

MANAGEMENT RESPONSE

The Partnering to Save Lives (PSL) Mid-Term Review (MTR) Cambodia

Activity Number and Name	12A411 Partnering to Save Lives (Cambodia)		
Commencement date	1 August 2013	Completion date	31 July 2016 (optional two-year extension period to 31 July 2018)
Total Funding	AUD14 million of approved funding (not including extension period for year 4 and 5). AUD19.75 million nominally allocated for full 5-year program.		
Funding Recipients	CARE Australia, Marie Stopes International Australia, Save the Children Australia		

Objective:

- Assess the program's progress against its objectives over the first two years of implementation including an assessment of the data and evidence that the project has improved utilisation and quality, improved access, and strengthened Ministry of Health reproductive health services in target areas.
- Make a recommendation regarding whether to proceed to the final two years of the program, pending budget availability.
- Make any recommendations regarding amending the program's scope, focus, priority areas, budget, or methods of implementation during the final two years of implementation, in line with DFAT's Health for Development Strategy 2015-2020 and Royal Government of Cambodia (RGC) health priorities.

Completion Date: 27 November 2015

Mid-term Review Team: Ms Ann Larson, team leader, and Mr Ok Amry, team member.

The mid- term review of Partnering to Save Lives (PSL) program found that PSL is performing well. Particular findings include:

- (a) The PSL structure of three independent Non-Government Organisations (NGOs) has met its objectives to work together to deliver PSL. The implementing NGOs have developed an effective governance model and have been diligent in following Ministry of Health (MoH) policies and guidelines.
- (b) PSL is meeting the expectations of the Australian Government for development assistance in the health sector. By improving Reproductive, Maternal and Newborn Health (RMNH), PSL is empowering women and reducing poverty. It has engaged private garment factories and trialled several innovative approaches to behaviour change communication (BCC) and community engagement.
- (c) PSL is supporting RNMH activities that very few other donors are involved with: specifically, comprehensive abortion care and RNMH in the north-east provinces.
- (d) The depth and breadth of PSL, as originally designed and implemented in Years 1, 2 and 3, was extensive but variable. Funding constraints, unrealistic expectations and some uncoordinated implementation has meant that inputs and outcomes are distributed unevenly across the project and across the country. The implementation of 28 different activities under 11 strategies made it difficult for the MTR team to come to conclusions regarding PSL-wide outcomes or impact.

- (e) The PSL efforts in the north-east (NE) are appropriately targeted. Development partners confirmed that RMNH services in the region are in need of support in order to meet an acceptable standard. Indicators of maternal health and family planning are among the lowest in the country. A significant proportion of the population have difficulties accessing RMNH services because they are geographically remote and members of ethnic minorities with their own indigenous languages.
- (f) One of the most effective PSL activities is support for Midwifery Coordination Alliance Team (MCAT) meetings, providing a useful platform for improving relations between primary health centres and referral hospitals and building the confidence and competence of midwives, many of whom have little practical experience.
- (g) The MoH continues to depend on the technical expertise of Marie Stopes International Cambodia (MSIC) and the financial support of the Australian Government to be able to offer comprehensive abortion care (CAC) services.
- (h) The MTR team was critical of PSL efforts to show outcomes and impact. The MTR noted that reporting should provide more narrative about trends, including identifying where and how PSL was most effective, and that greater use should be made of data routinely collected by the NGOs, through the national Health Information System and other routinely collected information to provide meaningful information on PSL progress.
- (i) The MTR team acknowledged the un-costed contributions that NGOs make to PSL and that, in the face of budget constraints, the NGOs have shifted some activities started under PSL to other funding sources. While this ensures future support for these activities, it makes it difficult to attribute achievements to PSL.

The MTR noted the following were highlights of PSL achievement to date:

- Activities in garment factories, and especially the infirmaries, which has led to national attention of this issue and, potentially, the formulation of laws and regulation.
- The support for MCATs in the north-east. MCAT is a uniquely Cambodian solution to the problem of connecting primary care midwives with hospital specialists. MCATs are conducted in many provinces in the country but had not been introduced to the north-east until PSL.
- Improving the capacity of some health centres (HCs) in the north-east to offer long acting family planning methods, conduct safe deliveries and give women pre- and post-natal care.
- Reaching women and communities in the north-east who have not previously used the public health system.
- Increasing willingness between the NGO partners to share information and approaches and to develop joint activities within and outside of PSL.

