

Partnering to Save Lives Midterm Review  
FINAL

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**Specialist  
Health  
Service**

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# PSL MIDTERM REVIEW

## Aid Activity Summary

Aid Investment Name	Partnering to Save Lives		
Investment commencement date	1 August 2013	Investment completion date	31 July 2016 (31 July 2018) 3 + 2 years
Total Australian \$	14.0 million for Years 1 -3		
Total other \$	n/a		
Delivery organisation(s)	CARE Australia, Marie Stopes International Australia and Save the Children Australia		
Country/Region	Cambodia		

## Executive Summary

Partnering to Save Lives (PSL) is a partnership between the Australian Government, the Cambodian Ministry of Health (MoH) and three non-governmental organisations (NGO) (CARE Australia, Marie Stopes International Australia and Save the Children Australia). The project is designed to draw upon and leverage the skills and resources of all partners to achieve better reproductive, maternal and newborn health (RMNH) outcomes.

The Mid-Term Review (MTR) found that PSL's focus, activities and outcomes to date were consistent with the Australian Government's targets for strategic investments in the health sector and aligned with the Royal Government of Cambodia's (RGC) health policies. The advisors recommend that PSL continues to be funded for Years 4 and 5.

## Summary of key findings

PSL is a complicated program. It operates in three distinct settings, has seven high level objectives and 11 major strategies that include 28 different types of activities each delivered independently by the NGO partners.

The MTR examined PSL activities across five broad areas:

1. The partnership and the role of the Coordination and Learning Unit (CLU)
2. Support of RMNH in the northeast (NE) provinces
3. Support of RMNH service delivery capacity in selected provinces outside of the NE
4. Support of RMNH in garment factories in the Phnom Penh metropolitan area
5. Monitoring, evaluation, learning and advocacy.

We found that the PSL structure of three independent NGOs, contracted separately by the Australian Government, DFAT 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 MoH policies and guidelines. Facilitated by the CLU, the NGO partners meet regularly to discuss strategic, operational and technical issues and there are a growing number of joint initiatives.

The PSL efforts in the 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

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population have difficulties accessing RMNH services because they are geographically remote and members of ethnic minorities with their own indigenous languages.

PSL activities in the NE involve building the capacity of the public health system to offer quality RMNH services and increasing demand for these services through Behaviour Change Communication (BCC), community engagement with health services and reduction of financial barriers. One of the most effective PSL activities is support for Midwifery Coordination Alliance Team (MCAT) meetings. These bring midwives from health centres (HC) throughout each province for one day meetings each quarter. These meetings provide a useful platform for improving relations between primary health centres and referral hospitals and build the confidence and competence of midwives, many of whom have little practical experience. PSL also supports refurbishments and purchase of minor equipment, in-service training for midwives, and supervisory visits by Provincial Health Department (PHD) and Operational District (OD) officers in selected HC.

As part of PSL, Marie Stopes International Cambodia (MSIC) supports training and quality assurance in comprehensive abortion care (CAC), to prevent maternal mortality and morbidity resulting from unsafe abortions and prevent repeat abortions through offering post-abortion family planning counselling and services in 13 provinces. The MoH depends on the technical expertise of MSIC and the financial support of the Australian Government to be able to offer this essential service.

An innovative feature of PSL is its work in garment factories in the Phnom Penh metropolitan area. Leveraging the NGOs extensive experience working with factory management, PSL is building the capacity of garment factory infirmaries and management to offer RMNH education, counselling, services and referrals. The partners are also trialling multi-media BCC packages.

PSL has used their experience to contribute to national policy development by supporting cross-agency efforts to develop national guidelines for MCATs and garment factory infirmaries.

### Summary of recommendations

The MTR advisors 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.

The funding available for Years 4 and 5 will determine which MTR recommendations can be actioned. We recommend that DFAT continue to fund PSL at approximately the same level of expenditure in Years 2 and 3. The anticipated amount of AUD5.75 million for Years 4 and 5 based on a total five-year budget of AUD19.75 million, would require a constriction of project activities, especially in light of the current exchange rate of an Australian dollar under USD0.75. If that is all of the money that is available, it would be advisable to have a larger spend in Year 4.

Regardless of the funding allocated for Years 4 and 5, the MTR advisors recommend that PSL should undertake the following actions, which are summaries of recommendations detailed in Section 5:

- Greater unified, transparent and strategic decision-making regarding which activities are supported.
- More sharing of skills and resources by NGOs to deliver PSL activities.
- 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.

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- 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.
- Implementing a single model of coaching and mentoring for RMNH skills across all PSL sites, aligned with Level 2 assessments and to be delivered with PHDs and ODs.
- Phase out of supply-side financing of long acting family planning (FP) methods and the mobile team model of quality improvement (QI).
- Find more sustainable models of BCC activities, including phasing out support for Village Savings and Loans Associations (VSLA) and delivering information on long acting FP within all PSL health education.
- Do not pilot a combined program of funding mechanisms to reduce financial obstacles to RMNH service utilisation.
- Continue to support CAC training and PHD-implemented model of CAC QI visits.
- Work with partners to find a solution for compensating CAC facilitators or their employers
- Work towards phasing out the need for donor support for assessing, training and supportive supervision for long acting FP methods. This may involve supporting new national curriculum or training of trainers.
- Phase out support of BCC activities in garment factories after the results the CARE BCC pilot
- Continue to work with Ministry of Labor and Vocational Training (MLVT), MoH and other stakeholders on guidelines for factory infirmaries.
- Cease any existing PSL support for peer educators in garment factories.
- Increase use of routinely collected data to monitor the outcomes of PSL activities.
- Incorporate questions about exposure to RMNH messages as part of the midterm or endline surveys.
- Disseminate evidence of the effectiveness of PSL activities and strategies based on mixed-methods evaluations and population surveys.

We also recommend that, depending on the resources available, PSL should consider the following actions:

- Greater role of CLU, especially in coordinating and managing PSL activities in the NE and liaising with MoH at a national and provincial level to define targets for capacity building.
- 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.
- Upgrade capacity of infirmaries to provide RMNH services and referrals in all PSL supported factories.
- Extend selected support to HCs in the NE that are not currently supported by PSL or other donor-funded organisation.
- 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.
- Greater engagement with commune councils to promote RMNH behaviours and demand for services.
- Increase capacity of all PSL supported infirmaries to provide RMNH services and referrals.
- Explore potential synergies with PSL's experience in working with garment factories and DFAT's Ending Violence Against Women's program.
- 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.

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## Acronyms

ANC	Antenatal care
AOP	Annual Operational Plans
BCC	Behaviour change communication
CAC	Comprehensive abortion care
CBD	Community based distributor
CDHS	Cambodian Demographic and Health Survey
CLU	Coordination and Learning Unit
DFAT	Department of Foreign Affairs and Trade
EmONC	Emergency Obstetric and Newborn Care
FP	Family Planning
FTIRMN	Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality
HC	Health Centres
HCMC	Health Centre Management Committee
HEF	Health Equity Fund
HIS	Health Information System
PSL	Partnering to Save Lives
NE	Northeast
MCAT	Midwifery Coordination Alliance Team
MERI	Monitoring, Evaluation, Reporting and Improvement framework
MLTV	Ministry of Labor and Vocational Training
MoH	Ministry of Health
MSIC	Marie Stopes International Cambodia
MTR	Midterm Review
NGO	Non-governmental organisations
NMCHC	National Maternal and Child Health Centre
OD	Operational Districts
PHD	Provincial Health Department
PNC	Postnatal care
PSC	Program Steering Committee
QA	Quality Assessment
QI	Quality Improvement
RGC	Royal Government of Cambodia
RH	Referral Hospital
RMNH	Reproductive, Maternal and Newborn Health
SHS	Specialist Health Service
TFR	Total Fertility Rate
ToR	Terms of Reference
TRG	Technical Reference Group
VHSG	Village Health Support Group
VSC	Voluntary Surgical Contraception
VSLA	Village Savings and Loan Associations

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## Acknowledgements

The Mid-Term Review team spent ten days in three provinces and five days conducting interviews and field trips within Phnom Penh. All together we spoke with 178 people about the Partnering to Save Lives (PSL) project. The smooth execution of such a large exercise requires a lot of work in the background: making initial contact, sending invitations, juggling schedules and handling logistics. Much of this effort was unseen by the advisors but resulted in a well organised review that enabled us to focus on learning about PSL's achievements and challenges. We are grateful for the efforts of Benita Sommerville and Meng Piseth of DFAT Cambodia; Heidi Brown and her team at PSL's Coordination and Learning Unit (CLU); and the field staff, project coordinators, program managers and directors of Care Cambodia, Save the Children Cambodia and Marie Stopes International Cambodia. The staff of CLU and the three NGOs provided us with a great deal of information and was very responsive and patient in answering our many questions.

