

# Partnering to Save Lives

## Final evaluation Report

July 2018

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## Abbreviations and Acronyms

ANC	Antenatal care
AOP	Annual operational plan
AUD	Australian dollar
BCC	Behaviour change communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
CAC	Comprehensive abortion care
CBD	Community-based distributor
CC	Commune Council
CCWC	Commune Council for Women and Children
CDHS	Cambodia Demographic and Health Survey
CDPO	Cambodian Disabled People's Organisation
CIAI	Centro Italiano Aiuti all'infanzia
CIP	Commune investment plan
CLU	Coordination and Learning Unit
DFAT	Department of Foreign Affairs and Trade
DPO	Disabled People's Organisation
EmONC	Emergency obstetric and neonatal care
FP	Family planning
FTIRM	Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality
GF	Garment factory
GFW	Garment factory worker
HC	Health centre
HCMC	Health centre management committee

HEF	Health Equity Fund
H-EQIP	Health Equity and Quality Improvement Project
HIS	Health information system
HSSP2	Health Sector Support Program 2
IEC	Information Education and Communication
I-SAF	Implementation of the Social Accountability Framework
IUD	Intrauterine device
LAPM	Long acting or permanent methods (family planning)
LDG	Listening and Dialogue Group
LTFP	Long term family planning
MCAT	Midwifery Coordination Alliance Team
MCH	Mother and Child Health
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MERI	Monitoring, evaluation, reporting and improvement
MoH	Ministry of Health
MoLVT	Ministry of Labour and Vocational Training
NE	North East
NGO	Non-governmental organisation
NMCHC	National Maternal and Child Health Centre
NQEM	National Quality Enhancement Monitoring
OD	Operational District
PHD	Provincial Health Department
PMG	Partnership Management Group
PNC	Postnatal care
PSC	Partnership Steering Committee

PSL	Partnering to Save Lives
QA	Quality Assurance
RGC	Royal Government of Cambodia
RMNH	Reproductive, maternal and newborn health
SA	Safe Abortion
SBA	Skilled birth attendant
SDG	Service Delivery Grants
SMS	Short Message Service
SRH	Sexual and reproductive health
TBA	Traditional birth attendant
ToR	Terms of reference
TRG	Technical Reference Group
TWG	Technical working group
UNFPA	United Nations Population Fund
VHSG	Village Health Support Group
VSO	Voluntary Service Overseas
VSLA	Village Savings and Loans Association
WHO	World Health Organisation
WRA	Women of reproductive age

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## Executive Summary

PSL is a partnership program between the Cambodian Ministry of Health (MoH) and three non-governmental organisations (NGOs): CARE, Marie Stopes International Cambodia (Marie Stopes), and Save the Children International in Cambodia<sup>1</sup>, funded by the Australian Department of Foreign Affairs and Trade (DFAT). The ultimate goal of PSL is to save the lives of women and newborns by contributing to the national efforts in improving quality, access and utilization of Reproductive, Maternal and Newborn Health (RMNH) services.

The purpose of the final evaluation is to: (1) Assess the program's progress against its goal and outcomes across the five years of implementation, including cross cutting elements; (2) Assess the relevance, effectiveness, efficiency, impact and sustainability of the program; (3) Make any recommendations regarding main successes and areas of improvement that partners could consider for further replication or in the context of future programs.

The final evaluation assessed the achievements of Partnering to Save Lives (PSL) against its six primary outcomes after five years of implementation, and made recommendations regarding main successes that could be considered for further replication and areas of improvement in the context of future programming. The study used a mixed qualitative and quantitative approach to answer 16 evaluation research questions formulated on the basis of six evaluation criteria: relevance, effectiveness, efficiency, impact, sustainability and equity.

The findings are based on evidence drawn from documentation, primary qualitative data from the field research [Focus group discussion (FGDs) with beneficiaries and interviews of key informants] supported by secondary quantitative data from surveys (baseline, midline and endline) and the mid-term review.

Relevance: PSL's interventions contributed to the MoH strategic priorities for RMNH by addressing all the seven components<sup>2</sup> of the Fast Track Initiative Road Map for reducing maternal and newborn mortality (FTIRM) 2016-2020 and PSL's focus, activities and outcomes were consistent with the Australian Government's targets for strategic investments in the health sector as well as the DFAT/High Commission's strategic directions in Cambodia. All key informants of the final evaluation (development partners, government counterparts at central and provincial levels, local authorities and community members) recognized the relevance of PSL's objectives and interventions. The interventions were targeting vulnerable groups: ethnic

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<sup>1</sup> Save the Children International (SCI) is subject to Protecting Life in Global Health Assistance (PLGHA) and has not engaged in activities that are not compliant with PLGHA.

<sup>2</sup> The seven components of FTIRM 2016-2020 are: Skilled birth attendance, Emergency obstetric and Newborn care, Newborn care, Family planning, Safe abortion, removing financial barriers to access health services, Behaviour change communication.



minorities in the four northeast (NE) provinces – Ratanak Kiri, Mondul Kiri, Kratie and Stung Treng, female garment factory workers (GFW) in 25 garment factories and women in need for safe abortion and long acting and permanent contraception methods (LAPM) in 19 provinces (in addition to the four NE provinces). Health service providers and local authorities were consulted in the program design and implementation phases. Their needs and challenges have been addressed: the low quality of health services, lack of awareness of beneficiaries about RMNH, access barriers to health services, lack of clinical and communication skills of the health staff. Associations of people living with disabilities have been consulted since the program design phase and actively involved in the second phase of the program implementation. Gender mainstreaming is an integral part of the PSL program. The main beneficiaries were women and service providers were midwives. Through its BCC interventions in the community and garment factories, PSL empowers women's autonomy in decision making on family planning and health service utilisation. Efforts have been to involve men so they are supportive in their wife's maternal and reproductive health issues. Child safeguarding was addressed through training of PSL staff on child protection.

Effectiveness: In the areas supported by PSL, key informants of the evaluation field research reported that there have been significant changes in the availability and access to health services over the past five years. Health centres (HC) are better equipped and on duty 24 hours. Health staff's attitudes have improved with many respondents acknowledging links to the Attitudes training for health service providers provided by PSL. Coaching and Midwifery Coordination Alliance Team (MCAT) meetings were also noted as having been effective in building technical skills and confidence of midwives. Community-based RMNH education further demonstrated that it raised awareness and health care demand. Beneficiaries know better about RMNH services availability. The endline survey showed that in the four NE provinces, the percentage of all women of reproductive age (WRA) who gave birth in a health facility with a skilled birth attendant has increased from 55.2% at baseline to 78.6% at endline (with a statistically significant DID of +21.9% at endline). The largest increases were observed in Mondul Kiri and Ratanak Kiri where the percentage of WRA giving birth in a health facility with a skilled birth attendant increased (respectively) from 58.8% and 39.2% at baseline to 86.5% and 63.4% at endline. In the four NE provinces, the percentage of WRA attending at least two antenatal care visits (ANC2) has increased from 73.4% at baseline to 89.5% at endline (with a statistically significant DID of +26.4% at endline), the percentage of WRA receiving at least four ante-natal care consultations (ANC4) has increased from 47.0% at baseline to 60.6% at endline (but the DID of +4.0% at endline was not statistically significant, indicating that this may be a general trend in Cambodia). The ANC4 value has almost doubled among WRA from ethnic minorities, from 30.6% at baseline to 59.5% at endline. The endline survey also found increase in PNC1, use of community referral mechanism, and awareness of danger signs during pregnancy and newborn diseases. But there was little progress regarding WRAs using modern contraceptives or long acting or permanent

methods, WRAs who report being highly satisfied with RMNH services provided, WRAs who feel empowered to discuss and use modern FP, and WRAs attending PNC who receive counselling in modern FP methods. The percentage of all WRA currently using any type of modern contraceptive method has remained stagnant in the four NE provinces with 25.9% at baseline and 26.4% at endline. The percentage of WRA using LAPM in the endline surveys across eight provinces, among the respondents who reported having had abortion in the last twelve months, less than 15% said that it was done in a public health facility. The percentage of WRA who are aware that abortion is legal in Cambodia has increased since the baseline but remains low at 14.6%. The evaluation field research found that WRA, adolescents and men know more about modern contraceptive methods than five years ago in contrast with the results of endline survey where the percentage of WRA who know about a modern contraceptive method went down at 95.0% as compared to 98.1% at baseline. The knowledge of contraceptive methods among female GFW is high at nearly 99% of respondents, and 43.1% of those who are sexually active, used a modern contraceptive method in the last 12 months. This is a significant increase from the baseline. The percentage of female GFW who know that abortion is legal has doubled from 7.9% at baseline to 15.3% at endline. *Chat! Contraception* was an innovative and effective behaviour change communication (BCC) intervention in the garment factories. The endline survey among GFW has found that *Chat!* participants were more likely to be using modern contraceptive methods than the non-participants.

During the five years of program implementation, the coordination and learning unit (CLU) has regularly collected evidences and lessons learnt from the field to share through publications and during the discussions for developments of RMNH policies and guidelines such as FTIRM 2016-2020, Guidelines for the Establishment of Enterprise Infirmaries, MCATs National Protocol, National Strategy for Reproductive and Sexual Health in Cambodia 2017-2020 and the Safe Motherhood Clinic Management Protocol for health centres (2016). Amongst evidence and lessons learnt informing development of policies and guidelines, there were the new approaches to strengthen midwives' clinical skills and interpersonal communication skills such as the training modules for the MCAT meeting, the on-site coaching and the Attitude training for health service providers.

Efficiency: The partnership was designed to allow the three NGO partners to share program management resources for coordination and harmonisation in order to achieve greater results. During the five-year program, the NGO partners often shared a joint implementation approach for similar interventions, using common tools such as Information Education and Communication (IEC) materials and training packages, allowing to save on the production costs and to obtain a bigger effect. They have developed and/or used joint products such as the Attitudes Training for Health Service Providers, *Chat!* package, Practical Coaching Guide, MCATs National Protocol, Health Facility Referral Directory and Village health Support Group (VHSG) BCC package. Other

contributing factors to the efficiency are the NGO partners' specific expertise in RMNH, past working experience in their target locations, the good support from the National Maternal and Child Health Centre (NMCHC), and the high commitment from Provincial Health Department (PHD) and Operational District (OD) in all the target provinces.

The mid-term internal partnership review, done by CLU/NGO partners in 2016, observed that "The partnership helped leveraging and combining strengths of the NGO partners, by providing greater diversity of implementation, opportunity to learn from each other, and to draw on each other's expertise to develop better packages and resources. Working together allows for a bigger reach and greater spread of messages", and "PSL's advocacy power is strong as three large international NGOs represent the partnership. In addition, having the PSL brand and weight behind them also helps the NGOs with their individual advocacy priorities, including invitation to high level policy dialogue through PSL".<sup>3</sup>

Moreover PSL complemented and extended the Health Equity and Quality Improvement Project (H-EQIP) (another DFAT-funded program) in the remote NE provinces. PSL worked with government officials to ensure they effectively implement the HEF and utilise Service Delivery Grant (SDG) funding to improve the quality of their RMNH services.

The CLU is the principal mechanism for coordinating, harmonising and leveraging partners' strengths to achieve greater RMNH outputs. The CLU not only played the facilitator role, but also provided leadership in many instances. On a regular basis, program reviews, annual planning and others learning processes have been implemented jointly under the leadership of the CLU. According to all key informants and supporting documents (annual reports, mid-term review report), the CLU has done a good job in enabling implementation throughout the five years of the program. However, the mid-term internal partnership review pointed out transactional costs such as time- and labour-intensive processes to harmonise across different systems, and staff had mixed views on the degree of technical harmonisation across the partnership.<sup>4</sup>

CLU is the representative of PSL in the health development arena, speaking for the program in national workshops, technical meetings, and policy discussions.

Impact: Over five years of implementation, PSL interventions have shown several impacts in its target areas. The impact of PSL's interventions can be evaluated through the difference-in-difference (DID) analysis of the results from baseline and endline surveys for the key indicators and the qualitative data collected in the evaluation field research. Improvement in the quality of

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<sup>3</sup> PSL Mid-Term Internal Partnership Review, CLU, January 2017

<sup>4</sup> PSL Mid-Term Internal Partnership Review, CLU, January 2017

health services and progress of health outcomes have resulted from PSL's support to the health facilities (equipment, capacity building of service providers through trainings and coaching) and interventions in the community (BCC activities, community engagement). PSL interventions also have had positive impacts on the RMNH behaviour of the beneficiaries in the target areas.

The information collected from the evaluation field research (FGDs and interviews in the community and health facilities) indicate that the knowledge about health services availability, safe delivery and family planning (FP) has greatly improved among WRA and GFW. HC midwives reported that their technical skills (for safe delivery, FP, health counselling) and communication skills have improved after receiving the Attitudes training for health service providers, MCAT meetings and on-site coaching supported by PSL. Improved infrastructure and equipment in health facilities are positive factors for quality of services and attractive factors for the beneficiaries. Village health support group (VHSG) and local authorities have contributed to better community awareness about RMNH issues. PSL's supports to traditional birth attendant (TBA)-Midwife Alliance and to the community referral mechanisms (non-emergency) have resulted in a big reduction in home delivery with the TBAs. However, there was less impact on the community emergency referral system, reduction of financial barriers, and social inclusion of people with disabilities. PSL was able to advocate and integrate inputs into new policy documents and technical guidelines such as the Guidelines for the Establishment of Enterprise Infirmaries, FTIRM 2016-2020, national strategy for reproductive and sexual health in Cambodia (2017-2020), and MCATs National Protocol, among others. During the program implementation, the partnership had to face some unexpected external factors, for instance Save the Children complied to Protecting Life in Global Health Assistance (PLGHA) and suspended its interventions related to comprehensive abortion care (CAC). Meanwhile PSL took mitigation actions such as transferring the CLU regional Midwife Coordinator to another partner.

Sustainability: To promote sustainability, PSL has aligned with the national and local systems, collaborated with PHD/OD, provincial authorities, commune council, village authorities and VHSG, garment factory management, and provided trainings through NMCHC using MoH curricula and protocols. Stakeholders in the provinces and garment factories said that they are committed to carry on key interventions such as MCAT meetings, on-site coaching, *Chat!* but there is uncertainty about access to national budget and commune investment plans (CIP) to support RMNH despite the advocacy efforts of PSL. There are still some gaps such as the weak implementation of CAC at the HC level, the relatively low quality of postnatal care (PNC) and access to health service for people in very remote villages.

The key informants of the evaluation's field research said that progress made with PSL's support will remain after the program will end, such as improved health facility infrastructure and materials/equipment for delivery, newborn resuscitation, and abortion care; improved skills of

midwives, changed staff attitude, training documents and clinical guidelines. During its exit phase, PSL has focused efforts in advocating PHD and OD to allocate budget in their annual operational plan (AOP) to maintain key supportive activities to the HC like coaching and MCAT meetings. The PSL coaching approach is being aligned with the new MoH's National Quality Enhancement Monitoring (NQEM) system to improve quality of health services at health facilities. This will lead to the sustainability when the program phase-out. For the community engagement, advocacy has been made with Commune Council (CC) to use their social funds to support VHSG meetings with HC and to support transports cost for the poor in complement to the Health Equity Fund (HEF). All the CC interviewed during the final evaluation's field research say that they used a limited amount of their social funds to support transports cost for some poor families who are not registered in HEF. In some garment factories, focal points who have received training from PSL to facilitate *Chat! Contraception*, say that they are willing to continue *Chat!* by themselves if they have support from their management. In the community, VHSG say that they are motivated to continue awareness raising in the village meetings or with pregnant women individually. The learning documents (learning Updates, evaluation reports, policy briefs) produced by PSL are important elements to sustain the program benefits and leave a legacy for the MoH and RMNH development community.

Equity: In the past five years, equity has improved in the four NE provinces supported by PSL. There is a good progress in access of vulnerable groups (women from ethnic minorities, women from poor households, women with disability, female adolescents, GFW) to RMNH services.

The endline surveys showed improvements in the utilisation of most key RMNH services by all vulnerable groups: delivery in a health facility, use of a modern contraceptive method, antenatal care, and postnatal care. On the other hand the percentage of poor WRA using modern contraceptive significantly decreased, the percentage of disabled WRAs, modern FP users using long acting or permanent methods significantly decreased, and the percentage of minority WRAs receiving PNC1 significantly decreased.

The percentage of WRA from ethnic communities who gave birth in a health facility with a skilled birth attendant increased from 37.4% at baseline to 63.3% at endline. The positive trend is also observed for the groups of adolescents women (from 51.2% at baseline to 66.7% at endline), poor women (from 42.2% at baseline to 58.0% at endline), and women with disability (from 56.6% at baseline to 70.0% at endline), although the difference-in-difference (DID) estimated effect is statistically insignificant for poor WRA and WRA with disability and thus may not be attributable to the PSL project.

An increase in women accessing at least 2 ANC visits (ANC2) can also be observed among adolescents from 68.3% at baseline to 90.5% at endline (although not statistically significant due to small sample size), among poor women from 57.8% at baseline to 79.0% at endline, among

women with disability from 71.1% at baseline to 88.0% at endline, and among WRA from ethnic minorities from 57.8% at baseline to 87.3% at endline. The progress in ANC2 among poor women is faster than in the comparison provinces. The ANC4 value has almost doubled among WRA from ethnic minorities, from 30.6% at baseline to 59.5% at endline.

The percentage of ethnic minorities WRA in the NE provinces currently using a modern contraceptive method has remained stagnant with 33.6% at baseline and 35.1% at endline, as well as for the percentage of female adolescents with 8.1% at baseline and 9.7% at endline and the percentage of women from poor households with 25.9% at baseline and 24.1% at endline. However, the percentage of women with disability increased from 27.4% at baseline reaching 34.9% at endline.

PNC2 has increased among ethnic minorities WRA from 4.6% at midline to 30.4% at endline, among women from poor households from 5.3% at midline to 38.3% at endline, among female adolescents from 6.3% at midline to 33.3% at endline, and among women with disability from 7.3% at midline to 32.0% at endline.

The percentage of GFW who gave birth in a health facility with a skilled birth attendant increased from 79.3% at baseline to 99.1% at endline. There is a significant increase in the use of modern contraceptive methods, from 10.6% at baseline to 25.2% at endline, however there was no significant change in the use of LAPM methods. ANC4 has increased from 64.1% to 98.1%.

At the HC, indigenous women face less discrimination because health staff adopted a better attitude after receiving the Attitudes training. The language barriers have also decreased due to radio spot in different indigenous languages. The target beneficiaries were involved in the program implementation, progress assessment and service provider's accountability mechanism. PSL has introduced activities that promoted gender equity and male engagement such as VHSG support, LDG, men's club, *Chat!*, male engagement sessions in the factories. PSL collaborated with Disable People Organisations (DPO) for inclusion of persons with disability, and created innovative BCC approaches adapted to the specific needs of ethnic minority groups and GFW.

PSL provided the Attitudes training for health care providers which includes a one day module on disability. Most persons with disability who were interviewed by PSL in Stung Treng and Ratanak Kiri, mentioned having access to medical services free of charge and did not report negative attitudes or discrimination from HC staff.

## Conclusions

PSL's program design is relevant to addressing the six components of the FTIRM (2011-2015) and the FTIRM (2016-2020). Its theory of change is clear, logical and translated into a collaborative

and holistic approach to supporting the RMNH services, complemented with community based interventions.

PSL has been an efficient and effective program to improve the quality and utilization of RMNH services with its partnership and holistic approach, through achieving key outcomes in the NE provinces and in the target garment factories. Nevertheless there was limited progress in the equity of access for the poor and people with disability, in the use of modern contraceptives and LAPM, in the utilization of public facilities for safe abortion, has been limited, in part due to the challenging social context and external constraints.

PSL has had several innovative trainings (Attitudes training, training modules for MCATs), community-based activities (LDG, VHSG BCC package), and garment factories interventions (*Chat!*, Health Facility Referral Directory of RMNH service providers) that can be considered as emerging best practices. The trainings significantly improved the capacity and attitude of service providers. The BCC activities have significantly changed the health care seeking behaviour of the target beneficiaries after 5 years of program intervention.