The MTR noted there had been less progress to date in:

- Supporting a coherent and sustainable approach to provincial health departments (PHDs) and operational districts (ODs) conducting quality assessments and quality improvements for RMNH in north-east and elsewhere.
- Demonstrating that BCC and community engagement strategies are targeting the communities in greatest need. There is little documentation or justification of why specific communities were targeted for specific strategies. This is true within provinces but particularly true between provinces assigned to different NGOs.
- Demonstrating that the BCC and community engagement strategies have been effective in producing a change in health care utilisation.

The MTR found indications that PSL is adopting practices which will lead to sustainability:

- They have, or are forming, diverse and multi-layered relationships, especially at the national level and within factories. There is scope for closer relationships at the PHD and OD level as PSL

transitions to supporting these officials to initiate and maintain quality improvement activities from their own budgets.

- Examples of abandoning or adapting ineffective strategies such as demand side vouchers for long acting family planning methods.

The high level assessment of aid effectiveness provides a useful summary of the MTR findings on PSL (located at [Annex 1](#)).

MANAGEMENT RESPONSES

The MTR team based their recommendations for Years 4 and 5 on four criteria: alignment with Australian and Cambodian Government health priorities and policies; no new strategies or activities; focus on sustainability; and continuing what works.

Overarching Funding Recommendation

The funding available for Years 4 and 5 will determine which MTR recommendations can be actioned.

The MTR recommend that DFAT continue to fund PSL at approximately the same level of expenditure in Years 2 and 3 (AUD 4.5 million per year). The anticipated amount of AUD 5.75 million for Years 4 and 5 based on a total five-year budget of AUD 19.75 million, would require a constriction of project activities, especially in light of the current exchange rate of an Australian dollar under USD 0.75. If that is all of the money that is available, the MTR has advised to have a larger spend in Year 4.

One reason the MTR cites for the lack of attention to sustainability by PSL was ambiguity around the project timeframe. PSL was designed as a 3+2-year program, anticipating that the scope and direction of the project may need to be adjusted after three years. The contracts with the implementing NGOs are for three years. However, PSL activities and anticipated outcomes were designed as a five year project. The MTR found that Year 3 planning was affected by the uncertainty of Years 4 and 5. Early certainty of funding levels for years 4 and 5 is important.

Response: Partially agree

DFAT agrees to continue PSL for years 4 and 5, but proposes to continue to allocate AUD19.75 million for the life of PSL (AUD5.75 million for years 4 and 5) (subject to financial delegate approval). No strong justification was given in the review that would alter this prior decision. The recommendations listed below stress the importance of developing exit strategies and ensuring sustainability of PSL achievements. Limited new activities will be approved for years 4 and 5 and DFAT will encourage PSL partners to prioritise how to exit from existing activities.

DFAT agrees to have a larger spend in Year 4 with a division of \$3.45 million in year 4 and \$2.3 million in year 5 (subject to financial delegate approval). This emphasises the requirement of PSL to increasingly exit from direct programming and ensure sustainability of outcomes.

DFAT agrees that timely certainty of funding levels for years 4 and 5 is required to ensure the extensive consultations and activities to develop the Annual Operating Plan can be conducted (for year 4 in particular).

Overarching Governance Recommendation

The PSL governance structure should remain the same for Years 4 and 5. However, as the focus switches to supporting MoH, garment factory managers and infirmary staff to maintain their new capacity after PSL ends, the NGOs will have to focus on the initiatives which are the most sustainable.

Response: Agree

Other Recommendations

All other recommendations are listed in [Annex 2](#).

DFAT fully agrees with all recommendations from the PSL MTR team except the following, to which we only partially agree:

- Recommendation to maintain funding at current levels (\$4.5 million per year) (Overarching Funding Recommendation).
- Phase out support of BCC activities in garment factories after the results the CARE BCC pilot (Recommendation 13).
- Greater role of CLU, especially in coordinating and managing PSL activities in the north-east and liaising with MoH at a national and provincial level to define targets for capacity building (Recommendation 19).