We are also grateful to the many representatives of development partners, Ministry of Health officials at the national, provincial and OD levels and the directors and midwives we meet at nine health centres and two Midwifery Alliance Coordination Team meetings. Finally, but not least, we were privileged to hear directly from commune councillors, health volunteers and men and women in villages and factories about their reproductive, maternal and newborn health needs, challenges and their resourcefulness in meeting them. We asked a lot of questions and took up a lot of their time, for no direct benefit. Their generosity is what made this review possible.

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## 1. Introduction

Partnering to Save Lives (PSL) project is a partnership between the Australian Government, the Cambodian Ministry of Health (MoH) and three NGOs (CARE Australia, Marie Stopes International Australia and Save the Children Australia). The project is designed to draw upon, and leverage, the skills and resources of all partners to achieve better reproductive, maternal and newborn health (RMNH) outcomes. Activities focus on supporting quality improvements in service delivery, demand creation, reduction of financial barriers to services and informing national policies and practices. Target beneficiaries include under-served populations in Cambodia's provinces and metropolitan garment factories.

The Project Design Document had a 3 + 2 year design, with the activities and budget frontloaded into the first three years. This was to maximise the prospect of achieving outcomes against multiple objectives in the early years and provide opportunity for reflection and re-direction in response to project learning and changes in the policy landscape. A midterm review (MTR) was planned to assess the project's progress against its objectives midway and inform the Australian Government's Department of Foreign Affairs and Trade's (DFAT) decisions regarding the continuation of the project and its funding and scope, should the project continue.

The MTR was held in September and October 2015 by two independent advisors (Annex 1). The specific purposes, as set out in the Terms of Reference (ToR), were to:

- Assess the program's progress against its objectives over the first two years of implementation including an assessment of the data and evidence around claims that the project has improved utilisation and quality, improved access, and strengthened MoH's reproductive health services
- 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 the Royal Government of Cambodia's (RGC) health priorities.

## 2. Background

### 2.1. Context of RMNH in Cambodia

Cambodia's rapid economic growth impacts on RMNH in many ways. With improving economic conditions more people are employed and there has been a growth in private sector health providers. The Royal Government of Cambodia has a larger budget and is taking responsibility for more of the health budget than it did in the past. Several donors who used to fund RMNH activities in the past have closed or reduced their support.

Health status and health service utilisation is improving, reflecting increasing living standards and improvements in health care. Preliminary results of the 2014 Cambodian Demographic and Health Survey (CDHS) were released in February and the full report in October 2015.<sup>1</sup> Maternal, neonatal and

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<sup>1</sup> National Institute of Statistics, Directorate General for Health, and ICF International. *Cambodia Demographic and Health Survey 2014*. Phnom Penh, Cambodia, and Rockville, Maryland, USA: National Institute of Statistics, Directorate General for Health, and ICF International, 2015. Available <http://dhsprogram.com/publications/publication-fr312-dhs-final-reports.cfm>

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child death rates have all declined since the last survey in 2010. Nearly all pregnant women attend antenatal care at least once and give birth in the presence of a skilled birth attendant.

The total fertility rate (TFR) has declined from 3.0 in 2010 to 2.7 in 2015. In Phnom Penh, the TFR is 2.0, meaning that, if current fertility rates continue, the average young woman will have two births during her lifetime. The highest TFRs are in the northeast (NE) provinces. The rates of teenage child-bearing is also highest in the NE, with between one-fifth and one-third of 15-19 year olds being pregnant or having given birth.

Knowledge and use of family planning is high. Knowledge of female sterilisation, male condom, oral contraceptives, IUDs and implants exceed 90 per cent for all women of reproductive age. Among currently married women, only 39 per cent use a modern contraceptive method, primarily short acting hormonal methods; oral contraceptives are used by 18 per cent and injectables by nine per cent of currently married women. Withdrawal is the second most used method, reported by 15 per cent of currently married women: in Phnom Penh it is the most common method, used by over one-quarter of currently married women. The popularity of withdrawal appears to result from a wide-spread concern about side effects of modern methods. Withdrawal is seen as a safer, healthier alternative.<sup>2</sup>

The policy frameworks under which PSL has operated--the Health Strategic Plan 2008-2015 and the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality (FTRMNM)--are expiring in 2015 and new strategies being developed. These are not expected to reflect any major shifts in approaching RMNH, but there will be an increased emphasis on adolescents and newborn care.

The roll out of the Health Equity Funds (HEF) system of financing is enabling health centres to offer subsidised service to poor households. Building on the HEF roll out and the high quality paper-based Health Information System (HIS), there is a phased expansion of an electronic system that integrates patient registration, diagnosis and treatment, user fees and HEF reimbursement. When complete, the system will enable very precise targeting of high and low performing facilities as well as better data on health service utilisation by location and type of service.

Over the past few years, the MoH, with support from donors, has instituted Level 2 assessments to measure the quality of care processes. There is active discussion about linking performance on Level 2 assessments to the financing of health facilities through HEF. Services offering higher quality services will be paid at a higher rate.

## 2.2. The Australian Government's international assistance

Expectations for the performance of Australian government assistance in the health sector is described in two recent policy documents: Making Performance Count (2014) and Health for Development Strategy (2015). The MTR has been designed to determine if PSL conforms to these expectations.

Making Performance Count is a framework for focusing Australia's aid program to ensure the greatest impact in contributing to sustainable economic growth and poverty reduction. The 10 targets are:

1. Promoting prosperity
2. Engaging the private sector
3. Reducing poverty

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<sup>2</sup> The RESPOND Project, Views on family planning and long-acting and permanent methods: Insights from Cambodia. RESPOND Project Brief No. 12, New York, EngenderHealth (The RESPOND Project), February 2013. Available: <http://www.respond-project.org/archive/files/4/4.1/4.1.1/Brief12-2013-Views-on-Family.pdf>

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4. Empowering women and girls
5. Focusing on the Indo-Pacific region
6. Delivering on commitments
7. Working with the most effective partners
8. Ensuring value-for-money
9. Increasing consolidation
10. Combatting corruption.

The Health for Development Strategy interprets this approach for aid programs in the health sector, starting from the premise that a stronger national health system will involve at a minimum:

- Target 2: engaging the private sector.
- Target 3: reducing poverty.
- Target 4: empowering women and girls.

It calls for health programs to invest in strengthening countries' core public health systems and capabilities, engage—where appropriate—the private sector, and incorporate innovations and new approaches to health strategies.

PSL, although designed prior to these policies, is consistent with these objectives. Maternal and newborn health and family planning are mentioned as core areas for Australian Government assistance because of their proven impact in reducing poverty and empowering women and the opportunities for partnership with the private sector and innovative approaches.

In conducting the MTR, we were guided by the questions for determining strategic performance of health sector aid programming described in the Health for Development Strategy:

- Are we focusing on the right issues to promote economic growth, reduce poverty, and maintain regional health security?
- Are we contributing to gender-equality outcomes?
- Are we investing adequately in the right countries and targeting the right populations?
- Are we achieving the impacts we intended?
- Are our investments effective and efficient?
- Are we working with appropriate partners and using appropriate modalities?
- Do we have the appropriate resources and systems to deliver impact and demonstrate results?
- Are we responding appropriately to context and to changes in the development environment?
- Are we engaging appropriately with the private sector?
- Are we investing adequately in innovation and research?

### 3. Methods

Prior to starting fieldwork, the review team prepared an evaluation plan (Annex 2) to answer the questions posed in the ToR. The evaluation plan was approved by DFAT after input from the implementing NGOs and the National Maternal and Child Health Center (NMCHC).

The plan specified five key evaluation questions:

- Has the PSL program achieved positive reproductive, maternal and newborn health outcomes through supporting improved service delivery and demand creation?
- Has the PSL program influenced the strengthening reproductive, maternal and newborn health system in Cambodia through its learning, communication and advocacy activities?

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- Which strategies were the most relevant, effective and cost-efficient?
- Was the partnership model of PSL effective and cost-effective compared to alternatives?
- Based on program achievements and MoH's and DFAT's current needs and priorities, which aspects of the program should continue and in what form and with what resources?

A methodology was developed to answer these questions in an efficient and rigorous manner, taking into account time constraints. It had four components:

- Documentation review
- Key informant interviews with PSL partners and national RMNH stakeholders
- Site visits, including individual and small group interviews with beneficiaries and partners and observations of facilities and community activities
- Presentation of an Aide Memoire.