A longer timeframe of PSL implementation would have been beneficial to allow the key interventions to achieve stronger progress and reinforce the changes induced in the attitude and practices of the RMNH service providers and the beneficiaries.

## Summary of Recommendations

### Areas of improvement in the context of future programming:

1. Encourage women to get at least 4 ANC visits, especially in Stung Treng where the endline survey has shown a negative trend.
2. Improve community awareness that CAC is legal and available in public health facility.
3. Promote PNC during antenatal care visits and community health education sessions.
4. Focus on remote villages: ensure visits of outreach team, HEF and commune social fund support to poor families for transport costs, encourage collaboration from TBA to refer pregnant women, set up village emergency referral system
5. Develop a specific approach for RMNH education of adolescent women in the community, following *Chat!* model with contents adapted to the social context of adolescents in the community of the NE provinces.
6. Increase men's participation in RMNH awareness activity by scheduling village men's club in the evening and conducting RMNH counselling for newly married couples.
7. In the final survey, nearly three-quarters of GFW reported using Facebook. In the future, BCC strategies should include more social media approach.
8. More work should be done with local DPOs to identify and support women with disability to access RMNH services.

9. Give more attention to promoting exclusive breastfeeding up to six months and later.
10. Continue delivering regular training and coaching to midwives in CAC & LAPM.
11. Advocate for consistent and adequate supply for long-term contraceptive commodities in health facilities.
12. Integrate CAC, IUD and Implant technical support into NQEM for the future update on the clinical vignette.
13. Ensure planning for future re-training of staff for new commodities is incorporated.
14. Increase supportive measures from health facility management, particularly concerning complications arising from safe abortion cases.
15. Consider restructuring financial incentives for CAC providers.
16. Support garment factory infirmaries to provide quality services to GFW: referral and short term contraception.

Main successes that should be sustained or promoted for replication:

1. Encourage continuation of existing self-running local initiatives such as community-based distributors (CBD) of oral contraceptives, and Village Savings and Loans Association (VSLA).
2. Provide spare IEC materials for VHSG to the health centres (if stock remaining), to replace the VHSG's old IEC set in the future when needed.
3. Advocate other NGOs in the NE provinces to include PSL radio spots/LDG in their community meetings.
4. Advocate that MCAT and coaching are included and budgeted in the PHD and OD's AOP 2019, as well as the VHSG meeting in the CIP 2019.
5. Final package of Learning should balance targeting national level and sub-national level.
6. PSL should issue a Learning Update on final review of program achievements (with translation in Khmer for easy access by sub-national counterparts).
7. Make presentation on PSL's achievements in four NE provinces at the MoH TWG Health.
8. Organize a half day presentation on achievements of Garment Factory Component to MoH, MoLVT, Brands and Garment Manufacturer Association of Cambodia (GMAC).
9. Hand over TRG facilitation to RMNH development partners (GIZ volunteering).
10. For future replication, make available on Internet all PSL publications, annual plans, annual reports, studies, evaluations and surveys.
11. In a future program, a newsletter in Khmer should be produced and used as a media to keep health staff at PHD, OD, and HC levels informed about the progress of program implementation.





## **1. Introduction**

Partnering to Save Lives (PSL) is a partnership program between the Cambodian Ministry of Health (MoH) and three non-governmental organisations (NGOs): CARE, Marie Stopes International Cambodia (Marie Stopes), Save the Children, funded by the Australian Department of Foreign Affairs and Trade (DFAT). The ultimate goal of PSL is to save the lives of women and newborns by contributing to the national efforts in improving quality, access and utilization of Reproductive, Maternal and Newborn Health (RMNH) services.

PSL was designed as a five-year program. It started in August 2013 and will end in July 2018. The program received 14 million Australian Dollars (AUD) in funding for the first three years and an additional 5.75 million AUD for two more years after DFAT completed an external mid-term review which recommended continuing funding PSL due to its effectiveness.

In order to measure the achievements of the five year program, three rounds of surveys were implemented, at the beginning, at the mid-term and at the end of the program. The baseline survey was done in the first year of program implementation to get pre-intervention reference data against outcomes indicators, the midline survey in the third year to assess the progress of outcome indicators and the endline survey in the fifth year to measure the program's achievements at the end of its implementation. Moreover, DFAT conducted an external program midterm review at the beginning of the third year to assess the program's progress and to inform the decision on the continuation of the program. During the implementation of PSL, several studies, reviews, and evaluations were done to inform about the progress and for learning/advocacy purpose such as program annual reviews, partnership internal review, research on financial barriers to accessing RMNH, evaluation of Behaviour Change Communication (BCC) activities, snapshot surveys on community referral systems.

As PSL's end date is approaching, the partnership commissioned this independent final evaluation to measure how successful the program has been in reaching its objectives, as well as to assess the results of the program based on six evaluation criteria (relevance, effectiveness, efficiency, sustainability, impact and equity).

## **2. Background**

### **2.1. Reproductive, Maternal and Newborn Health Context**

The health situation of the Cambodia's population has significantly improved over the past 20 years. The joint efforts of the Royal Government of Cambodia (RGC), health development partners and NGOs to improve the access and service quality of public health facilities, complemented by the positive effects of the economic growth and improvement of infrastructure in the rural areas, have led to a better utilisation of essential health services. The

Cambodia Demographic and Health Surveys (CDHS) in 2010 showed that the country made remarkable progress towards achieving most of its health-related Millennium Development Goals (MDGs) for 2015, especially regarding the infant mortality and under-five mortality. Comparison between results of CDHS 2000 and CDHS 2010 indicated a drop in infant mortality rate from 58 to 45 deaths per 1000 live births (MDG target is 50), under-five mortality rate from 124 to 54 deaths per 1000 live births (MDG 4 target is 65) and maternal mortality ratio from 437 to 206 (MDG 5 target is 250). Meanwhile the newborn mortality rate has reduced in a lesser degree from 37 to 27 deaths per 1000 live births (MDG target is 22).

In 2009 the MoH and development partners have developed the Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality (FTIRM 2010-2015) as a means of accelerating reductions in maternal and newborn mortality through seven components: Emergency obstetric and newborn care (EmONC), Skilled birth attendance, Family planning (FP), Safe abortion (SA), Behaviour change communication (BCC), Removing financial barriers to access health services, and Maternal death surveillance and response.

The results of the CDHS 2014 showed a further decrease in infant mortality rate as compared to 2010 (from 45 to 28 deaths per 1000 live births), under-five mortality rate (from 54 to 35 deaths per 1000 live births), maternal mortality ratio (from 206 to 170 deaths per 100,000 live births), and neonatal mortality rate (from 27 to 18 deaths per 1000 live births)<sup>5</sup>. These results, as well as those relating to attending at least one ante-natal care (ANC) visit, delivery with a skilled birth attendant (SBA) and delivery at a health facility, have exceeded Cambodia's MDG targets for 2015. However the use of modern contraceptive methods has made limited progress from 35% in 2010 to 39% in 2014 (the most commonly used modern methods are the daily pill and injectable, 18% and 9% respectively).

Nevertheless, significant challenges remain as the CDHS 2014 results also showed high disparities in RMNH indicators between urban and rural populations, with remote areas (including the four north-eastern (NE) provinces: Ratanak Kiri, Mondul Kiri, Kratie, Stung Treng) and vulnerable groups (poor, ethnic minorities) lagging behind the national averages. For instance, only between 35.2% and 48.4% of all women across the four provinces were receiving four ANC visits, compared with the national average of 75.6%. Similarly, only about half of all women across the four provinces were delivering in a health facility, compared to the national average of 83.2%. Teenage pregnancy was a growing concern in the NE provinces with 33.8% of women aged 15-19 in Mondul Kiri/Ratanak Kiri, 25.1% in Stung Treng and 19.5% in Kratie as compared to the national average of 12%<sup>6</sup>.

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<sup>5</sup> National Institute of Statistics, Directorate General for Health, and ICF Macro, 2015: CDHS 2014

<sup>6</sup> National Institute of Statistics, Directorate General for Health, and ICF Macro, 2015: CDHS 2014

Building on the success of FTIRM 2010-2015, the FTIRM was revised to extend from 2016 to 2020. It aims to address the remaining gaps in providing quality RMNH services. The priorities include increasing the quality and the coverage of family planning, emergency obstetric and newborn care, safe abortion, and improving individual, family and community care practices. It also addresses the emerging issue of teenage pregnancy, prioritise newborn care and continues to promote greater community engagement to increase demand and improve the sustainability, quality and reach of health services<sup>7</sup>. The 2020 goal is to reduce maternal mortality to 140 maternal deaths per 100,000 live births and to reduce neonatal mortality to 14 neonatal deaths per 1000 live birth.

Approximately 700,000 people are working in the garment factories, mainly young women who have migrated from rural areas. They are isolated from their family and live in precarious situation and difficult environment (shared rooms in unhygienic compounds, minimum spending on foods for savings)<sup>8</sup>. They are vulnerable with regard to sexual and reproductive health (SRH) (burden on pregnant workers) and sexual violence (nearly one out of three women experienced sexual harassment in their workplaces, 16.5% of women experienced sexual harassment outside the factory)<sup>9</sup>.

Abortion is still a taboo in Cambodia traditional society. A number of maternal deaths are linked to complications of abortion done in the unregulated and uncontrolled private sector. Abortion has become legal since 1997 but many people still don't know about it. In the recent years, MoH has initiated efforts to promote safe abortion in public health facilities via the implementation of comprehensive abortion care (CAC) program.

## **2.2. Australian Government Support to the FTIRM and PSL**

Australia has been a long-standing major development partner in Cambodia and is the country's third largest bilateral donor. Under DFAT's Aid Investment Plan 2015-18 for Cambodia, investments in health focused on strengthening health financing systems to improve efficiency and quality of care and addressing the ongoing challenge of poor RMNH indicators for vulnerable women, including those working in the garment factories or living in remote communities. Two cross-cutting issues are also high priorities for DFAT: gender equality and disability social inclusion.<sup>10</sup>

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<sup>7</sup> Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality 2016-2020, MOH

<sup>8</sup> Action-oriented research on gender equality and the working and living conditions of garment factory workers in Cambodia. ILO, 2012

<sup>9</sup> "I know I cannot quit." The Prevalence and Productivity Cost of Sexual Harassment to the Cambodian Garment Industry, CARE, 2017

<sup>10</sup> DFAT's Aid Investment Plan Cambodia 2015-2018

Consequently, Australia's investment focused on supporting the Cambodian Government's RMNH priorities, which are articulated in the FTIRM. For this purpose, the PSL program was conceived and designed in line with the expected results of Australia's Comprehensive Aid Policy Framework 2012-2016. It also contributes to several of the 10 strategic-level targets in the Performance Framework approach outlined by DFAT in June 2014. PSL was designed as a five-year program, but with committed funds only for the first three years (AUD-14 million) and a nominal allocation for the additional two years (AUD 5.75 million). DFAT conducted an external mid-term review of PSL in November 2015, and consequently agreed to continue funding PSL for the additional two years at the aforementioned funding level.

Also under the support of DFAT, the Health Equity and Quality Improvement Project (H-EQIP), a five-year program focusing on improving access of Cambodia's poor to quality health services, started in July 2016 as a continuation of the second Health Sector Support Program (HSSP2). Health sector financing mechanisms under this project offer opportunities for PSL to promote greater sustainability of key interventions after its termination.

### **3. Overview of PSL Program**

The overall goal of PSL is to save the lives of women and neonates in Cambodia through improved quality, access and utilisation of RMNH services through a partnership approach.

The PSL program contributes specifically to the achievement of health outcomes described in the FTIRM, by improving quality, access and utilisation of RMNH services in its target areas. PSL supports all seven components of the current FTIRM 2016-2020: emergency obstetric and newborn care, skilled birth attendance, newborn care, family planning, safe abortion, behaviour change communication, and removing financial barriers. PSL focuses on vulnerable groups (women from ethnic minorities, poor women, women living with disability, garment factory workers (GFW)).

The PSL theory of change is articulated as follows: "If a partnership of NGOs, MoH and donors coordinate resources to strengthen the health system, while simultaneously supporting communities and local authorities to promote, facilitate and engage in improved health behaviours, a significant contribution to saving the lives of women and neonates in Cambodia will be made"<sup>11</sup>.

PSL includes 3 components: (1) Improving Health Services Delivery; (2) Community Strengthening and Engagement; (3) Translating Learning and Knowledge into Policy

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<sup>11</sup> Partnering to Save Lives: Australia-Cambodia RMNH Program, Program Design Document (PDD)

At the conclusion of its five years period, PSL aims to achieve six primary outcomes and seven intermediate outcomes.

Table 1. Summary of Programme Components and Outcomes

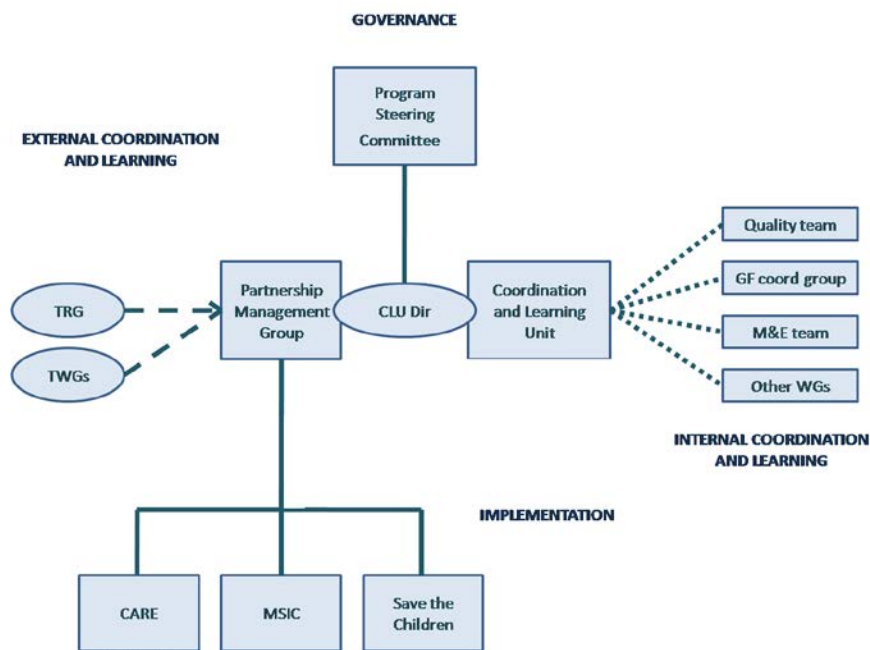
<b>Program Components</b>	<b>End of Program Primary Outcomes</b>	<b>Intermediate Outcomes</b>
<i>Improving Health Service Delivery:</i> The delivery of health services in target areas is strengthened and there is improved capacity to provide equitable and quality RMNH services	1. Improved quality RMNH services for target populations 2. Greater equity of access to appropriate RMNH services for target populations	1. Health facilities have improved capacity and resources to deliver on FTIRMN outcomes 2. Client-centred, equitable RMNH services are improved at health facilities 3. Referral system is improved for targeted populations
<i>Community Strengthening and Engagement:</i> Populations in target areas have strengthened capacity to actively engage with and use health care services	3. More responsive RMNH services meet the needs of target populations 4. Improved RMNH behaviours amongst target populations	4. Increased participation of communities and their representatives with services providers 5. Financial mechanisms enable access to RMNH services 6. RMNH BCC strategy developed and implemented 7. Increased community demand for RMNH services
<i>Knowledge Into Policy:</i> Innovation, evidence-based learning and delivery models inform policy and practices for sustained improvement in RMNH outcomes	5. Evidence-based innovation and learning that contributes to improved policy and practices 6. A partnership model that demonstrates impact and value for money to achieve RMNH outcomes	8. Program learning agenda developed and implemented

Practically, PSL operates in three distinct areas: (1) CARE and Save the Children implement a holistic approach to RMNH initiatives, including improving health service delivery in target health centres (HC) and strengthening community engagement in the underserved NE provinces (CARE in Mondul Kiri and Ratanak Kiri, Save the Children in Kratie and Stung Treng) targeting women of reproductive age (15-49 years old) and newborn babies up to 28 days; (2) Marie Stopes is responsible for support to long term and permanent family planning methods in 23 provinces (included the four NE provinces) and training on CAC in 13 provinces across the country (included the four NE provinces); (3) CARE and Marie Stopes work to improve access to RMNH information and services for vulnerable young women working in 25 garment factories in Phnom Penh and Kandal employing 38,440 workers (31,889 women). At the field level, each NGO operated independently with their own team but shared some joint initiatives and common processes such

as Annual Operational Plan (AOP), annual review, monitoring and evaluation, training curriculum and materials, Information Education and Communication (IEC) materials. During the first two/three years, each of the NGOs had at least one staff member stationed in the Kratie office to enable regional coordination.

The partnership model requires an elaborate coordination mechanism, essentially supported by a Coordination and Learning Unit (CLU). At the strategic governance level, PSL is overseen by a Partnership Steering Committee (PSC) chaired by the director of National Maternal and Child Health Centre (NMCHC), representative of DFAT and the country directors of the three NGO partners. The CLU acts as the secretariat of the PSC. At the management level, PSL activities are guided by a Partnership Management Group (PMG) chaired by the CLU Director and includes one or two representatives from each of the three NGO partners. The CLU is also responsible for facilitating planning, harmonisation and coordination of activities, monitoring and evaluation, synthesising and sharing learning. The CLU director represents PSL in external technical working groups and health partners meetings.

Figure 1: PSL’s Management and Governance Structure



Abbreviations: TRG (technical reference group), TWG (technical working group), CLU (coordination & learning unit)

The CLU is staffed by a director, a national M&E coordinator and an administrative officer based in Phnom Penh at one of the NGO partners in rotation. During the first three years of PSL, there was a regional office for CLU in Kratie with a regional manager, a midwife coordinator (still in

place until the end of the program), and VSO clinical quality advisor (has been in post for one year).

Each of the three NGO partners brings to the partnership their specific expertise and experiences in the Cambodian health sector:

- CARE has over 40 years of experience in Cambodia implementing sexual, reproductive and maternal health programs which combined support to service delivery at the health facilities and promoting health care demand and utilisation in the communities, especially by the most vulnerable groups and ethnic minority populations in Mondul Kiri, Ratanak Kiri and Koh Kong. CARE supports trainings to build clinical capacity of health staff as well as to improve their attitudes. At the village level, community volunteers provide health awareness and mobilise demand for appropriate health services. CARE also works with the garment factories to improve the sexual and reproductive health of their workers.
- Marie Stopes has been providing high quality and affordable family planning and sexual and reproductive health services to under-served populations since 1998 in Cambodia via its network of clinical centres and mobile outreach program. Additionally, Marie Stopes provides trainings to the health staff in the HCs and referral hospitals, as well as technical support, clinical quality assurance (QA), advocacy in the private sector and for government at both national and provincial levels.
- Save the Children International in Cambodia has over 20 years of experience in Cambodia focusing on equitable provision of RMNH services to women and newborns, and working with the provincial health department (PHD) and operational districts (OD) in Siem Reap, Battambang, Pursat, Stung Treng and Kratie provinces to improve the quality of RMNH service delivery at the facility level. Save the Children works with local authorities and Village Health Support Groups (VHSGs) to promote health awareness/ positive behaviour change and support health service access, especially by marginalised and vulnerable populations.

In year three of program implementation, DFAT conducted an external mid-term review which found that the program made good progress against its objectives and made recommendations, which have largely been followed by the NGO partners. Following the recommendations, more efforts have been made to unify programmatic processes and harmonize interventions, to share skills and resources. Plan to phase out were developed since year four to increase the chance to sustain activities. PSL has also dropped out some community-based interventions such as Village Savings and Loans Associations (VSLA), vouchers and others elements of reducing financial barriers to RMNH services based on the recommendations.