The following recommendations were not agreed as the PSL budget will not be maintained at current levels for years 4 and 5, and PSL need to focus on ensuring the sustainability and scale-down of existing activities:

- Train midwives in long acting family planning methods in all PSL-supported HCs in the north-east and non-supported HCs in Pursat and Sihanoukville that do not currently have the capacity (Recommendation 20).
- Extend selected support to HCs in the NE that are not currently supported by PSL or other donor-funded organisation (Recommendation 21).
- Conduct and disseminate the results of a feasibility study on working with factories in provincial Cambodia to address RMNH, building on the experience of Phnom Penh factories (Recommendation 26).

Prepared by: Benita Sommerville, First Secretary, Development Cooperation

Approved by: Ruth Stewart, Deputy Head of Mission

Date Approved: 17 February 2016

Annex 1: PSL MTR High Level Assessment of Aid Effectiveness

Assessment	High level evaluation questions specific to PSL	Rating	Evidence
<p>Relevance Extent to which activity is suited/appropriate to the priorities and policies of target group</p>	<ul style="list-style-type: none"> Are the program objectives and activities aligned with RGC and DFAT policies for RMNCH (Reproductive, Maternal, Neonatal and Child Health)? Are the objectives and activities addressing priority needs for partners, health services, communities and other beneficiaries? 	5	<p>RMNH are essential primary health services; the activities are aligned with the RGC's approach to improving maternal and newborn health through increasing the quality of services and enabling greater access and utilisation. The NE provinces and garment factories are recognised as priorities areas by all stakeholders. PSL activities are conscientiously designed and implemented in accordance with MoH policies and will continue to be relevant to the country's new Health Strategic Plan.</p>
<p>Effectiveness A measure of the extent to which an aid activity attains its objectives and managing the risks. Includes social inclusion</p>	<ul style="list-style-type: none"> Have program objectives been achieved or are on track to being achieved (as measured against the MERI indicators)? What additional or unintended benefits have occurred? What have been the enablers and barriers to achieving results? Were benefits directed towards communities and individuals with the greatest need? 	4	<p>Beneficiaries speak highly of individual PSL inputs and activities, especially support for MCAT, Comprehensive Abortion Care, garment factory infirmaries and engagement of commune councils and Village Health Support Groups in RNMH and with HC management.</p> <p>It is more difficult to understand what effect the sum of PSL activities has had on RMNH service quality and utilisation. Some activities are only directed towards some of the HCs in a province, raising the question of whether it would be better to spread assistance to new sites to achieve greater impact.</p> <p>Many of the MERI indicators depend on a midterm survey which has been commissioned. Results will not be available until early 2016. At that point it may be possible to be more certain about PSL's achievements.</p>
<p>Efficiency Qualitative and quantitative measure of outputs in relation to inputs (including resource inputs)</p>	<ul style="list-style-type: none"> Were project objectives and achievements achieved on time; what facilitated or impeded timely delivery. Were program activities conducted in the most cost-effective and efficient manner, compared to alternatives? What additional financial and other resources were leveraged to achieve PSL objectives? 	4	<p>Although some activities were slow to start, there was activity from Year 1. Changes in budgets and focus have meant reductions in activities in certain areas. Marie Stopes International switched their focus in the NE from Ratanakiri to Kratie in 2015. The NGOs have attracted other funding to support some activities formerly done under PSL.</p> <p>The PSL model of separate managing partners is inherently inefficient and limits the potential for directing resources where they are most needed or effective. Information on expenditure by activity or setting is not available and the programmatic rationale for stopping or starting specific activities is not transparent. The intensive support by PSL field staff on organising meetings, verification of supply-side financing and hands-on support for supervision, BCC activities and training is not only expensive but also raises serious concerns about sustainability.</p>