## 3.1. Data collection and analysis

The documentation review informed the evaluation plan and continued throughout the fieldwork and report preparation as new questions emerged and other reports were brought to our attention. The principal documents included: the project design document, annual operational plans and annual reports; MoH's Health Strategic Plan 2008-2015 and FTIRMN; relevant DFAT policies; reports of the 2010 and 2014 Cambodian Demographic and Health Survey; and a number of working papers and draft documents describing the Cambodian health sector and preparation for the new Health Strategic Plan.

Following briefing by DFAT in Cambodia, the advisors conducted interviews with representatives of major donors and technical agencies involved with RMNH. The purpose of these interviews was to understand how PSL contributed to a broader program of support for RMNH and views about the project's relevance and effectiveness. At the end of field visits, the advisors met with the Director of the NMCHC who is MoH's representative on the PSL Program Steering Committee. In total, the advisors interviewed 11 key informants.

The visits to observe project activities and meet with beneficiaries and MoH partners were arranged in consultation with DFAT officers and staff from PSL's implementing NGOs and Coordinating and Learning Unit (CLU). Details are in Table 1. We went to Pursat to see PSL's work in long acting family planning outside of the NE. We went to two provinces in the NE to see government health facilities, speak with MoH officers and midwives, and observe community activities. In one province most PSL activities were conducted by CARE and in the other activities were conducted by Save the Children and Marie Stopes International Cambodia (MSIC). In Phnom Penh we spent several hours each at two factories supported by PSL. We also had lengthy interviews and more informal discussions with staff involved at all levels of PSL.

For another perspective on the impact of PSL, in two provinces we visited HCs that were not supported by the project. To learn more about garment factory workers' choices for RMNH services we went to one government and one private health clinic in the vicinity of one of the factories.

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**Table 1:** Location of field visits, including numbers of people interviewed

Location	Health centre/factory	MCAT meeting	FP awareness activities	Persons interviewed individually or in a group
Pursat	3 HC – 2 PSL and one non PSL	—	One BCC activity	16
Ratanakiri	3 HC – 2 PSL and one non PSL	Morning session	VSLA meeting VHSG meeting Men’s radio club Woman’s radio club	52
Kratie	3 PSL supported HC	Afternoon session	Two separate RNMH awareness activities One VHSG meetings	50
Phnom Penh factories	2 supported factories and their infirmaries; 1 HC and 1 private clinic located near one factory	—	BCC activities at both factories	29

To maximise the number of people and activities we saw, the Team Leader and Team member occasionally observed separate activities. The Australian Team Leader was accompanied by a translator. The Team Member was a Cambodian national, fluent in Khmer and English. PSL staff translated between an indigenous language and Khmer when the team visited ethnic communities in the NE.

Prior to each interview a question line was prepared, using open-ended questions to elicit information about PSL supported activities and outcomes and the wider context. The aid effectiveness criteria were used as a guide to construct the question lines.

An information sheet, in English and Khmer, was given to each person prior to the interview. Using the sheet as a guide, an advisor explained the purpose of the MTR and gave a guarantee that the information would be treated as confidential. No persons under 18 years old were interviewed. Hand written notes were taken during the interview, which, with permission, were also recorded. Photographs were taken as a memory aid and to record examples of project material. We expanded and electronically entered our notes, using the aid effectiveness criteria as a guide.

Analysis started in the field. At the end of each cluster of field visits in a province the advisors discussed their findings, recorded our observations and initial conclusions and identified issues to explore further. At the end of the field visits, the advisors prepared an Aide Memoire to present initial findings and offer tentative recommendations. These were discussed at a presentation on 6 October, attended by DFAT officers and representatives of the implementing NGOs and CLU. Feedback from that meeting was incorporated into the final report.

### 3.2. Limitations and alterations to the evaluation plan

Limitations and constraints reflect lack of data and some of the inevitable shortcomings of having to understand many activities in a short time. Here we describe those limitations and actions taken to reduce their impact.

We have little outcome data that show trends in service quality or service utilisation over time and, except for the visits to two unsupported HCs, we have no comparison data with unsupported providers,

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HCs or ODs. This makes drawing robust conclusions about effectiveness challenging. More importantly it makes it difficult to comment on exit strategies or criteria for selection.

Much of this information is routinely collected by the NGOs or MoH's HIS and would have expected to be part of PSL's routine M&E activities. However, during our short visits to provinces we were not able to obtain the information and when we asked were told it was difficult to obtain. There is some progress on this front; we understand that CLU has been compiling data on PSL inputs at the HC level, along with some outcome data.

Financial data in the annual reports and plans were not sufficiently detailed to estimate cost-effectiveness of specific activities.

As would be expected, there were a few people, especially at the Provincial Health Department (PHD) and Operational District (OD) levels, we were not able to see. Furthermore, even though each interview was at least 30 minutes long and many went for more than one hour, we did not ask about everything in every interview.

Another challenge for the advisors in the field was understanding recent changes in PSL-supported activities, especially in the NE provinces. The Annual Operating Plan for Year 3 (AOP3) flagged that some activities supported by PSL in Years 1 or 2 would be discontinued. These include the community scorecard in CARE supported provinces, support by CARE and Save the Children for supervision visits by PHDs and ODs to HCs and for meetings of community health volunteers, commune councils and health centre management. There were also changes in professional development activities supported in the NE and elsewhere due to capacity issues, including changes in regulations concerning preceptors' and facilitators' fees. In addition, opportunities such as new sources of funding for activities such as community score cards had emerged after AOP3 and were affecting activities on-the-ground. During the field visits it was always not clear if these changes had been implemented or communicated to stakeholders; some informants told us support had ceased for some of these activities and others told us the support was on-going. These operational changes made it difficult to confirm exactly which activities were still supported while we were in the field.

We saw a fraction of PSL sites and beneficiaries. We also acknowledge that respondents may have been reluctant to talk about things that reflected negatively on the project for fear that it would risk future funding. We mitigated the risks of being influenced by a small number of cases by using a number of techniques to verify the conclusions we drew from the information we collected such as confirming findings across a number of sites and respondents. These methods are described in the evaluation plan (Annex 2).

## 4. Overview of Partnering to Save Lives

### 4.1. Structure, funding, objectives and activities

The original discussions for a RMNH project implemented by three Australian NGOs began in mid-2011. CARE, MSIC and Save the Children successfully tendered for the project in early 2012. A design process and inception phase stretched from mid-2012 into 2013. During that period the leadership and consultants of the three NGOs planned the project and conducted some activities related to existing projects or emerging PSL priorities.



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PSL is structured as a single project implemented by three NGOs with separate contracts and budgets. Their actions are coordinated through a set of project governance arrangements, a single set of Monitoring, Evaluation, Reporting and Improvement (MERI) indicators and a joint annual plan.

At the time PSL contacts were being finalised, reductions to the Australia aid budget saw the budget for this activity decreased by between 10 and 20 per cent. The final budget for the first three years of PSL was AUD14 million, out of an anticipated but uncommitted total of AUD19.75 million for the five years. Funding was front-loaded towards the first three years. This budget reduction led to reprogramming. Activity implementation was slower than expected in Year 1, resulting in an underspend in that year that continued through Year 2. The total annual budget was AUD5 million in Year 1 and AUD4.5 million in Years 2 and 3.

The PSL goal is:

*To save the lives of women and neonates in Cambodia through improved quality, access and utilisation of RMNH services through a partnership approach.*

PSL works at multiple levels within the government health service and the community to achieve this goal. The program logic, which provides a framework for the project activities, is described in the PSL documents as:

*If a partnership of NGOs, MoH and donors coordinate resources to strengthen health service delivery while simultaneously supporting communities and local authorities to promote, facilitate and engage in improved health behaviours, a significant contribution to saving the lives of women and neonates in Cambodia will be made.*

PSL has three components, described in the Project Design Document and used in its annual reports and plans. These are aligned with five project outcomes as shown in Table 2.

**Table 2:** PSL components and outcomes

Outcomes	Project components		
	Improving health service delivery	Community strengthening and engagement	Knowledge and practice
Improved quality RMNH services for target populations	✓		
Greater equity of access to appropriate RMNH services for target populations	✓		
More responsive RMNH services to meet the needs of target populations	✓	✓	
Improved RMNH behaviours amongst target populations		✓	
Evidence-based innovation and learning that contributes to improved policies and practice			✓

The priority target populations for PSL, selected in consultation with MoH and DFAT and more widely discussed with other national RMNH stakeholders, are the health services and communities in the four NE provinces of Kratie, Steung Treng, Mondoliri and Ratanakiri and garment factory workers and managers in the Phnom Penh metropolitan area. Additional reproductive health activities outside of the NE were also included in consultations with partners and stakeholders.



