC					
	Total LOE per person	50	46	34	30	19
	Total LOE	**50**	**138**	**102**	**30**	**57**

If overseas, is a 6-day workweek permitted? ■ Yes ☐ No

Travel anticipated: List international and local travel anticipated by what team members.
Siem Reap, Banteay Meanchey, and Battambang (for QHS and SHP only)

XII. LOGISTICS

Note: Most evaluation/analytic teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access
Specify who will require Facility Access: _____

☐ Electronic County Clearance (ECC) (International travelers only)
☐ GH Pro workspace
Specify who will require workspace at GH Pro: _____

■ Travel-other than posting (specify): International travel to Cambodia, and in-country travel for data collection
☐ Other (specify): _____

XIII. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/analytic team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, work plan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production-If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC

and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XIV. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before field work

- SOW:
  - Develop SOW.
  - Peer review SOW.
  - Respond to queries about the SOW and/or the assignment at large.
- Consultant conflict of interest (COI): To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents: Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local consultants: Assist with identification of potential local consultants, including contact information.
- Site visit preparations: Provide a list of site visit locations, key contacts and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line-item costs.
- Lodgings and travel: Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During field work

- Mission point of contact: Throughout the in-country work, ensure constant availability of the point of contact person and provide technical leadership and direction for the team's work.
- Meeting space: Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available, or other known office/hotel meeting space).
- Meeting arrangements: Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate contact with implementing partners: Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After field work

- Timely reviews: Provide timely review of draft/final reports and approval of deliverables.

XV. EVALUATION REPORT

Provide any desired guidance or specifications for final report. (See *How-To Note: Preparing Evaluation Reports)*

All deliverables that are in written format must be in plain, grammatically correct English language; be submitted in appropriate electronic format (i.e., Microsoft Word, Excel, Power Point Presentation, and PDF); and meet all the requirements.

All findings must be substantiated by quantitative and/or qualitative data (evidence). Use of the qualitative data as evidence must be specific and clear (e.g., how many informants out of how many interviewed reported finding "A," instead of "many" or "some" of the informants said so, although it is not meant to be used against representativeness). Data shall be disaggregated by sex as appropriate to the most possible extent. Each of the recommendations needs to be

supported by a specific conclusion that is drawn upon a specific set of findings. They must be action-oriented and practical, and be accompanied by recommended responsible parties.

The **evaluation/analytic final report** must follow USAID's *Criteria to Ensure the Quality of the Evaluation Report* (found in Appendix I of the *USAID Evaluation Policy*).

a. The report must not exceed **50 pages** (excluding executive summary, table of contents, acronym list and annexes).
b. The structure of the report should follow the evaluation report template, including branding, found here or here.
c. Draft reports must be provided electronically, in English, to GH Pro, which will then submit it to USAID.
d. For additional guidance, please see the *How-To Note on preparing Evaluation Draft Reports* found here.

Reporting guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Executive Summary: concisely state the most salient findings, conclusions and recommendations (not more than 4 pages);
- Table of Contents (1 page);
- Acronyms
- Evaluation Purpose and Evaluation Questions (1-2 pages)
- Project Background (1-3 pages)
- Evaluation Methods and Limitations (1-3 pages)
- Findings, Conclusions and Recommendations
    - Findings
    - Conclusions
    - Recommendations
- Annexes
    - Annex I: Evaluation/Analytic Statement of Work
    - Annex II: Evaluation/Analytic Methods and Limitations
    - Annex III: Data Collection Instruments
    - Annex IV: Sources of Information
        - List of Persons Interviews
        - Bibliography of Documents Reviewed
        - Databases
        - [etc]
    - Annex V: Disclosure of Any Conflicts of Interest
    - Annex VI: Statement of Differences (if applicable)

The evaluation methodology and report will be compliant with the *USAID Evaluation Policy* and *Checklist for Assessing USAID Evaluation Reports*

The evaluation report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement-sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USAID separately from the evaluation report.

All data instruments, datasets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be provided to GH Pro and presented to USAID electronically to the program manager. All datasets will be in an unlocked, electronic format (CSV or XML). GH Pro will submit datasets to the evaluation COR on a CD ROM, separately from the report.

XVI. USAID CONTACTS

	Primary Contact	Alternate Contact	Alternate Contact
Name:	Alison Bird	Peoulida Ros	Serey Rathanak Suon
Title:	Deputy Program Officer	M&E Specialist	M&E Specialist
USAID Mission:	Program Office, USAID/Cambodia	Program Office, USAID/Cambodia	Office of Public Health and Education, USAID Cambodia
Email:	abird@usaid.gov	pros@usaid.gov	ssuon@usaid.gov
Telephone:			
Cell Phone:			

List other contacts who will be supporting the requesting team with technical support, such as reviewing SOW and report (such as USAID/W GH Pro management team staff)

	USAID/Cambodia GH Pro Liaison	Technical Support Contact
Name:	Noah Sprafkin	
Title:	MCH/FP/Nutrition Team Leader	
USAID Office/Mission	Office of Public Health and Education USAID/Cambodia	
Email:	nsprafkin@usaid.gov	
Telephone:	855-23-728387	
Cell Phone:	855-12-421180	

XVII. REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

Draft evaluation matrix for detailed evaluation questions
Note: To be updated to align with evaluation questions

Questions	Suggested Data Sources (*)	Suggested Data Collection Methods	Data Analysis Methods
1- How can QHS, ECH and SHP interventions that are being implemented in the same target areas reduce potential overlap and develop synergies/align better to improve the quality health services and health outcomes that are targeted by the USAID/Cambodia health project?	*Program descriptions of each mechanism* *Project staff* *Stakeholders & expert knowledge*	*Desk review* *Key informant interviews*	*[To be determined by evaluation team]* *[Requested level of disaggregation—location (district, province), etc.…]*
2- What are the potential milestones for the USAID/Cambodia health portfolio to transit from activity implementation to a pooled technical assistance (Pooled TA) mechanism with other donors that would improve health quality and financial sustainability?	*National policy related to pooled TA* *Stakeholders & expert knowledge* *Health project PAD 2013-2018*	*Desk review* *Key informant interviews*	*[To be determined by evaluation team]*
3- What are the potential challenges and opportunities for the USAID/Cambodia health portfolio given current RGC strategic direction in Health Strategic Plan 3 (HSP3)?	*Health strategic plan 3 2016-2020* *Health project PAD 2013-2018* *Government official* *Stakeholders (Donors, partners, other USG agencies…etc)*	*Desk review* *Key informant interviews*	*[To be determined by evaluation team]*

QHS-specific evaluation questions:

Questions	Suggested Data Sources (*)	Suggested Data Collection Methods	Data Analysis Methods
1- To what extent has QHS achieved its objectives and expected results?	*Activity program description* *Mechanism progress report* *Activity M&E plan* *Project staff* *Stakeholders* *Beneficiaries*	*[Key informant interviews, focus group discussions, direct observation, desk review…]*	*[To be determined by evaluation team]* *[Requested level of disaggregation—gender, location (district, province), etc.…]*
2- Which QHS components appear to be most effective to change health providers' services and practices and improve the quality of health services?	*Activity program description* *Mechanism progress report* *Quality assessment tool* *Service providers* *Project staff* *Implementing partner*	*[Key informant interviews, focus group discussions, direct observation, desk review…]*	*[To be determined by evaluation team]*

Questions	Suggested Data Sources (*)	Suggested Data Collection Methods	Data Analysis Methods
	Expert knowledge		
3- What are barriers to the effective implementation of QHS? How can the implementer overcome those barriers?	*Activity program description* *Mechanism progress report* *Quality assessment tool* *Stakeholders* *Project staff* *Implementing partner* *Expert knowledge*	*Desk review* *Key informant interviews*	*[To be determined by evaluation team]*
4- What are strengths and weaknesses of QHS's team-based learning approaches? How do QHS's team-based learning approaches complement the MOH's in-service training strategies? What needs to be adjusted to improve coaching and mentoring efforts? How receptive are services providers to QHS's team-based learning approaches?	*National service training policy* *Activity program description* *Activity progress report* *Activity learning approach documents* *Stakeholders* *Service providers* *Project staff* *Implementing partners* *Expert knowledge*	*[Key informant interviews, focus group discussions, direct observation, desk review…]*	*[To be determined by evaluation team]* *[Requested level of disaggregation—gender]*
5- Are the current monitoring tools and systems sufficient for measuring activity results?	*Activity M&E plan and tools* *Project staff* *Implementing partner* *Expert knowledge*	*Desk review* *Key informant interviews*	*[To be determined by evaluation team]*

ECH-specific evaluation questions:

Questions	Suggested Data Sources (*)	Suggested Data Collection Methods	Data Analysis Methods
1- Has ECH achieved its objectives and results in cluster 1? What project components should be strengthened/modified toward achieving project objectives?	*Activity program description* *Mechanism progress report* *Activity M&E plan* *Project staff* *Stakeholders* *Beneficiaries*	*[Key informant interviews, focus group discussions, direct observation, desk review…]*	*[To be determined by evaluation team]* *[Requested level of disaggregation—gender, location (district, province), etc.…]*
2- What are the strengths and weaknesses of project implementation, management and financial structure to support the implementation of ECH; specifically related to location of head office, implementing partner management structure and	*Activity program description* *Mechanism progress report* *Activity M&E plan* *Project staff* *Stakeholders* *Implementing partners* *Expert knowledge*	*[Key informant interviews, desk review…]*	*[To be determined by evaluation team]*

Questions	Suggested Data Sources (*)	Suggested Data Collection Methods	Data Analysis Methods
financial management structure? What prevents RACHA from implementing the full coverage of 2 assigned provinces in cluster 1?			
3- Will Implementation of the Social Accountability Framework (I-SAF) be able to influence the institutionalization of VHSG?	*ISAF framework* *Stakeholders (commune council, provincial authority, world bank, other donors…etc)* *Implementing partners* *Village health support groups (VHSG)* *Expert knowledge*	*[Key informant interviews, focus group discussions, direct observation, desk review…]*	*[To be determined by evaluation team]*
4- How effective is it to have VHSG disseminate health information to change behaviors? What could be improved?	*Village health support group (VHSG)* *Beneficiaries*	*[Focus group discussions, direct observation]*	*[To be determined by evaluation team]* *[Requested level of disaggregation—gender, location (district, province), etc.…]*
5- Are the various approaches of the Behavioral Change Campaign, including a comedy show and interpersonal communication, effective for disseminating messages to people?	*Village health support group (VHSG)* *Beneficiaries* *Implementing partners* *Project staff* *Stakeholders*	*[Key informant interview, focus group discussions, direct observation]*	*[To be determined by evaluation team]*
6- Are the current monitoring tools and systems sufficient for measuring the results of these project activities?	*Activity M&E plan and tools* *Project staff* *Implementing partner* *Expert knowledge*	*Desk review* *Key informant interviews*	*[To be determined by evaluation team]*

SHP-specific evaluation questions:

Questions	Suggested Data Sources (*)	Suggested Data Collection Methods	Data Analysis Methods
1- To what extent did SHP achieve its objectives and expected results? What project components should be strengthened/modified toward achieving project objectives?	*Activity program description* *Mechanism progress report* *Activity M&E plan* *Project staff* *Stakeholders* *Beneficiaries*	*[Key informant interviews, focus group discussions, direct observation, desk review…]*	*[To be determined by evaluation team]* *[Requested level of disaggregation—gender, location (district, province), etc.…]*

Questions	Suggested Data Sources (*)	Suggested Data Collection Methods	Data Analysis Methods
2- How do contextual changes in the political and socio-economic environment in Cambodia affect the project in achieving its objectives?	*Draft national health financing policy* *Health Strategic Plan 3* *Activity program description* *Ministry of Health officials* *Stakeholders* *Project staff* *Implementing partner*	*Desk review* *Key informant interviews*	*[To be determined by evaluation team]*
3- How can the HEF monitoring system be institutionalized in a cost-effective manner?	*Activity M&E plan and tools* *Project staff* *Implementing partner* *Expert knowledge*	*Desk review* *Key informant interviews*	*[To be determined by evaluation team]*
4- What should be the future roles of SHP in HEF expansion system and broader social health protection schemes?	*Draft national health financing policy* *Health strategic plan 3* *Activity program description* *Ministry of health officials* *Stakeholders* *Project staff* *Implementing partner*	*Desk review* *Key informant interviews*	*[To be determined by evaluation team]*
5- What are strengths and weaknesses of project management structures to support the implementation of SHP?	*Activity program description* *Mechanism progress report* *Activity M&E plan* *Project staff* *Stakeholders* *Implementing partners* *Expert knowledge*	*[Key informant interviews, desk review…]*	*[To be determined by evaluation team]*

ANNEX II: EVALUATION APPROACH MATRICES

Evaluation Matrix–Cross-Cutting Questions

Evaluation Questions	Data Sources	Sampling/ Selection Criteria	Information Collection Tools
Cross-cutting questions			
How can QHS, ECH and SHP interventions that are being implemented in the same target areas reduce potential overlap and develop synergies/align better to improve the quality health services and health outcomes that are targeted by the USAID/ Cambodia Health Project?	• Implementing Partners • MoH counterpart - MNCHC, DPHI, HEF Secretariat • Other donors (DFAT, WB, GIZ, UNFPA, WHO, UNICEF) • PHD, District governor, Provincial Governor, OD Manager • CC, HCMC/HC Manager • Health providers • Clients • VHSG • Provincial Planning Manager - SHP • HEF Operator	• Policymakers/key stakeholders • Practitioners • 3 targeted provinces (Battambang, Siem Reap, Banteay Meanchey) • Sampling of ODs based on geographic access, socio-economic status, duration of implementation, level of local government buy-in, and presence of other donor-funded projects	• Key Informant Interview • Group interview guide • Site visits • Scorecard • Documentation review • Observation checklist • Key indicator tables
What are the potential milestones for the USAID/Cambodia health portfolio to transition from discrete activity implementation/projects to more consolidated mechanisms (such as a World Bank single-donor trust fund or other consolidated mechanisms) with other donors that would improve health quality and financial sustainability of Ministry of Health?	• USAID AORs • Donor partners • MOH counterparts and other policymakers • IPs	• Policymakers/key influencers • 100% of donors under HSSP2 and H-EQIP • 100% of IPs' COPS and Senior Management Team	• Key Informant Interview • Documentation review
What are the potential challenges and opportunities for the USAID/Cambodia health portfolio given current Royal Government of Cambodia strategic direction in health strategic plan 3 (HSP3)?	• USAID AORs • Donor partners • MOH counterparts and other policymakers • IPs	• Policymakers/key influencers • 100% of donors under HSSP2 and H-EQIP • 100% of IPs' COPS and Senior Management Team	• Key Informant Interview • Documentation review
To what extent did QHS, ECH and SHP achieve their objectives and expected results at this time?	• USAID AORs • Donor partners • MOH counterparts and other policymakers • IPs	• Key central level policymakers • 100% of donors under HSSP2 and H-EQIP • 100% of IPs' COPS and Senior Management Team	• Key Informant Interview • Scorecard • Site visits • Documentation review • Key indicator tables

Evaluation Matrix–HS Mechanism

Evaluation Questions	Data Sources	Sampling/ Selection Criteria	Information Collection Tools
To what extent has QHS achieved its objectives and expected results?	• Project Staff • MOH Senior Staff at Central & PHDs • Implementing Partner Staff	• Stakeholders & Experts • Practitioners	• Key informant interview • Scorecards • Documentation review • Data analysis • Focused observations • Group discussions
Which QHS components (activities) appear to be most effective to change health providers' services and practices and improve the quality of health services?	• Project Staff • MOH Senior Staff at Central & PHDs • Providers (doctors, midwives, nurses) at PHD, ODs, RHs and HCs • Implementing Partner Staff	• Stakeholders & Experts • Practitioners • Beneficiaries	• Key Informant Interviews • Scorecards • Focused observations • Group discussions and focus groups • Documentation review
What are barriers to the effective implementation of QHS? How can the implementer overcome those barriers?	• Stakeholders & Experts • Project Staff • MOH Senior Staff at Central & PHDs • Providers (doctors, midwives, nurses) at PHD, ODs, RHs and HCs • Implementing Partner Staff	• Stakeholders & Experts • Practitioners • Beneficiaries	• Key Informant Interviews • Scorecards • Focused observations • Group discussions and focus groups • Documentation review
What are strengths and weaknesses of QHS's team-based learning approaches? How do QHS's team-based learning approaches complement MoH's in-service training strategies? What needs to be adjusted to improve coaching and mentoring efforts? How receptive are services providers to QHS's team-based learning approaches?	• Stakeholders & Experts • Project Staff • MOH Senior Staff at Central & PHDs • Providers (doctors, midwives, nurses) at PHD, ODs, RHs and HCs • Implementing Partner Staff	• Stakeholders & Experts • Practitioners • Beneficiaries	• Key Informant Interviews • Scorecards • Focused observations • Group discussions and focus groups • Documentation review
Are the current monitoring tools and systems sufficient for measuring activity results?	• Project Staff • MOH staff • Stakeholders and Experts	• Stakeholders & Experts • Practitioners	• Key informant interviews

Evaluation Matrix–SHP Mechanism

Evaluation Questions	Data Sources	Sampling/ Selection Criteria	Information Collection Tools
To what extent did SHP achieve its objectives and expected results? What project components should be strengthened/modified toward achieving project objectives?	• MOH – DPHI, HEF Secretariat • Donors – WB, KFW, Australian, etc. • PHD, OD • Provincial/District Health Social Protection Steering Committee (P/DHSPSC) • CMHEF Committee • USAID • HEF Operators • Health providers (HC, RH) • Project documentation	• Key central level policymakers • 100% of donors under HSSP2 and H-EQIP • 100% of IPs' COPS and Senior Management Team	• Key Informant Interview • Scorecard • Documentation review • Key indicator tables
How do contextual changes in the political and socio-economic environment in Cambodia affect the project in achieving its objectives?	• MOH – DPHI, HEF Secretariat • Donors – WB, KFW, Australian, etc. • Implementing partner • Project documentation, research and policy papers	• Key central level policymakers • 100% of donors under HSSP2 and H-EQIP • 100% of IPs' COPS and Senior Management Team	• Key Informant Interview • Documentation review
How can the HEF monitoring system be institutionalized in a cost-effective manner?	• MOH – DPHI, HEF Secretariat • IP • PHD, OD • PHSPSC • HEF Operator	Sampling of ODs and health facilities based on geographic access, socio-economic status, duration of implementation, level of local government buy-in, and presence of other donor-funded projects	• Key Informant Interview • Scorecard • Site visits
What should be the future roles of SHP/URC in HEF expansion system and broader social health protection schemes?	• MOH – DPHI, HEF Secretariat • Donors – WB, KFW, Australian, etc. • IP	Sampling of ODs based on geographic access, socio-economic status, duration of implementation, level of local government buy-in, and presence of other donor-funded projects	• Key Informant Interview • Site visits • Documentation review
What are strengths and weaknesses of project management structures to support the implementation of SHP?	• MOH – DPHI, HEF Secretariat • Donors • IP • Sub-agreement partners • PHD, OD • PHSPSC • HEF Operator	Sampling of ODs based on geographic access, socio-economic status, duration of implementation, level of local government buy-in, and presence of other donor-funded projects	• Key Informant Interview • Scorecard • Site visits • SWOT analysis

Evaluation Matrix–ECH Mechanism, Part 1

Evaluation Questions	Data Sources	Sampling/ Selection Criteria	Information Collection Tools
Has ECH achieved its objectives and results in cluster 1? What project components should be strengthened/ modified toward achieving project objectives?	• Key informants: RACHA Executive Director; ECH COP; Component Team Leaders; M&E team; Regional Directors; Provincial Managers • Project data and reports: RACHA ECH MIS; baseline survey; special studies; Annual and Semi-Annual Reports	National and provincial perspective:	• Key informant interview (KII) guide • Group discussion guide • Most significant change questions • Key indicator tables • Document review
What are the strengths and weaknesses of project implementation, management and financial structure to support the implementation of ECH; specifically related to location of head office, implementing partner management structure and financial management structure? What prevents RACHA from implementing the full coverage of 2 assigned provinces in cluster 1?	• Key informants within RACHA: RACHA Board of Directors including Executive Director; ECH COP; Finance and Operations Manager; ECH Component Team Leaders; Regional Directors; Provincial Managers • Key informants external to RACHA: NMCHC, Provincial Health Department (PHD), Provincial CSO partners • Documentation: Project reports	• Stakeholder communities: • Governance body • RACHA leadership and management team at the national level • RACHA provincial management • External Government and non-governmental partners	• Group discussion guide • Scorecard • Document review
Will Implementation of the Social Accountability Framework (I-SAF) be able to influence the institutionalization of VHSG?	• Documentation: ISAF related policy and project documents; DIP and CIP plans • Key informants within RACHA: COP; Component Team Leaders; Regional Directors; Provincial Managers • Policy level informants: NCDD Social Accountability Adviser; World Bank; Director DPHI, MOH; CSOs involved in ISAF • Sub-national bodies/key informants: Provincial level ISAF Coordinating Body; District Governor; Commune Council (Chief); CCWC • ISAF facilitators at local level: CAF	• Stakeholder communities: • Policy influencers • Implementation bodies • Practitioners • Geographical areas: selection as per criteria discussed above	• KII guide • Group discussion guide • Most significant change questions • Document review