Assessment	High level evaluation questions specific to PSL	Rating	Evidence
Monitoring and evaluation	<ul style="list-style-type: none"> Does the logic model drive program implementation and strategic review? Is the MERI plan appropriate and effective in monitoring process and outcomes? Have the program learning strategies been appropriate and effective in improving program impact? 	4	The MERI plan is the main tool for measuring project performance and outcomes. Some of the indicators do not capture outcomes that could be realistically expected from project activities. PSL has effectively commissioned external studies that they have used to design programs and several mechanisms to review and plan activities. However, there is very little use of timely information about service utilisation and service capacity to assist in targeting.
Sustainability	<ul style="list-style-type: none"> How probable is it that program benefits continue at the end of donor funding? What are the major factors contributing to sustainability of program? What strategies or actions need to be continued or put in place to increase the likelihood of sustainability? 	4	The quality and utilisation of health services is lower in the NE than the rest of the country. Investment by PSL to bring them up to an acceptable level is a sustainable strategy. The benefits of improved infrastructure and equipment, increased skills of midwives, greater RMNH knowledge in the communities and relationship building between HC and Referral Hospital clinicians and commune councils and HC management will outlast PSL. However, at this stage PSL has not been actively working with PHDs, ODs, HCs and communities to maintain gains in service quality and community engagement. This needs to be the focus for Years 4 and 5.
Gender Equality How does the investment address gender equality and women's empowerment?	<ul style="list-style-type: none"> How have program objectives and activities addressed gender equality and women's empowerment, including reduction in risk of gender-violence? What benefits have been achieved or are on track to being achieved? What, if anything, could be done within the program to enhance gender equality and women's empowerment? 	5	PSL focuses on key women's health issues, seeking to reduce unwanted pregnancies and maternal deaths through providing women with a range of safe, affordable options to control the timing and number of pregnancies and have safe, healthy pregnancies and thriving newborns. Some BCC activities focus exclusively on men and many others recognise RMNH has a community and family responsibility. There is scope to re-focus messages to acknowledge women's concerns and constraints in addition to providing basic information and simple messages. The vast majority of providers benefiting from PSL capacity building are women, enabling them to have more satisfying careers.
Risk Management What else is at stake? And Safeguards <ul style="list-style-type: none"> Child protection Displacement and resettlement Environment Other 	<ul style="list-style-type: none"> Has the program put into place effective risk identification and minimisation strategies? What, if any, negative incidences or consequences have arisen and how effectively were they addressed? Have safeguards been put in place? What continuing and new risks are foreseeable in the future if the project were to continue and how should they be managed? 	4 5	PSL accurately recognised risks related to level of funding and exchange rates. While they have adjusted their budgets, the consequences of their decisions on the impact that the project can have has not been made transparent. PSL has conformed to changes in per diem and facilitator rates, but several activities have slowed or are threatened. In some circumstances PSL could have been more proactive in finding solutions with PHD, OD, HC and community partners. No issues arose during the MTR regarding adverse effects on children, displaced persons and the environment. The methods of program delivery would seem to minimise those risks. All NGOs have child protection policies and the focus on ethnic minorities is a form of empowerment of this marginalised group.

Assessment	High level evaluation questions specific to PSL	Rating	Evidence
Innovation and Private Sector Innovative development approaches?	<ul style="list-style-type: none"> • What are the aspects of innovation and private sector involvement demonstrated by this program? • Have the innovative and private sector activities been appropriate and effective? • What new or current innovation and private sector activities should form part of the program if continued? 	5	The PSL work with selected garment factories is very good and is a model for the development of national guidelines and new projects to expand the work. Several BCC activities are innovative, in that they use new media or indigenous languages. Piloting is showing that they are acceptable to the target groups but usually involve considerable support of skilled facilitators. Evaluations are necessary to determine the reach, impact and cost-effectiveness. The MTR was not as convinced about the value of several innovations to reduce financial burden. The commissioned study is a good initiative to make more informed decisions about these interventions.
Quality rating: poor– 1,2; less than adequate – 3; Adequate – 4; Good quality – 5, 6; N/A not able to be assessed			

Annex 2 – Management Response to detailed PSL MTR Recommendations

Priority Recommendations

Regardless of the funding allocated for Years 4 and 5, the MTR advisors recommend that PSL should undertake the following actions.

