MIDTERM EVALUATION OF USAID HEALTH PROJECT AND IMPLEMENTATION ACTIVITIES IN CAMBODIA

August 2016

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Cover Photo by: Mr. Yong Lyheng, Nurse at Snam Preah Health Center, Operational District, Pursat Province
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<tr>
<td>BCC</td>
<td>Behavior change communication</td>
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<tr>
<td>CAF</td>
<td>Community accountability facilitator</td>
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<tr>
<td>CBD</td>
<td>Community-based distribution</td>
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<td>CC</td>
<td>Commune Council</td>
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<td>CCWC</td>
<td>Commune Committee for Women and Children</td>
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<tr>
<td>CDHS</td>
<td>Cambodia Demographic and Health Survey</td>
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<tr>
<td>C-DOT</td>
<td>Community directly observed treatment</td>
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<tr>
<td>CENAT</td>
<td>National Center for Tuberculosis</td>
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<tr>
<td>CIP</td>
<td>Commune investment plan</td>
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<tr>
<td>CPG</td>
<td>Clinical practice guidelines</td>
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<tr>
<td>CMHEF</td>
<td>Community-Managed Health Equity Fund</td>
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<tr>
<td>CSO</td>
<td>Civil society organization</td>
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<tr>
<td>D&amp;D</td>
<td>Deconcentration and decentralization</td>
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<tr>
<td>DPHI</td>
<td>Department of Planning and Health Information (MOH)</td>
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<td>ECH</td>
<td>Empowering Communities for Health</td>
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<td>FHI 360</td>
<td>Family Health International 360</td>
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<td>GH Pro</td>
<td>Global Health Program Cycle Improvement Project</td>
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<td>HCMC</td>
<td>Health Center Management Committee</td>
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<td>HCQI</td>
<td>Health Center Quality Improvement</td>
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<tr>
<td>HEF</td>
<td>Health Equity Fund</td>
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<tr>
<td>H-EQIP</td>
<td>Health Equity and Quality Improvement Program</td>
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<tr>
<td>HMIS</td>
<td>Health management information system</td>
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<td>HSP3</td>
<td>Third Health Strategic Plan</td>
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<td>HSSP2</td>
<td>Second Health Systems Strengthening Program</td>
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<tr>
<td>I-SAF</td>
<td>Implementation of Social Accountability Framework</td>
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<tr>
<td>IT</td>
<td>Information technology</td>
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<tr>
<td>IUD</td>
<td>Intrauterine device</td>
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<tr>
<td>LAPM</td>
<td>Long-acting and permanent method</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<td>MCAT</td>
<td>Midwifery coordination alliance team</td>
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<td>MCH</td>
<td>Maternal and child health</td>
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<tr>
<td>MEF</td>
<td>Ministry of Economy and Finance</td>
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<td>MNCH</td>
<td>Maternal, newborn and child health</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>MNH</td>
<td>Maternal and newborn health</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NCDD</td>
<td>National Committee for Democratic Development (sub-national)</td>
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<td>NMCHC</td>
<td>National Maternal and Child Health Center</td>
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<tr>
<td>NOURISH</td>
<td>USAID-funded nutrition project launched in August 2014</td>
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<tr>
<td>PAE</td>
<td>Public Administrative Establishment/Entity</td>
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<tr>
<td>PCA</td>
<td>Purchase Certification Authority</td>
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<td>PCAT</td>
<td>Pediatric coordination alliance team</td>
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<tr>
<td>P/DHFSC</td>
<td>Provincial/District Health Financing Steering Committee</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<tr>
<td>PMRS</td>
<td>Patient Management and Registration System</td>
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<td>PNC</td>
<td>Postnatal care</td>
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<td>QHS</td>
<td>Quality Health Services</td>
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<tr>
<td>RACHA</td>
<td>Reproductive and Child Health Alliance</td>
</tr>
<tr>
<td>RCRS</td>
<td>RACHA Central Reporting System</td>
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<tr>
<td>RGC</td>
<td>Royal Government of Cambodia</td>
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<tr>
<td>SHP</td>
<td>Social Health Protection</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TBC</td>
<td>Targeted Benefit Contracts</td>
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<tr>
<td>URC</td>
<td>University Research Company</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VHSG</td>
<td>Village Health Support Group</td>
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<td>WHO</td>
<td>World Health Organization</td>
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EXECUTIVE SUMMARY

EVALUATION PURPOSE AND QUESTIONS

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

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

PROJECT BACKGROUND

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

EVALUATION DESIGN AND METHODS

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

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

Health portfolio

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

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

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

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

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

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

**Challenge 1**—The process of decentralizing government functions involves a number of ministries and is multisectoral, affecting more than health services.
Challenge 2—Decentralization in Cambodia is an ongoing process that is still being defined and will take several years, changing further over time.