Evaluation Matrix–ECH Mechanism, Part 2

Evaluation Questions	Data Sources	Sampling/ Selection Criteria	Information Collection Tools
How effective is it to have VHSG disseminate health information to change behaviors? What could be improved?	• RACHA Component Team Leader • Community people: women; men; family influencers • VHSG members • Health centre staff • Health Centre Management Committee • Village Chief • Document review: national guidelines and project documents	• Stakeholder communities: • Geographical areas: selection as per criteria discussed above	• Focus Group Discussion (FGD) guide • KII guide • Focused observation checklist • Scorecard • Most significant change questions • Document review
Are the various approaches of the Behavioral Change Campaign, including a comedy show and interpersonal communication, effective for disseminating messages to people?	• RACHA Component Team Leader • Community people: women; men; family influencers • VHSG members • Health centre staff • Health Centre Management Committee • Village Chief • Document review: Secondary data; project documents	• Stakeholder communities: • Geographical areas: selection as per criteria discussed above	• Focus Group Discussion (FGD) guide • KII guide • Focused observation checklist • Scorecard • Most significant change questions • Document review
Are the current monitoring tools and systems sufficient for measuring the results of these project activities?	• RACHA internal stakeholders: RACHA M&E team at national level; RACHA Regional Directors, Provincial Managers, Field Coordinators • External stakeholders: NMCHC; Commune Chief; Health Centre Chief/HCMC • Document review	• Stakeholder communities: • Managers and users of M&E data • Government partners	• KII guide • Scorecard • Most significant change questions • Document review

ANNEX III: MECHANISM SITE VISIT PLANS

Site Visit Plan–QHS Mechanism

Project	Province	OD	AD	Type or Identifier	Location	Activity	Selection or Sampling Criteria	Information Gathering Methods	Remarks
QHS	Battambang	Maung Russei	Maung Russei	Health Center	Prey Svay	Meeting with HC chief, HC midwives, OD midwives	Lower competency, just started HCQI	Individual and Group Key Informant Interviews, Observations	HCQI follow up; Mothers questioned about care in settings in between KIIs with staff
	Battambang	Sangke	Sangke	Operational District	Sangke	Meeting with OD head, MCH chief, MIS officer	MCAT and PCAT both rated medium	Group Key Informant Interviews	
	Battambang	Sompov Loun	Sompov Loun	Referral Hospital	Sompov Loun	Meeting with RH deputy & midwife	Remote rural area with high rates of migration & poverty	Individual and Group Key Informant Interviews, Observations	
	Battambang	Sompov Loun	Sompov Loun	Health Center	Trav Chou	Meeting with HC chief, deputy, midwife and nurse	Remote rural area with high rates of migration & poverty	Individual and Group Key Informant Interviews, Observations	
	Battambang	Maung Russei	Maung Russei	Referral Hospital	Maung Russei	Meeting with RH head, midwives & nurses	Higher competency, Poor SAM treatment, Good SAM screening	Individual and Group Key Informant Interviews, Observations	CSP follow up
	Battambang	Battambang	Battambang	Provincial Hospital	Battambang town	Meeting with PH head & midwife	Lower competency, Good SAM treatment, Average FP & Referral system	Individual and Group Key Informant Interviews, Observations	
	Banteay Meanchey	Poipet	Poipet	Health Center	Sophy	Meeting with HC chief, midwives and nurses	Lower competency, just started HCQI, SHP also visiting	Individual and Group Key Informant Interviews, Observations	
	Banteay Meanchey	Mongkul Borei	Mongkul Borei	Referral Hospital	Mongkul Borei	Meeting with HC chief, midwives and nurses	Higher SAM treatment, Good TB & CSP, Poor FP, Average referral system	Individual and Group Key Informant Interviews, Observations	
	Banteay Meanchey	Poipet	Poipet	Referral Hospital	Poipet	Meeting with HC chief, midwives and nurses	Average SAM treatment, TB & FP, Poor referral system, Strong PCAT	Individual and Group Key Informant Interviews, Observations	MCAT meeting
	Siem Reap	Kralanch	Kralanch	Referral Hospital	Kralanch	Meeting with HC chief, midwives and nurses	Poor triage, Good SAM & Screening, Good TB, Poor F	Individual and Group Key Informant Interviews, Observations	Triage follow up
	Siem Reap	Kralanch	Kralanch	Operational District	Kralanch	Meeting with OD head, MCH chief, MIS officer	MCAT not initiated yet	Individual and Group Key Informant Interviews	
	Siem Reap	Kralanch	Kralanch	Health Center	Kampong Thkov	Meeting with HC chief, midwives and nurses	Higher competency	Individual and Group Key Informant Interviews, Observations	HCQI follow up
	Siem Reap	Kralanch	Kralanch	Health Center	Moung	Meeting with HC chief, midwives and nurses	Average competency	Individual and Group Key Informant Interviews, Observations	HCQI follow up
	Siem Reap	Angkor Chum	Angkor Chum	Operational District	Angkor Chum	Meeting with OD head, MCH chief, MIS officer	Strong PCAT, Medium MCAT	Individual and Group Key Informant Interviews	
	Siem Reap	Angkor Chum	Angkor Chum	Referral Hospital	Angkor Chum	Meeting with HC chief, midwives and nurses	Higher competency, Good FP, Haven't started referral system, Good triage	Individual and Group Key Informant Interviews, Observations	SAM/TB follow up
	Siem Reap	Angkor Chum	Angkor Chum	Health Center	Prey Chrouk	Meeting with HC chief, midwives and nurses	Higher competency	Individual and Group Key Informant Interviews, Observations	

Site Visit Plan–ECH Mechanism Part I

Project	Province	OD	AD	Type or Identifier	Location	Activity	Selection or Sampling	Information Gathering	Remarks
ECH	Siem Reap	Siem Reap	Siem Reap	Provincial government	Siem Reap Town	Deputy Provincial Governor		Key informant interview	
	Siem Reap	Siem Reap	Siem Reap	NCDD/PPMA	Siem Reap Town	Provincial Program Management Adviser		Key informant interview	
	Siem Reap	Siem Reap	Siem Reap	NCDD/PPMA	Siem Reap Town			Key informant interview	
	Siem Reap	Siem Reap	Siem Reap	Provincial Health Department	Siem Reap Town	Deputy Provincial Health Director,		Key informant interview	
	Siem Reap	Siem Reap	Siem Reap	RACHA staff	Siem Reap Town	Regional Director		Key informant interview	
	Siem Reap	Siem Reap	Siem Reap	RACHA staff	Siem Reap Town	Provincial Manager		Key informant interview	
	Siem Reap	Angkor Chum	Angkor Chum	RACHA staff		OD manager, Local Governance and Capacity Building Officer, MCH/TB Officer	High performing, easy access	Focus group discussion	
	Siem Reap	Kralanh	Kralanh	RACHA staff		OD manager, Local Governance and Capacity Building Officer, MCH Officer, TB Officer	High performing, easy access	Focus group discussion	
	Siem Reap	Siem Reap	Siem Reap	RACHA staff		MCH Officer	High performing, easy access, less poor	Focus group discussion	
	Siem Reap	Angkor Chum	Angkor Chum	OD Office		OD Director	High performing, easy access	Key informant interview	40km from Siem Reap Town
	Siem Reap	Angkor Chum	Angkor Chum	Community	Pram Damleung Village, Tasom Commune	Community Accountability Facilitator	High performing, easy access, less poor	Observation of I4C dissemination meeting, key informant interview	40km from Siem Reap Town; planned project event
	Siem Reap	Siem Reap	Banteay Srey	Health Center	Tbeng HC	Health workers	Mid performing, easy access	Focus group discussion	
	Siem Reap	Siem Reap	Banteay Srey	Commune Council	Tbeng	Deputy Commune Chief and two commune council members	Mid performing, easy access, less poor	Focus group discussion	New ECH site
	Siem Reap	Siem Reap	Angkor Thom	Community	Peak Sneng Commune	Community women	Mid performing, easy access, poor	Focus group discussion	New ECH site
	Siem Reap	Siem Reap	Angkor Thom	Community	Peak Sneng Commune	Community men	Mid performing, easy access, poor	Focus group discussion	New ECH site
	Siem Reap	Siem Reap	Angkor Thom	Community	Samrong	CBD agent/VHSG member	Mid performing, easy access, poor	Key informant interview	New ECH site

Site Visit Plan–ECH Mechanism, Part 2

Project	Province	OD	AD	Type or Identifier	Location	Activity	Selection or Sampling Criteria	Information Gathering	Remarks
ECH	Banteay Mean Chey			Provincial government		Provincial Governor		Key informant interview	
	Banteay Mean Chey	Mongkul Borey	Mongkul Borey	Health center	Banteay Neang	Health workers	High performing, easy access	Key informant interview	
	Banteay Mean Chey	Thmour Pourk	Svey Chek	Health center	Chok Pouk	Health workers	High performing, more difficult to reach, poor	Key informant interview	
	Banteay Mean Chey	Thmour Pourk	Svey Chek	Commune Council		CCWC	High performing, more difficult to reach, poor	Key informant interview	
	Banteay Mean Chey	Thmour Pourk	Svey Chek	Community		FGD women	High performing, more difficult to reach, poor	Focus group discussion	
	Banteay Mean Chey	Mongkul Borey	Mongkul Borey	OD Office		OD Director	High performing, easy access	Key informant interview	
	Banteay Mean Chey	Mongkul Borey	Mongkul Borey	Commune Council	O Prasat Commune	Commune Chief	High performing, easy access, less poor	Key informant interview	
	Banteay Mean Chey	Mongkul Borey	Mongkul Borey	Community	O Prasat Commune	Community women	High performing, easy access, less poor	Focus group discussion	
	Banteay Mean Chey	Mongkul Borey	Serei Sophoin	Health centre	Kampong Svay 2	HCMC meeting	High performing, easy access, less poor	Observation, focus group discussion	Planned event
	Banteay Mean Chey	Poipet	Poipet	OD Office		OD Director	Lack of government OD support	Key informant interview	
	Banteay Mean Chey	Poipet	Malai	Commune Council	O Sampur Commune	Commune Chief	High performing, easy access, less poor	Key informant interview	
	Banteay Mean Chey	Poipet	Malai	Community	O Sampur Commune	Community Accountability Facilitator	High performing, easy access, less poor	Observation of I4C dissemination meeting, key informant interview	Planned event
	Banteay Mean Chey	Poipet	O Chrov	Health center	Soeung	CBD Agents	High performing, easy access, less poor	Observation, focus group discussion	Planned capacity building event
	Banteay Mean Chey	Banteay Mean Chey	Banteay Mean Chey	NCDD/PPMA		Provincial Capacity Building Adviser		Key informant interview	
	Banteay Mean Chey	Banteay Mean Chey	Banteay Mean Chey	NCDD/PPMA		ISAF Officer		Key informant interview	
	Banteay Mean Chey	Preah Netr Preah	Preah Netr Preah	District Administration	Preah Netr Preah OD	District DPMA		Key informant interview	
	Banteay Mean Chey	Preah Netr Preah	Preah Netr Preah	District Administration	Preah Netr Preah	District ISAF		Key informant interview	

Site Visit Plan–ECH Mechanism, Part 3

Project	Province	OD	AD	Type or Identifier	Location	Activity	Selection or Sampling	Information Gathering	Remarks
ECH	Siem Reap	Angkor Chum	Angkor Chum	Health center	Nokor Pheas	CDOT Watchers	High performing, easy access, less poor	Key informant interview	Semi-active TB case finding planned event
	Siem Reap	Angkor Chum	Pouk	Health center	Roeul	CBD Agents	High performing, easy access, less poor	Observation, key informant interview	Planned event
	Siem Reap	Siem Reap	Bakong	Community	Trapeang Thom Commune	Community Accountability Facilitator	High performing, easy access, less poor	Observation of I4C dissemination meeting, key informant interview	Planned event
	Siem Reap	Kralanh	Kralanh	Health center	Sambour	VHSG meeting	Mid performing, hard to reach, poor	Observation, focus group discussion	Planned event
	Siem Reap	Angkor Chum	Pouk	Health center	Damnak slanh	CDOT Watchers	High performing, easy access	Observation, focus group discussion	Planned capacity building event
	Siem Reap	Kralanh	Varin	Health center			Easy access, poor	Key informant interview	
	Siem Reap	Kralanh	Varin	Commune Council		Commune Chief	Difficult to reach, poor	Key informant interview	
	Siem Reap	Kralanh	Varin	Commune Council		CCWC	Difficult to reach, poor	Key informant interview	
	Siem Reap	Kralanh	Varin	Community		Community women	Difficult to reach, poor	Focus group discussion	

Site Visit Plan–SHP Project

Project	Province	OD	AD	Type or Identifier	Location	Activity	Selection or Sampling Criteria	Information Gathering	Remarks
SHP	Battambang	BTB	BTB City	Government	PHD	Introduction meeting with PHD	Good buy-in, high-performing	Key informant interview	
	Battambang	BTB	BTB City	Government	BTB Municipality	HEF Governance - meet with Deputy Mayor who is a member of PHFSC		Key informant interview	
	Battambang	BTB	BTB City	Community	BTB City	Buddhism for Health Provincial Coordinator for CMHEF		Key informant interview	
	Battambang	BTB	BTB City	Health Facility	Battambang PRH	HEF, PMRS		Key informant interview, observation checklist, bedside monitoring, household visits	
	Battambang	BTB	BTB City	Religious leade	Po Veal Pagoda	Involvement of religious leaders in CMHEF		Key informant interview	
	Battambang	Thma Kol		Health Facility	Thma Kol RH	HEF, PMRS	Remote access	Key informant interview, observation checklist, bedside monitoring	
	Battambang	Thma Kol	Thma Kol	Community	Chroy Sdao Pagoda	Training of CMHEF leaders	Remote access, newly launched CMHEF	Key informant interview	
	Battambang	Mung Russey	Mung Russey	Community	Prey Tauch HC	Meet HC Head + Attend CMHEF Members Meeting	Good rating	Key informant interview, Focus Group Discussion	
	Battambang	Mung Russey	Mung Russey	Community	Robos Mongkol HC	CMHEF Steering Committee Members	Poor rating	Focus Group Discussion	
	Battambang	Sampov Luon	Sampov Luon	Health Facility	Sampov Luon RH	HEF, PMRS	Good rating	Key informant interview, observation checklist, bedside monitoring, household visits	
	Bantey Meanchey	Mongkol Borey	Mongkol Borey	Government	Banteay Meanchey City	BMC Provincial Governor and PHD Director	Good buy-in, high-performing	Key informant interview	
	Bantey Meanchey	Mongkol Borey	Serey Sophoan	Government	Serey Sophoan	HEF Governance - meet with P/DHFSC members	Good rating	Key informant interview/group discussion	
	Bantey Meanchey	Mongkol Borey	Serey Sophoan	Community	Serey Sophoan	CHMEF provincial authorities + District Facilitation Team	Good rating	Key informant interview/group discussion	
	Bantey Meanchey	Poipet	Poipet	Facility/ Community	Nimet HC	Meet HC Head + CMHEF Steering Committee Members	Average rating	Key informant interview/group discussion	
	Bantey Meanchey	Poipet	Ou Chrov	Facility/ Community	Sophy HC	Meet HC Head + CMHEF Steering Committee Members	Poor rating	Key informant interview/group discussion	
	Siem Reap	Siem Reap	Siem Reap City	Facility	Siem Reap PRH	HEF Governance, PMRS	Low buy-in but good performance	Key informant interview, observation checklist, bedside monitoring	

ANNEX IV: DATA COLLECTION TOOLS

Oral Consent Statement
Midterm Evaluation of USAID Health Project and Implementing Activities–Cambodia

Introduction

Thank you for making the time to talk with me today.

The USAID mission in Cambodia has asked for an independent team to gather information for a midterm evaluation of three health projects it is financing. The three projects included in the evaluation are: Empowering Communities for Health (ECH) Project; Strengthening Facilities for Health Project (SHP); and Quality Health Services (QHS) Project. The purpose of this evaluation is to measure the overall progress of the three projects and to identify lessons learned thus far to better inform USAID's future assistance to Cambodia's health sector.

You were suggested as a person with some familiarity with these projects who can inform this activity, and we greatly appreciate your perspective, experiences and views on the successes, challenges and lessons learned related to the projects' efforts.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [*Interviewer/Recorder initials*]

Key Informant Interview Guide–Cross-Cutting
General Stakeholder Informant
Theme: Project Objectives and Results

Introduction to the midterm evaluation and consent to proceed:

- Thank the key informant for agreeing to participate in the interview.
- Explain that the purpose of this interview is to contribute to the USAID-commissioned midterm evaluation of the three projects of Empowering Communities for Health, Quality Health Services and Social Health Protection.
- The purpose of the evaluation is:
    - to identify lessons learned from the project and inform the design of USAID's future portfolio given the Ministry of Health's strategic direction;
    - to measure the progress of specific implementing activities under the three projects on their performance, namely: Quality Health Services (QHS), Empowering Communities for Health (ECH) and Social Health Protection (SHP), and identify the potential synergies among these activities to improve outcomes for the health project.
- The interview will include questions on the policy and implementation environment and management of the project.
- Ask the key informant if they have any questions for clarification before we start the interview.
- Explain that the interview is likely to take one hour.
- Explain that the key informant's name will not be recorded or quoted without their permission.

Guiding interview questions:

1. To what extent has the project(s) achieved its objectives and results?
2. What have been the opportunities and challenges that have supported/undermined progress?
3. Looking at each of the project(s) components, do you see the need for modification or strengthening of any of them, which one, how and why?
4. What are the factors affecting full coverage within implementation provinces?
5. How are you planning to use the lessons learned from implementation thus far in future efforts?
6. What has been the most significant change(s) achieved by the project(s) so far?

Key Informant Interview Guide–Cross-Cutting
National Level Government Counterparts

Introduction to the midterm evaluation and consent to proceed:

- Thank the key informant for agreeing to participate in the interview.
- Explain that the purpose of this interview is to contribute to the USAID-commissioned midterm evaluation of the three projects of Empowering Communities for Health, Quality Health Services and Social Health Protection.
- The purpose of the evaluation is:
  - to identify lessons learned from the project and inform the design of USAID's future portfolio given the Ministry of Health's strategic direction;
  - to measure the progress of specific implementing activities under the three projects on their performance, namely: Quality Health Services (QHS), Empowering Communities for Health (ECH) and Social Health Protection (SHP), and identify the potential synergies among these activities to improve outcomes for the health project.
- The interview will include questions on the policy and implementation environment and management of the three projects.
- Ask the key informant if they have any questions for clarification before we start the interview.
- Explain that the interview is likely to take one hour.
- Explain that the key informant's name will not be recorded or quoted without their permission.
- Explain that for efficiency we would like to ask some project specific questions and then move to some overarching and policy level issues.

Project-specific interview questions:

A. ECH:

1. Although ECH is just 18 months into implementation, to what extent do you think the project is on track in achieving it objectives and results? Why is that the case?
2. ECH has three main areas of work and many activity streams; is there any specific area of work or activity that you/MNCHC is most interested and involved in? What is that?
3. In the changing policy environment and with the development of HSP3, do you see any challenges and opportunities for the success of ECH? For example:
   a. What do you see as the key challenges and opportunities related to the institutionalization of VHSGs? Are there the policy frameworks in place to connect VHSGs to the MOH as they increasingly align with Commune Council and decentralization?
   b. Are VHSGs an appropriate agent for MNCH and reproductive health behavior change? Given the variety of community-based health agents present at the village level, does the government have plans to strengthen coordination and synergies among them?
   c. There are various efforts to increase accountability to and the participation of communities in health sector management, for example HCMCs, complaints systems and monitoring of HEFs. To what extent do you see this as a priority for improving RMNCH (and TB) outcomes, and how can these various mechanisms and approaches have maximum effect? What will be key factors to making this work in the political, policy and economic environment?

d. Are there any policy-level stakeholders that you suggest we meet to support the evaluation of ECH?

4. Are there any formal mechanisms for you/MNCHC to oversee the direction and progress of ECH? Do you think these are working well, and how would you like to see them strengthened? Are there other members of your staff you suggest we meet that are involved in monitoring and engaging on ECH?
5. Scoring: we are asking a range of key informants to score RACHA's management of ECH; the scores will be kept anonymous. How would you score RACHA management on a scale of 1-5, with 1 being the lowest and 5 the highest in performance? Why is this your score?
6. Do you have any specific suggestions on how management of the project could be improved?