	MTR Recommendation	Response	Comment / Actions
1	<p>Greater unified, transparent and strategic decision-making regarding which activities are supported.</p> <p>The NGO partners to take a more unified, transparent and strategic position on which PSL activities to be conducted.</p>	Agree	<p>This will be particularly important as the program scales down and exits to ensure a coordinated approach.</p> <p>DFAT to work with CLU and PSL Implementing Partners to ensure this is strengthened in the planning processes for years 4 and 5.</p> <p>The CLU Director is instrumental in ensuring this occurs. As such, it is DFAT preference for the CLU Director to remain an expatriate position (original plan and budget was based on nationalising the position in years 4 and 5).</p>
2	<p>More sharing of skills and resources by NGOs to deliver PSL activities</p> <p>At the national, regional and provincial levels, greater sharing of skills and resources between NGOs - or single teams of field staff undertaking the work of more than one NGO.</p>	Agree	<p>DFAT to work with CLU and PSL Implementing Partners to ensure this approach is adopted (where appropriate) in the final 6 months of year 3 and years 4 and 5. NGO partners have already confirmed they will formalise cross-partnership technical teams and add advocacy (incorporating financial barriers), including a role in representation.</p>
3	<p>Work with PHDs and ODs to develop plans to phase out support based on clear targets for quality indicators from Level 1 and 2 assessments</p> <p>Develop a plan in Year 3 for a phased withdrawal of support from currently supported HCs in Year 4 and 5. This plan should include targeting a short list of indicators of service quality (from the Level 1 and 2 assessments) used in all four provinces so that the HCs with the greatest needs receive the most support.</p>	Agree	<p>This will be particularly important as the program scales down and exits activities.</p> <p>DFAT to work with CLU and PSL Implementing Partners to ensure this is part of the planning process for years 4 and 5.</p>
4	<p>Support HCs, ODs and PHDs to include key RMNH quality improvement activities such as MCAT, in-service training and supervision in their annual operation plans (AOPs)</p> <p>Support HCs, ODs and PHDs to include key RMNH quality improvement activities such as MCAT, in-service training and supervision in their annual operation</p>	Agree	<p>DFAT to work with CLU and PSL Implementing Partners to ensure this is part of the planning process for years 4 and 5 and advocate at OD/PHD level as well as national MoH level.</p> <p>PSL will aim for full transition to the MoH/PHD AOP by Dec 2017 ahead of AOP FY2018. CLU will coordinate this in the north east.</p>

	MTR Recommendation	Response	Comment / Actions
	plans.		
5	<p>Implement a single model of coaching and mentoring for RMNH skills across all PSL sites (aligned with Level 2 assessments) to be delivered with PHDs and ODs</p> <p>In consultation with NMCHC, ODs and PHDs as well as development partners, PSL should work towards a single strategy for supportive supervision and quality improvement aligned with Level 2 assessments for all RNMH services. Efforts being done in Year 3 should be redirected to achieve this goal and a new system applied from Year 4. This may require one NGO or the CLU taking the lead, pulling on the work of the PSL partners and other initiatives in Cambodia. The harmonising within PSL should align with and complement advocacy efforts to standardise approaches nationally.</p>	Agree	<p>DFAT to work with CLU and PSL Implementing Partners to ensure this is part of the planning process for years 4 and 5. The extent to which the model can be aligned with Level 2 assessments will depend on the outcome of the MoH Level 2 assessment tools pilot. DFAT to ensure PSL is closely aligned with the Health Sector Support Program 2 (HSSP2) (and its successor program H-EQIP) supervision and quality improvement programs.</p> <p>Regardless of this pilot:</p> <ul style="list-style-type: none"> • Clinical technical harmonisation will continue under PSL in years 4 and 5 in line with MoH protocol development. • The quality improvement package will be formalised by the PSL Clinical Quality Team for advocacy purposes. • Comprehensive Abortion Care (CAC) quality improvement tools will be reviewed and developed as modules that can be added to national MoH protocols.
6	<p>Phase out of supply-side financing of long acting family planning methods and the mobile team model of quality improvement</p> <p>The extent to which MSIC quality improvement visits for long-acting family planning should be ascertained and addressed. We recommend that the current model should be phased out of PSL and alternative strategies that are better integrated with government service delivery and promotion be instituted.</p>	Agree	<p>DFAT is proposing that all PSL Financial Barriers activities cease by the end of year 3, with any residual activity in years 4 and 5 to be confined to advocacy. Family planning and CAC messaging will be integrated into other BCC in the north east.</p> <p>Agree to the recommendation to phase out mobile quality improvement visits by the end of year 4.</p> <p>DFAT agrees that the extent to which quality improvement visits are resulting in poor family planning service delivery practices needs to be ascertained and addressed. DFAT will work with CLU and Marie Stopes International Cambodia to determine the scale of the problem.</p>
7	<p>Find more sustainable models of BCC activities, including phasing out support for Village Savings and Loans Associations (VSLA) and delivering information on long acting family planning within all PSL health education</p>	Agree	<p>DFAT is proposing that all PSL Financial Barriers activities cease by the end of year 3, with any residual activity in years 4 and 5 to be confined to advocacy.</p> <p>DFAT agrees that promotion of long acting family planning methods should be</p>