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The PSL-targeted RMNH services and behaviours include but are not limited to antenatal care, safe delivery, emergency obstetrics and immediate newborn care, neonatal care, comprehensive abortion care, short and long acting family planning methods, behaviour change communication (BCC) and reduction of financial barriers. These are directly aligned with MoH's FTRMNM objectives for 2010-2015. PSL only targets infant health for the first 28 days and, except within garment factories, works only with public health care facilities.

For the purposes of conducting the MTR and analysing findings, project activities were re-categorised into five areas:

1. Partnership and the role of the CLU
2. Support of RMNH in the NE provinces
3. Support of RNMH service delivery capacity in selected provinces outside of the NE
4. Support of RMNH in garment factories in the Phnom Penh metropolitan area
5. Monitoring, evaluation, learning and advocacy.

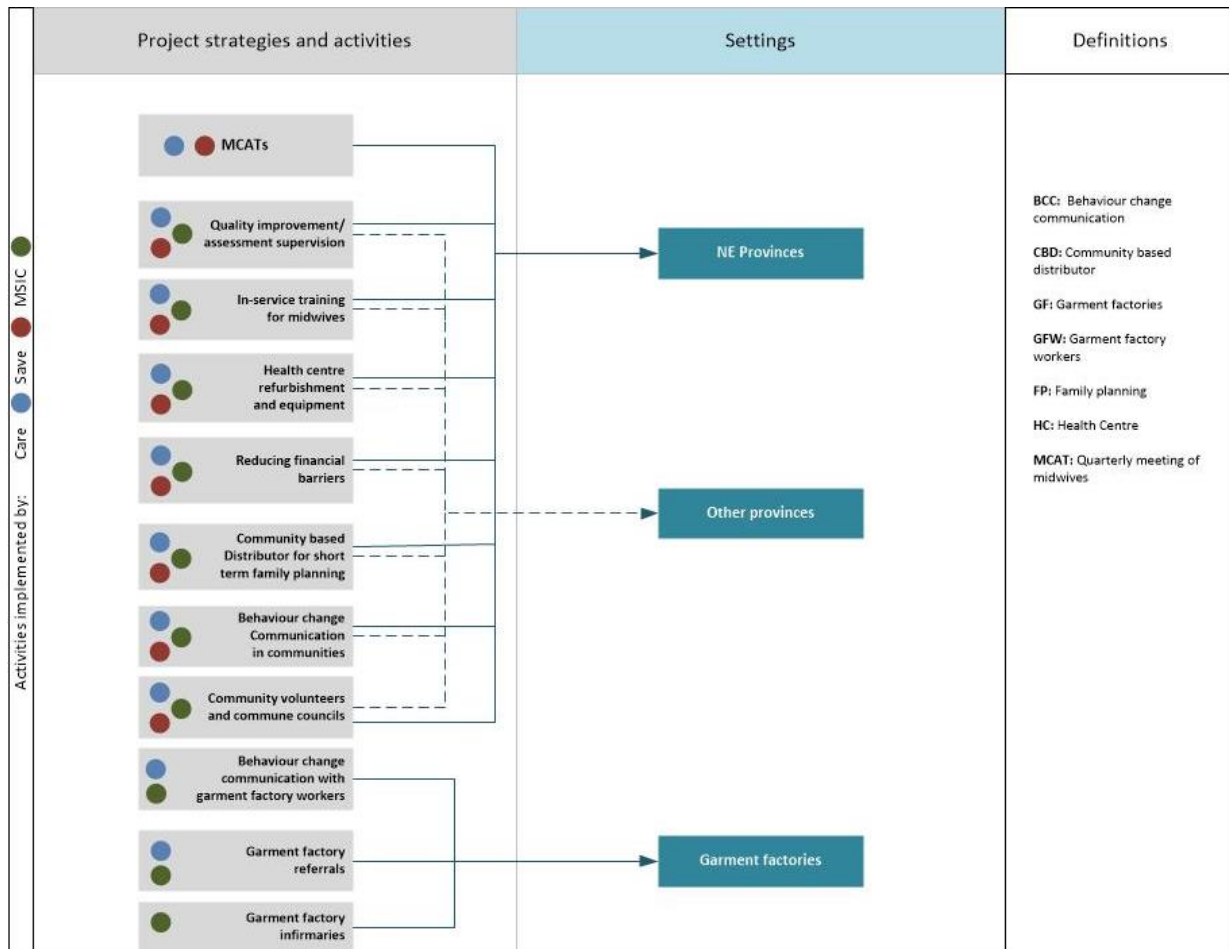
Areas 2-4 are settings of project activities (the NE, garment factories and other selected provinces). Areas 1 and 5 relate to project management and governance through the partnership and use of monitoring, evaluation and learning to inform national and PSL-specific policies and practices.

Each NGO implements activities within the overall PSL program logic. CARE uses its experience working in garment factories, ethnic minorities in the NE and safe motherhood to implement BCC and service delivery capacity building in garment factories and in Ratanakiri and Mondulkiri provinces in the NE. MSIC applies its expertise in sexual and reproductive health to build clinical capacity in provinces inside and outside of the NE and in garment factories and support BCC and reduction of financial barriers for short and long term FP methods. Save the Children works with communities and MoH health facilities to increase access to affordable, quality care for mothers and infants in Kratie and Strung Treng provinces in the NE.

The diverse interests, approaches, objectives and settings mean that PSL is operated in many different ways in different places. This is captured in Figure 1, which links project activities with settings. The dots next to each activity indicate the implementing NGOs. In almost all cases, all three NGOs implement the activity. In only a few cases, discussed in the findings, are the activities conducted jointly or use the same tools or approaches. This makes PSL a very complicated project to describe. Furthermore, the implementation of 28 different activities (the number of dots in Figure 1) under 11 strategies makes it very difficult to come to conclusions regarding PSL-wide outcomes or impact.

# PSL MIDTERM REVIEW

## 4.2. Changes in the context of implementing PSL



**Figure 1:** PSL activities by implementing NGO and settings

The PSL design process started in 2011-2012, a period of significant growth in the Australian Government’s international aid program. Soon after implementation began, in August 2013, new Australian aid policies and processes were being introduced.

PSL’s NGO partners have had to manage their budgets within a rapidly changing financial environment. Each NGO has made its own decisions about how to respond to the reduced funding available for PSL.

First, following the finalisation of the project design and three year budget, the total budget was reduced by 20 per cent. This caused the partners to reallocate resources while trying to achieve the same activities and outcomes.

Second, the declining exchange rate between the AUD and USD started in September 2014 and accelerated since early 2015. The project was designed when the Australian dollar was equivalent to USD0.90 to USD0.95; it is currently around USD0.70 to USD0.73.

Most recently, changes in Royal Government of Cambodia regulations have resulted in changes to per diem costs and facilitator fees for government employees, which significantly increased the costs of many PSL activities in the NE that depend on bringing people together from remote locations.

# PSL MIDTERM REVIEW

## 5. Findings related to project areas

Because PSL activities are so diverse, the findings are presented separately for each of the five project areas: the partnership; activities in the NE, other provinces and in garment factories; and, learning and advocacy. In each section we describe the PSL activities, give our assessment on their relevance, effectiveness, efficiency and sustainability, and offer recommendations for the focus in Years 4 and 5.

In the next section we summarise high level findings of PSL's performance using the aid effectiveness criteria.

### 5.1. The PSL partnership and role of the CLU

#### Project identity

Although the three equal and independent implementing NGOs is the defining feature of PSL, the NGOs are committed to ensuring that their separate identities do not adversely affect the reputation, operation and effectiveness of PSL.

As many informants mentioned, PSL brought together three NGOs that were accustomed to competing for the same funds. Each maintains its own brand and reputation, networks with government, communities, other NGOs and donors, its own approaches, policies and procedures; and all have health programming outside of PSL. Nevertheless, several informants spoke of the efforts made by all three NGOs to map out a project design that would achieve results by utilising the strengths of each organisation. They all had ownership of the final document and the project has stayed reasonably close to the intention of the original design. Furthermore, the partnership has remained on course, being relatively unaffected by changes in all three Country Directors and in a number of the project managers.

PSL branding is highly visible on websites, equipment and materials purchased through the project and the t-shirts of field staff and the community members and service providers with whom they work. The PSL name was known by almost everyone we interviewed. At the national level, RMNH stakeholders outside of PSL understood the structure of PSL but viewed the CLU Director as its public face.