B. SHP:

1. SHP has several components: HEF, MIS, MOH capacity building, and CMHEFs. In your opinion, which of these components achieved the best results (met the targeted objectives)? Which have only partially met their objectives? What do you think are the factors behind these results?
2. What contribution(s) has the SHP program made towards social health protection in Cambodia? Are there areas that still require support from SHP and USAID (e.g, expanding the benefits covered under the HEF, expanding coverage to non-poor and other vulnerable populations, etc.)?
3. In the changing policy environment with HSP3, and the transition from HSP2 to H-EQIP, what is the potential impact of these changes on the SHP's implementation of the HEF and its ability to meet its objectives?
    a. How do you assess the project's response to the transition from HSSP2 to H-EQIP? Is it sufficient or effective? Are there other actions that the project can take to adapt to the changing environment?
    b. If external support is reduced or discontinued, what would be the potential impact on HEF? Would the MOH and RGC be able to continue to fund and operate the HEF independently?
    c. Do you perceive any other changes in the socioeconomic environment (beyond the policy level) that also affected how SHP is being implemented?
4. SHP is supposed to transfer the HEF monitoring function to the MOH. What is your opinion about the proposed transition plan by SHP? Do you perceive any obstacles/barriers/ challenges in implementing this transition plan? What are they (probes: financial, technical, management capacity, etc.) and how can they be overcome?
5. Scoring: just as with ECH, we would like to ask you to score URC's management of SHP; the scores will be kept anonymous. How would you score URC management on a scale of 1-5 with 1 being the lowest and 5 the highest in performance? Why is this your score?
6. Do you have any specific suggestions on how management of the project could be improved?

C. Cross-cutting evaluation questions:

1. Given that the three projects are addressing key drivers of improved health access and health service quality and therefore are expected to contribute to improved outcomes, do you think the synergies between them could be strengthened and how?

2. Do you perceive any potential gaps that are not currently being addressed by these three projects?
3. As the RGC moves into HSP3 and the new H-EQIP project will be starting soon, what do you think should be the programmatic focus and aid mechanism of future USAID assistance to the sector?
4. We would like to ask you to score the level of coordination among the different parties involved in the USAID projects, on a scale of 1-5 with 1 being poor and 5 being very good:
    a. MOH and URC
    b. MOH and RACHA
    c. MOH and PHD, OD
    d. MOH and USAID and other donors
    e. URC and HEF operators and facilities

    Why are these your scores?

Key Informant Interview Guide–Cross-Cutting
Director PHD

Oral Consent Statement

Introduction

Thank you for making the time to talk with me today.

The USAID mission in Cambodia has asked for an independent team to gather information for a midterm evaluation of three health projects it is financing. The three projects included in the evaluation are: Empowering Communities for Health (ECH) Project; Strengthening Facilities for Health Project (SHP); and Quality Health Services (QHS) Project. The purpose of this evaluation is to measure the overall progress of the three projects and to identify lessons learned thus far to better inform USAID's future assistance to Cambodia's health sector.

You were suggested as a person with some familiarity with these projects who can inform this activity, and we greatly appreciate your perspective, experiences and views on the successes, challenges and lessons learned related to the projects' efforts.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding questions:

1. What are the major health challenges in the province, and how does USAID support help address these?
2. ECH project aims to strengthen Commune Council funding of health and VHSGs as a community mobilizer. How relevant do you think these approaches are in the current policy environment, and how do you think they need to be developed?
3. What do you see as the role of Commune Councils in promoting better health outcomes?
4. How does PHD support/encourage ODs to strengthen inclusion of health into CIPs?
5. What are the linkages between health centers, Commune Councils and CCWC?
6. How can the health system be prepared to support the responsibility of CCs funding and engaging and monitoring health?
7. There are many different community-level agents; what do you see to be the challenge of motivating them when they receive various levels of reward?
8. Can community health workers be harmonized and how? How can they be sustained beyond project funding cycles?

9. What do you see to be the challenges of implementing C-DOTS? How can these be addressed?
10. How can health workers be motivated to better provide information and counseling to patients and community people?
11. What do you think is the most successful aspect of the project?
12. Are there any challenges/gaps that are affecting achievement of the project's objectives?
13. Are there any changes or solutions to existing project related problems that you suggest?
14. How are you involved in the project and how often does the ECH team consult with you? Do you think this needs to be changed?
15. As you know there are two other USAID projects that we are evaluating, QHS and SHP which are implemented by URC. Do you see any scope for better coordination and synergy between the USAID projects and other projects in this district?

QHS Multipurpose Information Collection Tool

We Are Trying to Identify in Every Area
• Best practices • Lessons learned • Recommendations for overcoming barriers and obstacles • Recommendations for future roles of QHS (ECH & SHP)

Expected Results for SHP
• Nationwide expansion of HEF ensures access to MNCH services for the poor. • A system of checks and balances enables the MOH to manage the HEFs without provider bias and with a high level of accountability. • HEF reimbursements are linked to objective measures of quality and client satisfaction. • Develop the capacity of a cadre of civil servants within the MOH to oversee HEF operations and monitoring. • The health benefits and modalities of the NSSF are detailed in government directives and include the comprehensive preventive and curative services, including FP. • NGO RH clinics are eligible for reimbursement under the NSSF. • HEF expands as necessary, and as determined by the government, to cover HIV/AIDS services for the poor as other donor resources decline.

Expected Results for ECH
• VHSGs administratively report to CCs with continued technical linkages to HCs. • CCs support VHSG training and operating expenses (e.g., monthly meeting with the HC, BCC material production, travel costs associated with C-DOTS) from their *sangkat* funds. • VHSGs continue to actively provide BCC, C-DOTS and community based-sales of contraceptives. • Communities are aware of their rights under the Client Rights Charter, and demands and expectations of the health system increase accordingly. • CCs actively investigate client complaints and ensure enforcement of the Client Rights Charter. • CC oversight of HC activities leads to greater accountability in terms of staff attendance and adherence to official user fees.

Expected Results for QHS in Synergy with All the Components
• Routine provision of essential newborn care (ENC) in HC and RH deliveries • Identification, referral and appropriate treatment of illness in neonates • Close monitoring and appropriate treatment obstetric complications in RHs • Routine measurement of hemoglobin in ANC, with identification and treatment of anemia in pregnancy per national guidelines • Routine identification of anemia among children, followed by provision of essential care/treatment • Monitoring of weight gain during ANC, accompanied by appropriate nutritional counseling • Routine follow-up of newborns for the first week after delivery by VHSGs • Availability of full range of FP methods in public facilities and increased utilization of LAPMs • Integration of FP services into postpartum care and PAC

QHS and **ECH** share the **EXPECTED RESULT** of: **Improved maternal and child health practices in communities and facilities**

QHS Program Components and Key Activities across Components

Component Key Activity	Basic NBC	NB Complications	EmOC & PNC	Family Planning	Emergency Medicines & Referrals	Nutrition & Nutrition-Related Diseases TB
Health center quality improvement (HCQI)						
Clinical skills practice (CSP)						
Midwifery Coordination Alliance Team (MCAT)						
Pediatric Coordination Alliance Team (PCAT)						
HMIS, SHP and M&E						
Referral systems						
Infection control						
Counseling						
Infection control						

QHS Components and Activities

Components	Activities
Basic newborn care Newborn complications Emergency obstetric care Postnatal care Family planning Emergency medicine and referrals Child nutrition and related diseases (including pediatric TB)	Health center quality improvement Clinical skills practice in referral hospitals Midwifery Coordination Alliance Teams Pediatric Coordination Alliance Teams Health management information system Social health protection Monitoring and evaluation

Key Actors, Recipients, Target Beneficiaries

Central MOH, donors and other stakeholders, plus:

PHD	OD	RH	HCs
Staff and managers in charge of nutrition or child health (IMCI)	Staff and managers in charge of nutrition or child health (IMCI)	Managers, physicians, midwives and nurses	Managers, physicians, midwives and nurses

QHS Evaluation Questions
1. To what extent has QHS achieved its objectives and expected results? What are the major barriers to implementation? 2. Which QHS components ("activities") appear to be most effective to change health providers' services and practices and improve the quality of care? 3. What are the strengths and weaknesses of QHS's team-based learning approaches, including those meant to complement MOH's in-service training strategies; and QHS's coaching and mentoring efforts? 4. Are the current monitoring tools and systems sufficient for measuring activity results?

Component 1: Basic Newborn Care

Sub-purpose: Improve the quality of basic NBC in HCs and RHs in the nine target provinces.

Expected Results
• Improved quality and timeliness of basic NBC • Improved capacity at OD and PHD levels to carry out mentoring and supervision, and follow-up to ensure skill competency • Improved capacity of OD and PHD managers to assess the quality of care given to newborns • Improved infection control practices in HCs and RHs

Key Activities
• Roll out MOH/WHO immediate newborn care (INC) and/or essential newborn care (ENC) training package to RHs and HCs in the nine provinces. • Strengthen capacity at OD and PHD levels to carry out mentoring, supervision, and follow-up to ensure skill competency. • Strengthen capacity of OD, PHD and facility managers to assess the quality of care given to newborns. • Improve infection control practices in HCs and RHs. • Quarterly updates and coaching through MCATs, PCATs, HCQI, and CSP • Update the Safe Motherhood Protocols. • Ensure linkages with and appropriate reimbursements through HEFs. • Rigorously monitor results and adjust implementation to needs and gaps. • Collaboration with other donors and key partners

Component 2: Newborn Complications

Sub-purpose: Strengthen the detection, referral and management of newborn complications.

Expected Results
• Increased identification and referral of sick neonates, both by HCs and the community • All RHs have the capacity to diagnose and treat neonatal sepsis in accordance with the MOH approved CPG. • Application of KMC for premature infants in all facilities • All health facilities in the target provinces receive HEF reimbursement for treating sick newborns.

Key Activities
• Application of KMC and additional key interventions (e.g., ACS) for premature infants in facilities

- Identification and referral of sick neonates, both by HCs and the community
- Strengthen RHs, HCs, and communities' capacities to diagnose and treat neonatal sepsis and other critical newborn conditions.
- Incorporate identification and treatment of critical newborn conditions into capacity-assessment tools and processes.
- Periodic clinical audits
- HMIS improvements and use

Component 3: Emergency Obstetric Care and PNC (postnatal care)

Sub-purpose 1: To improve the timeliness and quality of care provided to women with obstetric complications

Sub-purpose 2: To improve the care for maternal and newborn patients once they arrive at the facility (RHs and HCs) and the maternity ward. Identification and referral for critically-ill maternal and newborn patients to facilities, as well as the immediate triage and emergency care upon arrival to the referral facility are covered in Component 5; these two areas are related, and many activities described below and in Component 5 address both components of the project.

Expected Results

- RH and HC staff routinely provide high-impact interventions, including AMSTL and provision of MgSO4 for eclampsia.
- RH and HC staff implement good infection prevention and control practices.
- Increased coverage of daily IFA supplementation in pregnancy and postpartum
- Increased identification of moderate and severe anemia in pregnancy and treatment in accordance with existing protocols
- Appropriate laboratory investigations are undertaken in a timely manner, abnormal results are acted upon, and repeat investigations performed in a timely manner.
- Increased coverage of 3 PNC visits
- Increased PNC by women living in remote villages

Key Activities

- Develop, test and implement locally applicable protocols and innovations in key areas: NASG and AMSTL Stamp.
- Roll out CEmONC and BEmONC in designated HRs and HCs.
- Prevent and treat maternal anemia during pregnancy to avoid unnecessary maternal deaths due to PPH.
- Identify needs for maternity waiting homes/areas and postpartum rooms.
- Improve the quality and coverage of PNC.
- Improve provider capacities in PNC service provision at HCs.
- Incorporate mHealth technologies in PNC routines.
- Develop materials for HC staff to use to motivate VHSGs to encourage at least 3 PNC visits.
- Ensure linkages with and appropriate support from HEFs.

Component 4: Family Planning

Sub-purpose: To increase the availability, quality and utilization of FP services, with an emphasis on long-acting and permanent methods (LAPM)

Expected Results
• Increased modern contraceptive prevalence rate, and increased distribution from LAPM • Availability of a full range of FP methods in USG-assisted facilities • Integration of FP services into PAC and postpartum services

Key Activities
• Provide competency-based training and follow-up on LAPMs in HCs and RHs. • Incorporate FP modules into CSP, HCQI and MCAT. • Improve access to permanent methods of FP. • Advocate for adequate supplies of FP commodities. • Ensure linkages to and appropriate reimbursements through HEFs and SHP efforts. • HMIS improvements and use • FP Compliance Report

Component 5: Emergency Medicine and Referrals

Purpose: To develop and strengthen referral linkages for obstetric and newborn care

Expected Results
• RHs immediately assess/triage maternal patients on arrival. • Timeliness and intensity of care provided in RHs is commensurate with patient severity and risk factors. • Patient condition is closely monitored around the clock in ICUs and remedial measures are promptly instituted in response to abnormal findings/changes of condition. • OD/PHD managers identify and act upon serious deficiencies in the timeliness and/or quality of care provided to critically ill maternal patients. • Increased identification and correct treatment of postnatal and newborn complications. • A functioning referral system in place to serve the nine focus provinces and beyond • Increased facility deliveries by women living in remote villages

Key Activities
• Comprehensive referral systems improvements in nine provinces • Scale up provincial clinical hotlines. • Improve assessment/triage at RHs. • Develop, test and implement locally applicable emergency medicine protocols in key areas in RHs, with a focus on maternal and pediatric emergencies. • Develop and scale up pre-hospital emergency care. • National policies and guidelines • Develop training materials for HC staff to use to train VHSGs to recognize danger signs and refer appropriately.

Component 6: Child Nutrition and Related Diseases Including Pediatric TB

Purpose: To strengthen screening, counseling, referral, prevention and treatment of child malnutrition and malnutrition-related diseases (including pediatric TB)

Expected Results
• Improved feeding of ill children during and after illness episodes • Improved management of severely malnourished children in RHs • Increased detection and treatment of pediatric TB and other underlying wasting diseases

- Increased provision and quality of screening, counseling, referral, prevention and treatment of malnutrition in HCs

Key Activities

- Improve HC delivery of key nutrition services: OPD/IMCI (including SAM screening) services <5 years of age and GMP in children <2 years of age.
- Conduct regular GMP and SAM screening by health staff during outreach.
- Improve management of SAM at RHs.
- Develop and scale up PCATs.
- Further integrate nutrition information in HMIS and use data for QI.
- Ensure linkages with and appropriate reimbursement of nutrition services and care through HEFs.
- Rigorously monitor results and adjust implementation to needs and gaps.
- Team staffing, project orientation and management
- Improve detection and treatment of pediatric TB and other underlying wasting syndromes.

Question #1

- To what extent has QHS achieved its objectives and expected results?
- What are the major barriers to implementation?

What QHS project activities have you been involved in/are familiar with?

- What has been the most significant change as a result of the project?
- What was it that made the difference and why? Please give examples.
- What are the main barriers to implementation and what would you recommend be done to overcome them?

Question #2:
Which QHS components (**"activities"**) appear to be most effective to change health providers' services and practices and improve the quality of health services?

What QHS project activities have you been involved in/are familiar with?

- Which activities have made the most significant change/impact on changing providers' practices and improving the quality of care?
- Why? Please give examples:

Question #3:
What are the strengths and weaknesses of QHS's team-based learning approaches, including those meant to complement MOH's in-service training strategies; and QHS's coaching and mentoring efforts?

Approaches

On-site skills building at referral hospitals and health centers (coaching, supervision & follow-up):

- *HCQI at HCs*
- *Coaching/clinical-skills-practice approaches at RH*: Clinical skills practice on maternity ward, SAM (severe acute malnutrition), pediatric TB, neonatal sepsis MCATS for midwives and ob/gyns and PCATS for nurses and pediatricians
- *A few formal trainings* (IUD, Implant, VSC and INC (Immediate Newborn Care))

What QHS project activities have you been involved in/are familiar with?

- What are the strengths of the on-site skills building (at HC or RH)?
- What are challenges of the on-site skills building?

- Please give examples.

- What are the strengths of the HCQI approach?
- What are the challenges of the HCQI approach?
- Please give examples.

Question #4:
Are the current monitoring tools and systems sufficient for measuring activity results?

- Project Database System
- Project Training Data
- Performance Indicators
- Component and Team Capacity Assessments and Monitoring Tools
- MNH Survey of Delivery/Post-Delivery Care Practices in RHs (2014/15)
- Level 2 Quality Assessment in 9 USAID Supported Provinces

What QHS project activities have you been involved in/are familiar with?

- Are the current monitoring tools and systems sufficient for measuring activity results?
- If not, why not and what would you recommend?
- If yes, which are the most effective and why?

Midterm Performance Evaluation of the Health Project and implementing activities in USAID/Cambodia

SOCIAL HEALTH PROTECTION PROJECT (SHP)

Observation Checklist &
Bedside Monitoring Guide

- **RH–for HEF and PMRS**

Introduction and informed consent:

Hello. My name is_____. I am working for the Global Health Program Cycle Improvement Project, called GH Pro. We are conducting a midterm performance evaluation of the USAID-funded Social Health Protection Project implemented by URC.

The purpose of the evaluation is two-fold: the first is to identify lessons learned of USAID/Cambodia's current health office portfolio and inform the future portfolio currently in design, given the Ministry of Health's strategic direction; and the second is to measure the progress of SHP and identify potential synergies with the Empowering Communities for Health (ECH) and Quality Health Services (QHS) projects.

As a key stakeholder of the SHP project, we greatly appreciate your willingness to provide us your perspective about the project. The information you provide will help us to assess the project performance and to identify potential improvements to the project's implementation. Your response will be kept strictly confidential and will not be quoted directly unless personally authorized by you.

PMRS Implementation Observation Checklist

Central point for receiving clients

Clear process for client flow

Clerk completion of patient record

Separation of clerk and cashier roles

Space for storing patient files

Organization of the patient files–easy to find, etc.

Verify patient files with what's in the PMRS.

Examine financial report–income from HEF vs non-HEF.

Any lag in entry of referral cases received at night time

Payment of allowances to HEF patients–amount and frequency, backup documentation

HEF bedside monitoring

When did you first receive your HEF card?

Is this the first time you have accessed the HEF benefits? If no, how often/how many times before?

Have you been to this facility before?

Ask if the individual went to the HC first?

When did your caretaker receive payment for transportation and food?

Have you had any difficulties receiving payment?

Do you know the procedures for filing a complaint?

Has a HEF monitor come to visit your house to verify your visit to the HC/RH?

How was the quality of care at this facility?

What do you think can be improved?

Conclude by thanking the participant for his/her time and ideas.

Midterm Performance Evaluation of the Health Project and implementing activities in USAID/Cambodia

SOCIAL HEALTH PROTECTION PROJECT (SHP)

Interview Guide for

- MOH–DPHI
- HEF secretariat
- Donors–WB, KFW, Australian
- PHD, OD
- Provincial/District Health Social Protection Steering Committee (P/DHSPSC)
- CMHEF Committee, USAID
- IPs (COP, component manager, M&E manager)
- PHSPSC
- HEF Operator

IDENTIFICATION

Date data collected

Interviewer name

Key informant name and title

Province/city name

OD name

Facility name

Introduction and inform consent:

Hello. My name is_____ I am working for the Global Health Program Cycle Improvement Project, called GH Pro. We are conducting a midterm performance evaluation of the health project and implementing activities of USAID/Cambodia on the Social Health Protection project.

We would very much appreciate your participation in providing us some information related to the evaluation. The information you provide will help us to improve the implementation of the SHP project. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

The purpose of the evaluation is to identify lessons learned of USAID/Cambodia's current health office portfolio and inform the future portfolio currently in design, given the Ministry of Health's strategic direction, and to measure the progress of specific implementing activities on their performance, namely: Quality Health Services (QHS), Empowering Communities for Health (ECH) and Social Health Protection (SHP), and to identify the potential synergies among these activities to improve outcomes for the health project. My team will interview you on the SHP project only. However some questions may cross-cutting within ECH and QHS projects.

Participation in this evaluation is completely voluntary, and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this interview since your views are very important.

If you don't mind, we would like to ask your permission to record the voices of the interview to transcribe or make quotation in the report. However, your name will not be recorded or quoted without your permission.

There are five main questions, and the duration for the interview may take around one hour.

At this time, do you want to ask me to clarify anything about the process of the interview for the evaluation?

May I begin the interview now?

I- To what extent did SHP achieve its objectives and expected results? What project components should be strengthened/modified toward achieving project objectives?