During the five years of program implementation, PSL has provided holistic support to the NE provinces through CARE in Mondul Kiri and Ratanak Kiri and Save the Children in Kratie and Stung Treng. The interventions in those provinces are broadly similar although there are sometimes small differences in the approach to field implementation due to the specific style and expertise of the two NGOs. The population size of the four NE provinces is 693,724 with an expected number of pregnant women of 20,811 (HIS 2013). PSL worked in all six ODs of these provinces and targeted health facilities which need the most assistance in coordination with the PHDs and ODs. The key support to improving the quality of RMNH services in the target HCs was identified through facility and capacity needs assessments completed by each NGO at the start of the project with their respective PHD and OD counterparts. The following is a summary of actions: facilities refurbishment, waiting house, waste management installation, materials and equipment for delivery and newborn resuscitation, capacity building (in service training/placement in referral hospital, on-site coaching, Midwifery Coordination Alliance Team Meeting (MCAT), Attitudes Training for Health Service Providers, meetings of VHSG and Health Centre Management Committee (HCMC).

At the community level, PSL collaborated with the VHSG, village authorities, traditional birth attendants (TBA) to do RMNH awareness raising, behaviour change promotion and monitoring the accountability of public health service providers. PSL supported BCC activities targeting women of reproductive age (WRA), female adolescents and men. Beneficiaries are Khmer and ethnic minorities (including Phnong, Tompoun, Kreung and Jaray). Those interventions consisted of village health promotion events, live radio broadcasts in the form of acted dramas and call in shows with RMNH counsellors, short public service announcements, phone short message service (SMS), voice messaging with RMNH messages, listening and dialogue group (LDG), pregnancy club and men club with local facilitator to listen and discuss the pre-recorded audio programs, with radio spots/audio material in ethnic minority languages in Mondul Kiri and Ratanak Kiri. The local facilitators are most often the VHSG. They are equipped with flip charts and cards, audio materials and community games, for participatory and interactive communication on birth spacing, antenatal care and healthy pregnancy, safe delivery, postpartum care, newborn care, and safe abortion. PSL also supported provision of short term family planning through community-based distributors (CBD).

The second area of PSL's interventions is the Marie Stopes' support to long term family planning (LTFP), access to permanent contraception methods and CAC through trainings for health service providers on LAPM in 23 provinces and on CAC in 13 provinces, with the follow-up QA of those two interventions in the health facilities. The trainings were provided in collaboration with the NMCHC. The trainings included 'training of trainer' for national CAC and LTFP trainers, training for service providers from the provinces in CAC, intrauterine device (IUD) and implant. After the capacity building of service providers, PSL teams conducted follow-up activities to ensure the

quality of services provision with QA visits, training to PHD/OD to conduct CAC and LTFP QA themselves in the context of transition of CAC/LTFP QA to MoH/PHD/OD. In addition, MCAT meetings dedicated to CAC and its complications were organised.

In the third area of PSL program, CARE and Marie Stopes cooperated with 25 garment factories to improve female workers' access to SRH services, their awareness, practices and self-confidence in care seeking and decision making about SRH choices. They implement BCC innovative interventions such as "*Chat!*" and the Health Facility Referral Directory of RMNH service providers, as well as strengthen the capacity of the factory's infirmary to provide advice and refer to external health providers. PSL has contributed to the development of the Guidelines for the Establishment of Enterprise Infirmaries by the Ministry of Labour and Vocational Training (MoLVT).

Progress towards the primary outcomes is verified using PSL's monitoring, evaluation, reporting and improvement (MERI) framework, which covers all indicators and their definitions, target areas and planned annual targets. It is updated annually. For the baseline, midline and endline surveys, there were for each round two separate field data collection: one targeting WRA in eight provinces (four NE provinces and four comparison provinces in the west of the country); and the other one targeting GFW in Phnom Penh and Kandal.

Learning and advocacy is an important component of PSL, under the responsibility of CLU. The key features are: Learning agenda; conducting Annual review and joint planning; Publication of learning updates; development of an Advocacy action plan with four advocacy priority areas (financial barriers, Guidelines for garment factory infirmary, coaching and sustaining PSL interventions). PSL has contributed to the development of strategy documents, policy papers and technical guidelines such as revised FTIRM 2016-2020, Guidelines for the Establishment of Enterprise Infirmaries, MCATs National Protocol, and Practical Coaching Guide.

## **4. The Final evaluation**

As the program ending date is approaching, the PSL partnership contracted an external Final Evaluation to assess how successful the program has been in reaching its objectives, as well as to inform the results of the program based on six evaluation criteria (relevance, effectiveness, efficiency, sustainability, impact and equity).

### **4.1.Objectives**

1. Assess the program's progress against its goal and outcomes across the five years of implementation, including cross cutting elements.

2. Assess the relevance, effectiveness, efficiency, impact and sustainability of the program.
3. Make recommendations regarding main successes and areas of improvement that partners could consider for further replication or in the context of future programs.

## 4.2. Methodology

To meet the above evaluation objectives, the final evaluation reviewed the 16 research questions stipulated in the Terms of Reference (TOR), guided by the six evaluation criteria. The three program components are covered: 1) *Improving Health Service Delivery*; 2) *Community Strengthening and Engagement*; and, 3) *Translating learning and Knowledge into Policy*, to verify the achievement of six primary outcomes, across all three program implementation areas: (1) The holistic support to RMNH services and demand in the four NE provinces; (2) Support to BCC in garment factories; and (3) support to LAPM in 23 provinces and CAC in 13 provinces. The evaluation has integrated cross cutting elements such as gender equity, disability inclusion, ethnic minorities/indigenous people, child protection/child safeguarding<sup>12</sup>, fraud prevention and environment.

Table 2: Summary of the evaluation conceptual framework

Research Questions	Type of data	Sources of Data	Collection Methods
<b>Relevance</b>			
1. To what extent have the project interventions contributed to the MoH strategic priorities for RMNH and to DFAT / High Commission's strategic directions in Cambodia?	Number and % of RMNH strategic priorities addressed by PSL	Program documents, FTIRM, DFAT Aid Investment Plan Cambodia 2015-2018	Literature Review. Interviews key informants
2. Has the program addressed the aspirations, needs and challenges of healthcare providers and local communities and involved them in relevant stages of the project?	Qualitative information collected from key informants	Health staff, PHD, local authorities, PSL staff at central and provincial levels. AOPs	Interviews of key informants. FGD. Review Activities reports
3. To what extent has the PSL integrated broader gender concerns and child safeguarding issues into the design and implementation of its interventions?	Qualitative information collected from key informants	Program design document, AOPs, key informants	Documents review, Semi-structured interviews
<b>Effectiveness</b>			
4. To what extent has PSL achieved its outcomes, as set out in the program design and measured through the monitoring, evaluation, reporting and improvement framework, and based on level of effort in terms of investments with HC and communities? What changes can be observed in PSL target areas in the last 5 years?	Outcomes Indicators reach their targets. Qualitative information collected from key informants	MERI, baseline & endline Surveys	Project visits Interviews with key informants at project level

<sup>12</sup> Note: "DFAT's Child protection policy outlines requirements for child safeguarding rather than child protection programming".

5. Specific to component one, to what extent has PSL observed particular changes in relation to health providers' attitude (this includes attitude towards vulnerable groups as well as provision of sensitive services such as comprehensive abortion care (CAC) and other services where weaknesses were observed during midline)? Overall, how effective has the PSL coaching and quality improvement approach been in building technical skills and confidence of health providers (e.g. are health providers more confident and skilled to provide services, including CAC?)	Nb health staff trained in CAC Nb health staff trained on Attitude Training etc. Qualitative information collected from key informants	Key informants: CMA, midwives in provinces, PHD director, CAC trainers, LTFP trainers	Health providers Interviews, FGDs, Annual reports, MERI
6. Component two focused on community involvement. How effective has PSL's Behaviour Change Communication (BCC) approach been in creating demand for RMNH services? Has women's self-efficacy improved, as well as male engagement in RMNH? Have PSL supported community based referral mechanisms (e.g. clubs, LDGs, Traditional Birth Attendant (TBA)- midwife alliances, Village Health Support Groups (VHSG), Community Based Distributors (CBDs), referral directory) been effective in increasing access to RMNH services in public facilities, especially for vulnerable groups?	Intermediate Outcomes & outputs Indicators reach their targets. Qualitative information collected from key informants	Key informants: PHD mother and child health (MCH), midwives in provinces, local authorities, direct beneficiaries, provincial NGOs	Interviews and FGDs , Annual reports, MERI
7. With regards to component three, to what extent has PSL complemented Royal Government of Cambodia (RGC) efforts to implement its FTIRM as well as to influence new strategies and policies in the field of RMNH? Has PSL learning been effectively documented and shared in order to influence policies and strategies?	Qualitative information collected from key informants	Key informant at central level: MoH, development partners	Interviews, report from CLU
<b>Efficiency</b>			
8. Have the program's operations been efficient, including comparative value for money and outcomes of interventions in the remote north-eastern provinces, garment factories, and reproductive health focus provinces?	Total Budget spending figures and outputs results	Financial reports	Documents review, cost analysis
9. Have the three NGOs worked in a coordinated way leveraging organizational strengths, complementing each other, and sharing information, resources, and decision-making (i.e. have used a partnership approach)? Has PSL's Coordination and Learning Unit (CLU) been effective and brought added value in facilitating this unique partnership?	Qualitative information collected from key informants	Key informant at central level: NMCHC, Steering Committee, CLU, PSL staff, documents	Interviews key informants
<b>Impact</b>			
10. What are the main contributions and impacts (positive/negative, expected/unexpected) perceived by the different actors and beneficiaries of the program?	Qualitative information collected from key informants	Key informants in provinces Beneficiaries Reports	Interviews, Focus Group Discussions. Review reports
11. What have been the most successful or unsuccessful interventions and why? Where any deemed as innovative? What lessons have we learnt from these? What potential multiplying effects could be observed? Are there external opportunities and challenges that have impacted positively or negatively on successes and limitations?	Outcome/output indicators. Qualitative information collected from key informants	Annual reports, Surveys, Key informants	Data collection & analysis, Interviews, Focus Group Discussions.
<b>Sustainability</b>			
12. Has the program aligned with RGC local and national systems and mechanisms to promote sustainability?	Qualitative information collected from documents and informants	MoH and RGC guidelines, NMCHC, key informants	Documents reviews, interviews
13. What are the main remaining gaps in provision of quality RMNH services and remaining barriers in access to RMNH services? How can PSL successes, learning and remaining gaps	Qualitative information collected from	MoH and RGC guidelines,	Documents reviews,

be used to shape future government and/or donor funded RMNH programs?	documents and informants	NMCHC, key informants	interviews key informants
<b>Equity</b>			
14. How effectively has the project reached the most vulnerable and marginalized women, men, girls, boys in targeted area?	Outcome/output indicators. Qualitative information collected from key informants	Annual reports, Surveys, Key informants	Data collection & analysis, Interviews, Focus Group Discussions.
15. How effectively and appropriately have those we seek to benefit been involved at design, implementation and M&E stages of the project?	Qualitative information collected from key informants	Local authorities, beneficiaries, health staff	Interviews, Focus group discussions
16. What have been the most successful/meaningful contributions to vulnerable groups including cross cutting elements, in particular gender equity and male engagement in RMNH, garment factory workers, disability inclusion, ethnic and indigenous minority reach and engagement, child protection and environment that could be brought to scale?	Qualitative information collected from key informants	Local authorities, beneficiaries, health staff, CMA, CDPO, factories	Interviews, Focus group discussions

The research methodology uses a mixed qualitative and quantitative approach. For the qualitative analysis, in addition to the desk review of documents, the evaluation team conducted a three weeks of field research consisting of interviews, focus group discussions (FGD) and observation of HCs to collect primary qualitative data. For the quantitative analysis, secondary quantitative data gathered from PSL surveys (baseline and endline) and available data from the routine MERI system were used to support and complement the findings of this evaluation. Two endline surveys were completed: One focused on RMNH Knowledge, Attitude and Practices among female GFW and one on Reproductive, Maternal and Neonatal Health in Eight Provinces (the four NE provinces and four comparison provinces).

Semi-structured interviews and FGDs were used to collect qualitative data and to better understand issues from the perspectives of the stakeholders on the ground, the experiences of the target populations with the RMNH services and community interventions provided with the support of PSL, the availability and gaps of health and social services, strengths, weaknesses, threats and identify opportunities for improving services. In the four target NE provinces, the researchers have done interviews with eleven mother and child health (MCH) managers at the PHDs and ODs, FGDs with beneficiaries (six FGDs with WRA/mothers, four FGDs with female adolescents, three FGDs with men), ten FGDs with community volunteers (VHSG, CBD), TBA and village chief, as well as observation visit to eight HCs. In two selected garment factories, interviews were completed with two human resource managers and two infirmary staff, and two FGDs with panels of female workers averaging seven participants per FGD. In two selected provinces (Pursat, Battambang) supported for LAPM/CAC, interviews were completed with four health managers at PHD, three service providers at the referral hospitals and four HC staff (see

the List of persons interviewed in Annex 2). In addition to written notes, all group discussions are tape-recorded for review.

The FGDs with beneficiaries (WRA/mothers, female adolescents, GFW, men) and community stakeholders (VHSG, TBA, village chiefs, commune council for women and children (CCWC)) informed on the relevance (interventions responding to their needs), effectiveness (use of services, satisfaction), and impact (change in knowledge, attitude and practice) of PSL interventions. The Semi-structured interviews of HCs' staff, PHD/OD managers informed on some aspects of the Program (capacity building, ownership, motivation, resources availability, sustainability). The direct observation of health facilities informed on the quality of services and PSL's inputs for improvement of services. At the central level, the interviews of government counterparts and health development partners enabled the researchers to collect their views and opinions about PSL relevance and performance.

The evaluation team prepared evaluation tools consisting of evaluation workplan/schedule, data analysis plan, questionnaires for FGDs in English and Khmer, HC observation check-list, questionnaires for key informants' interviews.

To ensure that the evaluation is conducted in an ethical manner, the rights, confidentiality and anonymity of the respondents were respected. Every time before starting FGD, the researcher made a self-introduction and explained the purpose of the discussion, the independence of the evaluation and the right of the participants to ask for clarification and to remain silent if they feel uncomfortable to answer a question. The participants signed an informed consent after being explained that their answers will remain confidential and anonymous.

The sites selection for the field research was done purposively to get a balanced view of the program. All the four NE provinces (Kratie, Stung Treng, Mondul Kiri, Ratanak Kiri) benefiting from PSL's holistic support were included in the field research. Two garment factories (different from the factories selected for the endline survey) in the surroundings of Phnom Penh were selected for their participation in the PSL's BCC and infirmery activities. Two provinces (Pursat and Battambang) are selected among 19 provinces supported for LAPM and safe abortion. In the provinces, the selection of HCs and villages was done by PSL local staff to identify those that would provide a mixed representation of well and not so well functioning HCs, and remote and less remote villages.

The final evaluation has some limitations. The qualitative data was collected in a relatively small number of HCs, villages and garment factories, and there is no comparison data with unsupported HCs, ODs and factories. There were also some constraints to the implementation of the field research. The FGDs did not include the people living with disabilities as planned, because it was difficult to identify them or to convince them to participate (only one home interview of a

WRA with disability was done). However, the evaluation team has conducted at the central level a group interview with representatives of disabled people organisations (DPOs) and partners working on disability issues. Due to the lack of information about full expenditures and outputs figures of key interventions over the five-year program implementation, the final evaluation was not able not assess the cost-effectiveness of PSL. Instead, the evaluation made a general assessment as to what extent the partnership nature of the PSL created savings and boosted the results of interventions.

### 4.3. Main steps of the evaluation

1. The evaluation process started with the literature review of relevant documentations to inform the field research workplan, the questionnaires for interviews and FGDs, and the report preparation. The main documents were the PSL project design document, AOPs and annual reports, Health Strategic Plan 2008-2015, FTIRM 2010-2015, FTIRM 2016-2020, DFAT Health for Development Strategy 2015-2020, DFAT's Aid Investment Plan Cambodia 2015–2018, CDHS 2014, surveys reports (baseline, midline, endline), PSL Midterm Review, Learning updates. The list of documents is in the Annex 1.
2. Discussions with PSL staff at all levels about strengths, challenges and gaps of PSL's existing strategies and activities and about possible strategic development for future programs.
3. Consultation with the donor DFAT, key government counterpart (MoH/NMCHC), development agencies (GIZ, WHO, UNFPA, UNICEF) and NGOs (URC, Population Council) involved with RMNH, on their perspectives about RMNH and as how PSL contribute to the broader support of RMNH in Cambodia. The list of persons interviewed is in the Annex 2.
4. The field research in the provinces included individual and small group interviews, FGDs with local stakeholders (beneficiaries, health care providers, community volunteers, and local authorities), direct observation of health facility and community-based BCC activities.
5. Presentation of preliminary findings to partners and PSL for comments.
6. Analysis of the data/information collected, findings, conclusions and formulation of recommendations.
7. Writing of the draft evaluation report and finalisation after receiving the comments.

### 4.4. Field Research Implementation

During the three weeks of field research, the evaluation team consisting of five researchers: two public health specialists, two gender specialists and one midwife, conducted interviews of key informants at the central level: DFAT, RMNH development partners (GIZ, UNFPA, WHO, URC, UNICEF, Population Council), NMCHC, Cambodian Disabled People's Organisation (CDPO), Handicap International, Light of the World, Cambodian Midwives Association. Two researchers

spent two days in each of the four NE provinces (Mondul Kiri, Ratanak Kiri, Kratie, and Stung Treng). They interviewed stakeholders (PHD, OD, commune councils (CC), local NGOs), conducted FGDs with beneficiaries (WRA/Mothers, female adolescents, men) and community actors (VHSG, village chiefs, TBA). In total there were 16 villages visited for six FGD with WRA/mothers, four FGD with female adolescents, three FGD with men, and ten FGD with village chiefs/VHSG/TBA. At the commune level, the researchers did six FGD with CC/HCMC and they did direct observation of eight HCs. In Mondul Kiri and Ratanak Kiri, one indigenous translator assisted the researcher during the FGDs with the beneficiaries in the villages.

In each of the two selected garment factories supported by PSL, the researchers interviewed one human resource manager and one infirmary staff. They conducted one FGD with seven female workers at one factory and one FGD with seven female workers at the other one. Nearby each of the two factories, one private clinic was interviewed about their provision of RMNH services to GFW.

In two provinces (Pursat, Battambang) supported by PSL for LTFP/CAC, the researchers interviewed PHD MCH managers, health service providers in four HCs and two referral hospitals.

Table 3: Summary of field research in the provinces

	Mondul Kiri	Kratie	Ratanak Kiri	Stung Treng	Pursat	Battambang
<b>FGD with WRA/mothers</b>	•Chong Phang village	•Danghit village	•Kob village	•Sre Beng village •Tbong Khla village •Kanchanh Til village		
<b>FGD with adolescents</b>	•Puchrey Chang village	•Ampork village	•Leu Khaun village	•Khi Svay village		
<b>FGD with men</b>	•Royorng village	•Sre Thnot village	•Samuth Krom village			
<b>FGD with Volunteers/village authorities/TBAs</b>	•Chong Phang village •Puchrey Chang village •Royorng village •Srey Phreas village	•Pralay Treak village	•Kob village •Leu Khaun village •Samuth Krom village •Thmey village	•Khi Svay village		
<b>Interview of CC/CCWC, HCMC</b>	•Puchrey •Keo Seima	•Rolous Meanchey	•Kechong •Lomphat	•Sre Sambo		
<b>Observation of BCC activity (LDG)</b>	•Srey Phreas village	•Pralay Treak village	•Thmey village	•Khi Svay village		
<b>Observation of Health Facility</b>	•HC Puchrey •HC Keo Seima	•HC Rolous •HC Damrey Phong	•HC Kechong •HC Lomphat •PH maternity	•HC Sre Sambo •HC Sre Krasaing	•HC Samrong •HC Boeung Kantout	•HC Svay Por •HC Prey Touch



					•PH Maternity	•RH Mong Russey maternity
<b>Interview of OD/PHD</b>	•PHD MCH •OD MCH	•PHD MCH •2 OD MCH (Kratie, Chlong)	•PHD MCH •OD MCH	•PHD MCH •OD MCH	•PHD MCH •PH Director •PH Maternity chief	•PHD MCH •OD MCH •RH Mong Russey Maternity chief
<b>Interview of NGO</b>	•CARE •CIAI	•Unicef •Save the Children	•CARE •Unicef	•YWAM •Save the Children		

### 4.5.Data Analysis

The information obtained from interviews, FGDs and direct observations were screened to collect qualitative data that were relevant, significant and meaningful to the research questions. Those qualitative data were analysed, interpreted and grouped in themes of interest and/or common patterns. The evaluator determined how these emergent themes and patterns helped to answer the research questions. Responses that deviated from the common patterns were noted. The evaluator compared similarities and differences among different groups of respondents and locations. The synthesis of findings was done for clear presentations and easy conclusions. Some quotes and stories were collected to support the findings. The triangulation of selected key secondary quantitative data from baseline and endline surveys are done with the qualitative data from focus group discussions and in depth interviews to confirm or discuss the findings of the evaluation field research.