The closer one gets to the delivery of project activities, the more likely it is that beneficiaries and stakeholders refer to the implementing partner rather than PSL. Given that the NGOs will continue to be active in these settings beyond the life of PSL, keeping a separate identity alongside the PSL brand is understandable and does not appear to create confusion on the ground, where beneficiaries usually interact with only one NGO or with two conducting different activities.

It is also important to acknowledge the un-costed contributions that the NGOs make to PSL. CARE, for example, has a web of relationships among factories, brands retailers and other NGOs which is facilitating the development and uptake of PSL activities in garment factories. In the face of budget constraints, the NGOs have shifted some activities started under PSL to other funding sources. For example, MSIC's quality improvement visits to midwives trained in long acting FP methods in Pursat are now conducted through a USAID funded project. Save the Children and CARE have attracted other funding for community accountability activities in the NE, including community scorecards.

#### The NGO partnership

PSL was not designed to operate as a single, unified project. Delivering PSL has involved developing structures, processes and a collaborative culture.

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The NGOs are on track to meet the objectives for the partnership expressed in the MERI framework. They have developed coordination and harmonisation mechanisms, governance structures and charters and they have leveraged partners' strengths to have greater reach and capacity to improve RMNH than they would have on their own.

The CLU is the principal mechanism for achieving these results. The CLU is staffed by a director, national coordinator and administrative officer based in Phnom Penh at one of the NGOs in rotation. The regional office for CLU in the NE is in Kratie. It has a regional manager, midwife coordinator, part-time administrative assistant and VSO clinical quality advisor (midwife) from the UK.

The cost of coordination is both the cost of running the CLU, which is funded through the NGOs' budgets as per negotiation, and the additional human and financial resources required to participate in the joint initiatives. One of the two purposes of the CLU is to reduce the burden of coordination on the part of the implementing NGOs (the second role of learning and advocacy will be discussed in another section). The CLU has a very small budget. Any activities such as meetings, in-house trainings and commissioned research must be paid for by one of the NGOs out of their PSL budget. This lean management structure meant that the NGO partners had to develop procedures for recruiting, selecting and employing CLU staff and managing procurement for joint activities within the first year.

The PSL governance and harmonising structures (enabled and frequently facilitated by CLU) include formal mechanisms for coordination including the bi-annual Program Steering Committee

Examples of collaboration, from the minutes of the Nov 2014 Program Steering Committee:

Activities that embody PSL's partnership approach in Year 1, ... including: MSIC's technical input into development of MCAT modules on safe abortion and long-term family planning and integration of FP components into the CCMN curriculum for community representatives; invitation of other PSL partners to trainings, e.g. CARE's training-of-trainers on facility assessments; achieving economies of scale through joint procurements; learning from each other's implementation, e.g. CARE's new contract with Media One, following their work with Save the Children; technical input from partners on cross-cutting themes, e.g. CARE on gender, Save the Children on child protection.

meetings for country directors and representatives of DFAT and MoH, monthly Program Management Committee meetings for project managers, quarterly regional meetings for provincial coordinators and regular meetings across technical areas. In the NE the CLU also compiles the joint monthly work plans and provides technical support for quality improvement (QI). Facilitated by the CLU, the partners undergo a very extensive review process to identify learnings from the past year and formulate the next year's plan. Over time CLU has initiated other processes to facilitate efficient joint management of PSL activities. These include a shared drive for file transfers and archiving and centralised spreadsheets on PSL inputs and assessment and scorecard results by HC and by midwife in the NE.

There is some evidence of an evolution of the partnership going beyond harmonisation. There are examples of emerging joint activities, leveraging the specific strengths of the partners to create something new such as MCAT modules, the referral directory in garment factories and training documents for community volunteers. Conversations are happening between the leadership of the three country offices about future joint or complementary projects. At the country level the NGOs have been resourceful in acquiring new grants to continue the work in community accountability, quality improvement, garment factories that they have started or strengthened under PSL. Most of these grants have not started but in many cases they will involve shifting some activities from PSL to another funding source, to enable the work to continue. This, possibly unexpected, benefit of PSL will enhance its long term sustainability but it makes it difficult to attribute achievements to PSL.

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Despite the achievements in the partnership, there is evidence that the separate decision making structures are impeding strategic decision making. Decisions to cut or reallocate activities are made solely by the NGO concerned, leading to anomalies such as Village Health Support Groups supported in one province and not in another or activities such as community scorecards stopped without communicating the reasons to stakeholders. Field staff from different NGOs are not encouraged to share resources on the ground but only to 'coordinate' activities.

### Partnership of NGOs with DFAT and MoH

The Program Steering Committee (PSC) meets twice a year. It is the formal mechanism to gain feedback and endorsement on PSL plans from DFAT and the MoH representative, the director of the National Maternal and Child Health Centre (NMCHC). Evidence from minutes and subsequent plans and actions indicate that advice from these partners is taken seriously. DFAT and MoH (through NMCHC) undertake additional advocacy and policy activities to create an enabling environment for PSL and other RMNH activities to work. These include issues related to commodity supply chains and the government's proclamation concerning per diem and facilitator fees. On its part, PSL is diligent in adhering to MoH policies and guidelines and in conferring with PHD and OD.

PSL manages relationships with technical agencies and other stakeholders effectively through the Technical Reference Group and networking at national and international RMNH forums. Cambodia has a well-coordinated approach to RMNH programming and PSL has participated in key committees as its own entity and through the three NGOs operating separately.

### Recommendations for Years 4 & 5

The PSL governance structure should remain the same for Years 4 and 5. However, as the focus switches to supporting PHDs, ODs, HC directors, commune councils, and 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.

We would expect that in Years 4 and 5:

- The NGO partners taking a more unified, transparent and strategic position on which PSL activities to be conducted.
- At the national, regional and provincial levels, greater sharing of skills and resources between NGOs and even single teams of field staff undertaking the work of more than one NGO.

Also in Years 4 and 5, PSL should consider a greater role for CLU, including:

- 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.

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### 5.2. PSL activities in the northeast provinces

#### Relevance of PSL activities in the NE

RMNH stakeholders stressed that the NE was an appropriate target for PSL activities. It is a region of high need and has relatively little support from other development partners and large NGOs. Indicators of teenage pregnancy, unmet demand for family planning, use of modern and particularly long acting family planning methods, pre- and post-natal care and delivery in health facilities are all worse than the national average. Although there have been gains in most indicators between 2010 and 2014, the gap between the NE and the national average is still large (Table 3).

**Table 3:** Reproductive and maternal health indicators for northeast provinces, 2010 and 2014 Cambodian Demographic and Health Survey

Year / RMNH variables	Kratie		Preah Vihear/ Steung Treng		Mondolkiri/ Ratanakiri		Cambodia	
	2010	2014	2010	2014	2010	2014	2010	2014
Total Fertility Rate	3.9	3.6	3.5	3.6	4.5	3.3	3.0	2.7
Teenagers who have begun childbearing	11%	20%	12%	25%	17%	34%	8%	12%
Current users of any modern contraceptive method	24%	31%	33%	35%	33%	43%	35%	39%
Current users of IUD	>1%	5%	>1%	>1%	1%	1%	3%	4%
Current use of implant	>1%	2%	>1%	>1%	>1%	4%	>1%	2%
Unmet need for contraception	22%	12%	22%	18%	19%	14%	17%	13%
Received any antenatal care at last birth	65%	73%	67%	85.5%	62%	76%	89%	95%
Delivered in a health facility	26%	46%	21%	51%	30%	51%	54%	83%
Postnatal check within 2 days of delivery	19%	90%	23%	67%	27%	39%	70%	88%

PSL addresses poor health indicators through strategies to strengthen supply and demand of RMNH services.

RMNH services in the NE are of poorer quality than in other provinces, lacking in essential equipment and with younger and less experienced midwives and relatively few opportunities for in-service training and supportive supervision. Out of seven Basic EmONC facilities in the region, none are able to deliver all of the signal functions. The extent of the difference in quality will be confirmed when the results of Level 2 assessments, which measure service quality, are released in late 2015.

According to our informants, NE communities are relatively unaffected by out-migration for employment but seasonal in-migration for harvesting and circular migration over long distances for households dependent on income from forests or plantations, results in population fluctuations, especially in hard-to-reach and high risk areas. Many residents belong to non-Khmer ethnic minorities, speak their own languages and perceive discrimination from health facilities and other institutions. The road infrastructure is improving but there are still many isolated communities where timely transport for urgent health care is unavailable or expensive.