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

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

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

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

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

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

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

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

QHS Mechanism

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

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

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

No significant weaknesses were found in the learning approaches used by QHS. Strengths of its team-based and on-site approaches include: Training and materials used are high-quality, and the topics meet providers’ needs (life-saving skills, competency based); all trainings are conducted as or systematically followed up with on-site skills building and coaching, which reinforces new knowledge, skills and best practices. When staff turnover occurs or new staff arrive, they are oriented by MOH trainers and other facility staff who have been supported by QHS.
**Question 5c: Are the current monitoring tools and systems sufficient for measuring activity results?**

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

**ECH Mechanism**

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

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

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

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

The logic of how the various awareness-raising and behavior change activities connect, amplify and lead to changes in knowledge, attitudes and practices needs to be better articulated and to drive BCC programming. Therefore, it is recommended that a more coherent and mechanism-wide BCC strategy and plan be developed that includes monitoring of BCC processes and evaluation of behavior change outcomes; at the moment, this is a weakness in the evaluation framework. As part of this proposed planning process, the package of BCC health topics delivered by the mechanism needs to be reconsidered to fit good practice around the continuum of care, including adolescents’ reproductive and sexual health, pre-pregnancy
nutrition, infant and young child feeding, and the practical realities of behavior change programming. Evidence-based methods that have demonstrated appropriateness in Cambodia or similar contexts and existing community platforms, such as women’s saving groups and Wat grannies, need to be leveraged.

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

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

**SHP Mechanism**

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

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

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

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

The cost of the HEF monitoring function is estimated to be less than 6 percent of the overall system. Although there are no international or best-practice standards that are currently widely accepted, this cost ratio appears to be reasonable and could be absorbed by the PCA. To ensure that the cost expended for the HEF monitoring system will result in the same outcomes (i.e., fraud prevention, financial transparency and client protection), the institutionalization process should maintain the principle of third-party monitoring, ensure continuity in processes and staffing and build civic and community engagement to strengthen accountability.
**Question 7c: What should be the future roles of SHP in the HEF expansion system and broader social health protection schemes?**

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

**CONCLUSIONS**

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

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

**OBSERVATIONS ON MULTI-MECHANISM EVALUATION**

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

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

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

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

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

EVALUATION PURPOSE

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

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

EVALUATION QUESTIONS

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

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

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

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

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

QHS

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

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

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

ECH

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

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

SHP

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

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

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

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

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

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

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

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

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

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

EVALUATION APPROACH

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

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

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

Since the evaluation focused on three provinces, the team selected geographic areas within those provinces to visit based on where implementation efforts are or have been active. The site selection criteria are included in the evaluation matrix (see below and Annex I1). Site selection or sampling precepts included a variety of purposive elements; criteria included such factors as: high- and low-performing sites, hard- and easy-to-reach locations, low- and higher-income areas, established and recently commenced implementation areas, and areas with stronger and weaker network support.

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

EVALUATION MATRIX

In the development of an evaluation approach and information-collection tools, the team used a version of GH Pro’s evaluation matrix. This matrix (similar to the one in the scope of work) helped to align methods and tools to specific questions. A combination of methods was used to obtain information to answer each question. For each evaluation question (going from right to left in the matrix), the matrix lists the types of information-collection tools envisioned for use, source selection or site sampling preferences, and sources of data or information. The team developed a separate matrix for each of the three mechanisms and another for the more macro-level, crosscutting questions. All matrices are included in Annex I1.
DIVISION OF LABOR WITHIN THE EVALUATION TEAM

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

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

LIMITATIONS

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

INFORMATION-GATHERING TOOLS

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

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

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

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

ANALYSIS PLAN

As mentioned above, the analytical process involved a triangulation of the data from the three main source categories. Qualitative information was related to and compared with the available quantitative data from each of the three mechanisms’ MIS databases. Analyses were oriented to identify repeating patterns or trends. The focus of analysis was first upon each of the three evaluated mechanisms independently. Then, the analytical review determined if any patterns identified within one mechanism appeared in another or all of the mechanisms. The final stage determined what trends or patterns identified from the data collected are relevant for answering the evaluation’s health portfolio or crosscutting questions.
A thematic analysis of qualitative interview data and information was used in determining patterns or trends. Analytic techniques allowed for comparisons in trends among beneficiaries or mechanism participation by sex. Similarly, the patterns identified were checked to see if they appear at national, sub-national or local levels (if relevant).

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

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

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

A. QUALITY HEALTH SERVICES (QHS)

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

FINDINGS

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

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

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

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

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1 CPG—Clinical Practice Guideline (Cambodian guidelines for hospital care)
is more client-centered and the team approach to care and managing complications has improved confidence and decreased the stress and anxiety levels of midwives, nurses and physicians at all levels when life-threatening complications occur.

“The confidence of my staff has increased a lot and their capacity and skills have really improved. They are charting and keeping records better now and know how to examine patients head to toe.”