### 5. Findings

The findings of the final evaluation are presented according to six evaluation criteria and the 16 research questions. Under each criterion, contents are related to the three components (Improving Health Service Delivery, Community Strengthening and Engagement, Translating Learning and Knowledge into Policy) and the six final outcomes of PSL program.

Drawing on the findings, an indicative rating is given for each evaluation criterion, providing a marker for assessing project's achievement. Performance is rated using a six-point scale. Higher ratings reflect both higher levels of achievement and stronger evidence:

- 6 Very good; satisfies criteria across all relevant research questions
- 5 Good; satisfies criteria across most relevant research questions
- 4 Adequate; in average satisfies criteria; does not fail in any major area
- 3 Less than adequate; does not satisfy criteria and/or fails in at least one research question

- 2 Poor; does not satisfy criteria in several research questions
- 1 Very poor; does not satisfy criteria in any research question

In general, there are consistencies in the responses from the FGDs across all groups (WRA/mothers, adolescent women, men, volunteers and villages chiefs, CC& HCMC) and interviews (health staff, NGOs) in the 4 NE provinces, as well as in two garment factories (workers and staff), and consistencies in the responses in the interview of health staff in Pursat and Battambang. Their answers are most often similar, although sometimes with different details which are specific to the local situations. The findings of the field research are also consistent with the results of in-depth interviews of the endline Surveys

## 5.1.Relevance

*Definition: Extent to which objectives are aligned with government priorities and policies. Activities are adapted to meet the needs of target population, in particular vulnerable groups.*

Overall Rating: 6

Justification of rating: From the program's documents review and key informants interviews, the evaluation found that all PSL's objectives and interventions are relevant to RMNH priorities of the MoH as they addressed well the seven components of the FTIRM. PSL's focus, activities and outcomes are consistent with the Australian Government's targets for strategic investments in the Cambodia's health sector. PSL responded to the aspirations, needs and challenges of healthcare providers and local communities, and involved them in its design and implementation. PSL has also taken measures to address gender and child safeguarding issues.

### 5.1.1. Evaluation Question: To what extent have the program interventions contributed to the MoH strategic priorities for RMNH and to DFAT/High Commission's strategic directions in Cambodia?

The MoH strategic priorities for RMNH are articulated in seven components of the FTIRM 2016-2020: Emergency obstetric and newborn care; Skilled birth attendance; Newborn care; Family planning; Safe abortion; Behaviour change communication; and Removing financial barriers. Those components are also reflected in other policy documents such as the EmONC improvement plan 2016-2020 and the National strategy for reproductive and sexual health 2017-2020.

PSL was designed to respond to the need for accelerating progress against the FTIRM components<sup>13</sup>. They are addressed by the PSL's interventions, based on the organisational strengths of each NGO partner. In relation to those components, PSL has helped HCs and RHs in the target areas to improve the quality of RMNH key services by supporting them with essential equipment and materials (for safe delivery, newborn resuscitation, LTFP and CAC), midwives trainings, on-site coaching, and QA. In the community, PSL facilitated the access to health services with community referral mechanisms (TBA-Midwife Alliance in 100 villages in Mondul Kiri and Ratanak Kiri, VHSg, pregnancy club, LDG, men's club), and maternity extended waiting rooms (in 14 HCs in Kratie and Stung Treng). BCC activities were conducted through LDG in the villages using messages in indigenous languages for ethnic minorities, village events, radio broadcasting (drama, call-in programmes), phone SMS/voice messaging.

PSL has worked with garment factories in Phnom Penh and Kandal to improve GFW's access to SRH services through factory infirmary and external health care providers. The program also implemented BCC activities to promote knowledge on RMNH including contraception and safe abortion. PSL introduced in 2016 a new BCC package, *Chat!* with eight short training sessions, three video dramas, one interactive mobile game and a male engagement module. *Chat!* and has shown positive effects on the beneficiaries' knowledge and use of modern contraception, and women's empowerment<sup>14</sup>.

Table 4: Contribution of PSL interventions to the FTIRM

Components of FTIRM 2016-2020	Contributing PSL Interventions
1. Skilled Birth Attendance	In service trainings, MCATs, on-site coaching, QA of delivery
2. Emergency Obstetric and Newborn Care	Standardisation and upgrading of BEmONC and non-BEmONC facilities, In service trainings
3. Newborn Care	MCATs, on-site coaching, VHSg BCC package
4. Family Planning	LAMP training, LAMP QI, support to CBDs, MCATs, on-site coaching
5. Safe Abortion	CAC training, CAC QA
6. Removing Financial Barriers to Access Health Services	Research and Learning, VSLA, vouchers, TBA-Midwife Alliance

<sup>13</sup> Partnering to Save Lives: Australia-Cambodia RMNH Program, Program Design Document (PDD)

<sup>14</sup> Partnering to Save Lives and Angkor Research and Consulting Ltd. (2018) Endline Survey and Evaluation of RMNH Knowledge, Attitudes and Practices among Garment Factory Workers. Phnom Penh, Cambodia.

7. Behaviour Change Communication	<i>Chat!</i> , LDG, BCC Framework, VHSG BCC package, TBA-Midwife Alliance, support to community referrals and Referral directory in garment factories
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In the interviews, all the representatives of development partners and technical agencies involved with RMNH said that PSL's interventions appropriately responded to the challenges of maternal and newborn mortality in Cambodia. They found that the learning and research thematics of PSL are relevant to improving the quality, access, and utilization of RMNH health services. These included: technical harmonisation, non-emergency referral systems, financial barriers, issue of transportation to access RMNH services for vulnerable women in NE Cambodia, reaching most vulnerable groups, garment factories, capacity building of midwives. In the provinces, the provincial and district MCH managers said that PSL's support contributed significantly to improving the quality of health centre services and the skills of midwives for RMNH interventions.

Health is one of four key areas of Australia's strategy for aid in Cambodia, in particular, improving the health of mothers and children to reduce high rates of maternal and infant mortality<sup>15</sup>. Saving lives of women and children through greater access to quality maternal and child health services is one of five strategic pillars of AusAID's global contribution to achieving the Millennium Development Goals (MDGs), and represents one of the organisation's ten core strategic goals<sup>16</sup>.

PSL focused on the most vulnerable groups, gender equity and disability inclusion which are key priorities for the Government of Australia. In the DFAT's Aid Investment Plan Cambodia 2015–2018, it is said: “We will also tackle the ongoing challenge of poor reproductive, maternal and neonatal health, particularly for vulnerable women, such as those working in garment factories or living in remote communities”. In the same document it is also mentioned about the importance of empowering women, gender equality, ending violence against women, and support for the disability sector.

DFAT recognised that NGOs are important partners given their expertise, on-the-ground networks and experience working with local communities<sup>17</sup>, and has determined that a partnership approach involving the Ministry of Health (MoH) and NGOs is the most appropriate vehicle for achieving health outcomes in RMNH<sup>18</sup>.

<sup>15</sup> AusAID (2010), Australia's Strategic Approach to Aid in Cambodia 2010-15, Commonwealth of Australia

<sup>16</sup> Commonwealth of Australia (2011), An Effective Aid Program for Australia: Making a Real Difference–Delivering Real Results.

<sup>17</sup> DFAT (2015): Aid Investment Plan Cambodia 2015–2018

<sup>18</sup> Partnering to Save Lives: Australia-Cambodia RMNH Program, Program Design Document (PDD)

PSL represents a key element of Australian assistance to Cambodia's health sector, and complements other investments in health systems strengthening, primarily funded through the Health Sector Support Program Phase 2 (HSSP2) and later the Health Equity and Quality Improvement Project (H-EQIP).

The PSL midterm review conducted by DFAT found that PSL's focus, activities and outcomes to date were consistent with the Australian Government's targets for strategic investments in the health sector and aligned with the Royal Government of Cambodia's (RGC) health policies. The report stated: "the activities are aligned with the RGC's approach to improving maternal and newborn health through increasing the quality of services and enabling greater access and utilisation. The NE provinces and garment factories are recognised as priorities areas by all stakeholders. PSL activities are conscientiously designed and implemented in accordance with MoH policies and will continue to be relevant to the country's new Health Strategic Plan".<sup>19</sup>

#### 5.1.2. Evaluation Question: Has the program addressed the aspirations, needs and challenges of healthcare providers and local communities and involved them in relevant stages of the project?

In the interview, the NMCHC director stated that she has been involved in the PSL design since the beginning. It was a joint decision of MoH and PSL to give priority to targeting the hardest to reach and most vulnerable groups (WRA and female adolescents, ethnic minority groups, poor women, women living with disability) in the four NE provinces where RMNH indicators were worse than in the rest of the country, and also where there is significantly less presence of health partners. Other selected targets are female GFW who were isolated from their family and community and vulnerable with regards to sexual and reproductive health issues.

According to the PSL Program Design Document (PDD), the health managers at the PHD and OD levels and healthcare providers in the HCs have been consulted during the design phase of the program, and regularly thereafter during the implementation process. They also actively participated in activities including planning and facilitation. The CCs reported to the evaluators that they have been consulted during the design phase of PSL, and regularly during the program implementation process. Associations of people living with disabilities have been consulted in the design phase and the second phase of the program implementation.

The review of AOPs showed that PSL's interventions addressed key issues affecting the performance of public health services: the low quality of health care, low awareness of beneficiaries about RMNH services, various constraints and barriers in access to health care, and discriminations by health staff against indigenous, the poor and persons living with disability.

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<sup>19</sup> Partnering to Save Lives Midterm Review. November 2015, DFAT.

With regards to the health staff, PSL addressed the lack of clinical and communication skills with technical trainings and attitudes trainings, the weak supervision with on-site coaching. With regards to the health facilities, PSL addressed the lack of equipment and materials, and sometimes essential commodities such as electricity, clean water supply, waste management system. The HC health staff interviewed during the evaluation's field research reported that PSL's support have met their needs for improvement of the delivery room, the equipment and materials for RMNH essential services especially FP, delivery and BEmONC, and technical capacity building of the midwives. In the target garment factories, PSL worked in quality improvement of the infirmary's RMNH services and provided BCC interventions to address the needs for RMNH awareness and proper service utilisation among the GFW.

PSL's support to health service delivery is complemented by a strong support to the community engagement. . Before the program started, people in the community had low understanding of RMNH issues. There was generally no local initiative to support WRA to access health services. VSHG got little support to carry on their duties.

PSL's interventions aimed to build the capacity of community key actors and set-up local systems to better support WRA in the community to meet their RMNH needs. This included training of VSHG to provide health education, TBA-midwife alliance meetings, and non-emergency referral system. The support to reducing financial barriers included operational research and support to financial incentive schemes such as vouchers and VSLA in the first half of the program (interrupted after the mid-term review).

In the FGDs, respondents reported that VSHG are actively engaged in RMNH awareness and BCC activities in the villages, sometimes jointly with the village chief or TBA. PSL provided training to the VSHG to improve their knowledge and communication skills, and the VSHG BCC package (audio materials, brochure, flash cards, and flip chart) which is used for community health education. In Mondul Kiri and Ratanak Kiri, people appreciate that audio materials are made in local indigenous languages.

With regards to the community empowerment to keep health service providers accountable, the evaluator found in the villages in Ratanak Kiri that people did not hesitate to bring up their complaints when unhappy with quality of care or other issues. The situation is different in Stung Treng where respondents said that they don't complain because they are afraid on negative consequences when they go back to the HC in the future.

**Quote:** From a Focus Group Discussion in Ratanak Kiri Province

*"Now we rarely see a bad experience of woman delivering baby at the HC. And if community people are not satisfied with the services, people inform to VHSG who reports directly to the HC chief in monthly or quarterly meeting on the attitude of HC staff and service delivery".*

### 5.1.3. Evaluation Question: To what extent has PSL integrated broader gender concerns and child safeguarding issues into the design and implementation of its interventions?

The priority for addressing gender and child safeguarding issues was clearly exposed in the PSL PDD, which includes a specific situation analysis on gender and equity, and child protection in its annex on cross cutting issues<sup>20</sup>. PSL is primarily focused on gender by its objective to reduce maternal mortality. Gender mainstreaming is an integral part of PSL as the main beneficiaries are women and service providers are the midwives. In term of women's participation and access to information, the main attendants of the community BCC activities are WRA, female adolescents and GFW. Through its BCC interventions in the community and garment factories, PSL empowers women's autonomy in decision making on family planning and health service utilisation. The feedback mechanism on quality of service and staff attitude such as the Implementation of the Social Accountability Framework (I-SAF), have strengthened women's confidence in expressing their voice if their needs are not met. Gender equality is promoted through men's participation to RMNH awareness raising activities (men's clubs in Mondul Kiri/Ratanak Kiri and male engagement sessions in the factories, which included issues of communication and consent) and men are advocated to support and respect women's decision for their RSH. Yet men's participation was not as high as expected.

Child safeguarding, a priority for DFAT, has been integrated into the design of PSL to ensure the program maintains a child-safe environment and meets the needs of children. The Save the Children Child Protection Implementation Guidelines is used as a reference document that provides procedures, tools for staff to integrate child protection and safeguarding into the program. All PSL staff has been trained to appropriately deal with possible disclosure of abuse, neglect or violence on young people. During the implementation phase, PSL teams are regularly reminded of child protection. For the endline survey, all of the field and quality control staff participated in a Child Safeguarding Training session provided by Save the Children. The training ensured that all staff complied with the requested ethical commitments, were aware of the best practices and were comfortable with interviewing children (15 to 18 years old individuals for this survey).

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<sup>20</sup> Partnering to Save Lives: Australia-Cambodia RMNH Program, Program Design Document (PDD), Annex 3

## 5.2. Effectiveness

*Definition: Extent to which the objectives of the interventions have been reached.*

Overall Rating: 5

Justification of rating: PSL has made good progress toward achieving its six end-of program primary outcomes. Despite the endline surveys showed that many of MERI key indicators have not reached their target (see Table 5), program reviews and learning documents, as well as the evaluation field research have found that PSL's interventions were effective in changing staff attitude, increasing midwifery skills, and inducing positive behaviour change in the community. Over the past 5 years, the quality, availability, and access to key RMNH services in the target health facilities have significantly increased. The health awareness and care seeking behaviour of the beneficiaries in the target areas have improved. PSL's learning has contributed to RMNH policy documents and technical guidelines. However there is still room for improvement in some areas: CAC service provision, inclusion of persons with disability, reducing financial barriers.

5.2.1. Evaluation Question: To what extent has PSL achieved its outcomes, as set out in the program design and measured through the MERI framework, and based on level of effort in terms of investments with HC and communities? What changes can be observed in PSL target areas in the last five years

PSL has six primary outcomes. For each of them, the evaluation looked at the achievement against end-of-program targets. The achievements are measured with a set of indicators in the MERI framework. The key indicators are presented in the table 5.

Table 5: MERI Key Indicators measured by baseline and endline surveys

MERI Indicators	Description	Baseline	Endline	End of Program Target
O1.3	% of functioning BEmONC facilities	0/8	2/8	7/8
O1.4	% of WRAs delivering in a health facility with a skilled birth attendant (C1)	55.2%	78.6%	80%
O2.1	% of WRAs using modern contraceptive (all provinces)	26.8%	28.6%	25%
O2.2	% of WRAs, modern FP users using long acting or permanent methods (all provinces)	23.6%	21.3%	20%
O2.3	% of garment factory workers accessing RMNH services in the previous 12 months		12%	25%
O3.2	% of WRAs attending PNC who receive counselling in modern FP methods (C1)	26.0%	26.5%	40%
O3.3	% of WRAs who report being highly satisfied with RMNH services provided (C1)	44.4%	41.5%	75%
O4.1	% women attending 4 or more ANC visits (C1)	47.0%	60.6%	65%
O4.2	% of women receiving 2 or more PNC (C1)	NA	43.4%	50%



12.1	% of WRAs accessing RMNH services in past 12 months who were referred through a community referral mechanism (C1)	7.0%	3.8%	50%
13.1	% of WRAs accessing RMNH services using a financial support mechanism in the previous 12 months (all provinces)	7.5%	9.8%	16%
14.1	% of WRAs who can identify 3 danger signs during pregnancy (C1)	20.9%	12.6%	15%
14.2	% of WRAs who can identify 3 danger signs for neonatal distress (C1)	11.3%	7.3%	25%
14.3	% of WRAs who feel empowered to discuss and use modern FP (all provinces)	25.3%	14.4%	50%
14.4	% of WRAs who know that abortion is legal (all provinces)	11.7%	14.6%	25%

Note: C1= in the four NE provinces

#### 5.2.1.1. Primary Outcome 1: Improved quality RMNH services for target populations

*This primary outcome has four indicators in the MERI framework: Number of health facilities offering comprehensive modern contraceptive services, Number of health facilities offering CAC, Percentage of functioning BEmONC facilities, and Percentage of women delivering in a health facility with a SBA.*

In 23 provinces, PSL provided voluntary surgical contraception (VSC) trainings and on-site coaching to 27 surgical providers (to provide tubal ligation and vasectomy), 132 midwives (to provide implant) and 84 midwives (to provide IUD). And in 13 provinces, PSL trained 192 midwives to provide CAC. The objectives are achieved with 98 health facilities offering comprehensive modern contraceptive services versus the target of 70, and 179 health facilities offering CAC versus the target of 179.

PSL supported eight BEmONC facilities in the four NE provinces to become fully functional (score=100%). The final functionality assessment has found that six health facilities out of eight are nearly fully functioning. Over the life of the project, scores increased from 80% at baseline to 94% at endline.

PSL promoted the delivery with SBA in the four NE provinces through the BCC activities in the community. The endline survey showed that the percentage of WRA who gave birth in a health facility in the four NE provinces has increased from 55.2% at baseline to 78.6% at endline, which is a significant progress and nearly reached the end-of-program target of 80%.<sup>21</sup>

The information collected from the FGDs in 16 villages and from the interviews of PHD and OD MCH managers of the four NE provinces showed that delivery with a SBA at the health facility has increased in most of villages in the four NE provinces. Fewer women still delivered at home

<sup>21</sup> PSL and Angkor Research and Consulting Ltd. (2018) *Reproductive, Maternal and Neonatal Health in eight provinces (Lot 1) – Endline Survey* – Phnom Penh, Cambodia.

with the TBA, mainly in the remote villages and because of no other alternative rather than by choice. The information from the FGDs is in line with the finding of the surveys that the frequency of home deliveries has decreased significantly, from 29.2% at baseline to 10.4% at endline. All four NE provinces have made progress in delivery with a SBA at the health facility, with the largest increases observed in Mondul Kiri (from 58.8% at baseline to 86.5% at endline) and Ratanak Kiri (from 39.2% at baseline to 63.4% at endline). Kratie and Stung Treng have progressed respectively from 66.7% at baseline to 87.4% at endline and from 64.1% at baseline to 76.1% at endline.

#### **Beneficiary Story #1**

Choun Yart, 36 years old, is from Pralay Treak village, Damrey Phong commune, Chhlong district, Kratie province. She is now nine months pregnant with her fifth child. Yart and her husband are poor. They already have four children. Yart delivered her three oldest children at home with the TBA because she did not want to leave her village.