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CARE works on the ground in Ratanakiri and Mondalkiri, offering support to three HCs in each province and a range of BCC and community engagement activities in the communes and villages surrounding the HCs through savings groups, radio listening groups and support of Village Health Support Groups (VHSG) and Health Centre Management Committees (HCMC). CARE has worked in these provinces for many years although not specifically on RMNH.

Save the Children operates in Kratie and Stung Treng. They support most of the HCs in one OD in each province. In Kratie they support 17 out of the 29 HC; the other HCs are supported by a small NGO or UNICEF. In Stung Treng they support 10 out of 12 HCs. Four of the facilities are designated as Basic EmONC facilities. They support radio programming, train VHSG and HCMC members and support regular meetings between.

MSIC supports CAC training and QI in 54 HCs in the NE. In Year 1 and 2 it supported seven health facilities and communities with vouchers for long acting FP in Ratanakiri in Years 1 and 2. After consultant reviewed the effectiveness of the programs to reduce financial barriers, the MSIC moved its focus to Kratie in 2015, where it now supports 29 HCs with training, QI and supply-side financing for long-acting FP.

The MTR advisors noted that PSL activities do not address the high rate of teenage pregnancies and only has dedicated programs to promote long acting FP methods in one of the four provinces.

### Clinical service capacity building

PSL activities to improve RMNH services in the NE fall into the following categories:

- Refurbishment and purchase of equipment and materials
- MCAT meetings
- In-service training on specific topics such as infection control and safe delivery and rotations in training centres, provincial and referral hospitals to build clinical skills
- CAC, IUD and Implant training
- Quality assessments, quality improvement and supervision
- Assistance in forecasting and ordering commodities.

#### *Refurbishment and purchase of equipment*

All NGOs have funds to provide small items of essential equipment to HC in order to bring them up to MoH standards. These usually relate to the specific focus of the NGO although all are using the same Level 1 assessment which brings some consistency. Items include a vacuum aspiration pump, bins and autoclaves for infection control, delivery kits, spot lights for vaginal examinations. Save the Children in particular has invested in refurbishment of health centres including upgrading delivery and 'waiting rooms' with beds for women pre and post-natal, clean water and reliable electricity sources, toilets and placenta pits. It has had to stop its refurbishment plans in Year 3 because of budget constraints.

All of the beneficiaries from the health facilities, PHD and OD expressed gratitude for these inputs which enabled them to deliver services. We heard several reports of a component of the vacuum aspiration pump failing but otherwise PSL's contributions were praised. Delivery and counselling rooms in the non-PSL supported HCs we visited lacked the equipment that PSL had provided to other sites.



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## *MCAT*

PSL support for the quarterly MCAT meetings has been a great success. MCAT meetings are extremely popular among midwives and they all attend regularly. They especially value the feedback and opportunities to discuss specific cases and issues with doctors from referral hospitals (RH). They also value the refresher training and had many ideas of what other topics they would like covered. MCAT meetings were introduced in the NE through PSL support.

The national MCAT model as it developed since 2007 is for a morning session for updates and HC reports on complications and RH referrals. An RH doctor or senior midwife gives feedback about the outcome of cases and observations about what could have been done differently at the HC. The afternoon session is for refresher training and is designed to be based on issues that have arisen during supervision visits.

A joint PSL activity has been to develop modules for refresher training during MCAT meetings. These were principally done by the CARE clinical lead with support from the regional CLU midwife and input from MSIC on CAC. In all provinces there are pre-meetings of RH, OD and PHD representatives who select and review the topics and discuss how they will be presented. These clinicians are expected to deliver the sessions. PSL personnel were more involved in the delivery of MCAT training in Ratanakiri than in Kratie. OD and PHD representatives in both provinces said that they could prepare and deliver the sessions themselves. We did not learn if other modules, such as those prepared by URC's Quality Health Services package, are used.

Another aspect of the support for MCATs has been financial support for per diem and travel costs for participants. A current difficulty is that, due to recent changes in per diem guidelines, participants from the referral hospital and HCs based in the provincial capital cannot be compensated for attending. The viability of MCATs may be threatened; we heard from some PHD/OD officials that RH and HC providers may be 'busy' and unable to attend future MCATs. Until the costs are met from the annual operating budgets of the PHD, OD or HC, MCATs will be dependent on external support.

## *In service training*

PSL support PHDs and ODs to offer a number of in-service trainings. These include short trainings of two to three days on issues such as completing a partograph, infection control and safe delivery.

Perhaps more effective in increasing skills of rural midwives are rotations to provincial hospitals and national training centres for practical experience in RMNH practices. The HCs we visited had relatively low numbers of deliveries per month, ranging from 2 or 3 to about 30. These are not necessarily enough for an inexperienced midwife, especially the primary midwives with only one year of formal training, to become a confident and competent provider. Intensive, supported clinical exposure is very important. These rotations can be difficult to organise and expensive as both the preceptor and the trainee needs support over several weeks and spaces are limited. In the past, preceptors received a small fee. Recent government regulations have prohibited this practice and there is a concern that preceptors will be unwilling to take part.

## *CAC, IUD and Implant training*

MSIC's CAC training operates in almost half of the national provinces and we met some midwives who had taken the course. None of the HCs have more than a handful of abortions per year. MSIC supports IUD and implant training only in locations where they are involved in financing initiatives. In 2013-14



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some midwives were trained in Ratanakiri. There have been trainings in 2015 in Kratie. Since MSIC supports all of the HCs in the provinces in which they work, there is scope to target training to the providers and HC most likely to benefit. However, PSL budget constraints have meant not all of the midwives who need training have been supported and the trainings have not been included in the PHD and OD budgets. No other organisations are supporting training for long acting family planning services in the NE. The lack of trained providers will make it very difficult to increase use of these methods in the region in the next three years.

### *Quality assessment, quality improvement and supervision*

In Years 1 and 2 all PSL NGOs use a similar approach to assessing the capacity of HCs, based on MoH's Level 1 assessments which focus on infrastructure and equipment.

To improve service quality, CARE and Save the Children supported PHDs and ODs to undertake the monthly integrated supportive supervision visits to their selected HCs. These visits are required by MoH and are now funded through a special MoH grant to the PHDs in the NE. Informants said that the visits were more regular when supported by PSL. Opinions varied between HCs as to whether the visits were occasions to receive advice and guidance from the supervisors. With the support of CLU, PSL recently developed and delivered training on supervision for PSL field staff, ODs and PHDs. The plan is to deliver this in several NE provinces.

Each NGO has a different approach for regular coaching and mentoring activities in addition to the integrated visits by ODs and PHDs. CARE and Save the Children are at different stages of finalising theirs, but it is unclear how this is to be done in a way which is effective, efficient and complements the MoH activities. Initial plans for a coordinated system of mentoring and coaching midwives by PSL clinicians has not been implemented, in part because of the difficulty in recruiting qualified staff. Current clinical coaching and mentoring by PSL appears to be ad hoc or more for the purpose of measuring rather than improving skills. In general, we found the different approaches to be inefficient and ultimately unnecessary as MoH is increasingly relying on the Level 2 assessments to measure quality and direct support supervision and training activities.

The MTR advisors were particularly concerned about the unintended consequences of QI visits by MSIC for long acting FP methods. These involve visits to the trained provider once or twice a year to observe IUD or implant insertion. The QI visit is preceded by a promotion to encourage women to accept the method. In the two NE provinces we heard of or observed the confusion created by this process, threatening the trust the community has in the HC, PSL and the NGOs. There are several reasons that this was not a good process. Where there were regular shortages of implants, the MSIC team would organise supplies for this purpose. This would mean that implants would only be available when the QI team was present and not afterwards. Another problem was that QI visits were preceded by more intensive promotion than usual. This resulted in women coming to the clinic on the day of the QI visit expecting to receive a long acting FP method. In the case we observed, out of the eight women who came on the day of the QI visit because of the promotion, only two met the clinical criteria. Promotion that encourages women to seek counselling rather than going to the clinic on a specific day for a service would be more appropriate for these methods. The extent to which QI visits are resulting in poor FP service delivery practices should be ascertained and addressed.

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## Behaviour change communication, community engagement and reducing financial barriers

PSL's activities in communities was often the first benefit from PSL HC directors mentioned. There are several reasons for this. First, many HC are underutilised. With user fees and HEF reimbursement of fees for poor clients, more users directly translates into more funding for the HC. PSL promoting the value of using HC services was an immediate benefit and several claimed that the number of episodes of service was increasing as a result. (The trends for RMNH services were not as clear; some informants said women were bypassing the HC for deliveries and family planning services.) Second, HC directors are very aware of this work. They attend the HCMC and VHSG meetings that PSL supported and PSL officers from all NGOs come monthly to discuss the schedule of meetings and community awareness activities.