–Referral hospital director

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

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

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

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

**QHS Innovations/Job Aids**

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

2 It also costs less to print than the current MOH book, which has no illustrations or designs and far less information.
stamps are used at referral hospitals to screen incoming pediatric (under 5 years old) patients. Clinical posters are placed on the walls of every exam and delivery room in the health centers and referral hospitals; they guide staff during emergencies and routine care, reinforce knowledge and skills, and increase efficiency. Posters and stamps decrease stress and anxiety (“We know what to do now and don’t forget.”). The “emergency boxes” for postpartum hemorrhage, eclampsia and immediate newborn care/newborn asphyxia improve the management of routine care and emergencies. Midwives and nurses stated that QHS helped them chart more efficiently and effectively using simple terminology. The referral slip for complications and emergencies has four copies: one that the referring facility keeps, one the referral hospital keeps with the patient record, one for the referral box on one of three wards receiving referrals (maternity, pediatrics or emergency); and the last for the HEF. Referral hospital staff fill out a separate referral feedback form for the patient’s family to take home, which includes the treatment so the referring facility can follow up effectively.

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

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

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

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

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

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

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

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

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

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

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“**In 31 years of practicing this is the most effective method of training. I’ve been waiting a long time for this. Now the results of the training are seen by everyone, even the patients.**”

—*Health center manager/nurse*

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

—*Director, NMCHC*

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Most operational district and provincial health department staff felt included, empowered and better able to support facilities to improve quality as a result of the mechanism. The evaluation team also found strong evidence that relationships and trust between operational district, provincial health department and national staff and facility-based providers at health centers and referral hospitals (midwives, nurses and physicians) have been improved and strengthened greatly by the mechanism. Providers at health centers and referral hospitals stated that they now feel more supported by operational districts, provincial health departments and national levels.
• A database system with dashboards to monitor competencies, facility performance, training data, performance indicators, and component and team capacity assessments and monitoring tools
• Level 2 quality assessment in nine USAID-supported provinces (2014-2015)
• Level 2 quality assessment adopted nationwide by the MOH and partners, to be continued every two years and included in Health Equity and Quality Improvement Program (H-EQIP) [pooled fund partners after the Second Health Systems Strengthening Program (HSSP2)]
• A maternal and newborn health (MNH) survey of delivery/post-delivery care practices in referral hospitals (2014 and 2015)
• Technical assistance for health information system improvement and linkages to the MOH and other implementing partners.³

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

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

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

³ See Annex VII for charts of key indicators.
⁴ A recent study of 30 developing countries found that, among users of contraception, wealthier women were more likely than poorer women to use LAPM. In only two countries (Bangladesh and India) were poorer women more likely to use LAPM than wealthier women. *Global Health: Science and Practice*, June 2016.
Question 4 (part 1): To what extent has QHS achieved its objectives and expected results at this time?

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

Overall, the QHS mechanism has achieved its objectives and expected results at this time. QHS did experience a slight delay in making certain permanent methods [not intrauterine devices (IUDs) and implants] more widely available; but this delay was due to circumstances beyond the mechanism’s control. Provincial referral system improvements are at this point functional in fewer provinces than planned but are catching up. Current efforts to refocus have proven effective and useful, and the expansion of provincial referral system improvements to additional provinces is expected to show similar results in the remaining provinces moving forward.
Quality improvements are occurring in facilities supported by QHS, with substantial progress. Illustrative quality improvement interventions in health centers supported by the mechanism through December 2015 are shown in Figure 4. Such interventions have helped facilities achieve higher standards of quality in service delivery. Quality-improvement measurement within the QHS MIS includes eight separate indicators directly related to quality-improvement index scoring at the facility level: level 2 quality assessment scores for discharge (PNC1), overall quality of care, PNC2, family planning, outpatient/pediatric and well child (health center only); MNH survey (delivery/post-delivery) quality index; national level 2 quality assessment implemented annually in all referral hospitals and health centers in the nine targeted provinces; and MNH (delivery/post-delivery) quality survey implemented annually for the first two years (see Annex VII graph: Life of Project Target Achievement by Selected Indicators as of 3/31/2016: QHS–1). Other MIS indicators track additional service-delivery factors related to quality of care. All quality-related indicators show progress that is on track with mechanism targets or that exceeds objectives for the current point in the life of implementation.