For her fourth child, Yart chose to deliver at the health centre after receiving advices from the VHSG about maternal and neonatal health. She felt safer when she delivered with the midwife than when it was with the TBA.

Since she was pregnant with her fifth baby, Yart went to the health centre for antenatal care only once because she stayed with her husband at his plantation in the forest to cook for him (and her husband was worried to leave her alone at home during her pregnancy).

The couple has jointly decided to deliver the fifth baby at the health centre. Yart said she feels safer with midwives and equipment at the health centre. Importantly, the health centre is able to refer her in case she has a problem. Because they are poor, the family does not have any vehicle to travel to the health centre. They plan to borrow a motorbike from their neighbour. "After the awareness raising in the village by VHSG and village authority, I started to have the information about health centre for delivering baby and also started to feel afraid of being with TBA to deliver", Yart said.



#### 5.2.1.2. Primary Outcome 2: Greater equity of access to appropriate RMNH services for target populations

*This primary outcome has three indicators in the MERI framework: Percentage of target population using modern contraception, Percentage of women (modern FP users) using long acting or permanent methods (LAPM) of FP, Percentage of garment factory workers accessing RMNH services in the previous 12 months.*

PSL interventions aimed to ensure that all WRA in the target areas have equal access to modern contraceptive methods. The program supported the training on implant insertion for 144 service providers (HC midwives, medical assistants, doctors), on IUD insertion for 83 midwives and on CAC for 231 service providers (HC midwives, medical assistants, doctors). In the community, FP is promoted through BCC activities conducted in collaboration with VHSG and village authorities.

The PSL interventions in the garment factories mainly aimed to improve the awareness of female workers about SRH, especially birth spacing and safe abortion, as well as to increase the capacity of the GF Infirmary to advise, provide short-term contraceptive methods, and refer RMNH cases to external RMNH service providers. In 25 garment factories, PSL implemented BCC interventions and supported the referral with the Health Facility Referral Directory.

The percentage of all WRA currently using any type of modern contraceptive method has changed from 26.8% at baseline survey to 28.6% at endline survey (reaching the end-of program target). However, the percentage of women (modern FP users) using LAPM of FP went down from 23.6% at baseline to 21.3% at endline. The HC remained the first-choice provider of modern contraceptive methods despite it has decreased from 50% at baseline to 40.7% at endline. At the second rank, the private pharmacy has progressed from 18% at baseline to 29% at endline.

The proportion of workers who use the GF infirmary is high with 77% of GFW using the factory infirmary in last 12 months at endline (70% at baseline), with a high satisfaction rate at 95%, though nearly all cases were for minor health issues. Actually the percentage of GFW accessing RMNH services in the previous 12 months remains low even though there was a progress from 6.8% at baseline to 11.5% at endline. However, overall satisfaction with RMNH services has gone up significantly from 23% to 40% of women that accessed RMNH services, suggesting improvements in service delivery targeted toward factory workers.

#### 5.2.1.3. Primary Outcome 3: More responsive RMNH services meet the needs of target populations

*This primary outcome has three indicators in the MERI framework: Percentage of women receiving CAC who receive post abortion FP, Percentage of women attending PNC who receive counselling in modern FP methods, Percentage of target population who report being highly satisfied with RMNH services provided.*

The evaluation's field research found that in the HCs supported by PSL, there are more RMNH services available than prior to the program's intervention: ANC, delivery, PNC, reproductive health counselling, FP, STI treatment, pregnancy & HIV testing, and CAC. The midwives are on duty 24 hours with night guard on the spot or they leave their phone contact at the HC for emergency call. All the HCs visited by the evaluators (eight in the NE provinces, two in Pursat, two in Battambang) now have an extended waiting room for pregnant women and their relatives to stay until the day of delivery as well as to stay for PNC after the delivery.

PSL worked with the service providers in 13 provinces to ensure that women receive FP as part of CAC services, and in the four NE provinces to ensure that women attending PNC receive counselling on modern FP methods.

The outcome's achievement is measured with the percentage of target population (WRA who had used any of the five RMNH services: FP, Abortion and post abortion care, ANC, delivery and PNC) who report being highly satisfied with RMNH services provided. The endline surveys showed a decrease in percentage of "highly satisfied" among the respondents from 44.4% at baseline to 41.5% at endline. However, there is a discrepancy between the results of the endline survey and the findings of the evaluation's field research, as in general the participants of the FGD in the community reported that they are more satisfied now with the quality of RMNH health services than prior to PSL's interventions.

#### 5.2.1.4. Primary Outcome 4: Improved RMNH behaviours amongst target populations

*This primary outcome has two indicators in the MERI framework: Percentage of women attending 4 or more ANC, and Percentage of women attending 2 or more PNC.*

PSL's interventions have had a positive impact, statistically significant, on the percentage of WRA attending at least two antenatal care visits (ANC2) with increase from 73.4% at baseline to 89.5% at endline. All provinces surveyed have progressed on ANC2, the largest increases were in Mondul Kiri and Ratanak Kiri (17.7 and 23.9 percentage points increase respectively). The indicator ANC4 has increased among all WRA having pregnancy from 47.0% at baseline to 60.6% at endline. Unlike all others provinces, Stung Treng has seen a decrease in ANC4 from 65.6% at baseline to 59.2% at endline.

To promote the post-natal care (PNC), PSL has supported in Stung Treng and Kratie, the distribution of Happy Newborn Kits to mothers who stayed at the HC at least two days after delivery. The progress of PNC2 in the four NE provinces was considerable between midline (6.8%) to endline (43.4 %) albeit there was only a slight increase of PNC1 from baseline (43.3%) to endline (71.6%), excepting Mondul Kiri where PNC1 has dropped from 70.6% at baseline to 46.2% at endline. The percentage of neonates having received appropriate immediate newborn care has progressed from 43.2% at baseline to 49.1% at endline.

#### 5.2.1.5. Primary Outcome 5: Evidence-based innovation and learning that contributes to improved policy and practices

*This primary outcome has one indicator in the MERI framework: Policies and guidelines related to RMNH developed or strengthened with PSL learning.*

Translating Learning and Knowledge into Policy is one of the three components of PSL. During the five years of program implementation, PSL has used new technical approaches that are effective for improving the quality of RMNH services or changing the behaviour of the target beneficiaries. CLU has documented evidence and lessons learnt from the field, and shared them

in the MoH technical working groups for advocacy and contribution to the development of RMNH policy documents and technical guidelines.

For the health service quality improvement initiatives, PSL has developed new ways to strengthen midwives' clinical skills and interpersonal communication skills by developing 18 modules for the MCAT meeting, introducing the on-site coaching practices, and conducting the Attitude trainings for health service providers. Building on the positive experiences and lessons learnt, PSL has provided inputs into the MCATs National Protocol, the 2016-2020 FTIRM and the national strategy for reproductive and sexual health in Cambodia 2017-2020, among others. PSL has used its experiences in supporting the quality improvement of the garment factory's infirmary to contribute to the Guidelines for the Establishment of Enterprise Infirmaries developed by the MoLVT. PSL has also produced the Health Facility Referral Directory, a reference list of public and private (including NGO) health facilities that offer RMNH services. The document helps the factory's infirmary to refer the GFW to the service provider available nearby that meets their needs. The PSL practical coaching guide will serve as a basis for the development of coaching tool for NQEM system and that the attitude training is also considered by MoH as a foundation to develop a training module.

In the area of BCC, PSL has developed two innovative approaches that have been implemented successfully. The BCC package for VHSG is used for RMNH awareness raising activities in the community. It has audio materials translated in four local indigenous languages for the specific needs of ethnic minority groups. PSL advocates for the use of the BCC package for VHSG in the NE provinces by other development partners. *Chat! Contraception* is a BCC intervention for the GFW that has demonstrated its popularity and effectiveness. The endline survey has found that *Chat!* has positive influence on knowledge and use of modern contraception, and women's empowerment.

Regarding the financial barriers to access health services, PSL's research has documented gaps and challenges in the HEF support such as insufficient coverage (63.6% of the poorest households in the four NE provinces do not have the IDPoor Card), low awareness of HEF benefits, increased out-of pocket expenditures of IDPoor card bearers, distance identified as an aggravating factor to poverty in term of health service access, and the need for inclusion of CAC and FP permanent methods in the HEF benefits package. Those findings will contribute to the review process of HEF.

#### 5.2.1.6. Primary Outcome 6: A partnership model that demonstrates impact and value for money to achieve RMNH outcomes

*This primary outcome has two indicators in the MERI framework: Coordination and harmonisation mechanisms are effectively supporting the program to achieve outcomes, and Learning and innovation enhanced through leveraging partners' strengths.*

In the evaluation field research interviews, PSC members as well as the PSL staff at central and provincial level reported in that the good coordination and harmonisation of the program implementation has contributed to the achievement of program outcomes. They found that CLU has done an efficient job throughout the five years of program implementation. This allegation is in line with the observation of the DFAT PSL midterm review<sup>22</sup>: “the implementing NGOs have developed an effective governance model and have been diligent in following MoH policies and guidelines. Facilitated by the CLU, the NGO partners meet regularly to discuss strategic, operational and technical issues and there are a growing number of joint initiatives.”

The three NGO partners have brought their specific strengths and expertise to the program. The supports of Marie Stopes to build the capacity of health facilities for LTFP and CAC are a complement to the holistic supports of CARE and Save the Children to the improvement of RMNH services in the four NE provinces. They have collaborated in joint annual reviews and AOP process.

5.2.2. Evaluation Question: Specific to component one, to what extent has PSL observed particular changes in relation to health providers’ attitude (this includes attitude towards vulnerable groups as well as provision of sensitive services such as CAC and other services where weaknesses were observed during midline)? Overall, how effective has the PSL coaching and quality improvement approach been in building technical skills and confidence of health providers (e.g. are health providers more confident and skilled to provide services, including CAC?)

In the evaluation's field research, the key informants in the community (WRA, men, community volunteers, village authorities) reported in the FGD that health staff behaviour towards patients (including those who have IDPoor card) has remarkably changed in a positive way. People in the villages find that health staff are more respectful, more responsive and provide more explanations than before. The indigenous women from minority ethnic groups in Mondul Kiri and Stung Treng said that they do not face discrimination at the HC. Nevertheless, some women in Ratanak Kiri complained that there are still few staff who still had a bad attitude, especially in the health posts. In the interviews, the PHD and OD MCH supervisors and the HC staff gave credit to the "Attitudes Training for Health Service Providers" supported by PSL for this improvement of health service providers' attitude. This confirmed the findings from PSL annual review of year 4 which showed that "Attitudes Training for Health Service Providers" led to improved behaviour of health staff towards persons with disability and ethnic minorities.

The PSL coaching and quality improvement approach has been effective in building technical skills and confidence of health providers. When the Safe Motherhood Clinic Management Protocol and MCAT National Protocol have been launched in the last quarter of 2016, the PSL teams worked

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<sup>22</sup>Specialist Health Service, November 2015: Partnering to Save Lives Mid-Term Review

actively to make sure that PHD and OD staff understand those protocols and are confident in using them. Midwives reported to the evaluators that, after they received capacity building through MCAT, on-site coaching, and for some of them a 21 days internship at the provincial hospital, they felt much more able to deal with difficult delivery cases, resulting in reduced number of referrals to the referral hospital, and early identification of complications that required to refer the case.

At the PHD and OD level, the supervisors recognized that on-site coaching is more effective than a regular supervision visit in identifying and addressing weaknesses and mistakes in the care midwives are providing. The HC midwives appreciated very much the quarterly MCAT meetings where they can discuss management issues related to their practices and also receive half day training on a technical topic. In the fourth year of PSL program implementation, the CLU has taken steps (consultative meetings, fieldwork) to learn about effectiveness of MCAT and coaching as means to transfer skills and increase confidence and motivation of midwives to provide life-saving services to women and newborn, PNC and CAC. Their findings were consistent with the PSL field research's findings that health providers are now more confident and skilled to provide RMNH services including CAC, as compared to before PSL program implementation. At the OD level, coaches were more confident to provide coaching to HC midwives than before the training.

Quote: Prof. Tung Rathavy, Director of NMCHC, MoH
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<i>"On-site coaching is a good practice that could be an example to follow for others health sub-sector such as paediatric care because it builds the clinical skills of the health staff."</i>
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The health staffs interviewed during the field research in Pursat and Battambang have identified some issues regarding CAC services delivery in the public health facilities. The CAC activity seems to be low at the HC level. The reasons are partly the attitude of some staff regarding abortion practice. They have been trained in CAC but ultimately refuse to perform abortion at the HC, claiming religious beliefs or personal ethics. Another reason is that they get better payment when they perform abortion in their private practice. Also most women prefer to get abortion with a private health service provider for reasons related to confidentiality. Indeed, the endline survey results showed that there was a slight increase of abortion at the public HC but the most common locations were respondents' homes and private providers. The public sector accounted for less than 15%. The PSL/CLU fieldwork in 2017 and Marie Stope's CAC assessment in 2017 have found several issues with CAC implementation at the HC: health staff lacked practices and did not follow the protocol.

We have noted in the two provinces we visited (Pursat and Battambang) that the Marie Stopes' plan to transition all QI follow-up for CAC to PHDs in years five was not fully completed because of lack of national budget and insufficient skills of the supervisors. The results of endline survey showed that over the course of PSL program, the percentage of WRA who reported having had



induced abortion in the past 24 months remained steady with 2.7% at baseline and 2.8% at endline. The percentage of WRA who are aware that abortion is legal has increased from 11.7% at baseline to 14.6% at endline. The percentages of women working in garment factories who know that abortion is legal remained low with 7.9% at baseline and 15.3% at endline. And 44% don't know where to access safe abortion services.

5.2.3. Evaluation Question: Component two focused on community involvement. How effective has PSL's Behaviour Change Communication (BCC) approach been in creating demand for RMNH services? Has women's self-efficacy improved, as well as male engagement in RMNH? Have PSL supported community based referral mechanisms (e.g. clubs, LDGs), Traditional Birth Attendant (TBA)-midwife alliances, Village Health Support Groups (VHSG), CBD, Health Facility Referral Directory) been effective in increasing access to RMNH services in public facilities, especially for vulnerable groups?

In the visited villages in the NE provinces, women of reproductive age, female adolescents and men declared knowing more about RMNH services availability at the HC with the health awareness raising activities that took place in their village. VHSG & village chief were cited as first source of information through the health education activities supported by PSL (LDG, village events, women club). The second source of information is health staff going in the village on routine outreach activity for immunization and antenatal care). People in those villages said that they are more familiar with HC services than five years ago.

The FGD with female adolescents in the four NE provinces, in total 48 participants (10 married, 38 single), has revealed that their participation in the community health education is still low. The adolescents said that they feel shy to discuss or ask questions about RMNH in the presence of older WRA.

In most of the villages visited during the field research, it was reported by the beneficiaries, the community volunteers, and the village authorities that, compared to a few years ago, WRA are more aware of the dangers of delivery with TBA. More women now decide to deliver in the health facility because they understand that it is dangerous to deliver at home with a TBA and that delivery at the health facility is safer. However, in some remote villages, few traditional beliefs still endure such as the use of TBA for home delivery, roasting after delivery, and prohibition of abortion because it is believed to be the fate (karma).

Quote: A woman in her third pregnancy prefers to deliver at home. She is poor and her husband does not bring her to the HC. Ratanak Kiri Province.

*<<I have delivered my two first children at home without problem, so for my third baby I will deliver at home again>>*

Although the surveys showed that the percentage of WRAs who feel empowered to discuss and use modern FP has decreased (in all eight provinces surveyed) from 25.3% at baseline to 14.4%



at endline, the evaluation field research has found in the four NE provinces from the FGDs that more WRA make decision for their contraception and usually discuss the choice with their husband. And in general the women's self-efficacy has improved along with their knowledge about RMNH issues thanks to PSL's BCC intervention.

The FGD participants in the four NE provinces reported that male participation in the health education sessions is generally low. The reason is that they are generally busy with their daily work. Some men say that they get information about RMNH from their spouse. It is reported by the women and the community volunteers that husbands are more supportive to their wife than before. In general husbands are helping their wives during pregnancy and delivery. Additionally, they are more likely to be involved with the couple's decision making for family planning than previously.

#### Beneficiary Story #2



Srey Vy, 18 years old and married, lives with her husband in Pralay Treak village, Damrey Phong commune, Chhlong district, Kratie province. They are farmers and a poor family. She delivered her first baby last month at the health centre.

Her husband took her to the health centre five times during her pregnancy. They choose not to deliver with a TBA because they worried about safety issues of a first delivery. The couple decided together to deliver the baby at the health centre because they trust the midwife and the equipment's of the

health centre. Importantly, Srey Vy thought that if she has a problem, the health centre can refer her to the referral hospital. As she has the ID-Poor card, she did not pay the delivery fees; instead she received 5000 riel from the health centre for transport costs. Srey Vy and her husband already planned for family planning. Srey Vy will soon go to health centre to consult with the midwife for choosing a contraception method which fits her. *"My husband and I have already decided to have birth spacing. We will have one more child when our first child will be five years old", she said.*

PSL supported non-emergency community referral mechanisms, including the TBA-Midwife Alliance, pregnancy club, men's club, LDG, VSLA, VHSG, CBD, and CC/CCWC, to encourage and sometimes escort a woman to attend a HC for RMNH services. Those mechanisms contribute significantly to increasing the demand for RMNH health care with PSL snapshot surveys showing

an increase in community referrals between 2015 and 2017, from 29% to 90% in Mondul Kiri and from 50% to 87% in Ratanak Kiri. The results of the midline and endline surveys also suggest that the PSL project intervention had a significant and positive impact on WRAs accessing RMNH services through the promoted community referral mechanisms. A statistically significant effect was also observed at endline among WRAs from poor households and among women with disability. However, the evaluation's field research did not get the information that women living with disability were using HC services more than before, and interviewed health staff say that they rarely see women with disability coming to the HC. The PSL's support to women with disability has started late in the program implementation. After the mid-term review, more collaboration has been made with DPOs to provide RMNH education to women with disability through self-help groups.

**Quote:** Woman with disability, 33 years old, single, in Stung Treng

*"I really want to go to the health centre to consult for my reproductive health but no one brings me and accompanies me to the health centre. I could ask my younger brother but I do not want to disturb him. I never participated in any community's activity because I cannot move and also I was never informed about the event. And I have never been visited by local authorities".*

The TBA-Midwife Alliance started in 51 villages and was expanded to 100 villages in Mondul Kiri and Ratanak Kiri provinces. Seventy-one to start (and later 154) TBAs participated in quarterly TBA meetings during which TBAs were encouraged to raise awareness of women on the benefits to deliver in HCs and to accompany women at the time of delivery. According to the interviews of the health staff, local authorities and VHSG, most TBAs now refuse to perform delivery at home. They prefer to refer or accompany pregnant women to the HC because each time they refer a delivery case to the HC, they receive an incentive of 20,000 Riels (shared by the HC and PSL). Between April 2016 and March 2017, 46% of deliveries at target HCs were referred by TBAs.<sup>23</sup>

**Quote:** A TBA in Ratanak Kiri Province, Lum Phat District, Samuth Krom Village

*"I dare not to help delivering any more at home, I am afraid of making people die and I will be in prison. Even if the women or family come to beg me to help"*

#### 5.2.4. Evaluation Question: With regards to component three, to what extent has PSL complemented Royal Government of Cambodia (RGC) efforts to implement its FTIRM as

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<sup>23</sup> Policy Paper: Out of reach? The critical barrier of transportation to access RMNH services for vulnerable women in NE Cambodia, PSL

well as to influence new strategies and policies in the field of RMNH? Has PSL learning been effectively documented and shared in order to influence policies and strategies

PSL's interventions in the target areas filled the gaps of MoH's support to the PHD/OD and the lack of the national resources to implement the FTIRM, by providing supports to the health facilities in term of materials and equipment, and capacity building of staff. At the same time, PSL conducted BCC and community engagement activities in the villages which usually are the weakest parts of the public health system. PSL was not acting as a stand-alone program, instead PSL was diligent in adhering to MoH policies and guidelines, in consulting and collaborating with the PHD and OD of the target provinces.