No.	Questions	Respondent's Answers	Remarks
1	In your knowledge, what are the goals and objectives of SHP/HEF? What is the project supposed to achieve? (purpose of this question is to gauge respondent's awareness/understanding of the project)		- MOH-DPHI, HEF Secretariat - Donors–WB, KFW, Australian, etc. - PHD, OD - Provincial/District Health Social Protection Steering Committee (P/DHSPSC) - CMHEF Committee - USAID
2	The project has several components: HEF, MIS, MOH capacity building, and CMHEFs. In your opinion, which of these components achieved the best results, met the targeted objectives? What do you think are the factors behind these results? What is the most significant achievement?		- MOH-DPHI, HEF Secretariat - Donors–WB, KFW, Australian, etc. - PHD, OD - Provincial/District Health Social Protection Steering Committee (P/DHSPSC) - CMHEF Committee - USAID - IPs (COP, component manager, M&E manager)

No.	Questions	Respondent's Answers	Remarks
3	Which components only partially met the objectives? What are the reasons for the project not fully meeting these objectives? (Probe: external factors that are beyond the control of the project, such as policy changes, and internal factors of the project such as human resources or supervision structure)? Supported or undermined project implementation? Were there shifts in resources? What modifications are needed to ensure that these components meet the objectives?		- MOH-DPHI, HEF Secretariat - Donors–WB, KFW, Australian, etc. - PHD, OD - Provincial/District Health Social Protection Steering Committee (P/DHSPSC) - CMHEF Committee - USAID - IPs (COP, component manager, M&E manager)
4	How would you rate URC's performance in this area? [Ask respondent to give a score using the 1 to 5 score ladder and explain the factors behind the score.] - HEF: Monitoring and evaluation (fraud prevention, ensuring timely payment to the facilities, ensuring that HEF recipients actually receive their transportation and food allowance), Targeted Benefits Package, Level 2 assessment on quality of care - HMIS: PMRS implementation, HEF financial management - MoH capacity building: handover of HEF - CMHEF		- MOH-DPHI, HEF Secretariat - Donors–WB, KFW, Australian, etc. - PHD, OD - Provincial/District Health Social Protection Steering Committee (P/DHSPSC) - CMHEF Committee - USAID - IPs (COP, component manager, M&E manager)
5	Are you aware of any delays/complaints by the community about the HEF not being fair or transparent? What do you think are the reasons for these delays?		- HEF Operator - Health providers
6	Can you describe the HEF operating procedures–from client identification, quality of service delivery, payment of allowances (food and transport) to clients, payment to facilities?		- HEF Operator - Health providers

No.	Questions	Respondent's Answers	Remarks
7	What do you think of the current HEF procedures? Is it working well? What can be improved–registration, payment to the facility, client complaints? Any other challenges?		- HEF Operator - Health providers
8	How long does the payment/reimbursement take? Have there been issues with delays, disputes, or fraud?		- HEF Operator - Health providers
9	Does the current complaints system offer sufficient client protection and provide an effective mechanism for dispute resolution? Is there a role for the VHSG?		- HEF Operator - Health providers

II- How do contextual changes in the political and socioeconomic environment in Cambodia affect the project in achieving its objectives?

No.	Questions	Respondent's Answers	Remarks
10	What were the key differences/changes between HSSP2 and H-EQIP? What do you think are the reasons behind these policy changes? What are the direct effects of H-EQIP on the project? How did they affect the project's ability to meet its objectives? Are there other changes beyond the policy level that also affected the project?		- MOH-DPHI, HEF Secretariat - Donors–WB, KFW, Australian, etc.
11	How is the project responding to these changes? Is it sufficient or effective? If not sufficient, then are there other actions that the project can take to adapt to the changing environment? hat role should USAID play in this context?		- MOH-DPHI, HEF Secretariat - Donors–WB, KFW, Australian, etc. - IP (Chris Vickery)

III- How can the HEF monitoring system be institutionalized in a cost-effective manner?

No.	Questions	Respondent's Answers	Remarks
12	Can you describe the existing monitoring system? What is the organization structure/team composition (at the central, OD, and facility levels)?		- MOH-DPHI, HEF Secretariat - IP - PHD, OD - PHSPSC - HEF Operator
13	How has the current monitoring system contributed to the successful implementation of the HEF? In your opinion, which aspect of the monitoring has worked well and why: - Household visits - Bedside monitoring - Document reviews - Staff interviews - Monthly reports to the PHSPSC		- MOH-DPHI, HEF Secretariat - IP - PHD, OD - PHSPSC - HEF Operator
14	Does the project measure/track on how data from the HMIS are being used for decision making? Examples of actionable findings that led to changes in how the HEF operates? Similarly, were there issues flagged by the HMIS that were not acted upon, and did the lack of follow-up result in subsequent problems/issues?		- IP - MOH-DPHI, HEF Secretariat
15	What can be improved? Are there certain aspects of the current monitoring procedures that can be modified without affecting the transparency and financial integrity of the HEF?		- IP - MOH-DPHI, HEF Secretariat
16	SHP is supposed to transfer the monitoring function to the MoH. What is the transition plan from project to new structure at MoH? Can you describe the steps that are needed to enable this transition? Are there any obstacles/barriers/ challenges in implementing this transition plan?		- IP - MOH-DPHI, HEF Secretariat

No.	Questions	Respondent's Answers	Remarks
	What are they (probes: financial, technical, management capacity, etc.), and how can they be overcome?		

IV- What should be the future roles of SHP/URC in HEF expansion system and broader social health protection schemes?

No.	Questions	Respondent's Answers	Remarks
17	In your opinion, why is social health protection important? What contribution(s) has the SHP program made towards social health protection in Cambodia?		- MOH-DPHI, HEF Secretariat - Donors–WB, KFW, Australian, etc.
18	Are there areas that still require support from USAID and other donors (e.g,, expanding the benefits covered under the HEF, expanding coverage to non-poor populations, etc.)? If yes, what types of support (financial, technical, monitoring, etc.)? And who should provide this support?		- MOH-DPHI, HEF Secretariat - Donors–WB, KFW, Australian, etc. - IPs
19	If external support is reduced or discontinued, what would be the potential impact on HEF? Would the MOH and RGC be able to continue to fund and operate the HEF independently?		- MOH-DPHI, HEF Secretariat - Donors–WB, KFW, Australian, etc. - IPs

V- What are strengths and weaknesses of project management structures to support the implementation of SHP?

No.	Questions	Respondent's Answers	Remarks
20	What are the strengths of the current team structure? How has the structure facilitated the implementation of the project? Are there improvements/modifications you would make to the structure?		- MOH-DPHI, HEF Secretariat - IPs - Sub-agreement partners - USAID

No.	Questions	Respondent's Answers	Remarks
21	How would you rate the level of coordination among the different parties? Ask the respondent to give a rating and explain the reasons for the rating (very well, could be improved, not very well)? - MOH ←→ URC - MOH ←→ PHD, OD - MOH ←→ USAID, donors/pooled fund (HSSP2/H-EQIP) - URC ←→ HEF operators, facilities		- MOH-DPHI, HEF Secretariat - Donors - IP - Sub-agreement partners - PHD, OD - PHSPSC - HEF Operator
22	What has worked well at this level of coordination? What improvements can be made?		- MOH-DPHI, HEF Secretariat - Donors - IP - Sub-agreement partners - PHD, OD - PHSPSC - HEF Operator
23	Can you describe the relationship and coordination between the HCs/RHs (QHS), community-managed health equity fund (CMHEF), and the community-based VHSGs under ECH? Can you give an example of when this has worked well? What else needs to be done to improve or strengthen coordination and collaboration?		- MOH-DPHI, HEF Secretariat - Donors - IP - Sub-agreement partners - PHD, OD - PHSPSC - HEF Operator

Thanks to the participants for spending their valuable time with us.

Interview Guide–ECH Project
RACHA Executive Director
Theme: Project objectives, results, management and M&E

Oral Consent Statement

Introduction

Thank you for making the time to talk with me today.

The USAID mission in Cambodia has asked for an independent team to gather information for a midterm evaluation of three health projects it is financing. The three projects included in the evaluation are: Empowering Communities for Health (ECH) Project; Strengthening Facilities for Health Project (SHP); and, Quality Health Services (QHS) Project. The purpose of this evaluation is to measure the overall progress of the three projects and to identify lessons learned thus far to better inform USAID's future assistance to Cambodia's health sector.

You were suggested as a person with some familiarity with these projects who can inform this activity, and we greatly appreciate your perspective, experiences and views on the successes, challenges and lessons learned related to the projects' efforts.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding questions

Policy and organizational level

1. What is the vision for RACHA's development?

2. What governance arrangement does RACHA have in place, do you see any need to strengthen this?

3. How would you describe your relationship with USAID and the level of involvement they have in the management of ECH and influence over RACHA as an organization?

4. Do you feel that the organization is managing the relationship with USAID adequately?

5. Would you like to see any changes in the working relationship with USAID? How and what will be needed to facilitate this?

6. What do you see as the comparative strengths of RACHA and priority areas for development?

7. How would you describe relations with government and CSO partners? Do you see the need for strengthening this and how?

8. How would you describe your target stakeholder's perception or image of RACHA? Do you see the need for efforts to improve public profiling of the organization?

Management of ECH

9. How does ECH contribute to the operation and development of RACHA?

10. What is the experience with the management structure for ECH; has the new cluster approach been beneficial?

11. What are the HR and management challenges you face to implement ECH?

12. How do you think management of the project needs strengthening?

Progress of ECH

13. To what extent has ECH achieved its objectives and results in cluster 1?

14. What have been the opportunities and challenges that have supported/undermined progress?

15. Looking at each of the project components, do you see the need for modification or strengthening of any of them, which one, how and why?

16. What are the factors affecting full coverage in Siem Reap and Banteay Meanchey?

Learning from ECH

17. Do you feel that the M&E systems in place are sufficient to monitor and evaluate ECH results? What more is needed?

18. What has been the most significant change achieved by ECH so far?

19. How are you planning to take the learning from implementation in cluster 1 to cluster 2 and 3 and more broadly across RACHA?

20. What are priority strategic and senior management decisions ahead of you as ECH moves forward?

21. How do you score project management of ECH, from 1 to 5 with 1 being lowest?

1	2	3	4	5
Very Bad	Bad	Fair	Good	Very Good

Why is this your score?

Group Discussion Guide–ECH Project
RACHA Finance and Operations Team
Theme: Project Management

Oral Consent Statement

Introduction

Thank you for making the time to talk with me today.

The USAID mission in Cambodia has asked for an independent team to gather information for a midterm evaluation of three health projects it is financing. The three projects included in the evaluation are: Empowering Communities for Health (ECH) Project; Strengthening Facilities for Health Project (SHP); and Quality Health Services (QHS) Project. The purpose of this evaluation is to measure the overall progress of the three projects and to identify lessons learned thus far to better inform USAID's future assistance to Cambodia's health sector.

You were suggested as a person with some familiarity with these projects who can inform this activity, and we greatly appreciate your perspective, experiences and views on the successes, challenges and lessons learned related to the projects' efforts.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding questions

1. Can you explain the policies, structures, systems and SOPs in place to manage ECH? (probe financial management, information management, HR management, program management)

2. Are these structures, systems and SOPs standard for RACHA or specific to ECH?

3. What are the strengths and weaknesses/gaps of the management environment, structures, systems, culture and capacities (probe: head office location, compliance with financial management policies, cost-efficiencies, staffing retention and hiring).

4. How would you describe communication flows and communication effectiveness between the different levels of the management structure and between technical, program and operational staff?

5. Do you think communication flows and approaches need strengthening and how?

6. What has been the most significant management-related change related to ECH so far?

7. Are there any management and financial factors that are affecting full coverage in SR and BMC?

8. How are you/do you plan to use the learning and development of management structures, systems, SOPs and capacities related to ECH beyond the project and across the organization?

9. Ask the participants to score project management of ECH from 1 to 5 with 1 being lowest.

1	2	3	4	5
Very Bad	Bad	Fair	Good	Very Good

Why is this your score?

KII Guide Component Team Leaders–ECH Project
Theme: Project objectives, results, management and M&E

Oral Consent Statement

Introduction

Thank you for making the time to talk with me today.

The USAID mission in Cambodia has asked for an independent team to gather information for a midterm evaluation of three health projects it is financing. The three projects included in the evaluation are: Empowering Communities for Health (ECH) Project; Strengthening Facilities for Health Project (SHP); and Quality Health Services (QHS) Project. The purpose of this evaluation is to measure the overall progress of the three projects and to identify lessons learned thus far to better inform USAID's future assistance to Cambodia's health sector.

You were suggested as a person with some familiarity with these projects who can inform this activity, and we greatly appreciate your perspective, experiences and views on the successes, challenges and lessons learned related to the projects' efforts.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding questions

1. To what extent has ECH achieved its objectives and results in cluster 1?

2. What have been the opportunities and challenges that have supported/undermined progress? How are coverage targets set?

3. Looking at each of the project components, do you see the need for modification or strengthening of any of them, which one, how and why?

4. What are the factors affecting full coverage in Siem Reap and Banteay Meanchey? (Probe: incentive payments of VHSGs, motivation and drop out of VHSGs, capacity of Commune Councils, coordination and synergy with SHP and QHS, what does full coverage mean?)

5. What learning do you think can be taken from implementation in cluster 1 to cluster 2 and 3?

6. What has been the most significant change achieved by ECH so far?

7. What are the strengths and weaknesses of the management structure and systems of ECH? Can you provide some examples?

8. Are there any aspects of management that are affecting implementation of ECH?

9. How do you think management of the project needs strengthening?

10. How would you describe communication flows and communication effectiveness between the different levels of the management structure and between technical, program and operational staff?

11. Do you think communication flows and approaches need strengthening and how?

12. Are the M&E system and MIS sufficient to measure the results of the project? Are there any changes you would like to see to meet project needs?

13. How do you score project management of ECH from 1 to 5 with 1 being lowest?

1	2	3	4	5
Very Bad	Bad	Fair	Good	Very Good

Why is this your score?

KII Guide–ECH Project
RACHA Regional Directors, Provincial Managers
Theme: Project objectives, results, management and M&E

Oral Consent Statement

Introduction

Thank you for making the time to talk with me today.

The USAID mission in Cambodia has asked for an independent team to gather information for a midterm evaluation of three health projects it is financing. The three projects included in the evaluation are: Empowering Communities for Health (ECH) Project; Strengthening Facilities for Health Project (SHP); and Quality Health Services (QHS) Project. The purpose of this evaluation is to measure the overall progress of the three projects and to identify lessons learned thus far to better inform USAID's future assistance to Cambodia's health sector.

You were suggested as a person with some familiarity with these projects who can inform this activity, and we greatly appreciate your perspective, experiences and views on the successes, challenges and lessons learned related to the projects' efforts.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding questions

1. To what extent do you think ECH is achieving its objectives and results in cluster 1?

2. What have been the opportunities and challenges that have supported/undermined progress? How are coverage targets set?

3. Looking at each of the project components, do you see the need for modification or strengthening of any of them, which one, how and why?

4. What are the factors affecting full coverage in Siem Reap and Banteay Meanchey? (Probe: incentive payments of VHSGs, motivation and drop out of VHSGs, capacity of Commune Councils, coordination and synergy with SHP and QHS, what does full coverage mean?)

5. What learning do you think can be taken from implementation in cluster 1 to cluster 2 and 3? And RACHA programs more broadly?

6. What has been the most significant change achieved by ECH so far?

7. What are the strengths and weaknesses of the management structure and systems of ECH? Can you provide some examples?

8. Are there any aspects of management that are affecting implementation of ECH? (Probe incentive/reward structures and levels, image of the organization, authority of the regional structure, planning and decision making)

9. How do you think management of the project needs strengthening?

10. How would you describe communication flows and communication effectiveness between the different levels of the management structure and between technical, program and operational staff?

11. Do you think communication flows and approaches need strengthening and how?

12. Are the M&E system and MIS sufficient to measure the results of the project? Are there any changes you would like to see to meet project needs?

13. How do you score project management of ECH from 1 to 5 with 1 being lowest?

1	2	3	4	5
Very Bad	Bad	Fair	Good	Very Good

Why is this your score?

Key Informant Interview Guide–ECH Project
Theme: ISAF

Oral Consent Statement

Introduction

Thank you for making the time to talk with me today.

The USAID mission in Cambodia has asked for an independent team to gather information for a midterm evaluation of three health projects it is financing. The three projects included in the evaluation are: Empowering Communities for Health (ECH) Project; Strengthening Facilities for Health Project (SHP); and Quality Health Services (QHS) Project. The purpose of this evaluation is to measure the overall progress of the three projects and to identify lessons learned thus far to better inform USAID's future assistance to Cambodia's health sector.

You were suggested as a person with some familiarity with these projects who can inform this activity, and we greatly appreciate your perspective, experiences and views on the successes, challenges and lessons learned related to the projects' efforts.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding interview questions

1. Can you provide a short introduction to the status of ISAF implementation and the CSO coordinating mechanism? (probe where is ISAF being implemented, what tools are being used, plans for ISAF expansion)
2. What are the key achievements and challenges of operationalizing ISAF?
3. What do you see as the role of CSOs in strengthening social accountability in the future?
4. How does ISAF strengthen health accountability and what is the most significant change achieved so far?
5. How would you describe government support for ISAF and social accountability?
6. Are the policy frameworks in place for sector ministries such as MOH to engage on social accountability? What needs to be developed to support this? Are there good practices from other sectors to adapt?
7. How will ISAF support the institutionalization of VHSGs? How can this be process be strengthened?
8. What do you see as the strengths of RACHA to implement ISAF?

9. What are the challenges to CSO coordination on ISAF and how are these being addressed? What more needs to be done?

Key Informant Interview Guide–ECH Project
Health Center Staff

Oral Consent Statement

Introduction

Thank you for making the time to talk with me today.

The USAID mission in Cambodia has asked for an independent team to gather information for a midterm evaluation of three health projects it is financing. The three projects included in the evaluation are: Empowering Communities for Health (ECH) Project; Strengthening Facilities for Health Project (SHP); and Quality Health Services (QHS) Project. The purpose of this evaluation is to measure the overall progress of the three projects and to identify lessons learned thus far to better inform USAID's future assistance to Cambodia's health sector.

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Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding questions:

1. What are the approaches you use as health workers to improve the health-seeking behavior of women and men?
2. What motivates you (financial, professional, social, supervision) to provide health information and counseling to women and men: (i) in the provision of clinical services, and (ii) health education at the health center or in the community?
3. What has been the MSC you have seen in the community?
4. How effective are the VHSGs as behavior change agents? Why, and can you give some practical examples of changes you have seen?
5. Are there any other BCC activities in the catchment area of this health facility? What do you think has been effective and why?
6. What are the linkages between health center and (i) VHSG, (ii) HCMC? How do they work together?
7. What is the benefit of these relationships? How do you think this needs modifying/strengthening?
8. Does the health center supervise the VHSG? How?

9. How is the relationship between health center work and Commune Council?
10. What are the benefits and challenges in the relationship? How do you think this could be strengthened?
11. How do you hear and manage complaints from users? How do you feed back to the complainant and to the community more broadly? Do you think the complaints system needs improving and how?
12. What do you think is the priority for improving health in this area? How can the community contribute to this?

Key Informant Interview Guide-ECH Project
OD Director
Theme: Project progress

Oral Consent Statement

Introduction

Thank you for making the time to talk with me today.

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You were suggested as a person with some familiarity with these projects who can inform this activity, and we greatly appreciate your perspective, experiences and views on the successes, challenges and lessons learned related to the projects' efforts.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding interview questions

1. What project activities are being implemented in this district (probe for ECH, QHS and SHP)?
2. What do you think is the most successful aspect of the project?
3. Are there any challenges/gaps that are affecting achievement of the project's objectives?
4. Are there any changes or solutions to existing project related problems that you suggest?
5. How are you involved in the project, and how often does the ECH team consult with you? Do you think this needs to be changed?
6. How are you involved in supporting Commune Councils to:
    a. take responsibility for health
    b. improve linkages between CC and health center and VHSG
    c. prioritize health in commune investment plan (CIP)?
7. As you know, there are two other USAID projects that we are evaluating, QHS and SHP which are implemented by URC. Do you see any scope for better coordination and synergy between the USAID projects and other projects in this district?

Focus Group Discussion Guide–ECH Project
Community Men

Oral Consent Statement

Thank you for making the time to talk with me today.

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Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding questions

1. What are the main health problems women, men and children face in your community?
2. Who provides health information and advice you in the community? How do they do this? (probe different BCC methods, e.g., comedy show, home visit, group discussion, meetings with Commune)
3. What do you like and dislike the most about how information and advice is provided?
4. How could this be improved?
5. Which method do you think is the most influential in changing people's attitudes and behaviors?
6. Are some methods more effective with men versus women?
7. What are the barriers you and your families face in accessing health services?
8. Who supports you to overcome these barriers? How do they support you? (probe: role of VHSG in accessing funds, transport, support of Commune Chief, monks, health workers)
9. What do you like and dislike the most about how different people support you to access services?
10. How could this be improved?
11. What is the most significant behavior change you have seen in your community?

Focus Group Discussion Guide–ECH Project
Community Women

Oral Consent Statement

Thank you for making the time to talk with me today.

The USAID mission in Cambodia has asked for an independent team to gather information for a midterm evaluation of three health projects it is financing. The three projects included in the evaluation are: Empowering Communities for Health (ECH) Project; Strengthening Facilities for Health Project (SHP); and Quality Health Services (QHS) Project. The purpose of this evaluation is to measure the overall progress of the three projects and to identify lessons learned thus far to better inform USAID's future assistance to Cambodia's health sector.

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Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding questions

1. What are the main health problems women and children face in your community?
2. Who provides health information and advice to you in the community? How do they do this? (probe different BCC methods, e.g., comedy show, home visit, group discussion, meetings with Commune)
3. What do you like and dislike the most about how information and advice is provided?
4. How could this be improved?
5. Which method do you think is the most influential in changing people's attitudes and behaviors?
6. Are some methods more effective with men versus women?
7. What are the barriers you face in accessing health services?
8. Who supports you to overcome these barriers? How do they support you? (probe: role of VHSG in accessing funds, transport, support of Commune Chief, monks, health workers)
9. What do you like and dislike the most about how different people support you to access services?
10. How could this be improved?
11. What is the most significant behavior change you have seen in your community?