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

### Health facilities in nine provinces providing IUD services (cumulative total)

<table>
<thead>
<tr>
<th></th>
<th>2013 (Baseline)</th>
<th>By end PY1</th>
<th>By end PY2</th>
<th>By end Q2, PY3 (March 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral hospitals</td>
<td>10</td>
<td>13</td>
<td>25</td>
<td>35 referral hospitals (92 percent of target)</td>
</tr>
<tr>
<td>Health centers</td>
<td>424</td>
<td>438</td>
<td>451</td>
<td>470 health centers (85 percent of health centers at baseline)</td>
</tr>
</tbody>
</table>

### Health facilities in nine provinces providing implant services (cumulative total)

<table>
<thead>
<tr>
<th></th>
<th>2013 (Baseline)</th>
<th>By end PY1</th>
<th>By end PY2</th>
<th>By end Q2, PY3 (March 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral hospitals</td>
<td>8</td>
<td>13</td>
<td>21</td>
<td>34 referral hospitals (90 percent of target)</td>
</tr>
<tr>
<td>Health centers</td>
<td>259</td>
<td>282</td>
<td>298</td>
<td>319 health centers (60 percent of health centers at baseline)</td>
</tr>
</tbody>
</table>

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

Figure 5. Health facilities in nine provinces providing IUD and implant services
Voluntary surgical contraception is slightly behind schedule; however, increased efforts over the past six months are expected to improve progress. Demand for voluntary surgical contraception remains very low in Cambodia, despite considerable investments in this area by donors, including USAID, over the past 20 years. An additional factor is an issue with implants: The MOH recently switched from Implanon Classic to NXT (both one rod) and there have been stock-outs of implants in facilities. Additionally, the MOH is requesting that all providers be retrained for three days on the insertion, use and removal of the new implant—which would require resources beyond the capacity of QHS and other donors—instead of a short refresher training. As noted above, the referral system improvements were behind schedule; however, mechanism inputs were adjusted and significant improvements noted in the three provinces during field visits, and the indicator is getting back on track.

![Figure 6. QHS project indicator #4.1: Family planning couple-years of protection](image)

**CONCLUSIONS, BEST PRACTICES AND LESSONS LEARNED**

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

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

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

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

“*The project has changed the behavior of the staff. They are more motivated. Staff who were good before are even better now and those who were lazy before have improved a lot.*”

—Operational district manager

“*Midwives don’t use bad words with patients anymore.*”

—Key informant interview
**Demonstration and coaching on-site is more effective than teaching off-site.**

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

“The community has noticed how clean it is now, and we got feedback from the VHSGs that we have improved, and we have a lot more people coming to the HC now. We used to have only 1-2 births a month and now we have 20-30.”

— Health center manager

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

**Challenges, obstacles and issues**

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

The RGC significantly increased government per diem rates (from an overnight rate of $20 to $34, effective September 2015) without an increase in budgets at all levels (facility, operational district, provincial health department and national), resulting in decreased funds for all field activities. This affected MCATs most acutely, since QHS does not provide any per diem support for them because they are a national standard. However, this also affects other QHS activities and its overall budget. In addition, some operational district and provincial health department staff want their own budget from QHS that they can manage directly, and they tend to withhold support for implementation efforts if independent budgets are not provided for activities in their areas. Additional per diem increases that are under discussion between USAID and other donors will also affect QHS. These include an increase in
the non-overnight per diem rate to $14 (QHS is currently paying $8 as per the MOH outreach policy) and decreasing the distance criteria for per diem eligibility from 30 kilometers (current USAID policy) to 20 kilometers.

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

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

B. EMPOWERING COMMUNITIES FOR HEALTH (ECH)

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

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Reproductive and Child Health Alliance (RACHA) was awarded the cooperative agreement for implementing ECH in September 2014. At the time of the evaluation, the mechanism had been implemented for 19 months, of which the first 11 had been funded on a cost-reimbursement basis and the remainder as advance funding (September 2015). Delays in the approval of the annual work plan and budget (March 2015) and M&E plan (April 2015), as well as the constraints faced by RACHA to fund implementation during the cost-reimbursement period, slowed the pace of implementation in year 1 (see Figure 9).
ECH covers nine provinces that are divided among three clusters. As expected for a community-based program, coverage is being gradually rolled out across the focal provinces (see Figure 10 and Annex VI). Implementation started in Cluster 1, consisting of Siem Reap and Banteay Meanchey provinces, and has rolled out to one new cluster in each subsequent year. Given the early timing of the evaluation in the mechanism’s life, the evaluation focuses on Cluster 1 performance.

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

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

Component 1: Health Systems and Governance

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

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

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

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

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\(^6\) See Annex VI for background information on VHSGs and HCMCs.
From interviews with a wide range of government and community stakeholders, the evaluation found widespread support for social accountability and recognition of how it is improving service delivery.

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

"Community Scorecards have improved staff attendance, improved provider behavior and increased community outreach activities."