PSL was originally designed with a learning agenda. One important outcome of PSL under the responsibility of the CLU, is documenting learning and evidence that can contribute to improved policy and practices. During the five years of program implementation, CLU has regularly collected evidence and lessons learnt from the field and shared them through working groups, meetings and conferences. Since the beginning of program implementation, the CLU has produced a learning update each of the four years of implementation from year 1 to year 4, covering four themes (Theme 1: Technical Harmonisation, Theme 2: Non-Emergency Referral Systems, Theme 3: Garment factories, Theme 4: Financial barriers (years 1-3), Reaching most vulnerable groups (year 4)). PSL has also done several studies and evaluations: Evaluation of the BCC Activities in NE of Cambodia in June 2016; Research on financial barriers to accessing RMNH services in four NE provinces in August 2016; Community Referral system snapshot survey in 2015, 2016 and 2017; Assessment of CAC provision at health facilities in targeted provinces of PSL Project in 2018, and, a Policy Brief and Policy Paper on transportation issue in the NE.

Through its learning, communication and advocacy activities, PSL has been involved in the discussions and developments of RMNH policies and guidelines. CLU director and NGOs technical staff participated in technical working groups, workshops to support and provide inputs into the development of strategy documents, policy papers and technical guidelines such as revised FTIRM 2016-2020, Guidelines for the Establishment of Enterprise Infirmaries, MCATs National Protocol, revision of the Safe Motherhood Protocol, and Practical Coaching Guide.

PSL manages relationships with technical agencies and other stakeholders effectively through the networking at national and international RMNH forums. Cambodia has a well-coordinated approach to RMNH programming and PSL has participates in key committees as its own entity and through the three NGOs operating separately. PSL took initiative to set up a Technical Reference Group (TRG) which called RMNH development partners (GIZ, UNFPA, UNICEF, WHO, URC, FHI) informal meetings to present and discuss on technical issues. It was recognised by all the organisations that we interviewed that the meetings were useful to share information and to

prepare ground for dialogue with MoH/NMCHC on RMNH policies and guidelines. The TRG was well attended and appreciated.

Results of the surveys (baseline, midline, endline) are potentially useful for others organisations that are working in the same targets areas. UNICEF and UNFPA said that they have made use of data collected in the baseline surveys in the 4 NE provinces for their programming process.

### 5.3. Efficiency

*Definition: Efficiency measures the outputs - qualitative and quantitative - in relation to the inputs. It is an economic term which signifies that the aid uses the least costly resources possible in order to achieve the desired results. This generally requires comparing alternative approaches to achieving the same outputs, to see whether the most efficient process has been adopted.*

Overall Rating: 5

Justification of rating: The partnership coordination and harmonisation structure, leaded by the CLU has helped to rationalise the use of resources to conduct activities in order to achieve the program objectives. During the five-year program implementation, all interventions were done in a timely manner in the NE provinces, garment factories and reproductive health focus provinces. However, alternative approaches are not available for comparison.

#### 5.3.1. Evaluation Question: Have the program's operations been efficient, including comparative value for money and outcomes of interventions in the remote NE provinces, garment factories, and reproductive health focus provinces?

PSL is not a uniform and homogeneous program. Instead, it is a collaborative project of three autonomous sub-programs that have their own budget and their own operational modalities even though they share the same objectives and strategic approach. Under a common plan of action, the NGO partners have their own way of managing and conducting activities in their respective areas.

In the four NE provinces, PSL activities are well integrated and complementary to the MoH RMNH activities and are leveraging others external supports such as HSP2/H-EQIP. During the program's lifespan, all activities were implemented on time and achieved results according to the workplans. There is no overlap with the interventions of other local NGOs and a good coordination at the Provincial TWG level. There are examples where other stakeholders have been replacing PSL to support some community-based activities, like CIAI in Mondul Kiri and UNICEF in Kratie. Efficiency is also analysed through a lens of equity, which means to recognise

that reaching the marginalised and underserved populations in remote and hard to reach areas increases the costs.

In the garment factories, the NGO partners have used the same BCC interventions to promote RMNH awareness and facilitate the access to health service providers (*Chat!Contraception*, Health Facility Referral Directory).

Value for money does not necessarily mean doing activities with the cheapest option but rather finding ways to optimise the inputs and achieving the best quality results possible with the cost involved. For instance the trainings on CAC and LTFP were conducted in collaboration with the NMCHC. Each time the students have to travel from the provinces to stay in Phnom Penh for a ten days training session because only the health practitioners from two national hospitals have the capacity to be the trainers for those topics. The PSL's support to building the capacity of health facilities in 13 provinces to provide LTFP and CAC services has achieved its objectives without any issue or delay.

Marie Stopes has made impact calculations which showed that "LAPM are a cost-effective health service that have far reaching benefits for women, their families and the health system. As a result of PSL's training and quality assurance for LAPMs in public facilities, 13,207 unintended pregnancies were averted, 4,599 unsafe abortions were prevented, 295,751 Couple Years Protection generated to protect couples from unplanned pregnancy, \$561,793 direct healthcare costs saved"<sup>24</sup>.

5.3.2. Evaluation Question: Have the three NGOs worked in a coordinated way leveraging organizational strengths, complementing each other, and sharing information, resources, and decision-making (i.e. have used a partnership approach)? Has PSL's Coordination and Learning Unit (CLU) been effective and brought added value in facilitating this unique partnership?

The partnership was designed to allow the three NGO partners to share program management resources for coordination and harmonisation in order to achieve greater results. On a regular basis, program reviews, annual planning and other learning processes have been implemented jointly under the leadership of the CLU.

The partnership coordination structure provides an opportunity for combining strengths and resources, and a platform for sharing experiences and lessons learnt. The overall efficiency of PSL relies on how well the three NGO partners coordinate and harmonise their works with the

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<sup>24</sup> PSL Learning package: Improving service quality. Supporting reproductive choices with long-acting contraception

facilitation support by CLU, to obtain a synergistic effect and to avoid overlapping and divergence. During the five-year program, the three NGO partners have often shared a joint implementation approach for similar interventions, using common tools such as IEC materials and training packages, allowing to save on the production costs and to obtain a bigger effect. They have developed and/or used joint products such as curriculum and materials for Attitudes Training for Health Service Providers, *Chat! Contraception*, Practical Coaching Guide, MCATs National Protocol, Health Facility Referral Directory and VHSG BCC package. Shared activities and tools resulted in reducing the investment costs, gathering more ideas and expertise, saving time, boosting productivity and ultimately obtaining better results. To reinforce the strengths of PSL, CARE brought in the program their strong experience in community development, Marie Stopes their leadership in FP and CAC, and Save the Children their competency in supporting and working with the public health system. Other factors of efficiency are that the three NGO partners already have expertise and long experience in RMNH within their target locations, and that there is a good collaboration from NMCHC and a commitment from PHD, OD in all the target provinces. The partnership of MoH, DFAT, CARE, Marie Stopes and Save the Children got a high profile and a strong voice in policy advocacy.

The mid-term internal partnership review observed that "The partnership helped leveraging and combining strengths of the NGO partners, by providing greater diversity of implementation, opportunity to learn from each other, and to draw on each other's expertise to develop better packages and resources. Working together allows for a bigger reach and greater spread of messages", and "PSL's advocacy power is strong as three large international NGOs represent the partnership. In addition, having the PSL brand and weight behind them also helps the NGOs with their individual advocacy priorities, including invitation to high level policy dialogue through PSL".<sup>25</sup>

Moreover PSL complemented and extended the Health Equity and Quality Improvement Project (H-EQIP) (another DFAT-funded program) in the remote NE provinces. PSL worked with government officials to ensure they effectively implement the HEF and utilise Service Delivery Grant (SDG) funding to improve the quality of their RMNH services.

On the other hand, the partnership approach presents some constraints. The M&E process is complex and monitoring the progress of PSL was not an easy task given the complexity of the partnership. In the coordination structure, as part of the Internal Coordination and Learning component, there is the joint M&E team with participation from monitoring officers of each NGO partner who cooperate with CLU. The main M&E tool of PSL is the MERI. It was widely recognised that MERI has been useful to follow-up the progress of a quite complex program like PSL. During

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<sup>25</sup> PSL Mid-Term Internal Partnership Review, CLU, January 2017

the program implementation, routine data collection for monitoring purpose was challenging. For most of indicators, data are coming from the MoH Health Information System (HIS) which is not always timely or accurate. The compilation of three sets of data from the NGO partners, having different data reporting systems, is also a challenge for the CLU despite a common standard form for data collection is used.

The CLU is the principal mechanism for developing, coordinating and harmonising the governance structures and leveraging partners' strengths to achieve greater RMNH outputs than they would have on their own. There has been a continuous effort by CLU to improve the partnership. CLU not only played the facilitator role but also provided leadership in many instances. CLU is the "face" of PSL in the health development arena, speaking for the program in national workshops, technical meetings, and policy discussions. Its presence also helps counterparts to distinguish what is related to PSL from the specific business of the three NGOs. According to all key informants and supporting documents (annual reports, mid-term review report), CLU has done a good job throughout the five years of program implementation.

## 5.4. Impact

*Definition: Long term changes in the target population, positive or negative, intended or unintended, brought about by the program's interventions*

Overall Rating: 5

Justification of rating: The impact of PSL's interventions are assessed through difference-in-difference (DID) analysis of the results from the baseline and endline surveys for the relevant indicators. Improvement of the quality of health services and positive health outcomes have resulted from PSL's support to the health facilities (equipment, capacity building of service providers through trainings and coaching) and interventions in the community (BCC activities, community engagement). PSL interventions also have had positive impacts on the RMNH behaviour of the beneficiaries in the target areas. The rating is 5 out of 6 because despite the overall good impact of PSL, there still exist areas for continued development such as the emergency referral system, the provision of CAC in health facilities and the financial access through the HEF.

5.4.1. Evaluation Question: What are the main contributions and impacts (positive/negative, expected/unexpected) perceived by the different actors and beneficiaries of the program?

In the FGDs in the four NE provinces and two garment factories, the respondents (WRA, men, female adolescents, and GFW) declared that their knowledge about RMNH key issues (health



services availability, safe delivery and modern contraceptive methods) has improved after their participation to the BCC activities of PSL.

They say that they know better about birth spacing than five years ago. They generally can tell three modern contraceptive methods: pills, injection and IUD. By the way, the result of the endline survey showed a high percentage of WRA in the NE provinces who know about a modern contraceptive method but it went down from 98.1% at baseline to 95.0% at endline. The knowledge of modern contraceptive methods is also high among GFW, at over 95% of respondents in the endline survey.

The RMNH practices of the beneficiaries have also been impacted by PSL interventions. When observing the percentage of WRA giving birth in a health facility, a significant DID of +21.9 percentage point was calculated at endline, therefore identifying the positive impact of the PSL intervention on this indicator. The key informants of the evaluation field research said that the delivery practices have significantly changed thanks to the BCC campaigns in the community and health staff advices to the pregnant women and their family. WRA understand that it is safer to deliver at the HC rather than at home. In the same time, PSL's supports to TBA-Midwife Alliance and to the non-emergency referral system have contributed to the reduction of home delivery with the TBA.

In the garment factories, 78% of sexually active GFW used contraception in the last 12 months. Among the BCC interventions implemented by PSL, "*Chat! Contraception*" was the most innovative. The report of endline survey among GFW said: "Women that had ever participated in *Chat!* were more likely to be using modern contraception at both the midline and endline; a difference that was statistically significant between women that had not participated in *Chat!*, but had no effect on use of LAPMs. Other BCC campaign participation had no effect on the use of modern contraceptives or LAPMs"<sup>26</sup>.

In the interviews, the HC midwives said that they have improved their technical skills (for safe delivery, FP, health counselling) and communication skills after having received the Attitudes Training for Health Service Providers, MCAT meetings and on-site coaching supported by PSL.

Improved infrastructure and equipment in health facilities are positive factors for quality of services and attractive factors for the beneficiaries.

The community referral mechanisms set up by PSL have been shown to increase access to ANC, delivery and to some extent the PNC. However, PSL has not succeeded in creating sustainable emergency referral solutions at community level. CARE did set up the VSLA as a community led

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<sup>26</sup> Partnering to Save Lives and Angkor Research and Consulting Ltd. (2018) Endline Survey and Evaluation of RMNH Knowledge, Attitudes and Practices among Garment Factory Workers. Phnom Penh, Cambodia.



and owned solution and has supported contracting some vehicles at community level but the availability of vehicle and solutions for transport in remote areas, during rainy season, and when emergency arises is not secured yet.

During the second half of the program, more attention was given to disability inclusion. PSL made efforts in mainstreaming disability. There have been good practices such as consulting DPOs from design stage, developing a partnership with CDPO, using the Washington group question in all surveys, organising awareness raising training for teams and communities. Due to limited time and scale, it was not possible to show impact at the end of the program.

No negative impact on the people and environment has been observed from the PSL activities implementation.

5.4.2. Evaluation Question: What have been the most successful or unsuccessful interventions and why? Where any deemed as innovative? What lessons have we learnt from these? What potential multiplying effects could be observed? Are there external opportunities and challenges that have impacted positively or negatively on successes and limitations?

Several PSL's interventions were considered successful because they were effective, and considered innovative because they brought a new idea or action that had not been seen before in the RMNH sector in Cambodia.

The key informants (NMCHC, health development partners, PHD/OD MCH managers and the health staff, PSL staff) have quoted three interventions that helped improving the quality of RMNH services because they increased the skills and confidence of the health service providers:

1. MCATs meetings did well to improve knowledge and skills of midwives especially with the participatory approach and simulation. They also improve relationships and problem solving. Over its five years, PSL supported MCATs for over 1,600 Cambodian midwives. The quarterly MCAT meetings brought together all midwives in an OD to meet, network, discuss complex cases, and refresh clinical skills through interactive formats such as role play and simulation<sup>27</sup>.
2. On-site coaching is a key strategy of PSL to enable midwives to learn and practice skills for RMNH service provision. PSL collaborated with PHDs, ODs and RHs to deliver on-site coaching on a range of RMNH topics at health facilities. Coaching improves skills, self-confidence and relationships between PHD/OD, referral hospitals and midwives, and empowers midwives to make decisions<sup>28</sup>.

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<sup>27</sup> PSL Learning package: Improving service quality. Strengthening collaboration between midwives to improve patient care

<sup>28</sup> PSL Learning package: Improving service quality. Coaching for quality improvement

3. PSL rolled out an Attitudes Training for Health Service Providers in the NE provinces to encourage patient-centred care for vulnerable groups. The attitudes training encouraged providers to examine their pre-conceived ideas of different client groups and develop strategies to provide respectful and non-judgemental care. This included understanding challenges that different clients experience, such as, cross-cultural communication, or discrimination on the basis of wealth, age, gender, marital status, ethnicity and/or ability. PSL has trained 30 trainers (including PHD/OD officials) who can continue to run workshops into the future<sup>29</sup>.

For the community engagement and behaviour change in the target groups, there have been many innovative approaches to adapt to the specific needs of the target groups:

1. In the NE provinces, LDG materials and the VHSG BCC package have audio spots in four indigenous languages to facilitate the participation of ethnic minority groups.
2. In the garment factories, the GFW reported improved knowledge and behaviour change on RMNH after participation in *Chat!* campaigns with role play and video show. The factories human resource management mentioned that the BCC interventions increased staff retention and productivity. In 2017, PSL won the CARE global innovation award ScaleXDesign for its *Chat! Contraception* package which will be implemented in garment factories beyond Cambodia.

For some interventions, the outcomes have not always met the expectations:

1. CAC: after the training, PSL observed that many health facilities were not actively providing services to clients. Marie Stopes conducted a research in the last year of the program to better understand and address factors limiting this service provision. The study found that the key barriers were religious beliefs, age of clients, lack of support from HC management, lack of financial incentive, referral to own private practice, lack of technical confidence, suspicion from community and family, fear of complication, staff turnover and insufficient equipment and materials.
2. Eliminate financial barriers: Poor families who have an ID-Poor card get financial support from the Health Equity Fund (HEF) for health care fees and transport cost. However, the participants of the FGDs reported several issues about the HEF: the refunds rate for transportation is low compared to the actual cost, the transport cost is only covered for in patient/delivery, and the ID-Poor selection process has not included some poor households (for example because the persons were absent when the process took place). From July 2016 to February 2017, in the context of transition of HEF management to health facilities, the reimbursement of non-medical benefits (transport, food and funeral benefit) was frozen. A PSL snapshot survey in March 2017 found only 6% of patients receiving HEF support for expenses on RMNH services compared to 10% in a previous

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<sup>29</sup> PSL Learning package: Improving service quality. Fostering inclusive healthcare environments for vulnerable clients

survey in August 2015. Meanwhile the poor who don't have the ID-Poor card, get exemption from the HC without much difficulty (according to the respondents of the final evaluation's interviews in the four NE provinces).

There were a number of favourable external factors that improved the access to HC, in addition to the quality improvement of HC services resulting from PSL's support: Travelling from the village to the HC has become generally easier than before because more people have their own motorbike and the road conditions have overall improved in the remote areas during the dry season, especially in Mondul Kiri and Ratanak Kiri.

During its implementation, the partnership had to face some unexpected external factors. In year 4, Save the Children complied to Protecting Life in Global Health Assistance and suspended its interventions related to CAC. This has affected the Coordination on safe abortion BCC activities in Stung Treng and Kratie.

## 5.5.Sustainability

*Definition: The continuation of benefits from a development intervention after the cessation of program assistance.*

Overall Rating: 4

Justification of rating: To promote sustainability, PSL has aligned with the national and local systems, collaborated with PHD/OD, provincial authorities, commune council, village authorities and VHSG, garment factory management, provided trainings through NMCHC using MoH curricula and protocols. Stakeholders in the provinces and garment factories said that they are committed to carry on key interventions such as MCAT meetings, on-site coaching, *Chat!* but there is uncertainty about access to national budget and CIP to support RMNH despite the advocacy efforts of PSL. There are still some gaps such as the implementation of CAC at the HC level, the relatively low quality of PNC and access to health service for people in very remote villages.

### 5.5.1. Evaluation Question: Has the program aligned with RGC local and national systems and mechanisms to promote sustainability?

PSL has aligned with the national priorities and policies on RMNH. It collaborated with the public health system, from the central MoH down to the PHD/OD and health facilities. PSL mainly use the NMCHC trainers and PHD/OD supervisors for capacity building activities, and use preferably the national curricula and protocol when they are already in place. During its exit phase, PSL has focused efforts in advocating PHD and OD to allocate budget in their AOP to support key

supportive activities to the HC like MCAT and on-site coaching. PSL aligned its support to LAPM with the national policy and priorities. All LAPM activities were delivered alongside MoH or PHD/OD and adhered to the National Family Planning Guidelines. This engagement prepared the PHD/OD teams to take coaching and quality improvement forward.

Concomitantly PSL engaged with the provincial authorities and CC to foster a positive environment for RMNH interventions and to create good conditions for sustainability. PSL staff has advocated CC to use their budget for social funds to support key community-based RMNH activities (VHSG meetings, transports cost for the poor in complement to the HEF). The CC in the communes visited by the evaluation teams have taken initiative to use their social funds to support travel costs for poor women to deliver at the HC but only in a small number because their budget is limited. The commune chiefs and clerks also said that they are not currently allowed to use their Commune investment plan (CIP) to support community engagement activities such as meeting of VHSG or community based health education. PSL has engaged with communes to advocate for inclusion of RMNH activities in their 2017 CIP, leading to 28 communes requesting support for health activities. However the efforts of dialogue between PSL and CC to include RMNH in the commune annual plan of action and budget were not reflected in our interviews with CC. In the communes selected for the evaluation's field research, the CC/HCMC informants declared that the collaboration between PSL and CC was limited and there was little involvement of the CCWC in the community-based activities. The mid-term review has already observed that "CC were not used by PSL as a conduit into the community except through supporting HCMC meetings in some provinces"<sup>30</sup>.

PSL has worked on the local community mobilisation and the engagement of VHSG and village chief to carry on key activities and sustain the achievements of the program. VHSG is a health volunteer system officially set-up by the MoH. The FGD participants said that after PSL will end, VHSG are motivated to continue awareness raising with pregnant women individually or in village meetings.