	MTR Recommendation	Response	Comment / Actions
	<p>The role of VSLA groups with PSL should be reconsidered from a perspective of scalability and sustainability. If the goal is to have people use savings groups as part of birth planning or other RMNH needs, than encouraging commune leaders, village chiefs and VHSGs to promote RMNH messages to existing groups may be more efficient and effective. If the VSLA model is to continue to be used then there needs to be some decisions about scaling. Expanding the number of VSLAs would mean reducing the level of support to existing VSLAs and accepting some of them may fail.</p> <p>Promotion of long-acting family planning methods, including information on safety, should be incorporated into all PSL BCC, and MSIC's activities in direct provision of BCC be phased out although the organisation should assist PSL partners to include long-acting family planning methods in their BCC activities.</p>		<p>incorporated into all PSL BCC, and MSIC's activities in BCC phased out by end of Year 4 with sustainability promoted through capacity building of Village Agents.</p>
8	<p>Do not pilot a combined program of funding mechanisms to reduce financial obstacles to RMNH service utilisation</p> <p>The decision to commission independent researchers to study financial barriers to accessing RMNH services is a good one and should be used to determine the most useful ways to intervene. The financial mechanisms proposed at present are extremely costly in terms of PSL support and may not be an improvement over simple reimbursement of travel costs. Complicated financial mechanisms to support the near-poor or non-poor should only be undertaken with robust monitoring and evaluation so that the results can be shared with the MoH and other partners. Offering all mechanisms in a single health centre is unlikely to be able to answer the important question if any one of them is effective.</p>	Agree	<p>DFAT is proposing that all PSL Financial Barriers activities cease by the end of year 3, with any residual activity in years 4 and 5 to be confined to advocacy. As such, the pilot is no longer required.</p>
9	<p>Continue to support CAC training and PHD-implemented model of CAC QI visits</p> <p>PSL should continue to support training in CAC training and follow up supportive supervision/assessment until another funding mechanism can be used. Ensuring that abortions are conducted safely and that repeat abortions are prevented through provision of counselling and provision of contraceptives is an essential component of an integrated strategy to reduce maternal mortality.</p>	Agree	<p>DFAT agrees to phase this out as long as alternative strategies are found.</p> <ul style="list-style-type: none"> • CAC training to be completed by end year 4. • All provinces to be transitioned to PHD/OD-implemented CAC quality improvement by mid-year 5 (includes roll out of CAC MCAT to an additional 9 provinces). <p>DFAT agrees with PSL partners that long acting family planning financing options should be reviewed and incorporate programs such as H-EQIP and Social Health</p>