### *Health promotion*

CARE and Save the Children have developed their own BCC strategies, incorporating aspects of the PSL BCC framework. A unified approach is not necessarily required in BCC. Between the PSL partners there are BCC initiatives using a range of formats including radio, games and mobile enabled education, as well as more conventional videos and small group education sessions by outside facilitators and community volunteers. A consensus in the research literature is that multiple, mutually reinforcing messages, especially if they are directed at multiple levels (mass media, enabling community environments, generic support to individuals and tailored support to individuals with specific needs) are much more effective than single approaches.

We were disappointed that at least one BCC package positioned pregnant women as ignorant and unable to make decisions for themselves, instead of as adults with many responsibilities that they needed to balance and legitimate questions they wanted answered. This was in an indigenous language radio drama, which both advisors listened to separately. We came to the same conclusion about the gender stereotypes in the drama after hearing separate translations.

Women's knowledge of RMNH will be monitored through PSL's baseline, midterm and endline surveys in the NE and other provinces.

### *Community-HC relations*

The NGO partners are using similar approaches to improving HC – community relations but the details vary. Also, several strategies have been suspended due to budget constraints. Among the strategies are:

- Community score cards (which seems to have been postponed pending new funding)
- Support for Village Health Support Groups through formal training, meetings and sometimes both
- Support for HCMC meetings involving commune representatives, HC, OD and PHD (at least one of the NGOs is no longer supporting these)
- Community based distributors (only supported by MSIC in the provinces in which they have supply side financing for long acting FP).

As mentioned above, these initiatives are valued by HC directors. They build trust between the HC and the community and provide a platform for articulating and problem-solving grievances which, if left unchecked can result in little or no use of the facility by the community.

We have a few observations about the relevance, effectiveness and efficiencies of these efforts.

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CBDs are important but only in the context of the other roles that they have in the community. The PSL baseline survey found that only five per cent of modern contraceptive users obtained supplies from CBDs. The highly engaged CBDs that we meet were also VHSG members, often also with roles on the commune council and at HCMC meetings. These are similar findings to a 2010 evaluation of CBDs which found that they were most suited to very poor and isolated communities without access to private shops and providers supplying short acting contraceptives and that CBDs was a component of an active VHSG.<sup>3</sup> The evaluation also found poor targeting of communities for CBDs and lack of information on where CBDs were located and their share of the supply of contraceptives. It is not a question of whether there should be CBDs or VHSG but rather how to motivate health volunteers to include RMNH messages among many other health messages.

We also observed that commune councils were not currently used by PSL as a conduit into the community except through supporting HCMC meetings in some provinces. Commune councils are a powerful force. They can mobilise groups and volunteers and have a Community Investment Fund at their disposal. They are committed to meeting government indicators for social and economic well-being. With decentralisation they may become more important to the health sector. We heard of a number of innovative approaches taken by commune councils related to RMNH; some encouraged by PSL and others on their own initiative.

### Innovation by commune councils

We encountered many examples of initiatives by commune councils. One used their social fund to give every woman who delivered at a HC USD10. Two others made agreements with traditional birth attendants not to conduct home deliveries. Communes provided money to defray transport and meal costs to people accompanying women who are in labour and midwives who come to the villages for outreach.

### *Reducing financial barriers*

PSL has three strategies for addressing financial barriers for women to access RMNH services: community-led financing solutions and a number of different approaches to reduced service fees (and in some cases transportation costs) for eligible women.

Village Savings and Loans Associations (VSLA) is CARE's global model for encouraging savings. In Cambodia VSLAs enable families to amass funds for major purchases, including those related to RMNH and other health issues as well as to invest in farming or other enterprises. Participants can also borrow small amounts, to be paid back within one or two months. VSLAs are heavily dependent on PSL staff to initiate and maintain the group. CARE has a strategy for monitoring group capability but does not yet know how long they need to continue to support the groups, or if the groups have a natural life course. The group we observed was in a village with many non-health Care-supported activities; supporting a VSLA may have had a relatively low marginal cost in this setting.

MSIC and Save the Children have two very different approaches to reducing the financial barriers to RMNH service utilisation or incentivising use. MSIC is currently implementing a supply-side strategy to reduce financial barriers to accepting long acting family planning methods in Kratie in the NE and in two other provinces: Pursat and Sihanoukville. The method is combined with promotion of family planning and improved counselling and service delivery capacity at the HC. It requires monthly verification of acceptors and reimbursement of fees for acceptors who are not eligible for HEF reimbursement. It is

<sup>3</sup> Sheryl Keller, Evaluation of community-based sales of contraceptives in Cambodia, Ministry of Health and UNFPA, October 2010.

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expensive because the supply-side financing program is the only reason we can see for MSIC to field a team in each of these provinces. According to informants most of their work is in verification, risk mitigation and, in some provinces, supporting the CBD. There is no evidence that the reimbursements add value over and above the BCC and service improvements. MISC field staff do very little direct BCC activities for long acting FP.

Save the Children is developing a conditional case transfer to encourage the poorest families to adopt good maternal and newborn health practices. The details will be based on their experience of implementing similar approaches elsewhere in Cambodia.

The request we heard from PHD, OD and HC staff was that all maternal care should be free, an approach used in many other countries with user fees for other services. This is also being discussed within MoH. While additional assistance may be needed to help the poor and near poor with transport, food and other out-of-pocket costs, these payments do not necessarily need complex and costly mechanisms.

PSL has recently commissioned a study on financial barriers to accessing RMNH services in the NE. This will be of great value, providing the partners and other stakeholders with valuable information. We are not convinced that offering all funding mechanisms at one site, as proposed by PSL in AOP3, especially prior to the results of the study, would be cost effective. It would be expensive, it is not aligned with current government approaches and a single site is unlikely to produce generalizable information.

### Monitoring, evaluation and sustainability

Given the concentration of PSL resources in the NE, we were disappointed that there was so little tracking of RMNH inputs and outcomes. The Year 2 reports found little change in utilisation of several RMNH services. This may not mean that the activities have not made a difference. But understanding what the results mean requires much finer grained analysis of the data by HC over time and in comparison to unsupported HCs.

A couple of examples will indicate what we mean. We observed in Ratanakiri the creation of new HCs. This has consequences for monitoring and evaluation. A new unsupported HC was taking clients from a supported HC. A nearby community, receiving BCC from PSL, now had a HC much closer than previously. This will exaggerate the impact of the BCC program but it will also affect the supported HC which now has a smaller catchment. The director at another supported HC told us that his catchment had been halved but the monthly number of births at his facility had remained the same; he interpreted this as a sign of an increase.

Our concern is that the integrated, strategic approach to improving service quality and RMNH behaviours which is necessary as PSL enters the second half of its five years, will be compromised by a lack of clear information about the current situation and progress towards targets. It will also be difficult to support PHDs, ODs and HCs to maintain and expand the successes under PSL without a clearer idea of the inputs, outcomes and gaps.

A promising initiative to address this is a combined spreadsheet of all of the assessments and training for HCs in the NE supported by CARE and Save the Children. The spreadsheet has the potential to be used to track PSL activities, link improved outcomes and target midwives and HCs for additional support.

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## Recommendations for Years 4 & 5

The initial plans for the NE may have been too ambitious given the level of project resources and prior experience in RNMH in the region. Years 4 and 5 will be a time to focus on areas of support which are most valued by beneficiaries and devising strategies for PHDs, ODs, HCs and commune councils to maintain the gains and to enable them to take advantage of proposed mechanisms to reward quality health services.

In Years 4 and 5 we would expect PSL to take the following actions:

- Develop a plan in Year 3 for a phased withdrawal of support from currently supported HC (exit plans) 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. The recording of HC inputs and outputs developed by CLU's regional office will be a valuable tool in tracking progress.
- Discussions should start as soon as possible with ODs and PHDs about a planned approach to transfer MCAT financial support to PHD, OD and HC, while recognising the higher costs of transport and greater distances in the NE. PSL should be proactive in developing a planned exit by ODs and PHDs to put these costs in their Annual Operation Plans.
- The extent to which MSIC QI visits for long-acting FP 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.
- 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.
- 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, then 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.
- Promotion of long-acting FP 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 FP methods in their BCC activities.
- The decision to commission independent researchers to study financial barriers to accessing RMNH services is a good one and should be used to determine which the most useful ways to intervene are. 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.