**Quote:** Village chief and community volunteer in Kob village, Ratanak Kiri Province

*"We want improvement in our community; we do not want to see/hear anyone die from delivery which is preventable. We want to keep this custom of delivery at the health centre for the next generation. Even if our education materials are too old or broken, we still have that knowledge in our head, so we can integrate the messages in the village meeting to remind people".*

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<sup>30</sup> Cambodia Partnering to Save Lives Mid Term Review 2015, DFAT, 2015

PSL contributed to the health system strengthening by aligning its health service quality assurance activities to the MoH's initiative, National Quality Enhancement Monitoring (NQEM). LTFP is being taken up in NQEM and Marie Stopes has trained assessors on LTFP. The remaining challenge is to also obtain the integration of CAC QA in the NQEM system, and to integrate CAC, IUD and Implant technical support into NQEM for the future update on the clinical vignette.

Resulting from PSL's support to BCC activities in the garment factories, *Chat!* model has been replicated by other partnerships and projects in 19 factories. In the two garment factories visited by the evaluation team, focal points who have received training from PSL to facilitate *Chat!*, say that they are willing to continue *Chat!* by themselves if they get support from the management of the factory. The infirmaries will be able to continue providing family planning counselling, short-term contraceptive methods and referral advice to the GFW by using the Health Facility Referral Directory of RMNH service providers.

Our interviews with national and sub-national counterparts have identified areas where the progress made with the supports from PSL will certainly be maintained. The improved health facility infrastructure (waiting room, waste management system, clean water system) and materials and equipment (for delivery, newborn resuscitation, and abortion care) will continue to be operational after PSL and HC can deal with their maintenance and small repair with user fee incomes. Others benefits of PSL that will continue are the improved technical skills of midwives, knowledge, experiences, changed staff attitude, technical documents (training documents, clinical guidelines).

Quote: MCH supervisors, OD Sen Monorom, Mondul Kiri province
<i>"After PSL, there are many things that will remain such as improved skills and changing attitude of service providers, better infrastructure and equipment, on-site coaching practice."</i>

5.5.2. Evaluation Question: What are the main remaining gaps in provision of quality RMNH services and remaining barriers in access to RMNH services? How can PSL successes, learning and remaining gaps be used to shape future government and/or donor funded RMNH programs?

In its target areas, PSL has helped improve the provision of quality RMNH services but weaknesses are still found for some services. For instance, even though PNC visits have increased among the beneficiaries according to the results of endline survey, PNC practice is still rare in remote villages, and only 36% of GFW had a proper PNC2 visit. During PSL Year 4 field review, it

was observed in a simulation of PNC1 that the national standards were not followed and very little attention was paid to the newborn.

Another example is that despite having trained 192 midwives, PSL observed that many health facilities were not actively providing CAC services to clients, due to several factors: lack of confidence, lack of support from the management, midwives' objections or fear of complications, competing private practice.

Despite the good progress made, there are still constraints to access health services. The PSL supported community referral mechanisms contributed to increasing the access to HC services but did not address the issue of emergency referral. In general, there is no organized emergency transportation system available at the village level. In case of birth emergency, families have to find themselves a means of transportation, sometimes borrowing a vehicle from the neighbours, or with the assistance from the VHSG and village chief. Transport costs can be very high in remote villages or when a boat is needed. Sometimes it is impossible for the pregnant woman to travel to the HC for delivery because the village is very far or the road conditions are very bad during the rainy season. The geographical barrier is the biggest constraint to accessing health service, ahead of the financial, cultural and language barriers.

As a development project, the biggest challenge for PSL is to sustain its results and to hand over to government counterparts its key interventions. The national budget is limited to maintain PSL key interventions such as MCATs meeting and on-site coaching. With the SDG of H-EQIP (another DFAT-funded program), there is an opportunity to sustain PSL's interventions as there will be more budget available at facility and PHD/OD levels but HC chiefs, OD and PHD team are not yet fully familiar with these new mechanisms and how to mobilise these potential new resources.

The learning documents produced by PSL (learning updates, evaluation reports, policy briefs) are important elements of the efforts to sustain the program benefits, to maintain some best practice and innovative interventions and to leave behind a knowledge legacy to the MoH and RMNH development community. PSL partners have built an Advocacy Action Plan and Exit Strategy to inform and guide the key advocacy activities. They started their implementation in the middle of year 4 of the program.

## 5.6. Equity

*Definition: Health services available and accessible for everyone disregarding race, gender, disability, economic or social status.*

Overall Rating: 5

Justification of rating: In the past five years, equity has improved in the PSL's supported areas. PSL has obtained notable progress with the vulnerable groups. In general, they have better access to RMNH services, but not all poor women have the IDPoor card and the key informants reported that few women with disability are using HC. The target beneficiaries are involved in the program implementation, progress assessment and service provider's accountability mechanism. PSL has introduced activities that contributed to the gender equity and male engagement, collaborated with DPO for inclusion of persons with disability, and created innovative BCC approaches for ethnic minority groups and GFW.

#### 5.6.1. Evaluation Question: How effectively has the project reached the most vulnerable and marginalized women, men, girls, boys in targeted area?

PSL has obtained notable progress with the vulnerable groups (ethnic minority women, women from poor households, women with disabilities, female adolescents, GFW). The endline surveys showed improvements in the utilisation of most key RMNH services by all vulnerable groups.

Women from ethnic minorities: The percentage of indigenous WRA who gave birth in a health facility increased from 37.4% at baseline to 63.3% at endline. The use of a modern contraceptive method has increased from 33.6% at baseline to 35.1% at endline. The percentage of ANC2 has increased from 57.8% at baseline to 87.3% at endline, and the ANC4 value has nearly doubled from 30.6% at baseline to 59.5% at endline. PNC2 among WRAs from ethnic minorities increased steeply from 4.6% at midline to 30.4% at endline.

Women from poor households: The percentage of poor WRA who gave birth in a health facility increased from 42.2% at baseline to 58.0% at endline. The percentage of ANC2 increased from 57.8% at baseline to 79.0% at endline. The progress of ANC4 among poor women is faster than in the comparison provinces. PNC2 increased from 5.3% at midline to 38.3% at endline. On the other hand the proportion of women from poor households using modern contraceptive method has dropped from 25.9% at baseline to 24.1% at endline. There is a progress of access to RMNH services for the poor women who got support from HEF. However, many poor women still do not have the IDPoor card. It is worth noting that poverty is still a big factor of vulnerability as still 42% of poor women are not delivering in the health facility at endline.

Female adolescents: The percentage of female adolescents who gave birth in a health facility increased from 51.2% at baseline to 66.7% at endline. The use of a modern contraceptive method for female adolescents increased from 8.1% at baseline to 9.7% at endline. An increase in ANC2 from 68.3% at baseline to 90.5% at endline (although not statistically significant due to small

sample size). The progress of ANC4 is similar, from 43.9% to 55.6%, but slower than in the comparison provinces. PNC2 increased from 6.3% at midline to 33.3% at endline.

Women living with disability: During the field research of the final evaluation, the key informants reported that women with disability are generally not using HC, often because of lack of mobility. This information is in contrast with the endline survey which found that the percentage of women living with disability who gave birth in a health facility increased from 56.6% at baseline to 70.0% at endline, and the use of a modern contraceptive method by women with disability increased from 27.4% at baseline to 34.9% at endline. ANC2 increased from 71.1% at baseline to 88.0% at endline. The progress in ANC4 among women with disability is faster than in the comparison provinces. PNC2 increased from 7.3% at midline to 32.0% at endline.

GFW: The percentage of GFW who gave birth in a health facility increased from 79.3% at baseline to 99.1% at endline. There is a significant increase in the use of modern contraceptive methods, from 11% at baseline to 25% of at endline, however there was no significant change in the use of LAPM methods. ANC4 has increased from 64.1% to 98.1%. Women’s feelings of empowerment to discuss and use contraceptives and to refuse sex with their husband/partner, have both increased significantly since the baseline. From less than 10% to over one-quarter of women now feel empowered in these aspects of their sexual and reproductive lives.

**Quote:** Woman, 35 years, from a poor household, having recently delivered at a health centre in Siembork district, Stung Treng

*“I had seven children, four of them died by diseases. I delivered six of my children at home, at that time the road was really difficult. I had more bleeding at each delivery and also I felt unwell during my last pregnancy. And I am getting older as well. So I decided with my husband to get the prenatal care and deliver at the health centre to save my life”.*

#### 5.6.2. Evaluation Question: How effectively and appropriately have those we seek to benefit been involved at design, implementation and M&E stages of the project?

The design of PSL has been prepared through a process of research and analysis, field consultations with key stakeholders.

From the FGDs in the community and interviews with health staff, the evaluators found that VHSG and village chief are actively engaged in the RMNH awareness activities in the villages, sometimes assisted by the TBA. To improve VHSG's communication skills, PSL provided them with training and a BCC package (audio materials, brochure, flash cards, and flip chart) which is used



for community health education on healthy pregnancy, danger signs, delivery preparedness, and family planning methods.

During the program implementation, PSL has used various approaches to assess the progress of achievements, to learn about the remaining barriers and to explore ways of improvement. Learning and research works have been done by CLU and NGO partners on equity issues during the program implementation. The CLU has conducted three community referral system snapshot surveys in 2015 and 2017, community members interviews as part of the annual review process every year, and during the 2017 annual review, a fieldwork with interviews and FGD to consult with beneficiaries and stakeholders on gender and disability inclusion.

Initiatives such as I-SAF make the services providers accountable by getting the feedback from the beneficiaries. With regards to the community empowerment to keep health service providers accountable, the evaluator has found in the visited villages in Ratanak Kiri, that people do not hesitate to bring up their complain when they are not happy with the quality of care or for other issue. The situation is different in Stung Treng where respondents said that they don't complain because they are afraid on negative consequences when they go back to the HC in the future.

5.6.3. Evaluation Question: What have been the most successful/meaningful contributions to vulnerable groups including cross cutting elements, in particular gender equity and male engagement in RMNH, GFW, disability inclusion, ethnic and indigenous minority reach and engagement, child protection and environment that could be brought to scale?

PSL has introduced several activities that contributed to the gender equity and male engagement: men's club in Mondul Kiri and Ratanak Kiri to meet specific needs of men, a male engagement module for male workers in *Chat!* for garment factories, LDG where both men and women are encouraged to participate, and a one day module on gender in the attitudes training for health care providers. In the FGD of the final evaluation's field research, participants reported that since the PSL's BCC activities have started in their area, men are more supportive of their wife, and husbands and wives discuss FP and make decision together. The findings of the PSL annual field review 2017 were similar.

PSL provided the attitudes training for health care providers which includes a one day module on disability. Most persons with disability who were interviewed by PSL in Stung Treng and Ratanak Kiri, mentioned having access to medical services free of charge and did not report negative attitudes or discrimination from HC staff. However, the PSL's annual field review 2017 found that the persons with disability interviewed had not received information on RMNH nor participated

in community health education activities<sup>31</sup>. In the program's year 4, PSL collaborated with CDPO to implement activities to improve the inclusion of persons with disability with self-help groups.

PSL has developed audio materials that are adapted to the culture and in the indigenous languages of different ethnic minority groups in the NE provinces. The VHSG BCC package has also been specifically designed for those indigenous populations. According to the key informants of the final evaluation's field research, this has contributed to the success of the community-based BCC activities. For the BCC interventions in the garment factories, *Chat!* was recognised by stakeholders and beneficiaries as a successful campaign. PSL had no intervention that specifically focuses on child protection and environment.

## 6. Emerging Best Practices

PSL has innovative interventions that have got positive feedback from NMCHC, health development partners, PHD/OD, health staff and for some of them from the community as well. We consider them as best practices that should be continued, replicated or advocated for adoption by the MoH:

MCAT: The concept existed prior to PSL. MCAT has been promoted as a key intervention for building the capacity of midwives to provide quality RMNH services. PSL has identified two key quality improvement mechanisms, MCAT and on-site coaching. Health staff and supervisors find that they are an effective means to transfer skills and increase confidence and motivation to deliver appropriate life-saving services to women and newborns. During PSL's annual field review of year 4, 30 midwives and five PHD staff were interviewed and shared their views on successes and challenges with MCAT meetings. Midwives found that MCATs function well to improve their knowledge on clinical skills especially when participatory approaches and simulation are used. MCAT meetings are mostly supported by development partner's budget and should be included in AOP budgets. The continuous education requirements for health professional licensing would be an incentive for PHDs and ODs to invest budget in MCATs.<sup>32</sup>

On-site coaching is an improved version of supervision where instead of just verifying the work of the midwives, the supervisors take a hands-on, supportive approach and assist the midwives in practicing their skills on real cases or simulations. Coaching requires more time (at least 2 days and one night stay on the spot) and more clinical competency from the supervisors than a regular supervision but it has positive effects on the skills and confidence of the service providers in

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<sup>31</sup> Learning Update-July 2017, Theme 4: Reaching most vulnerable groups

<sup>32</sup> Learning Update-July 2017, Theme 1: Technical Harmonisation, PSL

performing RMNH interventions. CARE has developed a practical guide to support the tasks of the coach.

The Attitudes Training for Health Service Providers has been developed by CARE. The four-day training is intended to stimulate discussion and action planning in relation to behaviour towards ethnic minorities, gender, people with disability, and adolescents. Seventeen staff from Provincial Health Department (PHD) and Operational District (OD) staff participated in a training-of-trainers (ToT) for the Attitudes Training for Health Service Providers. 46 health care providers (40 female) participated in the Attitudes Training for Health Service Providers in Mondul Kiri and Ratanak Kiri in January 2017. PSL's Year 4 annual review demonstrated improved attitude of providers especially towards persons with disability and ethnic minorities.

Training was provided to the volunteers to increase their capacity to effectively communicate essential RMNH message to their community. In complement they received the VHSG BCC Package of IEC materials developed by PSL and endorsed by the MoH, to be used as support tools during their interventions. Radio spot in indigenous language have also been developed for the minority ethnics in Mondul Kiri and Ratanak Kiri to overcome the language barrier. They have been much appreciated by the health educators and the beneficiaries.

Chat! Contraception module has been rolled out in 35 factories reaching a total of 27,703 workers, including over 11,401 workers in 16 PSL-targeted factories. It has also been introduced in nearby communities in collaboration with GRET. For the PSL factories, 5,802 workers have seen all three videos, most with guided discussions; 1,876 workers downloaded the mobile phone quiz; and 5,859 GFWs have completed the set of female sessions. The male engagement module has also been implemented in 16 factories reaching 750 male GFWs. *Chat!* also won ScaleXDesign, CARE's global innovation challenge.

The Health Facility Referral Directory of RMNH service providers that provides basic information for health facilities having RMNH services in Phnom Penh and Kandal has been updated. They have been distributed to garment factory's infirmaries and health educators. Referral sheets are updated for each targeted factory.

With regard to the policy and advocacy work of PSL, the Technical Reference Group (TRG) was a useful forum for sharing information, experience and discussing RMNH issues among health development partners. Its informal and flexible format allowed open technical discussions about RMNH issues. For instance, joint advocacy messages for on-site coaching were developed with TRG members to promote a common language on the issue

## 7. Key Lessons Learned

### 7.1. What has worked well

1. Coordination mechanism: PSL is an innovative approach to health development support programming, which has proved that it is feasible to get several agencies to work together under a partnership in an efficient manner when there is a good coordination mechanism and structure set-up. The key element of the partnership structure is the CLU, which has been instrumental in the success of the coordination and harmonization process despite the reach of CLU was limited to only an advisory role. It would have been beneficial for the program's efficiency if CLU have had more power to lead decision making such as about what direction should PSL take to adapt to changes during the implementation.
2. Learning process: PSL has included OD and PHD MCH managers in PSL key learning processes in year 4 and 5. They joined the annual review including field visits and all learning workshops. So they built the PSL learning with the program staff. PSL has produced several learning updates over the five-year implementation, and at the end of the program four final learning packages that are summarising the PSL partners learning across five years of implementation.
3. Holistic approach to health development program is effective: in the HC under PSL's support, the service utilization has been boosted by the combination of improved health facilities standards, better quality of services, increased health care demand with better RMNH awareness, improved access from the community and the empowered oversight of the community and local authorities which induced a dynamic for improvement. Those enabling factors are the results of PSL efforts in implementing the holistic approach to health sector development.
4. The capacity building of midwives helped improve the quality of care. On-site coaching and MCATs meetings have significantly improved their skills and confidence in practicing RMNH interventions. The Attitudes training for health care providers has a positive impact on the relationship between service providers and users, for instance the module on ethnicity helped staff to better behave with indigenous users.

### 7.2. What has not worked so well

1. PSL has been successful in providing HCs the capability to perform CAC, yet the actual service provision has met several constraints on the ground. The reported performance of CAC in those health facilities remained low. In year 3, a review of HCs supported by PSL has found that after having received CAC training, only 12 out of 23 HCs offered service for first-trimester manual vacuum aspiration (MVA)<sup>33</sup>.The reasons for non-action are

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<sup>33</sup> Learning Update-October 2016, Theme 1: Technical Harmonisation, PSL

various: staff turnover, staff religious beliefs, staff feeling that women were becoming reliant on abortion, lack of experience and confidence, past experiences with adverse events, lack of support from HC management and financial incentives issue. There is also a problem of under-reporting by the health staff about CAC activities in their private practice. While having done a good work on training and QA of CA, less communication work has been done by PSL on the demand side promotion in the community due to some constraints (the MoH does not have a clear policy to promote safe abortion). The endline survey's results showed that the community's awareness about the legitimacy and availability of CAC in the public health facilities is low.

2. It was not always easy to harmonize some field activities and IEC tools among the partners due to specific practices of each organization. For instance, the NGO partners have a different way to conduct the MCATS meetings, with Marie Stopes giving priority to training activities over the management discussions.

### **7.3. What was missing**

1. There was a good communication at the national level for sharing Learning into Policy but a gap does exist at sub national levels as most PSL's publications are in English, while few people at the provincial and district levels are able to read documents in English (and their contents are complicated for the PHD, OD and HC staff). It would have been useful to produce a quarterly newsletter in Khmer as a media to keep health staff at PHD, OD, HC levels informed about the progress of program implementation, and as a forum to encourage their participation in the consultation process and dialogue. This would also promote the visibility of PSL program at the sub-national level.
2. There may be some missed opportunities like cooperating with the national midwife association to promote the recognition of professional status of the midwives.
3. The representation of MoLVT in the steering committee could have helped to promote the Garment Factory component of PSL outside of the health sector, especially with regards to GMAC and big brands.

## **8. Conclusions**

The final evaluation has found that PSL's program design is relevant to addressing the six components of the FTIRM. Its theory of change is clear, logical and translated into a collaborative and holistic approach to supporting the RMNH services, complemented with community based interventions. The activities directly lead to the intermediate outcomes that clearly contribute to the achievements of program's five-year outcomes.

Most of planned interventions in the program design have been implemented, despite activities related to Reducing Financial Barriers having been interrupted following the recommendations of the mid-term review. The resources have been appropriate and sufficient to conduct successfully all the activities of the program.

PSL has been an efficient and effective program to improving the quality and utilization of RMNH services with its partnership and holistic approach, through achieving key outcomes in the NE provinces and in the target garment factories. Nevertheless the progress in equity of access for the poor and persons with disability, in the utilization of public facilities for safe abortion, has been partial.

PSL has had several innovative trainings and community-based activities that could be considered as emerging good practices. These interventions significantly improved the capacity and attitude of service providers (on-site coaching, MCAT, Attitudes Training for Health Service Providers). The BCC activities (*Chat! Contraception* in the GF, LDG and women clubs in the community) have significantly changed the health care seeking behaviour of the target beneficiaries after five years of program intervention. There are visible changes that will potentially persist in time: more awareness of the beneficiaries about the availability of RMNH services, increased attraction towards delivery in the health facility and modern contraception methods.

A longer timeframe of PSL implementation would have been beneficial to allow the key interventions to achieve stronger progress and reinforce the mutation induced in the attitude and practices on both sides, RMNH service providers and the beneficiaries.