Focus Group Discussion Guide–ECH Project
C-DOT Watchers

Oral Consent Statement

Introduction

Thank you for making the time to talk with me today.

The USAID mission in Cambodia has asked for an independent team to gather information for a midterm evaluation of three health projects it is financing. The three projects included in the evaluation are: Empowering Communities for Health (ECH) Project; Strengthening Facilities for Health Project (SHP); and Quality Health Services (QHS) Project. The purpose of this evaluation is to measure the overall progress of the three projects and to identify lessons learned thus far to better inform USAID's future assistance to Cambodia's health sector.

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Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding questions:

1. What is the role of C-DOT Watchers?
2. What is the most significant change you have seen C-DOT Watchers achieve in your community?
3. What are the challenges you face as a C-DOT Watcher (e.g., lack of compensation, time)? How can these be overcome?
4. How do you identify suspected TB patients and motivate them for screening tests?
5. Do you face any bottlenecks in referring suspected TB patients and in observing treatment?
6. How do the health center, Commune Council and VHSG support you?
7. How do you think this could be strengthened?
8. How much do you earn from your work as a C-DOT watcher in a month? What is the source of this money?
9. How does the RACHA ECH project support you? Are there any gaps in this support?

Focus Group Discussion Guide–ECH Project
CBD Agents

Oral Consent Statement

Introduction

Thank you for making the time to talk with me today.

The USAID mission in Cambodia has asked for an independent team to gather information for a midterm evaluation of three health projects it is financing. The three projects included in the evaluation are: Empowering Communities for Health (ECH) Project; Strengthening Facilities for Health Project (SHP); and Quality Health Services (QHS) Project. The purpose of this evaluation is to measure the overall progress of the three projects and to identify lessons learned thus far to better inform USAID's future assistance to Cambodia's health sector.

You were suggested as a person with some familiarity with these projects who can inform this activity, and we greatly appreciate your perspective, experiences and views on the successes, challenges and lessons learned related to the projects' efforts.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding questions:

1. What is the role of C-DOT Watchers?
2. What is the most significant change you have seen C-DOT Watchers achieve in your community?
3. What are the challenges you face as a C-DOT Watcher (e.g., lack of compensation, time)? How can these be overcome?
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7. How do you think this could be strengthened?
8. How much do you earn from your work as a C-DOT watcher in a month? What is the source of this money?
9. How does the RACHA ECH project support you? Are there any gaps in this support?

Focus Group Discussion Guide–ECH Project
VHSG members

Oral Consent Statement

Introduction

Thank you for making the time to talk with me today.

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You were suggested as a person with some familiarity with these projects who can inform this activity, and we greatly appreciate your perspective, experiences and views on the successes, challenges and lessons learned related to the projects' efforts.

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Our interview will take about one hour.

Do I have your permission to begin?

Before we begin, do you have any questions about this interview?

[ ] Consent provided _____ [Interviewer/Recorder initials]

Guiding questions:

1. What is the role of VHSG members?
2. What is the most significant change you have seen VHSGs achieve in your community?
3. What are the challenges you face as VHSG members (e.g., lack of compensation, time)? How can these be overcome?
4. What approaches do you use to influence people to change their behaviors?
5. Which method do you think is the more effective one and why?
6. Are some methods more effective with men versus women?
7. What is the relationship between VHSG and Commune Council?
8. What are the benefits and challenges in the relationship? How do you think this could be strengthened?
9. Are you involved in ISAF/social accountability exercises, how?
10. How do you hear and manage complaints from users? How do you feed back to the complainant and to the community more broadly? Do you think the complaints system needs improving, and how?

11. What do you think is the priority for improving health in this area? How can the community contribute to this?
12. How does RACHA's ECH project support you? Are there any gaps in the support you receive? Do you receive support from any other project?

Mid-Term Evaluation of USAID Health Project and Implementing Activities - Cambodia

Performance Indicator Data Table (to be populated from existing project databases)

Project Name:								
Indicator	**Year 1 Target**	**Year 1 Actual**	**% Achieved**	**Year 2 Target**	**Year 2 Actual**	**% Achieved**	**% of Total LOP Remaining**	**% of Total LOP Target Achieved to Date**

Midterm Evaluation of USAID Health Project and Implementing Activities– Cambodia

Contact Information Sheet for Key Informants and Persons Contacted for Information

Name	Position or Job Title	Organization	Location (City or Town)

Annex V: QHS Mechanism Background Information

Quality Health Services (QHS) is a five-year mechanism designed to improve the quality and availability of key reproductive, maternal, neonatal and child health services in public health facilities in nine focus provinces and to strengthen the capacity of the operational districts provincial health districts to support improved quality of care. The project objectives, components, reach and context are summarized in the charts below.

"HCQI approach is more practical and hands on and midwives are able to practice continuously now to reinforce the new skills they have learned." (Operational district staff)

"The HCs are managing complications better now." (Referral hospital staff)

Next steps and in-progress:

- QHS is working with the NMCHC to develop and approve national protocols for MCATS.
- QHS has worked with NMCHC to develop national Safe Motherhood Protocols, which are expected to be approved soon.

In collaboration with the WHO, NMCHC, provincial health departments and operational districts, QHS provided technical assistance in the development of clinical audits for maternal and perinatal deaths, and QHS staff routinely coach referral hospital and health center staff in the use of registers and other key data to correctly record and use HMIS data and information during HCQI and all on-site coaching sessions at referral hospitals (at OPD, on pediatric, maternity and gynecology wards, and in emergency departments). QHS facilitated the updating of key nutrition indicators with correct definitions and instructions for the HIS with donor partners and the MOH, including NNP, UNICEF and HIPA.

The QHS M&E system is comprehensive, dynamic and responsive. For example, the project has added new indicators and updated other indicators to be consistent with other provinces, MOH priorities and expectations, and targets of other major development partners. The Project Database System (PDS) incorporates results from ongoing activities, surveys and assessments, results and detailed information of capacity-building efforts in training and coaching (improving quality of care), and other M&E data, and it includes linkages to the MOH facility assessment data (Level 1 and 2 quality assessments).

QHS Innovations/Job Aids	
Clinical posters (PPH, INC, eclampsia, PNC, FP, handwashing, postpartum practices to avoid including roasting, & new posters in process for GMP & IMCI) MCH Book SAM screening stamp for RHs stamps for AMSTL and INC at RHs & HCs Referral slip and feedback form User-friendly recording terms	Provincial hotline poster Growth monitoring scale with basket Length/height measurement board Laminated weight for height SD card for identifying SAM NASG garment (PPH) Emergency boxes (PPH, INC/NB asphyxia & eclampsia)

The M&E team conducts monthly internal data quality audits in collaboration with the technical team leaders and staff and corrects any discrepancies to ensure all data reported are accurate. New data entry templates for HCQI, SAM, TB, FP, referral system, and triage have been

designed, and dashboards have been developed to enable staff to efficiently monitor competencies and the performance of facilities to improve on-site follow-up and coaching.

The primary focus of QHS is health systems strengthening with on-site skills and relationship building as the key building blocks.

Project Objectives

1. Improve the quality of basic newborn care
2. Strengthen the detection, referral and management of neonatal complications
3. Improve the timeliness and quality of care provided to women with obstetric complications
4. Increase the availability, quality and utilization of family planning services, with an emphasis on long-acting and permanent methods
5. Develop/strengthen referral linkages for obstetric, newborn and postnatal care
6. Strengthen screening, counseling, referral, prevention and treatment of child malnutrition and malnutrition-related diseases (including pediatric TB)
7. Increase the availability, quality and utilization of family planning services, with an emphasis on long-acting and permanent methods

Context

- Majority of deliveries currently take place in health centers (70 percent), with complications referred to referral hospitals (HIS 2015).
- Facility deliveries have increased from 10 percent to 83 percent since 2001 (CDHS 2014).
- Prior to QHS, staff at health centers (midwives and nurses) had little knowledge, skills or capacity to detect, manage and refer life-threatening complications; these skills were also limited at referral hospitals.
- Health center staff relationships with referral hospital, operational district and provincial health department staff were non-existent or poor.
- Quality of care at health centers was perceived to be low by communities who often went directly to referral hospitals or to those same providers in private practice/pharmacies (low utilization/poor reputation).

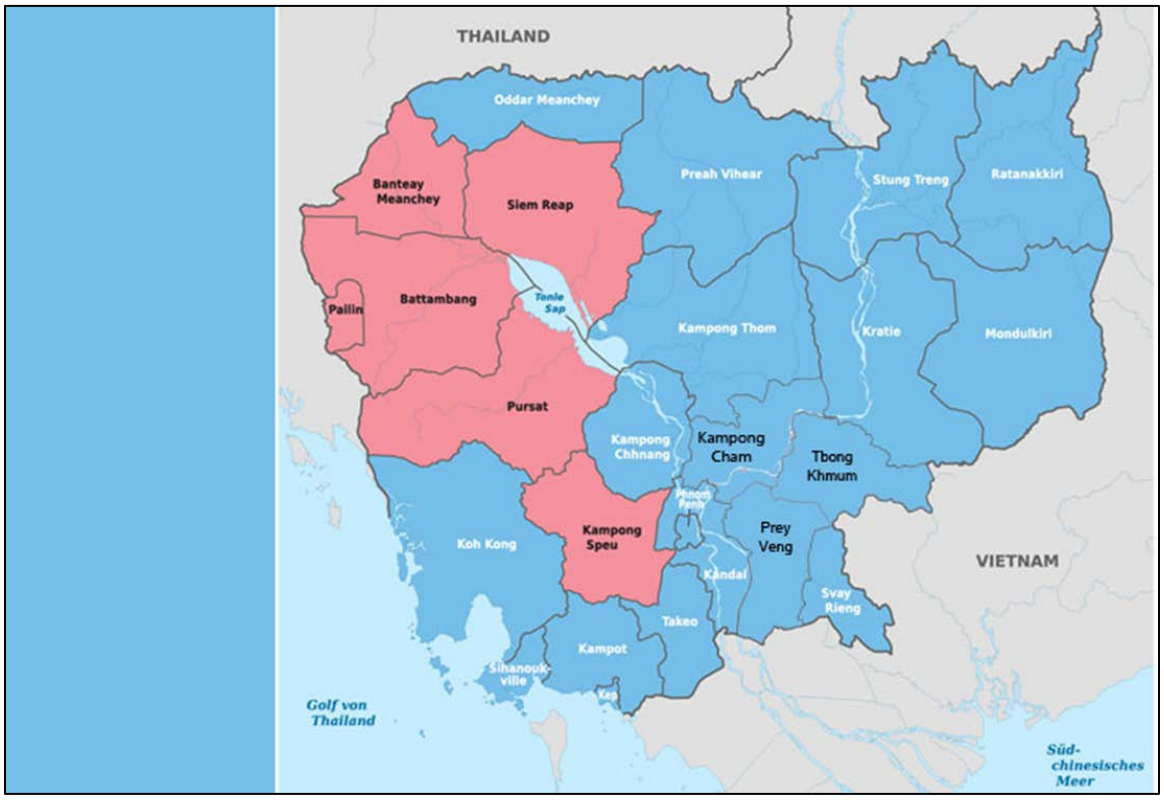
QHS Project Components			
On-site Coaching and Skills Building	**Relationship Building**	**A Few Foundational Trainings**	**Health Systems Strengthening**
HCQI at health centers Coaching and clinical skills practice at referral hospitals Basic newborn care and complications Emergency obstetric and postnatal care Family planning Emergency medicine and referrals Child nutrition and related diseases	MCAT (Midwifery Coordination Alliance Team) meetings PCAT (Pediatric Coordination Alliance Team) meetings	IUD Implant Voluntary surgical contraception Immediate newborn care	Referral systems HMIS/HIS Linkages with HEFs Level 2 quality assessments and competency assessments

- Reduced financial barriers (due to HEFs) are one of the key drivers of increased deliveries in facilities. (FTIRM 2016).

ANNEX VI: ECH MECHANISM ADDITIONAL INFORMATION

ECH COVERAGE AREA

As of March 31, 2016, the ECH project is operational in Cluster 1 provinces of Siem Reap and Banteay Meanchey and the four Cluster 2 provinces of Battambang, Pailin, Pursat and Kampong Speu.[4]



The following table sets out the coverage of key activities as reported by ECH in the April 2016 SAR.

The MCH Book is given to the pregnant woman during her first antenatal (prenatal) visit, and she keeps it as a record of her prenatal care, the delivery and postpartum, newborn and child health visits up to the age of 5 years.

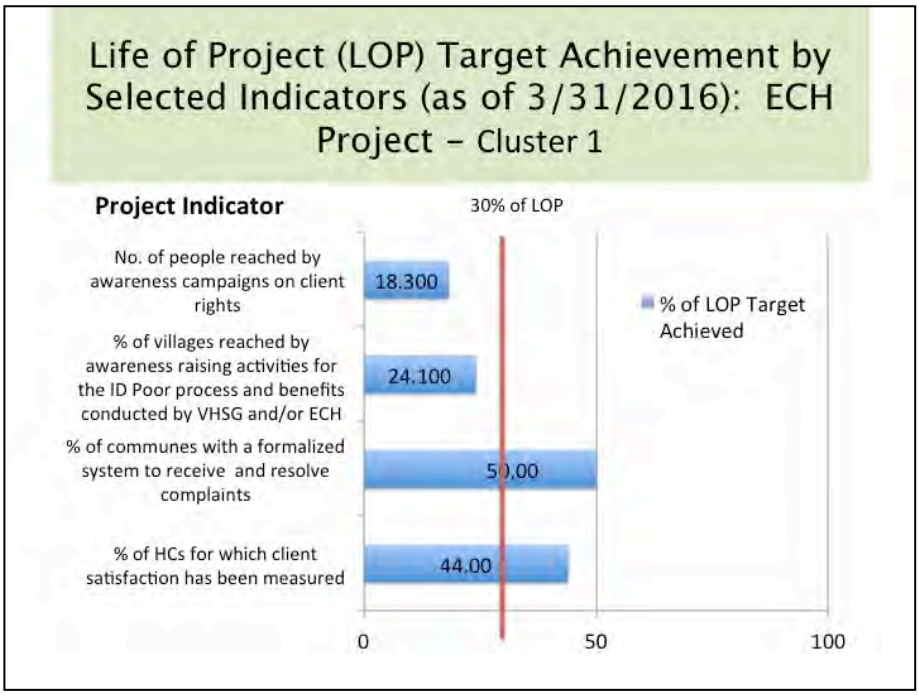
[4] Map taken from ECH SAR, April 2016.

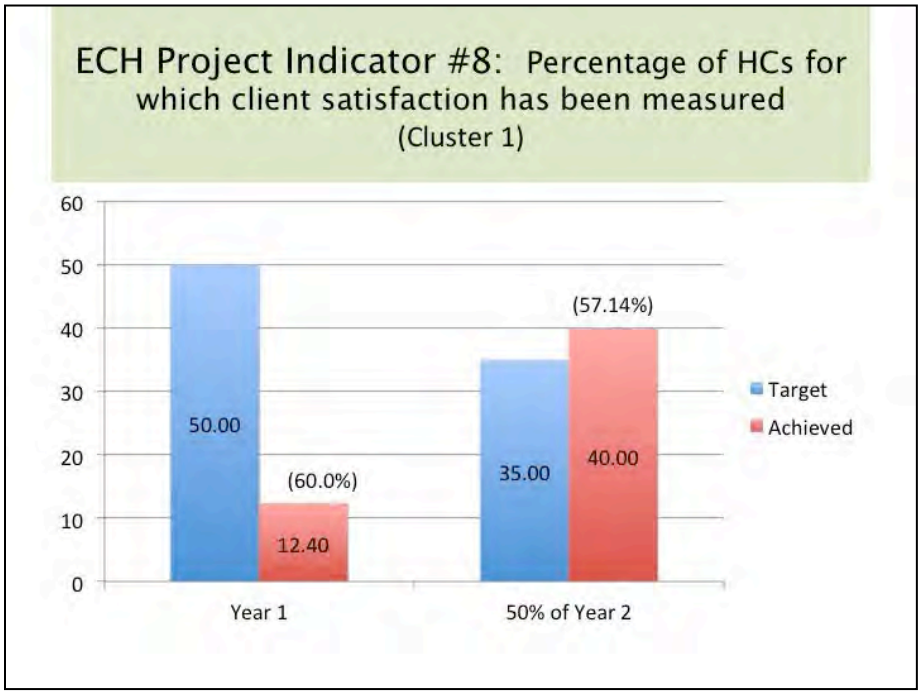
COVERAGE OF PROJECT ACTIVITIES

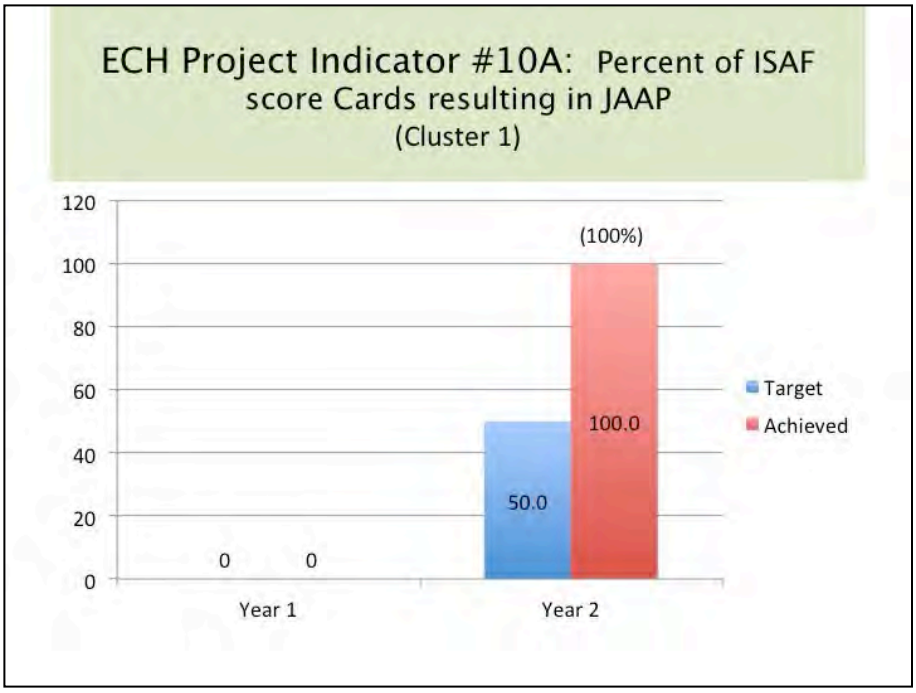
Province	# OD	# AD	# commune	# Health center	# village	Population
Siem Reap	4	12	100	90	931	1,011,500
ISAF	4	7	46	42	406	531,250
Good governance and VHSG institutionalization	4	11	74	66	701	662,644
MCH CBD	4	9	66	59	430	589,403
TB DOTs	4	6	42	38	357	348,945
Banteay Meanchey	4	9	65	65	667	723,857
ISAF	2	3	22	21	217	192,437
Good governance and VHSG institutionalization	4	9	64	64	645	674,491
MCH CBD	3	5	40	39	192	189,443
TB DOTs	2	4	28	29	329	300,235
Battambang	5	14	102	79	800	1,199,488
ISAF	5	10	74	54	600	848,722
Good governance and VHSG institutionalization	5	14	101	77	798	1,181,164
MCH CBD	5	14	89	70	403	607,609
TB DOTs	3	9	66	49	501	788,015
Pailin	1	2	8	6	83	72,486
ISAF	1		4	3	43	36,223
Good governance and VHSG institutionalization	1	2	8	6	83	72,486
MCH CBD	1	2	8	6	34	29,476
TB DOTs	1	2				
Pursat	4	6	49	40	510	436,728
ISAF						
Good governance and VHSG institutionalization	4	6	49	40	510	436,728
MCH CBD			47	38	251	223,794
TB DOTs	4	6	49	40	510	436,728
Kampong Speu	4	8	87	54	1384	812,576
ISAF						
Good governance and VHSG institutionalization	4	8	70	46	1122	647,508
MCH CBD	4	8	87	54	1118	660,597
TB DOTs	4	8	72	45	1153	685,869

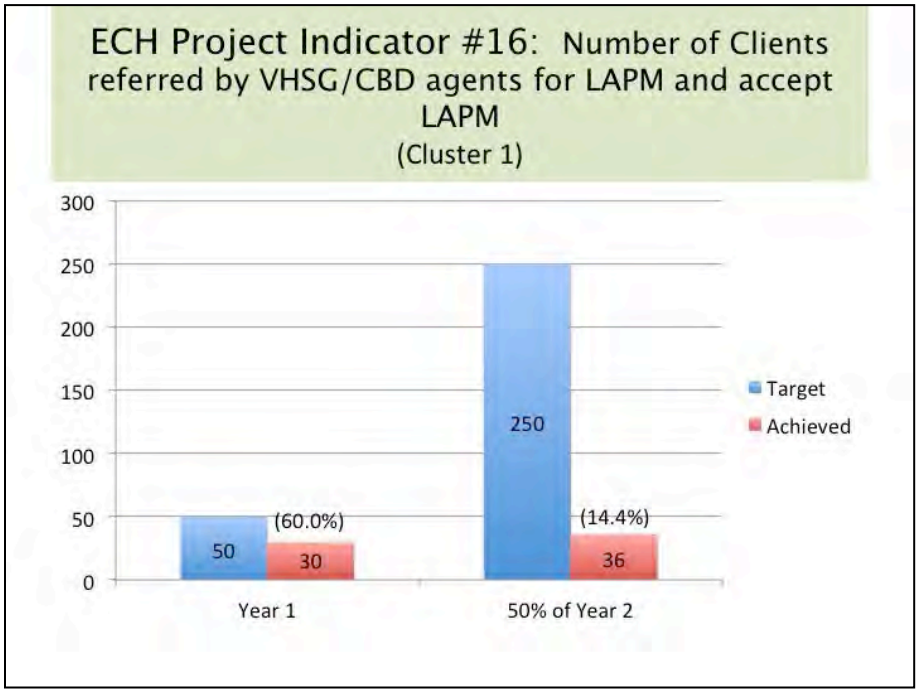
PROGRESS OF ADDITIONAL COMPONENT INDICATORS

Progress against indicators which are additional to those presented in the main report are shown in the graphs below.