--Operational district director

**Implementation challenges:**

**Decentralization:** The RGC is taking an incremental approach to D&D, experimenting through pilot projects and scaling up based on lessons learned. While this makes good sense, there is uncertainty among health providers as to the impact that decentralization of health services will have on their roles and responsibilities. In Cambodia’s hierarchical environment, service providers, health center managers and CCs are hesitant to initiate new working practices without direction from above. While the mechanism is making progress in forging relationships between the community health system and CC, and building CC capacity to take greater ownership of health, institutionalization of VHSGs and broader community health into the CC will greatly depend on the issuance of supporting policy directives.
Low government ownership: The community nature of ECH, compounded with low per diems provided to government officials engaged in mechanism activities, is constraining provincial health department and operational district ownership of the mechanism. There is a common perception among provincial and district health sector managers that because ECH is working with communities, it has limited benefit to health sector stakeholders. However, on further probing, we found that the conceptual linkages between ECH activities and health outcome targets are well understood by health managers and that the main barrier to provincial health department and operational district ownership is the low monetary rewards from the mechanism. In Banteay Meanchey, the low per diems severely affected engagement of government officials in mechanism activities in year 1, though this has eased in year 2.

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

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

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

I-SAF is a government pilot program that promotes citizen and provider participation in social accountability processes. It was designed with activities targeted to providers (supply side), funded by RGC, and to communities (demand side), funded by development partners and implemented by civil society organizations (CSOs). A shortfall in government funding of the program has left 14 of ECH’s 21 administrative districts earmarked for I-SAF in Cluster 1 and 2 areas without funding from government for supply-side activities. ECH therefore absorbed activities for both citizens and providers. This development has pros and cons. On one hand, this simplifies coordination of demand- and supply-side activities; on the other, it is difficult for a CSO to mobilize government systems to deliver supporting activities, such as compilation of government services and budget data for public dissemination. Field visits and discussions with NCDD, World Bank, and the CSO I-SAF coordinator (who represents all participating CSOs) show that health is a key subject in I-SAF activities at the community level and in learning being drawn from the pilot program.
High turnover of community facilitators: At the operational level, the low compensation provided to VHSGs and community accountability facilitators (CAF)\(^7\) leads to low motivation and high turnover of both. VHSG members receive $4 for a full day of participation in training and meetings; they are not compensated for time spent on other health-related tasks. CAFs, who are better educated than VHSG members, receive $5 per day. Both VHSGs and CAFs are compensated more favorably by other non-governmental organizations: $8 per day for VHSG members under USAID’s NOURISH project, and $10 per day for CAFs by World Vision Cambodia. RACHA staff in Poipet District estimated a 40-50 percent turnover of CAF staff within the past year due to low compensation and high work migration to Thailand. World Vision Cambodia reported a similar level of CAF turnover.

Component 2: Community MCH practices

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

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

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

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\(^7\) CAFs facilitate the social accountability process.

\(^8\) CBD agents sell oral pills and condoms and are also often VHSGs.
and continuing education of CBD agents is being rolled out (see Annex VI for analysis of additional indicators).

**Implementation and design challenges**

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

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

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


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

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

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

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

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

![Figure 16. ECH life-of-project target achievement by selected indicators](image)

**Component 3: Community support systems for tuberculosis (TB)**

**Sub-components**

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

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

**Progress:** As with other components, progress with Component 3 was slow in the first year, but is improving in year 2. Poor cooperation from Banteay Meanchey Provincial Health Department and some operational districts within the province prevented C-DOT training in some places. In addition, delays were reported in clarifying the division of labor between FHI 360’s Challenge TB and ECH, although this has now been resolved. In Cluster 1 districts where FHI 360’s Challenge TB is not present, ECH is facilitating the capacity building of health staff in addition to strengthening community TB support.
systems. This has helped to resolve some of the supply-side bottlenecks to identifying TB cases, although gaps in the availability of TB screening and testing resources continue to be an issue. CENAT is aware of the challenges, and ECH is working in close coordination with them.

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

**Implementation challenges:**

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

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

**Mechanism management and organizational structure:**

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

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12 Where FHI 360 Challenge TB is operational, ECH will focus only on community support systems.
Financial management and control: The current financial management system used by ECH has evolved to satisfy what RACHA perceives to be donor requirements. RACHA has embraced recommendations from various financial reviews in its effort to assure USAID of its financial integrity and compliance. However, the resulting financial system is too complicated and time-consuming for the operating context and is a bottleneck to implementation. Furthermore, the USAID/Cambodia agreement with RACHA may provide the organization financial-management flexibility that it is not utilizing currently.

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

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

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

Staffing and workload: Difficulties faced in recruiting appropriately qualified staff for management and field positions has led to staffing gaps that have hindered implementation, relationships with government partners and communities. This has resulted in high workload for some staff. Staff working in operational districts with a large number of health centers and communes also have a high workload and need extra support. The excessive administrative burden on field staff due to the financial management system and excessive reporting requirements is leading to significant levels of frustration.
Communication: The structure and flow of communication needs to be reviewed and enhanced to expedite the timely translation of decisions into action and strengthen communication between the field and central management.