## **9. Recommendations**

Based on the findings and key lessons learnt, the final evaluation can draw some recommendations for facilitating the sustainability of key interventions and future program replication:

### **9.1. Recommendations for Improving Health Service Delivery**

1. Ensure regular outreach visits by the HC midwives, especially in the remote villages, to provide ANC, PNC and RMNH counselling.
2. Reinforce the message for women in the NE provinces to get at least 4 ANC visits, especially in Stung Treng. At the HC, the midwife should insist that the women come for the next ANC visit.
3. PNC is an area for improvement. During antenatal care visits, the midwife should insist on the benefits for mothers and their baby to stay in the HC at least 48 hours after delivery.

4. Undertake "value clarification" with health service providers and health managers". Increase the minimum number of providers with CAC training so that ideally there are at least two per HC.
5. Continue delivering regular training and coaching to midwives in CAC & LAPM.
6. Advocate for consistent and adequate supply for long-term contraceptive commodities in health facilities.
7. Integrate CAC, IUD and Implant technical support into NQEM for the future update on the clinical vignette.
8. Ensure planning for future re-training of staff for new commodities is incorporated.
9. Increase supportive measures from health facility management, particularly concerning complications arising from safe abortion cases.
10. Consider restructuring financial incentives for CAC providers.

## **9.2. Recommendations for Community Strengthening and Engagement**

11. In the NE provinces, the RMNH situation has mainly improved for the villages that are not far from the health facility but many problems remain with the remote ones. Therefore, future support should focus on remote villages: ensure that poor families get support from HEF and commune social fund for transport costs, encourage collaboration from TBA to refer pregnant women, set up village emergency referral system.
12. Reinforce the message in the community for women in the NE provinces to get ANC visits (at least four visits) and PNC visits. VHSB should explain the specific benefits of the ANC and PNC in the health awareness raising meetings and during home visits to pregnant women.
13. Improve community awareness that CAC is legal and available in the public health facility by incorporating messages on LAPM and CAC in LDG package.
14. There should be a specific approach for RMNH education of adolescent women in the community, using *Chat!* model with stories adapted to social context of adolescents in the community of the NE provinces.
15. There should be more men's participation in RMNH awareness activity in the community. Alternative strategies could be tried like scheduling village men's club in the evening and conducting RMNH counselling for newly married couples.
16. In the final survey, nearly three-quarters of GFWs reported using Facebook. In the future, BCC strategy should include more social media approaches.
17. Regular community based interventions are not enough inclusive for people with disability. More work should be done with local DPOs to identify and support women with disability to access RMNH services and information. Continue to promote RMNH needs and rights of persons with disability in the community awareness sessions.

18. Health education is focused more on maternal health than newborn health. It was noted that not enough attention was paid to promoting exclusive breastfeeding up to six months and later. This should be clearly added to the RMNH messages.
19. Encourage continuation of existing self-running local initiatives like CBD, VSLA.
20. Provide spare IEC materials for VHSG to the health centres (if remaining stock), to replace the VHSG's old IEC set in the future when needed.
21. Advocate other NGOs in the NE provinces to include PSL radio spots/LDG in their community meetings.
22. Support garment factory infirmaries to provide quality services to GFW: referral and short term contraception.

### **9.3. Recommendations for Translating Learning and Knowledge into policy**

23. Advocate that activities that have been recognized as effective, like MCAT and coaching, are included and budgeted in AOP 2019, as well as VHSG meeting in commune CIP 2019.
24. The final package of learning should make a balance between targeting national level (surveys data analysis, policies and guidelines, coordination mechanism) and targeting sub-national level (lessons learnt from activities implementation, community engagement, collaboration with commune and village authorities, sustainability issues).
25. PSL should issue a Learning Update on final review of program achievements (with translation in Khmer for easy access by sub-national counterparts)
26. At the end of PSL program, take some high profile communication initiatives for sharing PSL experiences and doing advocacy at the strategy level. DFAT could propose to include a PSL presentation in the agenda of the MoH TWG Health meeting (if possible it could be programmed at the time a presentation by one of the NE provinces on the progress of their work in RMNH).
27. For the GF component, a half day meeting could be organized to present PSL works and achievements to key stakeholders in the GF sector: big brands, GF Association, GF participants to PSL program, concerned NGOs and IOs, ILO, MoLVT, and MoH.
28. Hand over TRG facilitation to a development partner (GIZ is volunteering).
29. For facilitating future replication of the partnership model, make widely available on Internet all PSL publications, annual plans, annual reports, evaluations and surveys. And produce a compilation DVD to share with partners and government.
30. In a future program, a newsletter in Khmer could be produced and used as a media to keep health staff at PHD, OD and HC levels informed about the progress of program implementation. It could also be a forum for participation and dialogue among service providers.



## ANNEX 1

### List of Desk Review's documents (in alphabetical order)

1. Action-oriented research on gender equality and the working and living conditions of garment factory workers in Cambodia. ILO, 2012
2. Assessment of comprehensive abortion care provision at health facilities in targeted provinces of the Partnering to Save Lives Project. March 2018, MBS Research (draft)
3. Cambodia Partnering to Save Lives Mid Term Review 2015, DFAT, 2015
4. CDHS 2014. National Institute of Statistics, Directorate General for Health, and ICF Macro, 2015
5. Consultant Report- Financial barriers to accessing RMNH services in four northeast provinces- PSL, August 2016
6. DFAT Health for Development Strategy 2015-2020
7. DFAT's Aid Investment Plan Cambodia 2015–2018
8. Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality 2016-2020, MOH
9. “I know I cannot quit.” The Prevalence and Productivity Cost of Sexual Harassment to the Cambodian Garment Industry, CARE, 2017
10. Learning Update – July 2017. Theme 1: Technical Harmonisation. PSL
11. Learning Update – October 2016. Theme 1: Technical Harmonisation
12. Learning Update – October 2016. Theme 2: Non-Emergency Referral Systems between Communities and Public Facilities
13. Learning Update – October 2016. Theme 3: Garment Factories
14. Learning Update – October 2016. Theme 4: Financial Barriers
15. Partnering to Save Lives and Angkor Research and Consulting Ltd. (2018) Reproductive, Maternal and Neonatal Health in eight provinces (Lot 1) – Endline Survey – Phnom Penh, Cambodia.
16. Partnering to Save Lives and Angkor Research and Consulting Ltd. (2018) Endline Survey and Evaluation of RMNH Knowledge, Attitudes and Practices among Garment Factory Workers. Phnom Penh, Cambodia.
17. Partnering to Save Lives Midterm Review. November 2015, Specialist Health Service/DFAT.
18. Partnering to Save Lives. Baseline Survey, Reproductive, Maternal and Neonatal Health Situation Analysis in Eight Cambodian Provinces. September 2014, National Institute of Public Health.
19. Partnering to Save Lives. Baseline Survey, Reproductive, Maternal and Neonatal Health Knowledge, Attitudes and Practices among Female Garment Factory Workers in Phnom Penh and Kandal Provinces. August 2014, National Institute of Public Health.
20. Partnering to Save Lives. Midterm Evaluation Report on Reproductive, Maternal and Neonatal Health in Eight Provinces of Cambodia 2016. National Institute of Public Health.

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23. Policy Paper: Out of reach? The critical barrier of transportation to access RMNH services for vulnerable women in NE Cambodia, PSL
24. PSL Learning Update – August 2014. Theme 1: Technical Harmonisation
25. PSL Learning Update – August 2014. Theme 2: Non-Emergency Referral Systems
26. PSL Learning Update – August 2014. Theme 3: Garment Factories
27. PSL Learning Update – June 2015. Theme 1: Technical Harmonisation
28. PSL Learning Update – June 2015. Theme 2: Non-Emergency Referral Systems between Communities and Public Facilities
29. PSL Learning Update – June 2015. Theme 3: Garment Factories
30. PSL Learning Update – June 2015. Theme 4: Financial Barriers
31. PSL Learning package: Improving service quality. Fostering inclusive healthcare environments for vulnerable clients
32. PSL Learning package: Improving service quality. Coaching for quality improvement
33. PSL Learning package: Improving service quality. Strengthening collaboration between midwives to improve patient care
34. PSL Learning package: Improving service quality
35. PSL Mid-Term Internal Partnership Review, CLU, January 201

## ANNEX 2

### List of Key Informants

Name	Function	Institution
<b>Phnom Penh</b>		
Prof. Tung Rathavy (Mrs)	Director NMCHC	NMCHC
Mrs. Benita Sommerville	First Secretary, Development Cooperation	DFAT/ Australian Embassy
Mrs Sayvouy Tuon	Program Manager, Development Cooperation,	DFAT/ Australian Embassy
Mrs. Cornelia Becker	Manager Improving Maternal and Newborn Care Project	GIZ
Mr. Klaus Baesel	Advisor Improving Maternal and Newborn Care Project	GIZ
Mr. Sok Sokun	Officer	UNFPA
Mr. Phal Sano	Newborn & Child Health Adviser	WHO
Mr. Etienne Poirot	Chief of Health and Nutrition	UNICEF
Mr. Ashish Bajracharya	Country Representative	Population Council
Mr. Som Hun	Chief Party Quality Health Services	URC
Mrs. Joanne Fairley	Country Director	CARE
Mrs. Amy Williamson	Country Director	Marie Stopes
Mrs. Elisabeth Pearce	Country Director	Save the Children
Mr. Chhlor Bonarath	DHS	CDPO
Mr. Kheng Virak	Director	LHW
Mrs. Edith Van Wyngaarden	Director	Handicap International
Mrs. Khan Sopheani	Human Resource Staff	Sportex Factory
Mrs. Vong Bora	Nurse	Sportex Factory
Mrs. Mouy Heang	Human Resource Officer	Gladpeer Factory
Mrs. Teng Sophy	Nurse	Gladpeer Factory
Mr. Phnon Somnang	Director	Clinic Odom
Mr. Som Sopisal	Manager	Clinic Moremet
Mrs. Lam Phirun Mrs. Oung Monyraksmey Mrs. Kong Solinina Mrs. Tuon Yanna Mrs. Eng Sophon Mrs. Ou Dal Mrs. Cheam Sokunthea	CAC and LTFP Trainers	NMCHC
Mrs. Chhay Sveng Chea Ath.	CMA Director	Cambodia Midwife Association(CMA)
Mrs. Abigail Beeson	Health and Nutrition Specialist	Save the Children
Mr. Yim Sovann	Health Program Manager	Save the Children

Mr. May Phalla	SRHR Senior Manager	CARE
Mrs. Julia Battle	SRHR Advisor	CARE
Mr. Aun Hemrin	Tech. Advisor Design, Monitoring Evaluation, Learning & Impact	CARE
Mrs. Soklay Luong	Head of Program	Marie Stopes
Mrs. Nicky		Marie Stopes
Mrs. Anne Rouve-Khiev	CLU Director	CLU
Mrs. Chhy Sophearith	M&E	CLU
Mrs. Sokleang	Midwife Coordinator	CLU
Mr. Mao Lan	Head of Worker Health	Marie Stopes
<b>Ratanak Kiri</b>		
Mrs. Taing Lyheang	PHD MCH Director	PHD
Mrs. Don Saran	OD MCH Director	OD Banloun
Mrs. Ram Sreymom	OD MCH Staff	OD Borkeo
Mr. Thorng Sikeak	Nutrition Program Officer	Plan International
Mr. Dul Setha	Project Manager	CARE
Mr. Heng Soheat	Project Officer	CARE
Mrs. Yeang Botum	Midwife	HC Kechong
Mrs. Teuk Maly	HC Chief, Midwife	HC Kechong
Mr. Tit Bunny	HC Chief, Nurse	HC Lomphat
Mrs. Bun Theary	Midwife	HC Lomphat
Mrs. Sokhom Sokhoeun	Midwife	HC Lomphat
Mrs. Sin Thol	Midwife	HC Lomphat
<b>Stung Treng</b>		
Mrs. San Channy	PHD MCH Director	PHD
Mrs. Prak Sophy	ODMCH staff	OD Stung Treng
Mrs. You Rath	Health Program Officer	Save the Children
Mr. Phan Kimsreng	Health Program Officer	Save the Children
Mr. Choun Samneang	HC Chief, Nurse	HC Sre Sambo
Mrs. Seng Sovanny	Midwife	HC Sre Sambo
Mrs. Bin Vouch Leng	Midwife	HC Sre Sambo
Mr. Em Vansom	HC Chief, Nurse	HC Sre Krasaing
Mrs. You Chan Sokunthea	Midwife	HC Sre Krasaing
Mrs. Hour Chan Thavy	Midwife	HC Sre Krasaing
Mrs. Chem Lay Heang	Midwife	HC Sre Krasaing
<b>Mondul Kiri</b>		
Mrs. Bin Ratana	Provincial MCH Director	PHD
Mr. Song Lavid	Health Promotion	OD Sen Monorom
Mrs. Our Kunthea	District MCH Director	OD Sen Monorom
Mrs. Len Molika	CCWC	Sre Preah Commune
Mr. Keun Rotha	Commune Chief	Pou Chrey Commune

Mr. Sieng Sen	Clerk	Pou Chrey Commune
Mr. Meuk Saroeun	CCWC	Pou Chrey Commune
Mr. Theng Bun Thoeun	HC Chief	HC Pou Chrey
Mrs. Kong Saroeun	Midwife	HC Keo Seyma
Mrs. Vama Lida	Midwife	HC Keo Seyma
Mrs. Rou Bom	Midwife	HC Keo Seyma
Mr. Hi Noy	Administrator	CIAI
Mrs. Ang Chanry	Staff, Midwife	CIAI
Mr. Pich Sabeun	Staff	CIAI
Mrs. Thin San	Team Leader Health Education	CIAI
Mr. Em Veasna	Senior Program Manager	CARE
Mrs. Sambath Sorphea	Senior Clinical Midwife	CARE
Mr. Sing Koemsen	Admin & Finance Officer	CARE
<b>Kratie</b>		
Mrs. Chum Villa	Deputy PHD MCH Director	PHD Kratie
Mrs. Chum Sokunthea	OD MCH Director	OD Kratie
Mrs. Man Lida	OD MCH Staff	OD Chlong
Mrs. Kieng Navy	MCH officer	UNICEF
Mr. Prum Lena	Provincial Coordinator	Save the Children
Mrs. Khiev Mouykea	Health Program Officer	Save the Children
Mr. Touy Gnok	Commune Chief	Rolous Commune
Mr. Or Le	Village chief, HCMC member	Rolous Commune
Mrs. Touch Samoun	CCWC	Rolous Commune
Mr. Theum Sovanop	CC, HCMC	Rolous Commune
Mrs. Choun Svany	Midwife	HC Rolous
Mrs. Mao Bunheng	Midwife	HC Rolous
Mrs. Mony Keun	Midwife	HC Rolous
Mr. Mean Bunna	HC Chief	HC Damrey Phong
<b>Pursat</b>		
Mrs. Men Phalla	PHD MCH Director	PHD Pursat
Mr. Chan Sokha	Director	Provincial Hospital
Mrs. Seng Botha	Chief of Maternity	Provincial Hospital
Mrs. Hort Kim Hong	Midwife	HC Beung Kantout
Mrs. Pen Yuthea	Midwife, HC Chief	HC Samrong
<b>Battambang</b>		
Mr. Voeung Bunreth	PHD director	PHD
Mrs. Maul Molika	Deputy PHD MCH Director	PHD
Mr. Vong Dy	PHD MCH Staff	PHD
Mrs. Ho Sidara	Chief of Maternity	Mong Russey Hospital
Mr. Meas Sambath,	Chief of HC	HC Svay Por
Mrs. Thoy Sokunthea,	Midwife	HC Prey Toch

## ANNEX 3

### 1-Team composition

- Principal investigator (Mr. Rasoka Thor), MD/MPH, is familiar with the Cambodia health system at all levels since he was a provincial health advisor with WHO then UNICEF in six different provinces during 7 years (1996-2002) and the MCH specialist of UNICEF for 8 years (2003-2010) advising national programs and central MOH. He also has substantial experience working on health equity and social protection issues. From 2011 to 2015, he has done consultancies (situation analysis, audits) in Cambodia for WHO, World Bank, HSSP2/MOH, UNICEF and GIZ. He has conducted several field researches in the health and social sectors in Cambodia including in-depth interviews and several focus group discussions (directly in Khmer) with villagers, local authorities, health volunteers, health staff and managers.
- Associate Investigator (Mr. Uy Sothy), MD/MPH, is an experienced public health national consultant. He has nearly 10 years experiences doing various consultancies and audits in the health sector for NGOs and MOH.
- Associate Investigator (Ms. Poch Bopha), Master in Development and Management, was national adviser on gender policy at NCDD for 2 years. In addition to her gender expertise, she has been working on Sexual and Reproductive Health and Right, developing behavior change communication Materials, doing research ( qualitative and quantitative), and monitoring & evaluation.
- Associate Investigator (Ms. Sem Chenda), Master in Social Sciences and Development Studies, was national adviser on gender policy at NCDD for 2 years. In addition to her gender expertise, she has experiences in awareness on sexual and reproductive health and has done project evaluations including several field interviews and FGD.
- Associate Investigator (Ms. Vart Daline) is a secondary midwife, having good working experiences in counselling on RMNH issues and has worked with reproductive health education programs.

### 2-Tasks distribution among team members

#### Principal investigator (Rasoka Thor):

1. Develop the methodology of the final evaluation and the inception report, submit to PSL partners for review and finalize.
2. Literature review of relevant documentations: PSL program documents (Program Design Document, MERI framework, AOPs etc.), annual and mid-term reviews, data monitoring, PSL surveys (baseline, midline, endline), national policies on RMNCH (family planning, safe abortion, EOMC), FTIRM 2010-2015, FTIRM 2016-2020 and others relevant documents listed in the TOR.
3. Prepare tools and questionnaires for interviews, focus group discussions and field observation in English and in Khmer. Prepare and submit inception report.

4. Conduct field works: interviews of key implementing partners and stakeholders at the central level. Conduct research (interviews, focus group discussions, field observation) in Kratie and Mondulkiri, and in 2 selected provinces with support for family planning/training on safe abortion.
5. Conduct jointly with female associate investigator, interviews of managers/infirmaries and focus group discussions with female workers in the 2 garment factories.
6. Consolidate and analyse available data and information collected during the field studies and draft preliminary findings.
7. Present preliminary findings to PSL partners and stakeholders
8. Produce the Evaluation Report (prepare draft, share draft for comments, revise and finalise the report).

Associate investigator (Uy Sothy): under the guidance and using tools/questionnaires prepared by the principal investigator, he will conduct field research in Stung Treng and Ratanak Kiri including interviews of health staff, focus group discussions with beneficiaries and activities observation.

Associate investigators (Poch Bopha, Sem Chenda): under the guidance of principal investigator, they will provide inputs to ensure the integration of gender equity and social inclusion, during the design of interview/FGD questionnaires, information analysis and formulation of recommendations. They will help with translation of questionnaires from English into Khmer. They will also facilitate focus group discussions with beneficiaries (mothers, WRA, adolescents, men) in the north-east provinces, and do interviews of selected stakeholders.

Associate Investigator (Vart Dalin): she will conduct with the assistance of lead consultant the focus group discussions with female workers in the garment factories and field visit to two provinces supported for LTFP/CAC.

During the research process, the team members will maintain continuous communication for information sharing, exchange ideas for analysis and recommendations. The lead consultant is responsible for the overall analysis, synthesis and report writing.

## ANNEX 4

### RATING SCALE OF THE SIX EVALUATION CRITERIA

Performance is rated using a six-point scale.

Higher rating reflects both higher level of achievement and stronger evidence:

**6 = Very good;** satisfies criteria across all relevant research questions

**5 = Good;** satisfies criteria across most relevant research questions

**4 = Adequate;** in average satisfies criteria; does not fail in any major area

**3 = Less than adequate;** does not satisfy criteria and/or fails in at least one research question

**2 = Poor;** does not satisfy criteria in several research questions

**1 = Very poor;** does not satisfy criteria in any research question