	MTR Recommendation	Response	Comment / Actions
			<p>Protection targeted benefit contract options.</p> <p>DFAT has funded the Reproductive Health Commodities Security program (through UNFPA) from 2013 to 2015 to assist the Royal Government of Cambodia to allocate national budget to procure commodities after 2015, and supported the Reducing Maternal and Newborn Mortality project prior to PSL. The decision to fund CAC and long-term family planning methods under PSL was a decision DFAT made in consultation with NMCHC.</p>
10	<p>Work with partners to find a solution for compensating CAC facilitators or their employers</p> <p>MSIC, with other PSL partners, should devise a solution to compensating CAC facilitators so that a regular training program can be resumed. As this training will be an on-going requirement for MoH there could be some benefits to developing a package for the training facilities that enable them to secure the services of their staff and paying for the additional hours of a replacement senior clinician. MSIC, in consultation with NMCHC, may also have to pay the high facilitation rates for some training tasks.</p>	Agree	DFAT agrees that a solution needs to be devised in consultation with MoH (especially NMCHC).
11	<p>Work towards phasing out the need for donor support for assessing, training and supportive supervision for long acting family planning methods. This may involve supporting new national curriculum or training of trainers.</p> <p>In consultation with MoH and other donors, PSL should support PHDs outside of the north-east to phase out reliance on external funding for building capacity to deliver long acting family planning methods by Year 5. MSIC may be able to use PSL funds to foster the sustainability of this training by assisting to revise the curriculum to include all implant devices and supporting refresher training of PHD and OD trainers on assessing training needs and conducting IUD and implant training and QI/supervision.</p>	Agree	<p>DFAT to work with CLU and PSL Implementing Partners to ensure this is part of the planning process for years 4 and 5.</p> <p>Early discussions with NGOs indicate that training will be completed and transitioned to PHD/OD-implemented QA by end of year 4. Pursat will transition to QHS by end Year 3.</p>
12	<p>Phase out the supply-side initiatives for long acting FP and related BCC and CBD support in Pursat, Sihanoukville and Kratie</p>	Agree	With less funding available in years 4 and 5, DFAT agrees that this should not be prioritised for PSL funding.

	MTR Recommendation	Response	Comment / Actions
13	<p>Phase out support of BCC activities in garment factories after the results the CARE BCC pilot</p> <p>Complete the pilot of CARE's BCC package, including dissemination of the results of the evaluation, paying particular attention to their effectiveness and efficiency in reaching large numbers of garment workers.</p> <p>Except for the pilot, phase out PSL support for BCC activities delivered face-to-face in factories which focus on reproductive health knowledge.</p>	Partially agree	<p>DFAT agrees with the MTR team that face-to-face BCC appears to not be as effective (the recommendation is not saying to phase out all BCC only BCC delivered face-to-face).</p> <p>However, agrees with the PSL partners to use the results of the pilot to determine what activities should be implemented in years 4 and 5.</p>
14	<p>Continue to work with Ministry of Labor and Vocational Training (MLVT), MoH and other stakeholders on guidelines for factory infirmaries</p>	Agree	<p>DFAT to work with CLU and PSL Implementing Partners to ensure this is part of the planning process for years 4 and 5. This should be coordinated with programs supported under DFAT's Ending Violence Against Women's program (as they relate to domestic violence).</p>
15	<p>Cease any existing PSL support for peer educators in garment factories</p> <p>Cease support for peer educators as a BCC tool.</p>	Agree	<p>DFAT and PSL partners have already agreed this will be phased out by the end of Year 3 (in line with phase-in of reviewed BCC package).</p>
16	<p>Increase use of routinely collected data to monitor the outcomes of PSL activities</p> <p>As PSL starts to focus on sustainability and exit plans, greater use should be made of data routinely collected by the NGOs, through the national HIS and other routinely collected information to provide meaningful information on PSL progress.</p>	Agree	<p>Agree, to the extent that data is available and reliable. The PSL M&E team will review and recommend on utilisation of routinely collected data and increased use of qualitative data and analysis.</p>
17	<p>Incorporate questions about exposure to RMNH messages as part of the midterm or endline surveys</p> <p>Including exposure to BCC activities in the mid-term (if possible) and endline surveys of women in reproductive ages in ODs supported by PSL in the NE and other provinces. This will enable some indication of how knowledge of danger signs in pregnancy and neonatal distress has improved.</p>	Agree	

	MTR Recommendation	Response	Comment / Actions
18	<p>Disseminate evidence of the effectiveness of PSL activities and strategies based on mixed-methods evaluations and population surveys</p> <p>As evidence becomes available through learning activities, disseminate results of PSL's evaluations of its impact.</p>	Agree	

Other Recommendations

In Years 4 and 5, subject to available funds, the MTR recommends that PSL consider prioritising the following actions:

	MTR Recommendation	Response	Comment / Actions
19	<p>Greater role of CLU, especially in coordinating and managing PSL activities in the north-east and liaising with MoH at a national and provincial level to define targets for capacity building</p> <p>In Years 4 and 5, PSL should consider a greater role for CLU, including:</p> <ul style="list-style-type: none"> - Leading NE activities in the future or at least taking on greater management responsibility for the field staff, including in-house capacity building. - Directing negotiating capacity building targets with MoH and PHDs to inform PSL investments in Years 4 and 5. 	Partially agree	While good in principle, careful thought will need to be made on the CLU's capacity to undertake these tasks within current resources. If additional resources are required, decisions will need to be made on which programs are forfeit.
20	<p>Train midwives in long acting family planning methods in all PSL-supported HCs in the NE and non-supported HCs in Pursat and Sihanoukville that do not currently have the capacity</p> <p>Training in safe IUD and implant insertions, removals and counselling should be provided to supported health centres in all four NE provinces, subject to the availability of supplies. Information about these methods (including side-effects and safety) should be incorporated into BCC activities conducted by all PSL NGOs.</p> <p>Subject to available resources and MoH support, In the short term,</p>	Disagree	<p>With less funding available in years 4 and 5, DFAT does not agree that this should not be prioritised for PSL funding. This must be included in future MoH training plans.</p> <p>Has the complication of training/facilitation fees which would likely slow implementation.</p>

	MTR Recommendation	Response	Comment / Actions
	compensating Pursat and Sihanoukville PHDs for losing the supply-side financing support by supporting training and related assessment activities in long acting family planning methods in the currently unsupported HCs which do not currently have the capacity to provide long acting family planning counselling and services.		
21	<p>Extend selected support to HCs in the NE that are not currently supported by PSL or other donor-funded organisation</p> <p>Any savings or additional funds should be used in the NE to give targeted support to health centres that have not yet had PSL support.</p>	Disagree	<p>With less funding available in years 4 and 5, careful thought needs to be made on how to prioritise which HCs are supported in the NE. Options include to bring the poorest HCs up to basic standard, or continue to focus on ensuring a number of Basic Emergency Obstetric and Newborn Care HCs are developed.</p> <p>DFAT would only agree to new HCs being supported if they replace current HCs.</p>
22	<p>New BCC materials should reinforce women’s own agency and address specific concerns such as side-effects of modern contraceptives and practical constraints to accessing health services such as child care</p> <p>In development of new health promotion materials, the PSL partners should incorporate messages that reinforce women’s own agency and empowerment in seeking health care.</p>	Agree	DFAT to work with CLU and PSL Implementing Partners to ensure this is part of the planning process for years 4 and 5.
23	<p>Greater engagement with commune councils to promote RMNH behaviours and demand for services</p> <p>Commune councils play a major role in the health and well-being of communities. PSL should increase or make more explicit their cooperation with the commune councils to support women’s access of health facilities for RMNH in all communities where PSL operates. This will require relationship building, as has been done in Kratie through Save the Children, to discuss how communes can become involved in many ways including, but not limited to, the Community Investment Fund. Examples of commune innovation should be disseminated and incentives for communes reaching RMNH targets should be considered.</p>	Agree	DFAT believes this is occurring more than the MTR found, but will work with CLU and PSL Implementing Partners to ensure this approach is adopted (where appropriate) in years 4 and 5.
24	Increase capacity of all PSL supported infirmaries to provide RMNH services	Agree	If funding allows, DFAT agrees to this activity.

	MTR Recommendation	Response	Comment / Actions
	<p>and referrals</p> <p>Build the capacity of infirmaries to delivery short-acting family planning methods and provide referrals for other RMNH services in the remaining PSL supported factories.</p> <p>Disseminate the results of the trends between the baseline and midterm surveys of garment factory workers, highlighting any learning for improving RMNH in factories.</p>		
25	<p>Explore potential synergies with PSL’s experience in working with garment factories and DFAT’s Ending Violence Against Women’s program</p>	Agree	
26	<p>Conduct and disseminate the results of a feasibility study on working with factories in provincial Cambodia to address RMNH, building on the experience of Phnom Penh factories</p>	Disagree	<p>With less funding available in years 4 and 5, DFAT does not agree that this should not be prioritised for PSL funding.</p>