ECH Project Indicator #10A: Percent of ISAF score Cards resulting in JAAP
(Cluster 1)
120
100
80
60
40
20
0
(100%)
100.0
50.0
0
0
Target
Achieved
Year 1
Year 2


ECH Project Indicator #16: Number of Clients referred by VHSG/CBD agents for LAPM and accept LAPM
(Cluster 1)
300
250
200
150
100
50
0
(60.0%)
50
30
250
(14.4%)
36
Target
Achieved
Year 1
50% of Year 2

Two other indicators in the M&E plan will be reported on through special studies.

Indicator	Source of monitoring	Date of monitoring
19: Percentage of remote villages that operationalize a village emergency referral system	Special report	July 2016
23: Percentage of VHSG with sufficient resources to undertake their work	Special report	July 2016

BACKGROUND INFORMATION ON VHSG AND HCMC

The structure, membership, roles and responsibilities of VHSGs and HCMCs has been most recently set out by the MOH in the 2008 *Community Participation Policy*.

VHSGs:

- A VHSG comprises one VHSG leader and one VHSG member per 10-50 households, selected to maintain a gender balance. They should live in the village where they serve, have good communication skills and be between 20 and 55 years old.
- A VHSG leader is to be elected by the community and is to be literate.
- VHSG members are to be selected by the community, the health center and the OD.

The VHSG leader is the primary point of contact for all health activities in the village. His/her main roles are to: (1) ensure the regular flow of information between the community and the health center, and (2) coordinate the VSHG to implement the scope of work for the VHSG in their village.

The elected VHSG leader from each village in the health center catchment area is responsible for:

- Providing feedback from the community to the health center, and keeping the VHSG and the community informed about health center activities.
- Coordinating training activities for the VHSG to support health center activities in the community.
- Providing information about health center services and fees to the community.
- Reporting consumer satisfaction and dissatisfaction to the HCMC regarding the quality of health care in health centers, access to health centers, user fee rates, etc.
- Facilitating outreach activities with the VHSG members, the health center and the community.
- Promoting client rights and good governance.

The scope of work of VHSG includes the following activities, which the *Community Participation Policy* notes is not exhaustive but a menu of activities.

Health information systems:

- Assist the health center with disease surveillance/monitoring and case reporting to the VHSG leader during monthly village health meetings (including "Zero Reporting").
- Report disease outbreaks to the health center in a timely manner.
- Keep a register of all children under 5 years of age in the village, recording each child's name, sex, date of birth and parents' name.

- Assist the health center in collecting vital registration statistics, including notification of pregnancies, births and deaths.
- Literate VHSG members should be trained and encouraged to complete verbal autopsies for deaths that occur in the village versus a simple checklist provided.
- Collect information through appropriate tools on health and health-related problems in the community, inform and report to the health center in a timely manner.

Provision and follow up of information and essential services:

- Facilitate the identification of the poor for fee exemption and HEF coverage.
- Provide health education, promote improved health practices and distribute health IEC materials. Health topics to be covered include: key family practices, family planning, antenatal care, clean delivery, postnatal care, breastfeeding, complementary feeding, safe water, hygiene and sanitation, malaria and dengue control, HIV/AIDS/STIs, tuberculosis, immunizations, non-communicable and chronic diseases, mental health, tobacco and alcohol, and gender-based and family violence.
- Mobilize families and assist health center staff during outreach activities and health campaigns.
- Assist in the mobilization of resources for sustainability of health centers.
- Assist families with early identification of the danger signs for severe/serious illnesses.
- Promote and strengthen the health center referral system and assist in logistics such as transportation.

Provision and follow up of essential diagnosis and treatment services (Following national guidelines):

- Promote correct home care for illnesses, following the C-IMCI training curriculum for community health volunteers.
- Provide community-based first aid and rehabilitation.
- Identify and refer children with acute malnutrition; follow up on children with acute malnutrition under community-based management; and provide health education on feeding malnourished children.
- Provide home-based care.
- Assist health centers to detect chronic diseases.
- Provide DOTS for TB patients when requested by the health center.
- Provide ORS including zinc for diarrhea in children.

In remote and difficult-to-access communities:

- Provide early diagnosis and treatment for malaria when delegated by the operational district director.
- Diagnose and treat ARI with antibiotics in children when delegated by the operational district director.

Provision of essential commodities:

- Distribute micronutrient supplementation (vitamin A, iron, folic acid, etc.).
- Distribute mebendazol.
- Distribute oral rehydration treatment with zinc.

- Distribute condoms and family planning supplies.
- Distribute long-lasting insecticide-treated mosquito bed nets and hammock nets.
- Distribute abate.
- Distribute food supplementation (i.e., sprinkles) and ready-to-use supplementary foods .

Regular meetings that VHSG leader and members should attend include:

- Monthly VHSG meetings in the village organized and facilitated by the VHSG leader.
- VHSG leader meetings held once every two months at the health center.
- HCMC meetings, which VHSG leaders attend once a quarter at the health center.

Health Center Management Committees

- Composed of 9-11 members, with the chair being the vice chief of the CC responsible for social affairs; the vice-chair is the chief of the health center; one additional person from the Commune Council, preferably the CCWC; one additional person from the health center, such as the midwife; and 4-7 VHSG leaders.

Roles and responsibilities of the HCMC are:

1. Oversee and provide strategic guidance for overall management and development of HC services.
   - Participate in the quarterly review and implementation of the health center annual operational plan (AoP) and ensure the link between the health center, the AoP and the commune investment plan (CIP).
   - Set and periodically review user fee levels in consultation with the VHSG leaders and the commune council.
   - Facilitate the process of the identification mechanism for the poor to be exempted in accordance with the Ministry of Planning guidelines for identification of poor.
   - Support health center in developing/setting up effective transportation arrangements/mechanisms for referrals.
2. Maintain linkages between the health center and communities through VHSG leaders and other community participation structures and facilitate intersectoral coordination to promote community participation in health and health-related areas:
   - Obtain and act upon comments/suggestions and complaints of community members/service users about the health center management and health service delivery and to identify appropriate solutions and opportunities for improvements.
   - Ensure through the VHSG leaders and other appropriate channels that important health information is given to the population, especially at the times of disease outbreaks.
   - Promote awareness of consumer and provider rights.
   - Through the VHSG, coordinate health and health-related activities of all health volunteers in the community.
3. Promote healthy behavior and community participation in health center activities with the VHSG:
   - Assist in the organization of health campaigns for health activities and communicable disease prevention.
   - Organize and support health service delivery as defined in the scope of work for the VHSG.

- Monitor the quality of services provided by the HC.

4. Strengthen an effective functioning of the HCMC and the VHSG:
   - Participate in defining the benefit package for the VHSG.
   - Support the functioning of HCMC and VHSGs through resource identification and mobilization and advocacy.

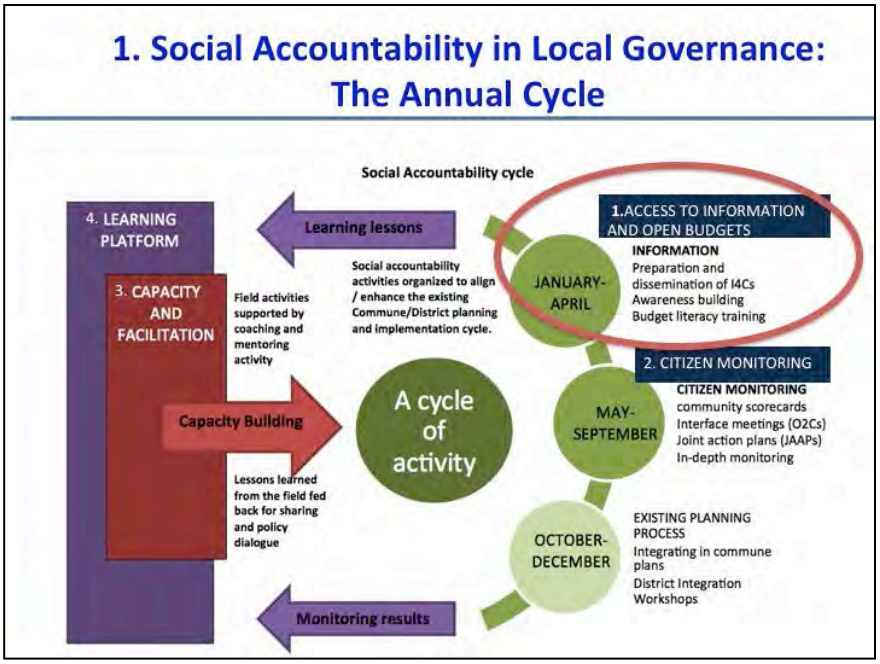
BACKGROUND INFORMATION ON I-SAF

I-SAF operationalizes the *Strategic Plan on Social Accountability for Sub-National Democratic Development* that was brought into policy by the RGC in July 2013. I-SAF is initially a three-year program from 2015-2018, though plans to scale up the approach are under development. The *Social Accountability Framework* provides a joint platform for action by civil society and government.

Social accountability is a means to increase cooperation between local authorities, local service providers, and citizens and communities to support service providers to improve their performance.

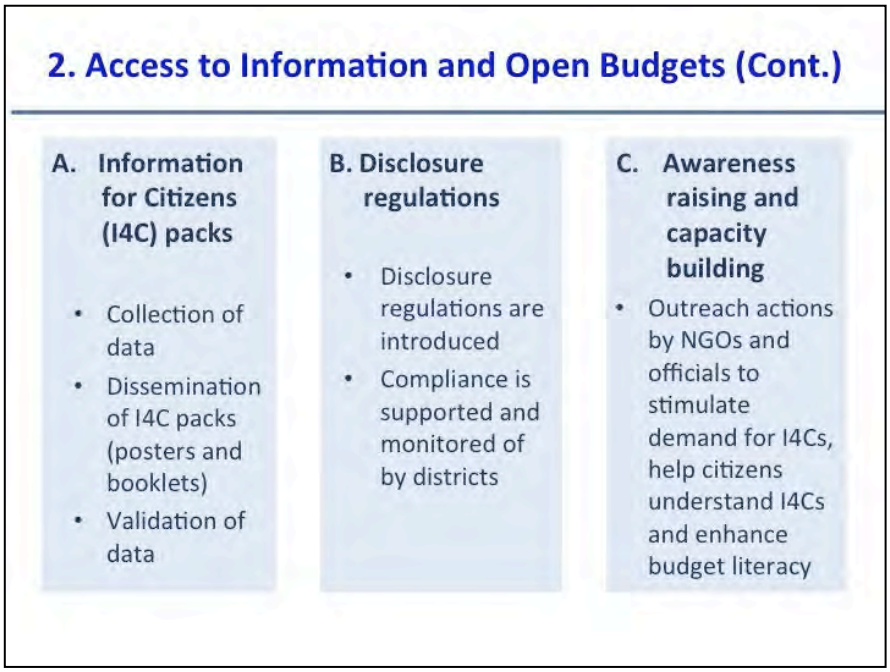
The social accountability cycle consists of four main components: access to information and open budgets, citizen monitoring, facilitation and capacity building, and learning and monitoring. It follows an annual cycle of activities as shown in the diagram below.[5]

Step 1: Access to information and open budgets is delivered through Information for Citizen (I4C) packs at community events facilitated by community accountability facilitators (CAF). Through I4C and the dissemination of information, CAFs seek to increase access to and the demand for public information and to strengthen the capacity of citizens and commune councilors to access and understand public information, including budgets.

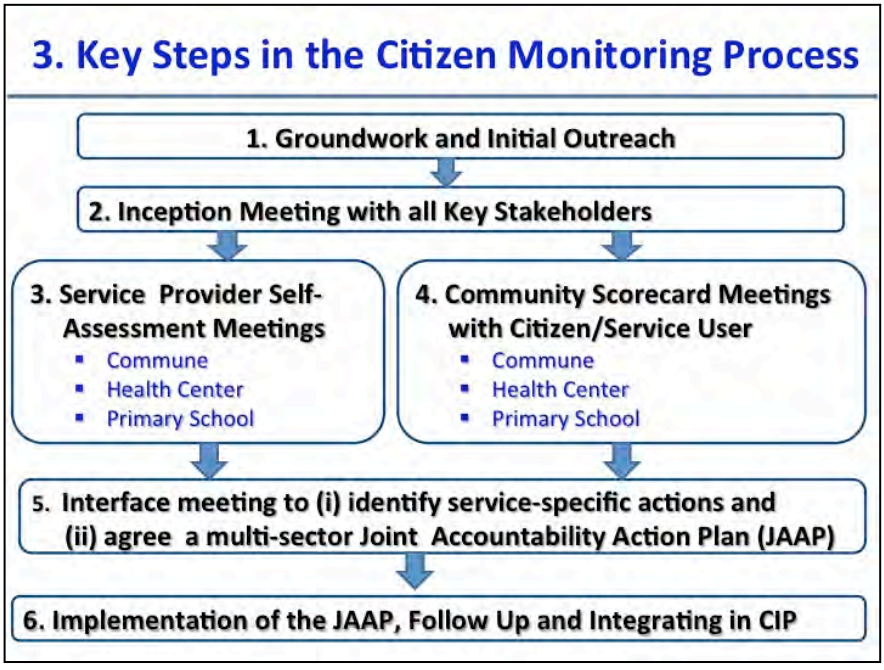


[5] Slides shared by Dr Samrith Wannak, ECH Local Governance and Capacity Building Team Leader

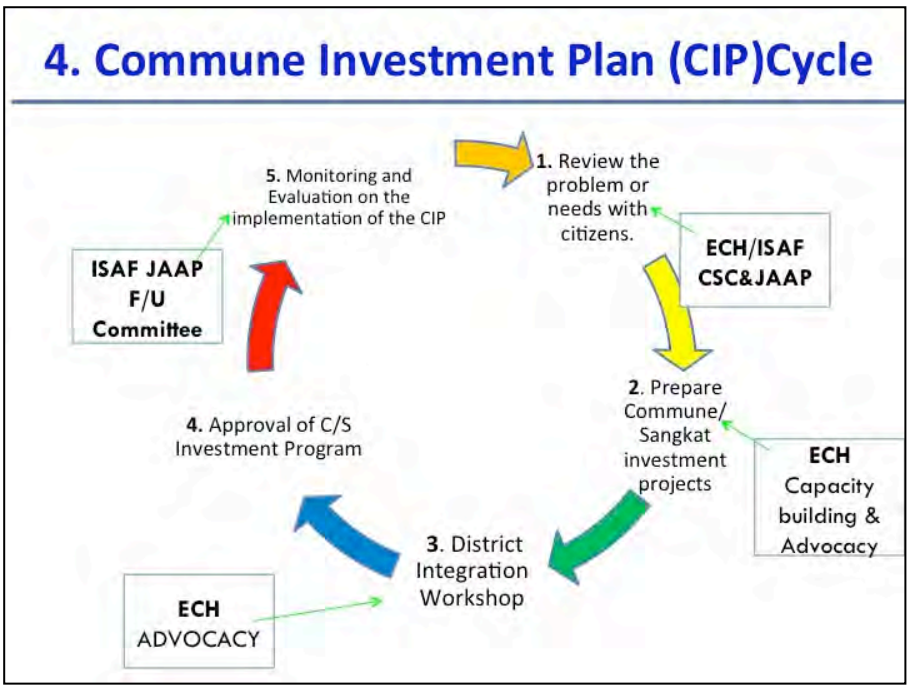
Step 2: Citizen monitoring includes provider self-assessments, citizen scoring of health, education and commune services, and an interface meeting between commune council, provider and citizens to identify service specific actions for improvement and develop a Joint Accountability Action Plan (JAAP).

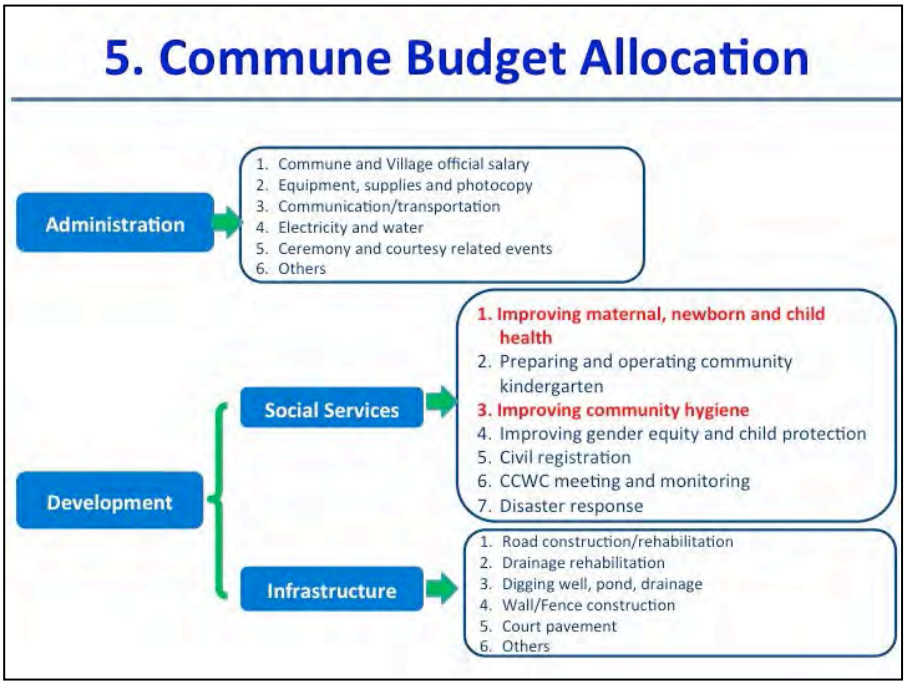


Step 3: The findings of citizen monitoring and JAAP are fed into existing commune and district council planning processes, including the Commune Investment Plan.