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

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

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

1. Shows are held in the evening in a central village location, often at the pagoda. The show that the evaluation team observed started at 7:30 p.m., and by 9 p.m. the majority of the audience was leaving, although the show had not finished. It was reported that 7:30 p.m. was a good start time because families have generally eaten and completed domestic chores by this time. After 9 p.m., it is difficult to retain a rural audience because people sleep early in preparation for work early in the morning. The current show is too long and needs to be reduced to approximately 90 minutes because it is difficult to retain the attention of a rural audience much beyond that duration.

2. The number and prioritization of messages needs attention. The evaluators recommend coverage of fewer messages that are woven into the drama, rather than reading a list of messages out loud.

3. The BCC team needs to lead the design of the script and ensure coherence and comprehension of the messaging through field testing.

4. In addition to the comedy show performed on the main stage, the mechanism could explore the opportunity to disseminate messages through information booths located around the pagoda and via IEC materials targeted to different audience segments. Information booths could be styled for specific audiences or themes, such as young people or “everything you want to know about I-SAF.”

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

\footnote{14} Chhea Chhorvann and Chea Chhordaphea. September 2012. Evaluation of the Effectiveness of the Comedy for Health Program of the Reproductive and Child Health Alliance (RACHA).
The comedy show provides health messages for VHSGs and other actors to draw on in their interaction with target groups in the community; however, this will require stronger linkages across the different BCC approaches being used. Monitoring of shows captures the number of people attending events but does not measure awareness raised at the event or the pathway from awareness to behavior change (this issue is discussed further below).

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

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

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

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

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

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

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

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

**Progress**

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

**Areas for strengthening**

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

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

*Balance between process, output and outcome indicators:* The indicators in the M&E plan measure the processes and outputs of the project’s three components, which include changes in community health systems and governance, capacity building of VHSGs and CBD agents, and delivery and use of select MCH, family planning and TB services at the commune and health center levels. The indicators carefully measure the process of building community health systems and the relationship between VHSGs/CBD agents and users, but they do not seek to comprehensively measure changes in individuals’ knowledge or practices in the areas of MCH, family planning or TB. For example, for newborn care, the indicators include #17 (number of postpartum/newborn pairs visited by VHSG within one week after birth), and #18 (number of sick newborns referred to a health facility by a VHSG). These indicators measure VHSG performance in providing postpartum newborn care visits and referral, but no indicator measures...
mothers’ knowledge of the newborn danger signs or use of postnatal care visits for the baby and/or mother (PNC2 and PNC3). Given the focus of the project on community health systems, the balance between systems versus individual practice indicators in the M&E plan seems reasonable. However, as noted below, further work is required to develop a higher-order evaluation plan that includes measurement of changes in individuals’ behavior; this will also provide direction to the BCC strategy.

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

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

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

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

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

¹⁸ These are rates for a “day return,” i.e., the officer goes to the training/meeting and returns to their place of work in one day.
built disincentive for government provincial and operational district staff to visit lower levels of the system.

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

**Crosscutting themes of sustainability and gender**

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

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

**CONCLUSIONS**

**Policy**

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

**Behavior change**

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

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

**Mechanism management**

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

**USAID programming**

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

**RECOMMENDATIONS**

**ECH mechanism management**

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

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

**Per diems**

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

**Compensation for loss of earnings**

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

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

M&E

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

Influencing policy

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

Capacity strengthening

- The BCC unit needs strengthening of its technical capacity and empowering to lead the design of BCC approaches.
- The capacity of the M&E unit needs strengthening to drive analytical work and support translation of learning into advocacy and knowledge management.
- The capacity of ECH to engage in advocacy and policy-influencing needs strengthening.
• Greater understanding of the impact of gender on health should be developed to support the better integration of gender into mechanism components, activities, ways of working, evidence, analysis and learning.

C. SOCIAL HEALTH PROTECTION (SHP)

FINDINGS

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

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

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

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

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

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

Figure 19. HEF Health Provider Coverage
Health facility staff and management, especially those at referral hospitals, report that a few poor clients still lack knowledge about their HEF benefits and patient rights. Some patients either forget to bring their IDPoor/Equity Card, or fail to show the card at registration. Some are willing to pay out of pocket for the consultation fee of 1,000 riels and only show the card when presented with more elevated fees.

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

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

The mechanism aims to keep the percentage of irregular cases below 5 percent. In year 2, the HEF achieved national coverage, and the number of new health facilities contracted by the MOH increased exponentially. The number of flagged cases also experienced a notable spike, especially at referral hospitals, where the patient volume tends to be higher (see Figure 20). However, by the middle of year 3, the percentage of reported irregularities has decreased substantially, to 3 percent for males and 2 percent for females at referral hospitals, and 0.3 percent for males and 1.3 percent for females at health centers.
1.3 percent for females at health centers. These results indicate that the SHP monitoring system is effective at flagging potential fraudulent practices at health facilities.