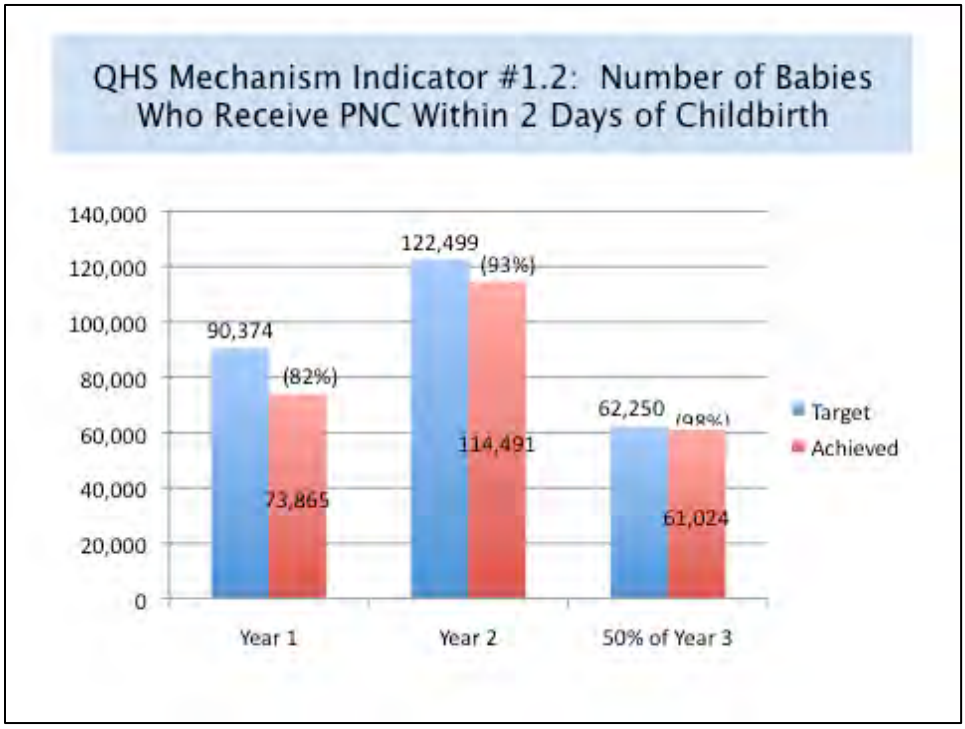


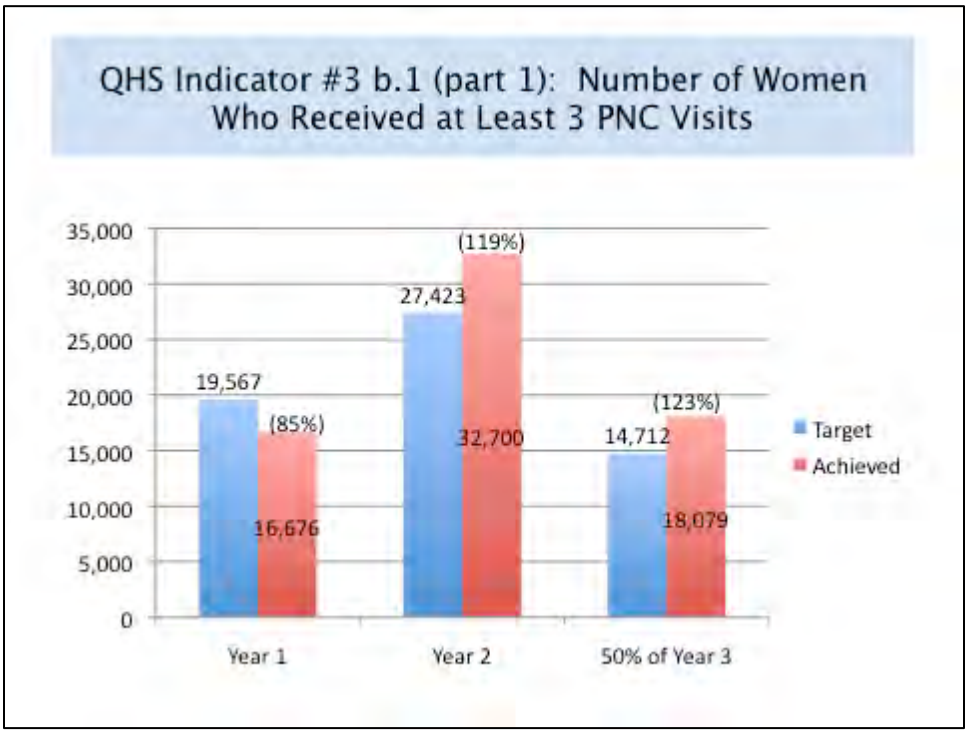
Step 4 is monitoring and learning from field experience for sharing, and feeding experience into policy development and future capacity building and facilitation.

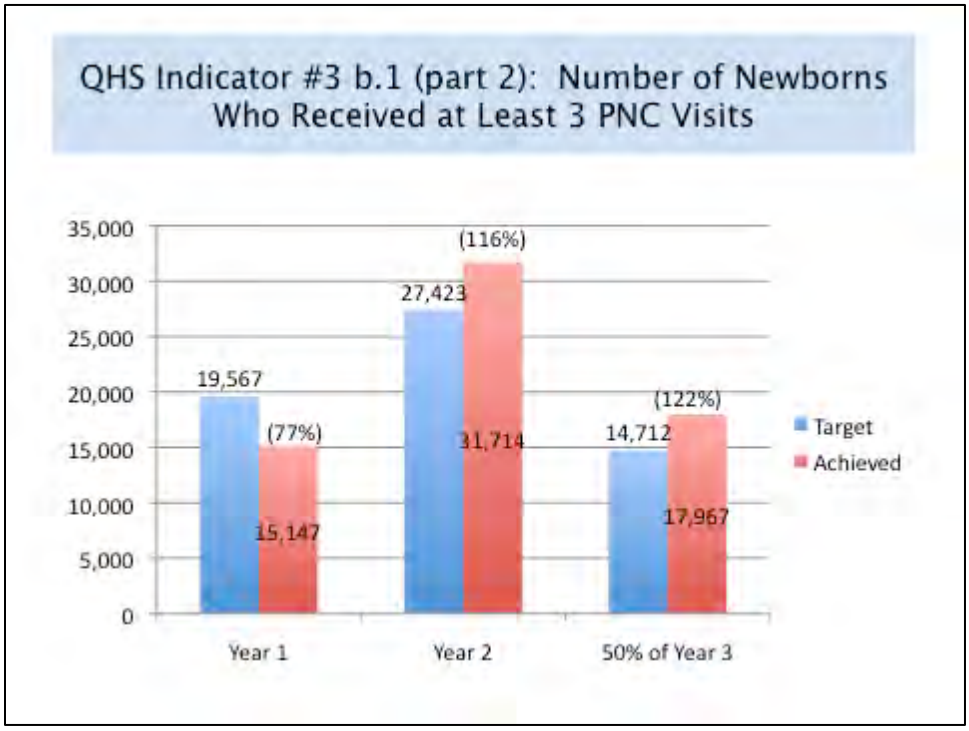


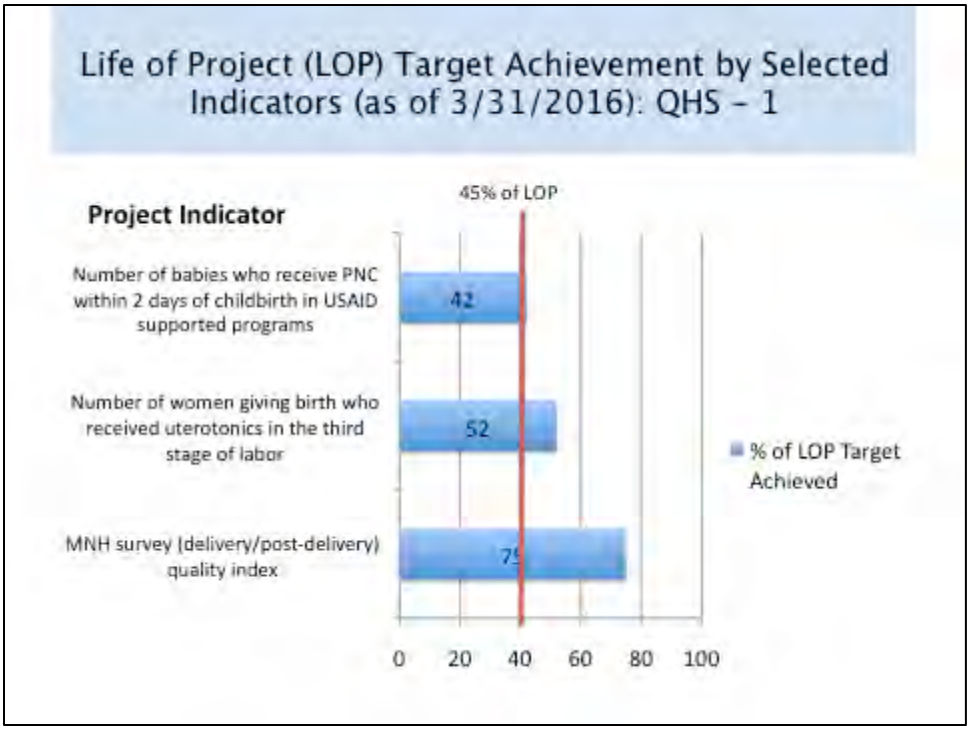


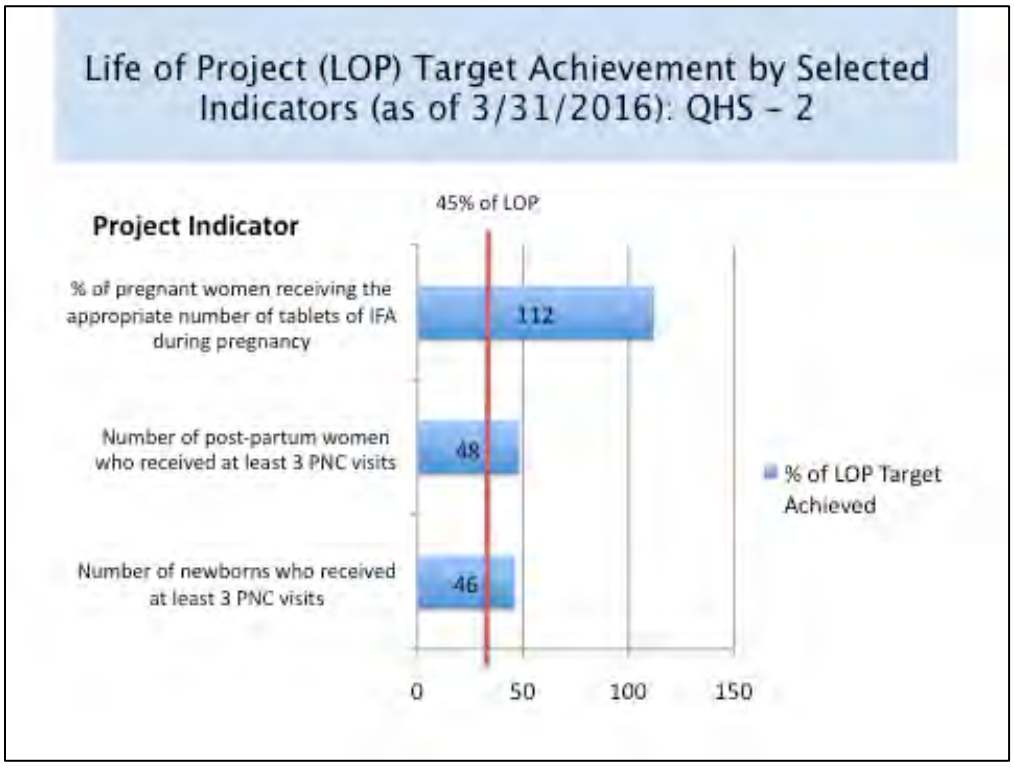
ANNEX VII: MECHANISM INDICATOR PROGRESS GRAPHS

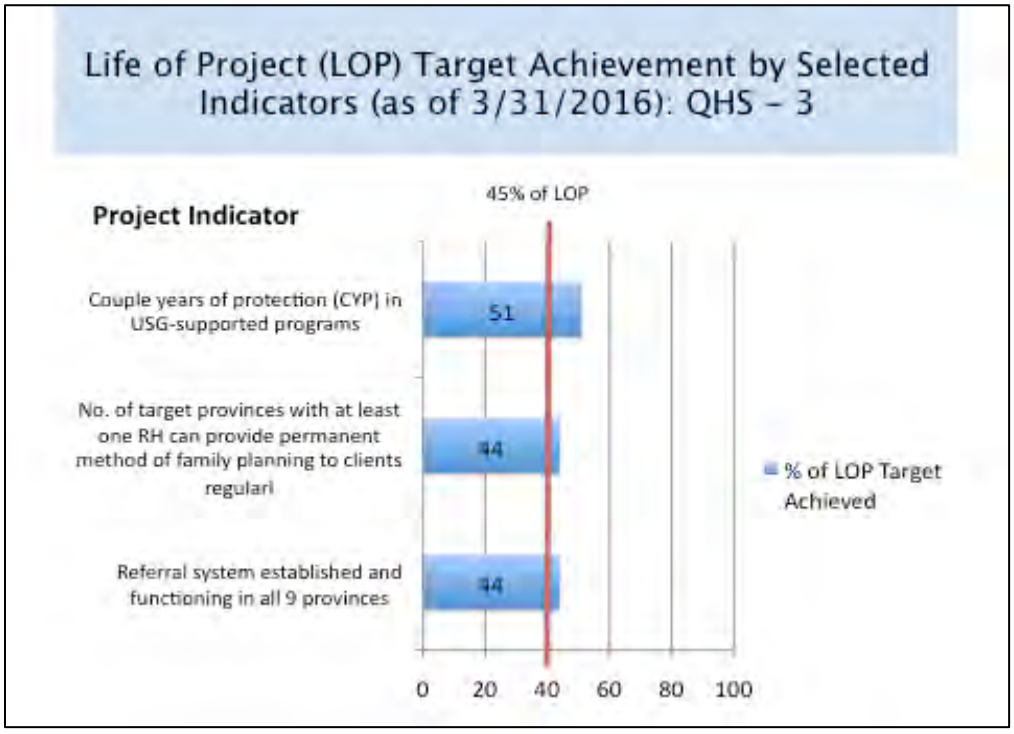


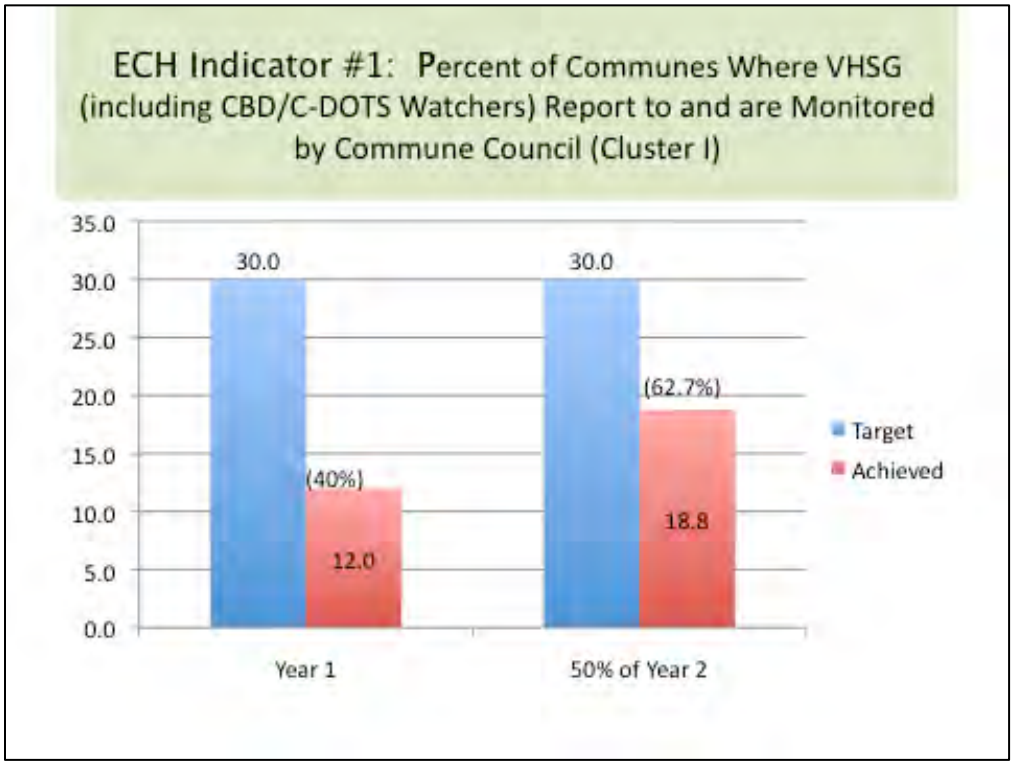


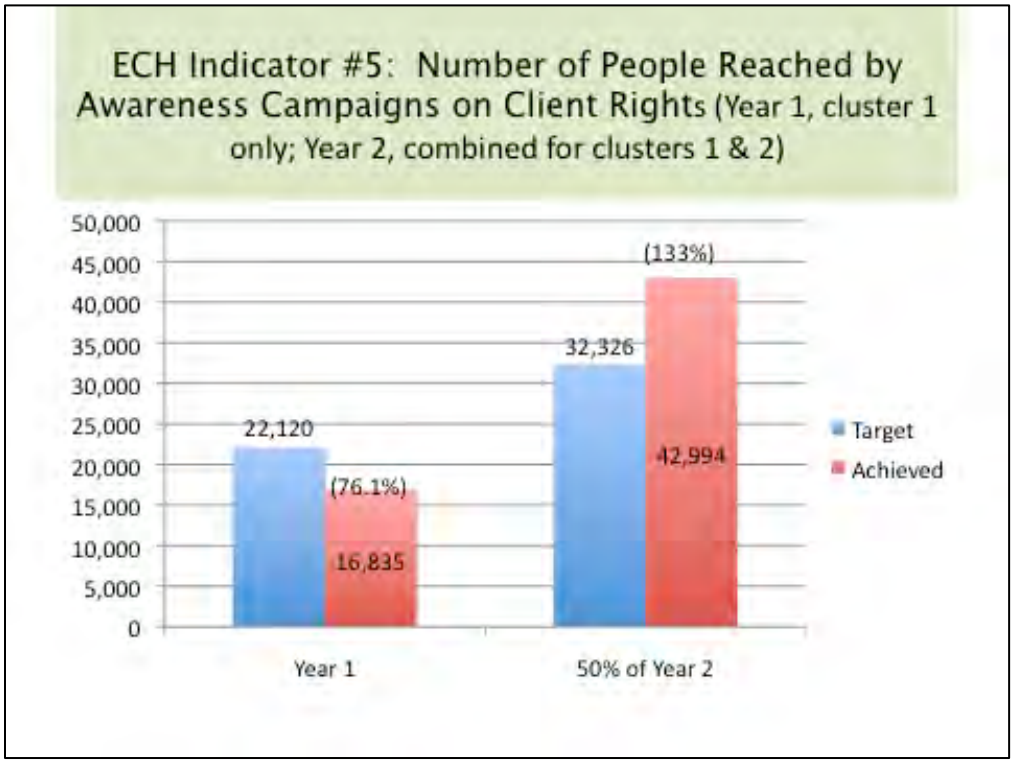

QHS Indicator #3 b.1 (part 2): Number of Newborns Who Received at Least 3 PNC Visits
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
19,567
(77%)
15,147
27,423
(116%)
31,714
14,712
(122%)
17,967
Year 1
Year 2
50% of Year 3
Target
Achieved

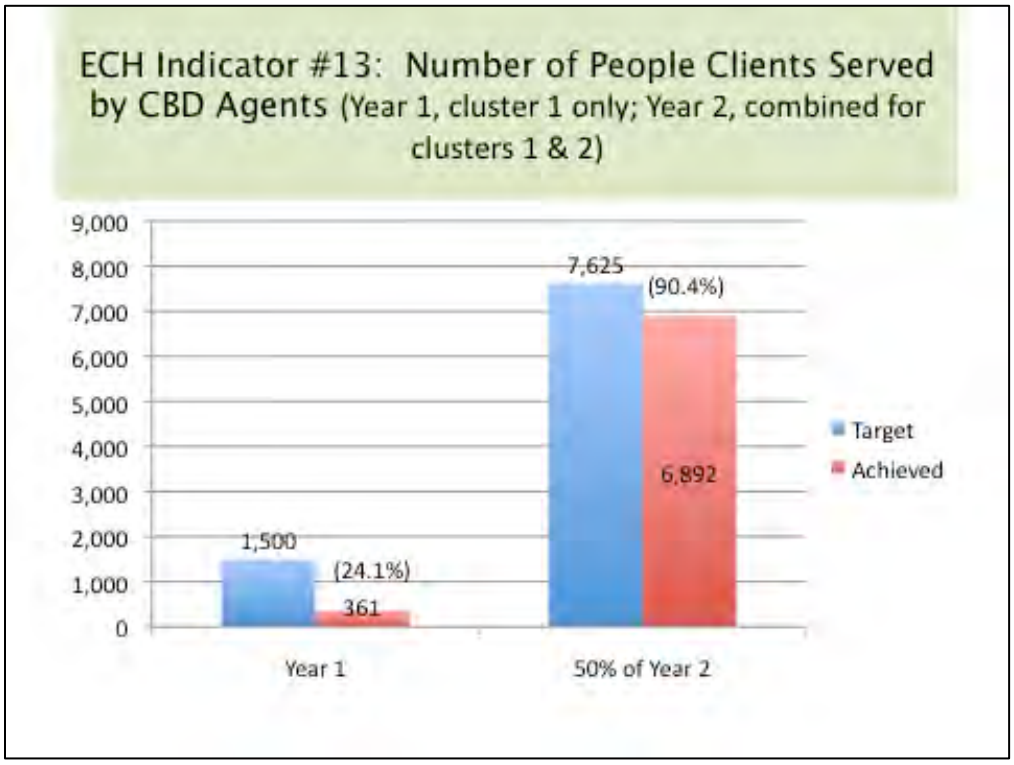

Life of Project (LOP) Target Achievement by Selected Indicators (as of 3/31/2016): QHS – 1
Project Indicator
45% of LOP
Number of babies who receive PNC within 2 days of childbirth in USAID supported programs
42
Number of women giving birth who received uterotonics in the third stage of labor
52
MNH survey (delivery/post-delivery) quality index
0
20
40
60
80
100
% of LOP Target Achieved

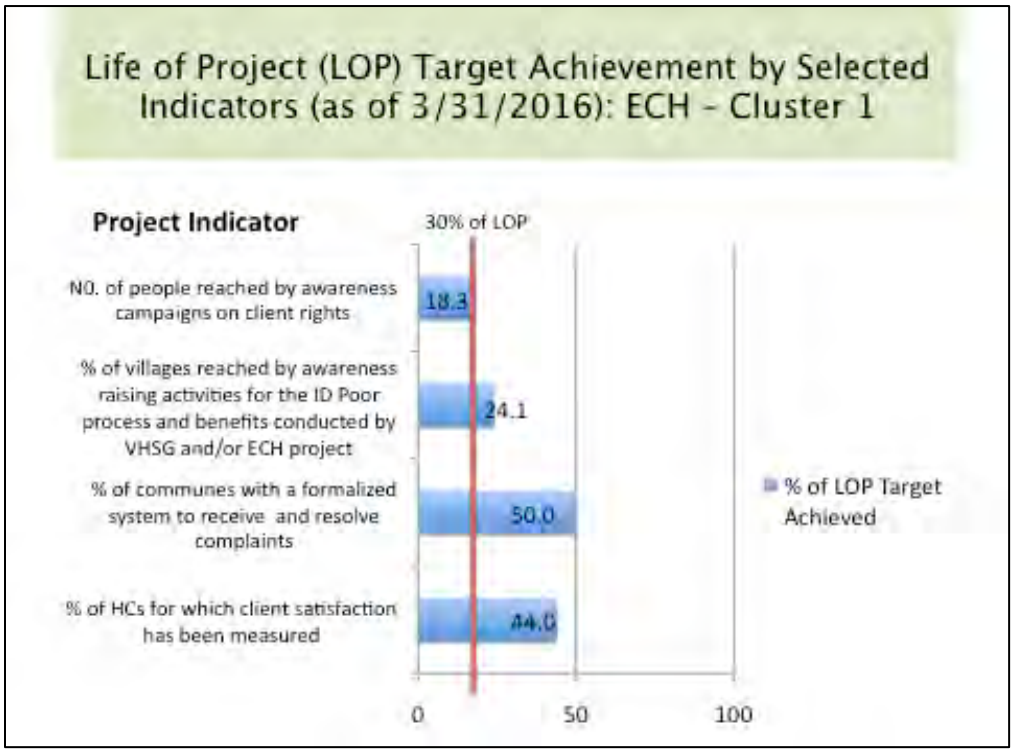

Life of Project (LOP) Target Achievement by Selected Indicators (as of 3/31/2016): QHS – 2
Project Indicator
45% of LOP
% of pregnant women receiving the appropriate number of tablets of IFA during pregnancy
112
Number of post-partum women who received at least 3 PNC visits
48
Number of newborns who received at least 3 PNC visits
46
% of LOP Target Achieved
0
50
100
150

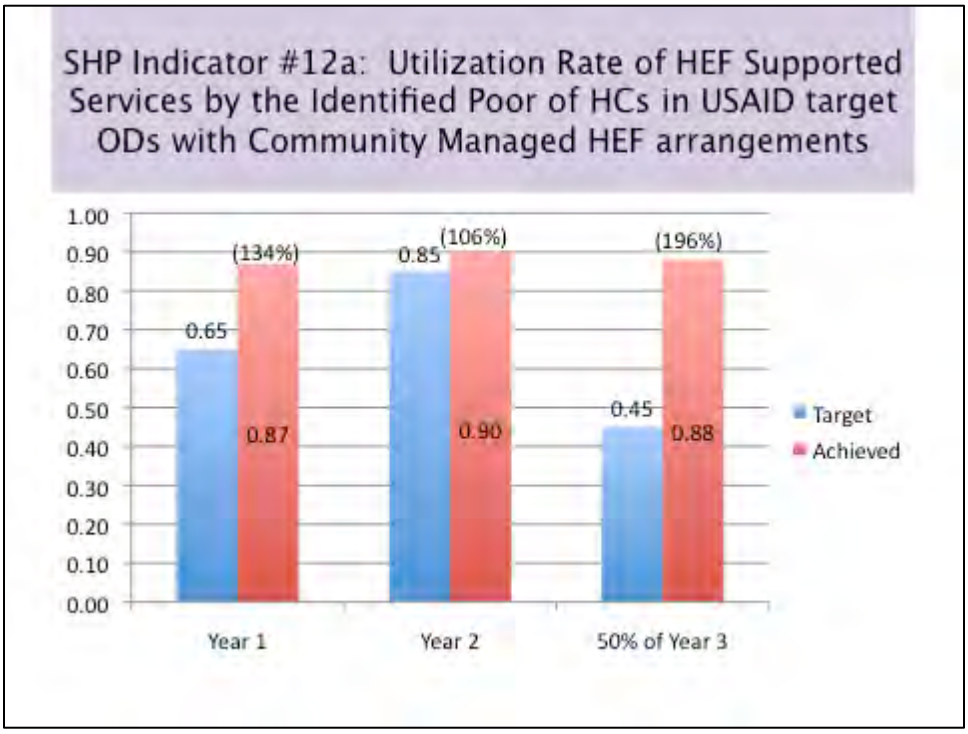

Life of Project (LOP) Target Achievement by Selected Indicators (as of 3/31/2016): QHS – 3
Project Indicator
45% of LOP
Couple years of protection (CYP) in USG-supported programs
51
No. of target provinces with at least one RH can provide permanent method of family planning to clients regulari
44
Referral system established and functioning in all 9 provinces
44
% of LOP Target Achieved
0
20
40
60
80
100

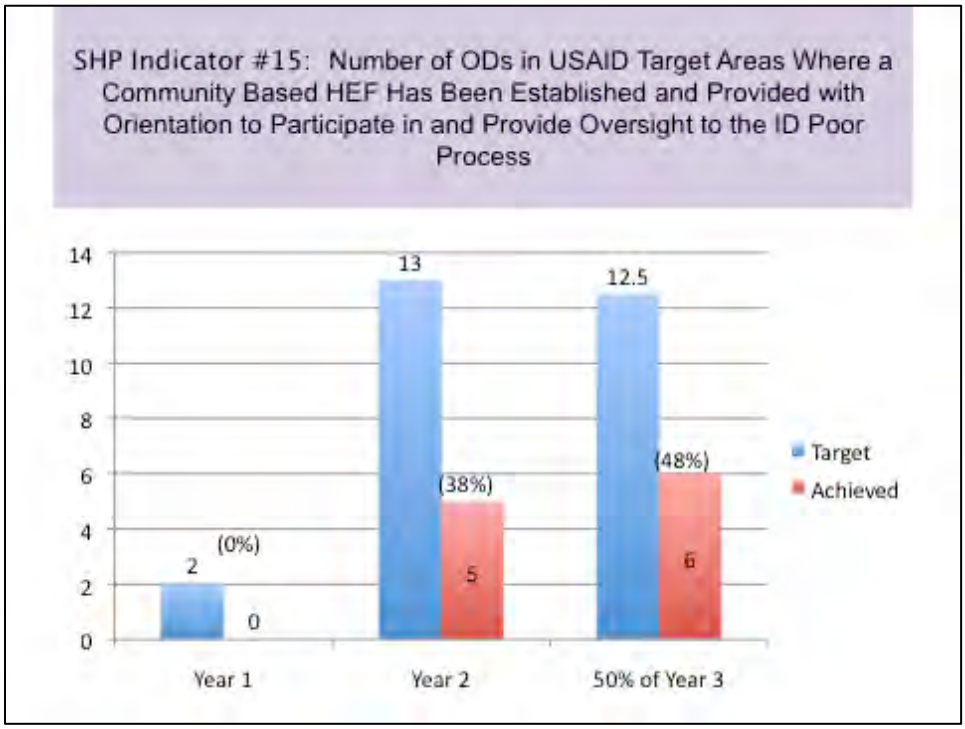

ECH Indicator #1: Percent of Communes Where VHSG (including CBD/C-DOTS Watchers) Report to and are Monitored by Commune Council (Cluster I)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
30.0
30.0
(40%)
12.0
(62.7%)
18.8
Target
Achieved
Year 1
50% of Year 2

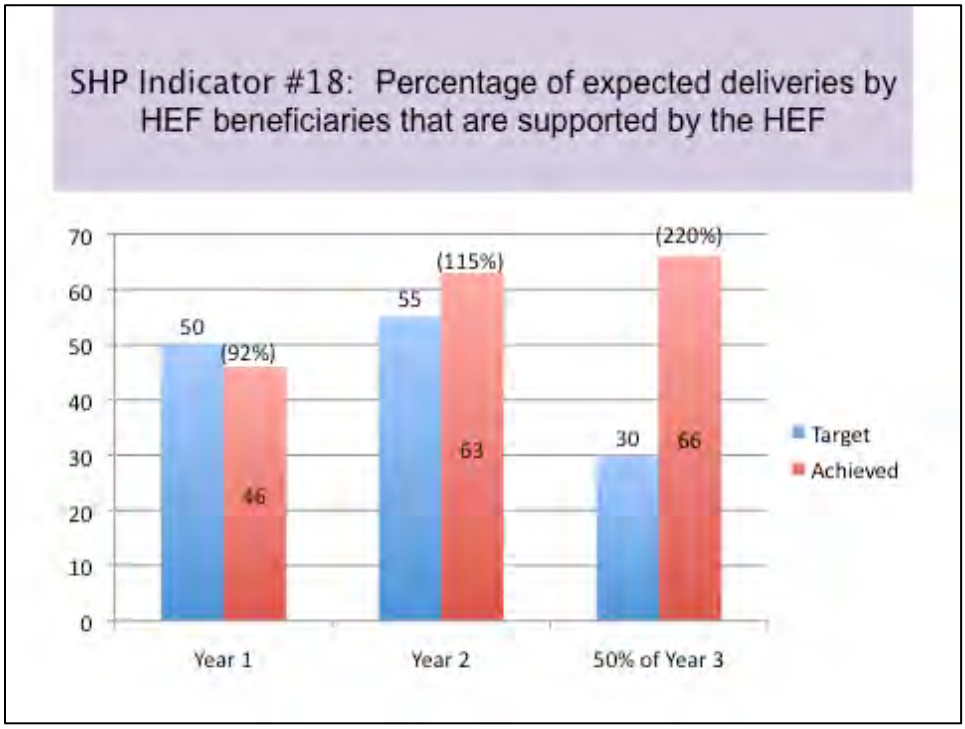

ECH Indicator #5: Number of People Reached by Awareness Campaigns on Client Rights (Year 1, cluster 1 only; Year 2, combined for clusters 1 & 2)
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
22,120
(76.1%)
16,835
32,326
(133%)
42,994
Target
Achieved
Year 1
50% of Year 2

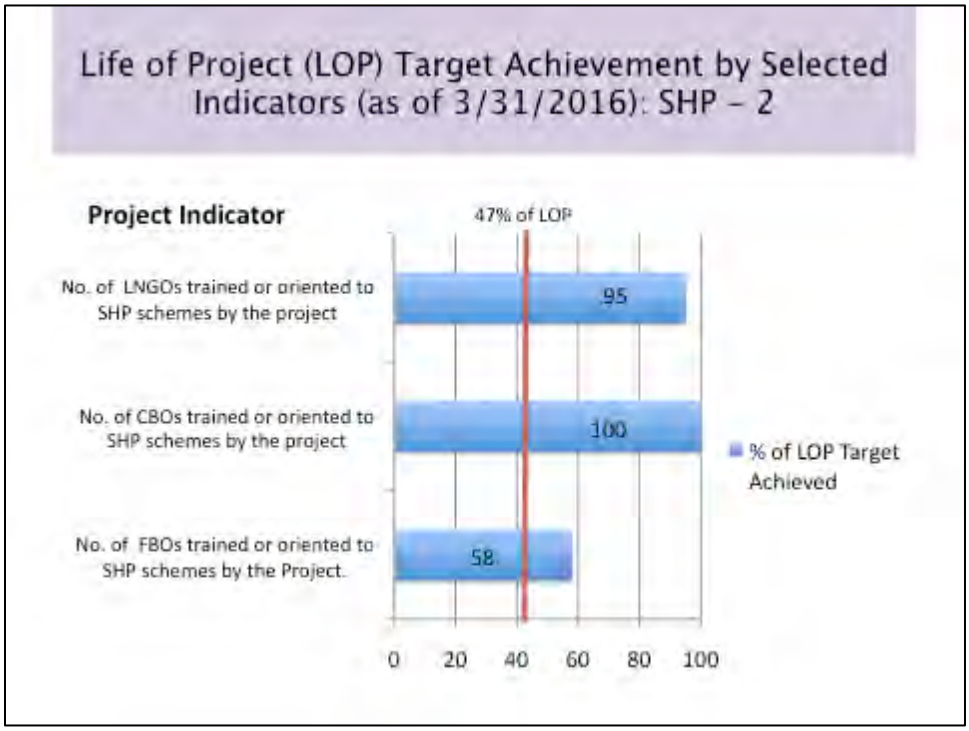

ECH Indicator #13: Number of People Clients Served by CBD Agents (Year 1, cluster 1 only; Year 2, combined for clusters 1 & 2)
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
1,500
(24.1%)
361
7,625
(90.4%)
6,892
Target
Achieved
Year 1
50% of Year 2

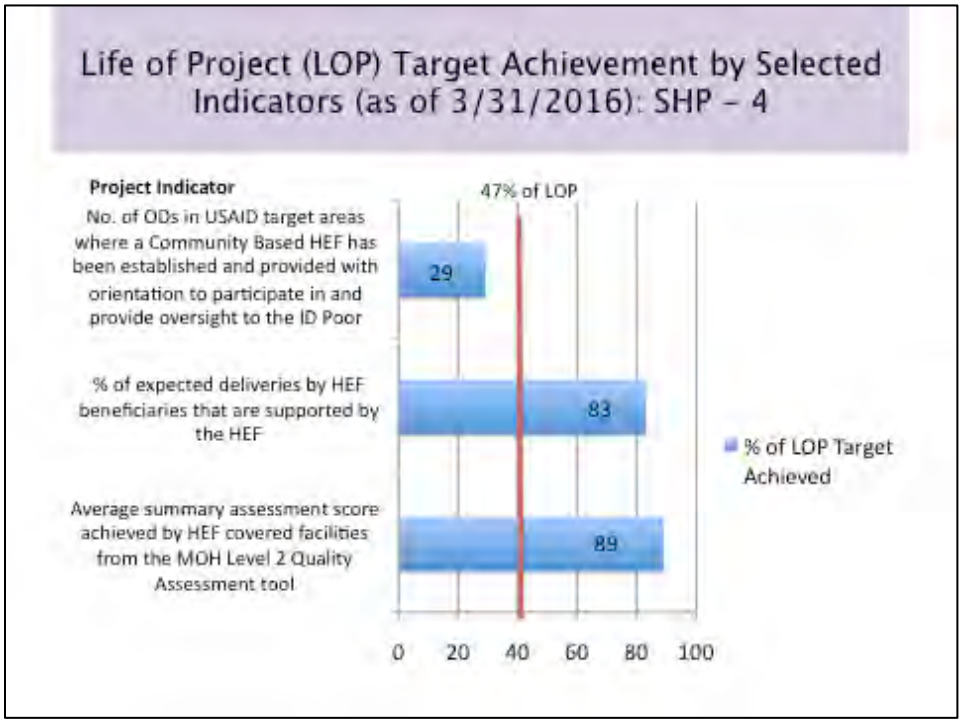

Life of Project (LOP) Target Achievement by Selected Indicators (as of 3/31/2016): ECH – Cluster 1
Project Indicator
30% of LOP
NO. of people reached by awareness campaigns on client rights
18.3
% of villages reached by awareness raising activities for the ID Poor process and benefits conducted by VHSG and/or ECH project
24.1
% of communes with a formalized system to receive and resolve complaints
50.0
% of HCs for which client satisfaction has been measured
44.0
% of LOP Target Achieved
0
50
100


SHP Indicator #12a: Utilization Rate of HEF Supported Services by the Identified Poor of HCs in USAID target ODs with Community Managed HEF arrangements
1.00
0.90
0.80
0.70
0.60
0.50
0.40
0.30
0.20
0.10
0.00
0.65
(134%)
0.87
0.85
(106%)
0.90
0.45
(196%)
0.88
Year 1
Year 2
50% of Year 3
Target
Achieved


SHP Indicator #15: Number of ODs in USAID Target Areas Where a Community Based HEF Has Been Established and Provided with Orientation to Participate in and Provide Oversight to the ID Poor Process
14
12
10
8
6
4
2
0
2
(0%)
0
13
(38%)
5
12.5
(48%)
6
Year 1
Year 2
50% of Year 3
Target
Achieved


SHP Indicator #18: Percentage of expected deliveries by HEF beneficiaries that are supported by the HEF
70
60
50
40
30
20
10
0
50
(92%)
46
55
(115%)
63
30
(220%)
66
Target
Achieved
Year 1
Year 2
50% of Year 3


Life of Project (LOP) Target Achievement by Selected Indicators (as of 3/31/2016): SHP – 2
Project Indicator
47% of LOP
No. of LNGOs trained or oriented to SHP schemes by the project
95
No. of CBOs trained or oriented to SHP schemes by the project
100
No. of FBOs trained or oriented to SHP schemes by the Project.
58
% of LOP Target Achieved
0
20
40
60
80
100


Life of Project (LOP) Target Achievement by Selected Indicators (as of 3/31/2016): SHP – 4
Project Indicator
No. of ODs in USAID target areas where a Community Based HEF has been established and provided with orientation to participate in and provide oversight to the ID Poor
% of expected deliveries by HEF beneficiaries that are supported by the HEF
Average summary assessment score achieved by HEF covered facilities from the MOH Level 2 Quality Assessment tool
47% of LOP
29
83
89
0
20
40
60
80
100
% of LOP Target Achieved

ANNEX VIII. CONFLICT OF INTEREST FORMS

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

Sensitive Data, or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature Date 04/26/2016

William Jansen

Name Title Consultant

Signature Certificate

Document Reference: XJB9BFJW835PRN4FI3NDWY

RightSignature
Easy Online Document Signing

William Jansen
Party ID: 9R3V42J7GLAAAJZZUUHEKS
IP Address: 41.248.217.168
VERIFIED EMAIL packardad@yahoo.com

Digital Fingerprint Checksum a034fb6c7e23147feb75654cde23a842e75bdd2c

Timestamp	Audit
2016-04-26 09:18:48 -0700	All parties have signed document. Signed copies sent to: Kate Bartram, William Jansen, and GH Pro Right Signature.
2016-04-26 09:18:47 -0700	Document signed by William Jansen (packardad@yahoo.com) with drawn signature. - 41.248.217.168
2016-04-26 09:12:49 -0700	Document viewed by William Jansen (packardad@yahoo.com). - 41.248.217.168
2016-04-26 09:05:47 -0700	Document created by GH Pro Right Signature (rightsignature@ghpro.com). - 173.233.56.214

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Page 1 of 1

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature

Date 3-9-16

Name Pamela J. Putney

Title Consultant

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

[signature]	24 March, 2016
Signature	Date
Deborah Thomas	24 March, 2016
Name	Title Ms.

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

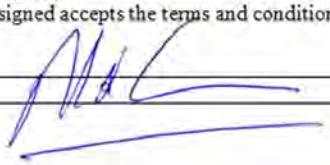
ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

[signature]	4/4/2016
Signature	Date
Nhu-An Tran	Consultant
Name	Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature  Date: March 30, 2016

Name: MAO Bunsoth Title: Team Leader, MBS Research

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature Ros Bandeth Date 01.04.2016

Name Ros, Bandeth Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature  Date 03/24/2016

Name MONY SREY Title DR.

GH Pro

Global Health Program Cycle Improvement (GH Pro) Project
NON-DISCLOSURE STATEMENT

Assignment Number/Name:

I certify that I, LUN THARATH, will not discuss with, or reveal to, any representative of any business organization or other entity, or any individual person (except persons specifically assigned to my specific proposal evaluation group) either within or without the United States Government, any aspects of the pending procurement.

The term "any aspects of the pending procurement" includes, but is not limited to, information such as the identity and number of applicants, the method of procurement, the number and identity of Government personnel involved, and the schedule of key technical and procurement events in the source selection process. Except as specifically authorized by the Agreement Officer, the release of such information constitutes the unauthorized release of advance procurement or procurement information.

The term "any aspects of the pending procurement" also includes but is not limited to, information dealing with the development and/or design of the procurement, its corresponding RFP/RFA/IDIQ, and information on the evaluation of another procurement that is/may be relevant to or influenced by the development and/or design of said procurement.

I recognize that a significant factor in the success and proper completion of the source selection process is the strict confidentiality observed by all Government participants in the various proposal evaluation and evaluation review groups concerning all of the activities and procedures involved in source selection and that failure to comply with these requirements may compromise the ultimate source selection. I acknowledge that the unauthorized release of advance procurement or procurement information as defined herein may result in the termination of my participation in this procurement.

In the event I have released any of the advance procurement or procurement information covered hereby, I agree to advise the technical panel chair of the proposal evaluation or proposal evaluation review group to which I am assigned as soon as practicable. That advice will identify the business organization or other entity, or individual person, to whom the information in question was divulged and the content of that information.

DATE: 04 - April - 2016

NAME: LUN THARATH

SIGNATURE: 

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