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

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

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

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

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

During the evaluation team’s visits of referral hospitals with the full PMRS, facility managers and staff unanimously agreed that the PMRS has been helpful in finding information about a client’s history. The head of the Preah Net Preah Referral Hospital in Bantay Meanchey stated that the PMRS records all
income, which makes it easy for him to “see the hospital’s financial situation, which results in improved management and better control of staff.”

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

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

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

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

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\(^{21}\) SHP presentation to GH Pro midterm evaluation team on May 12, 2016.
targeting other vulnerable groups such as the elderly, disabled and orphans. This is reinforced by mechanism data (Figure 22) showing that the utilization rate of health centers by the poor is higher in operational districts with CMHEFs than at the national level.

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

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

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

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

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

As a health systems strengthening mechanism that works in concert with the government at the policy level on social health protection, SHP is particularly reliant on the MOH counterpart, as well as the
actions of other development partners, to move forward with its own project objectives and work plan activities. Several developments in the external operating environment have had significant impact on the pace and substance of mechanism implementation.

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

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

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

The new H-EQIP also proposed a change of the HEF Operator into an HEF Promoter, with the health facility taking on the responsibility for distributing transportation reimbursements and caretaker food allowances while the HEF Promoter’s primary role will be patient advocacy, awareness-raising and promotion. This required that SHP carry out an accelerated roll-out of the PMRS in order to facilitate the transition. While the transfer of client registration and payment to the health facility streamlines the process, it also reduces a layer of external monitoring. Similarly, H-EQIP failed to take into account the funding for the quarterly meetings of the P/DHFSC, which was previously included into the HEF Operator contract with the MOH. The failure to fund this multisectoral governance structure would remove not only another layer of supervision but also an important forum for dispute resolution.
**Question 7b: How can the HEF monitoring system be institutionalized in a cost-effective manner?**

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

<table>
<thead>
<tr>
<th>Item</th>
<th>2014</th>
<th>2015</th>
<th>2016 (est.)</th>
</tr>
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<tr>
<td></td>
<td>Amount (US$ million)</td>
<td>Percent</td>
<td>Amount (US$ million)</td>
</tr>
<tr>
<td>Total cost of system (direct benefits)</td>
<td>8.96</td>
<td>100</td>
<td>11.6</td>
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<td>HEF verification and technical assistance</td>
<td>.62</td>
<td>5.4</td>
<td>.85</td>
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Source: MOH HMIS, SHP mechanism, and World Bank H-EQIP PAD

**Figure 23. Total HEF expenditures 2014-2016**

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

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

**Ensuring continuity in processes as well as in staffing:** Having the right processes alone is not sufficient; a good monitoring system also requires the right kind of staff. The transfer of current monitors to the new PCA is important to ensure continuity, for both technical reasons and for institutional knowledge. The HEF monitors have deep knowledge about the health system, the management and operational procedure of the health facilities and the working dynamics among stakeholders at the provincial and district levels. The main challenge for the PCA is to find a way to offer a commensurate level of compensation in order to encourage retention while still adhering to the salary scale of a civil servant. One option may be a cost-sharing arrangement between the PCA and the facility. Another is for the MOH to contract directly with Partners for Better Health through a performance-based contract, allowing Partners for Better Health to decide on the optimal staff level and allocation.
Building civic and community engagement to strengthen accountability: SHP’s engagement of non-governmental organizations such as Partners for Better Health and Buddhism for Health as sub-partners has helped to strengthen institutional capacity at the grassroots level. Nevertheless, the CMHEF structure can be further leveraged to inform, educate and engage the community to advocate for accountability and transparency not only at the local level, but also up the chain to the national level of the HEF. At the moment, the CMHEF community feedback mechanism is informal and not systematic. The linkage and coordination with the CC and the HCMC appear to be shallow and coincidental rather than strategic; strengthening these relationships can validate CMHEFs’ role as a viable intermediary between the community and the public health facilities.

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

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

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

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

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

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

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

**CONCLUSIONS AND LESSONS LEARNED**

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

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

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

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

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

**RECOMMENDATIONS**

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

**Policy**

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

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

**Advocate and support the review and update of IDPoor selection criteria to reflect current conditions and include other vulnerable populations.** While URC has limited influence over the Ministry of Planning’s final decision regarding the selection criteria and the implementation of the
IDPoor process, the mechanism can assess whether the CMHEF could play an increased role by collecting feedback from the communes where future rounds of IDPoor selection will be rolled out.

**Health systems and service delivery**

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

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

**Community engagement**

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

**Mechanism management**

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

FINDINGS

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

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

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

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

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

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

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

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

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

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

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

The evaluation team recommends that the following milestones be considered in any transition from discrete activities to consolidated mechanisms:
• **Assess the merits of a consolidated mechanism.** Such mechanisms can offer some advantages; however, these may not outweigh the strengths of discrete projects or implementation mechanisms. The pros and cons of using a consolidated versus a specific mechanism should be reviewed.

• **Explore various consolidated mechanism options.** Combined assistance approaches with other donors can be undertaken in a variety of ways and using different formats. For example, consolidated mechanisms are not limited to those that combine multi-donor funding within a single mechanism. Consolidation can also take the form of a concert of actions in which implementation plans and efforts are consolidated but independently funded by a variety of donors.

• **Identify and develop common sets of indicators and complementary targets for use across all implementation activities within a consolidated approach.** A unified system of objectives and methods for measuring progress will be an important part of any successful consolidated assistance format. Using common targets and indicators also will help promote greater implementation synergies. Common indicators and targets could be mapped across a range of intervention areas to show where complementarities exist and where consolidation would be advantageous.

• **Build upon the existing experience base.** QHS, ECH and SHP are already working in concert with national policies and building capacity of host-country health systems. Their experience and that of others can help identify the most appropriate interventions that should be supported within a future consolidated mechanism or assistance format.

• **Explore and define appropriate roles for civil society in support of decentralization, quality assurance and accountability in the health sector.** Within future assistance approaches that involve the use of consolidated or discrete implementation mechanisms, CSO roles need to be better defined (even if CSOs are not directly supported by the development assistance). It is clear that, as Cambodia’s D&D initiative matures and evolves, civil society will play a larger role in realizing stronger health care for the country.

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

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

• **Challenge 1** – The process of decentralizing government functions involves a number of ministries and is multisectoral. It is a larger phenomenon that also affects how health services are provided sub-nationally. With decentralization practices being developed across such a broad cross-government arena, developing appropriate development assistance approaches for a specific sector is more complex. Addressing common decentralization factors that affect one or more specific sectors may require development partners or donors to use more multisectoral approaches.

• **Challenge 2** – Decentralization in Cambodia is an ongoing process that is still being defined. The whole process will take several years, and the forms that decentralization may take could evolve
further, changing over time. The context of decentralization in Cambodia, consequently, will need to be monitored for changes and newly emerging trends. Development assistance approaches should be flexible, with frequent options for revision or modification as the decentralization environment evolves.

**Challenge 3**—Like decentralization, the transformation of the relationships between service delivery within the health sector and the country’s health financing systems is a long-term process. The overall transformation process could take 10 or more years and contain changes in direction. Since development assistance strategies or packages often cover a five-year timeframe, a development assistance approach may need to forecast a set of midpoint objectives or goals that could be achieved within the longer-term process. Even five-year strategies or packages may need considerable flexibility to adapt to changing dynamics for health sector financing in Cambodia.

**Challenge 4**—Health promotion and behavior change currently are not strongly represented in the HSP3. However, these factors are critical elements for future long-term success in improving health outcomes in Cambodia—particularly with the increasing profile of non-communicable diseases. The absence of a clear and detailed approach to promoting optimal health care behaviors and addressing non-clinic-based issues affecting the demand for and use of health services creates greater challenges for applying consistent approaches for reaching or serving potential health clients well. Donors could help address this challenge by providing technical assistance to the MOH to develop a more detailed, nationwide approach for health promotion and behavior change.

**Opportunity 1**—Recent development assistance experience within the health sector has generated a wealth of information about interventions that yield positive changes in the country. There are great opportunities to learn from the implementation experience in the health sector, as well as other sectors, within Cambodia. What has been learned from USAID’s support of development efforts, as well as from those supported by other donors, can help to better design future assistance.

**Opportunity 2**—Lessons learned and best practices identified in USAID/Cambodia’s portfolio of health sector assistance mechanisms can be transferred and applied within new mechanisms that provide for the HSP3 in the future. For example, the lessons learned in quality improvement for MNCH within QHS could be applied to quality improvement in other health services.

**Opportunity 3**—With decentralization still very much evolving, there are opportunities to help define how the overall process may unfold and affect health care. Donors may have opportunities to support decentralization pilots that explore how decentralization will work for health centers and how local authorities can best support the achievement of better health outcomes. Such pilots could identify options for building district administrative capacity (roles, responsibilities) and operationalizing social accountability for health (including at the commune level). The experience emerging from ECH implementation may provide relevant examples for replication in a pilot.

**Opportunity 4**—Within the changing health financing arena, opportunities exist to explore new funding avenues for expanding HEF coverage to additional vulnerable populations. Options to explore for supporting such an expansion include examining taxation policies (i.e., progressive tax on income and profit, value-added tax and sales taxes on certain products such as alcohol or tobacco products) that could provide a more stable and equitable health care funding source.
**Question 4: To what extent have QHS, ECH and SHP achieved their objectives and expected results at this time?**

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

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

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

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

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

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

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

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