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

- 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.
- 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.
- 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.
- Commune councils play a major role in the health and well-being of communities. We were impressed with the innovativeness of commune council representatives. 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.

## 5.3. Reproductive health outside of the NE provinces

### PSL Activities

As an outsider examining PSL, the MSIC activities in other provinces appears to be an add-on to the work in the NE. From within MSIC, their activities in the NE province of Kratie are part of an integrated national program to build the capacity of MoH midwives to provide quality reproductive health services.

These activities and their locations, including those in the NE, are summarised in Table 4. The first three lines describe the non-skills training components: supply-side financing, support to CBDs and conduct of BCC. These were discussed under NE activities, but here it is noted that the activities in Kratie are a part of a larger program which in Year 1 included four other provinces and by Year 3 included only two provinces. In Pursat, PSL has two types of support for HCs. One set of 28 HCs receives CAC training and associated QA support. These HCs were selected based on HC capacity and provider willingness and are located throughout the province. Another set of 29 HCs, all within one OD, have the supply side financing program which includes BCC, cost reimbursement and other support for providing long acting FP methods. The supply-side financing activities have ended in Battambang and Koh Kong due to PSL budget constraints.

The last three activities in Table 4 relate to skills capacity building for FP and reproductive health services. These include: conducting initial assessments, purchasing small items of equipment, supporting training and conducting quality improvement (QI) follow-up visits for permanent and long acting family planning methods and CAC in provinces using curriculum and quality assessment guidelines approved by the MoH to ensure national consistency and avoid duplication.

CAC training is held in one of the two training centres in Phnom Penh and takes eight days, five as a practicum. In 2015 PSL has supported very few CAC or long acting FP trainings. For CAC this is because of issues related to a new schedule of facilitators' fees. For IUDs and implants it is a matter of PSL budget constraints and the expectation that PHDs and ODs can deliver this activity from their own budgets.



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**Table 4:** MSIC activities by province in Years 1, 2 and 3

MSIC Activities	Year 1 provinces	Year 2 provinces	Year 3 provinces
Demand-Voucher side financing with long acting FP training and QI follow-up (For Year 1 to mid-Year 2)	Pursat Sihanoukville Battambang Koh Kong Ratanakiri (in NE)	Pursat Sihanoukville Battambang Ratanakiri(in NE)	
Supply Side Financing Long acting FP training and QI follow up (From mid-Year 2)		Pursat Sihanoukville Battambang Kratie (in NE)	Pursat Sihanoukville Kratie (in NE)
CBD/VHSG support	Pursat Sihanoukville Battambang Koh Kong Ratanakiri (in NE)	Pursat Sihanoukville Battambang Kratie (in NE) Ratanakiri (in NE)	Pursat Sihanoukville Kratie (in NE)
BCC community education	Pursat Sihanoukville Battambang Koh Kong Ratanakiri (in NE)	Pursat Sihanoukville Battambang Kratie (in NE) Ratanakiri (in NE)	Pursat Sihanoukville Kratie (in NE)
Voluntary Surgical Contraception (VSC) outreach (mobile) to referral hospitals	20 provinces	20 provinces	10 provinces
CAC training and QI follow-up	13 provinces (including the 4 NE and 2 non NE supply side long acting FP provinces)	13 provinces (including the 4 NE and 2 Non NE supply side long acting FP provinces)	13 provinces (including the 4 NE and 2 Non NE supply side long acting FP provinces)

### Relevance, efficiency and effectiveness

The supply-side financing activities and issues related to QI visits for long-acting FP methods have already been discussed under the PSL's work in the NE.

Abortion, both medical and 'surgical', is legal in Cambodia. Complications resulting from unsafe abortions cause up to one-third of maternal deaths. The intention of the legislation and the PSL support for CAC is to reduce that burden and to provide post-abortion family planning counselling and services to prevent repeat abortions. Having competent CAC providers is an essential part of an RMNH service.

The training and service delivery activities concerning CAC and long acting FP methods, including permanent methods that MSIC does under the PSL program is a legacy of programs funded by other donors (DFID UK and a large anonymous donor) who no longer give aid to Cambodia. These activities were supported by the Australian government under the Reducing Maternal and Newborn Mortality project prior to PSL. The MTR advisors understand the decision to fund this activity under PSL was a decision made by DFAT in consultation with NMCHC, which relies on MSIC's technical expertise in these areas.

MSIC has a plan to transition all QI follow-up for CAC to PHDs in Years 4 and 5.

From MSIC's perspective, the continuing involvement in long acting FP methods in projects outside of the NE leveraged previous investments in training. The provinces and ODs where the additional demand creation activities have taken place are ones where they had already trained midwives. For example, the

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midwives at the two PSL-supported HCs we visited in Pursat had been trained in IUDs and implants by MSIC in 2012. The demand creation activities built on that existing capacity. A representative from the supported OD shared figures showing an escalating increase in IUD and implant acceptors, although it is not possible to ascertain from this which components of MSIC support have driven this increase. In contrast, at the unsupported HC we visited in Pursat only one midwife had been trained, many years ago, in IUD insertion and none had been trained in implants. They did very few IUD insertions at this facility and reported they encouraged women interested in implant to adopt the IUD, because 'it was not hormonal'. The PHD representative expressed a desire for PSL to extend its support for long acting FP methods to the other OD.

## Sustainability

At present, there is no other mechanism to fund MSIC's capacity building work in CAC. Transitioning the responsibility for QI follow-up of providers trained in CAC to PHDs will promote sustainability.

MSIC is a subcontractor on a large project to improve the quality of RMNH services in referral hospitals and HCs in nine provinces; those nine provinces do not include the NE but they do include some provinces where MSIC had conducted long acting family planning training under PSL and support for QI for those provinces is now conducted under the Quality Health Services Project.

The NMCHC representative stressed that training is never finished. New midwives, new contraceptives and new facilities are regularly being added. For example, the introduction of two-rod implants requires new training material and updates for previously trained staff. Although she advocates for increases in the national budget to cover these trainings, until that money is secured in each annual budget and written into OD and PHD annual operational plans, there will be a need for external assistance. PSL can facilitate sustainability by supporting unfunded activities while advocating at a national level and supporting ODs and PHDs to include training and QI/supervision in their AOPs.

## Recommendations for Years 4 & 5

As mentioned above, we believe there is no justification to continue the supply-side financing in the NE or other provinces, although reimbursement of travel expenses for all FP consultations and services could be justified in the NE. We also support expanding training in all PSL-supported HCs in the NE having the capacity to offer counselling and services related to long acting family planning methods by the end of Year 5 and transitioning QI follow-up visits for long acting FP methods to PHDs and ODs.

Budgetary considerations, including new funding mechanisms, influences what activities related to reproductive health should take place outside of the NE provinces under PSL.

Our assessment is that in Years 4 and 5:

- 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.
- 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



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senior clinician. MSIC, in consultation with NMCHC, may also have to pay the high facilitation rates for some training tasks.

- In consultation with MoH and other donors, PSL should support PHDs outside of the NE to phase out reliance on external funding for building capacity to deliver long acting FP 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.
- Phase out the supply-side initiatives for long acting FP and related BCC and CBD support in Pursat and Sihanoukville as well as Kratie.

PSL should consider, subject to available resources and MoH support:

- In the short term, compensating Pursat and Sihanoukville PHDs for losing the supply-side financing support by supporting training and related assessment activities in long acting FP methods in the currently unsupported HCs which do not currently have the capacity to provide long acting FP counselling and services.

### 5.4. PSL activities in garment factories

#### PSL Activities

Under PSL, CARE and MSIC support 11 garment factories to increase workers' RMNH knowledge and access to services. Save the Children is not involved in this component of PSL. The factories are located in the wider Phnom Penh metropolitan area and are acknowledged to be amongst the best in terms of conditions for workers.

The PSL activities are informed by the baseline study of garment factory workers and a BCC framework of key messages, audiences and media for affecting improved RMNH outcomes conducted in Year 1.

#### CARE

In Years 1 and 2 CARE supported BCC sessions, delivered by a local NGO, principally concerning reproductive health. CARE's current PSL activity is to develop and trial a BCC package for female garment factory workers in three of these factories. The three elements of the package are: a video drama in three 15-minute segments set in a factory which can be viewed with or without a facilitated discussion; a series of eight RMNH modules to be delivered to small groups for up one hour; and a mobile game for smart phones. CARE sees the potential for using the material, once trialled, in a number of ways, depending on the preferences of factory management.

#### MSIC

Through PSL, MSIC works in eight factories; in three of the factories, CARE is also involved. In all eight factories MSIC is building the capacity of infirmaries to offer RNMH services, including short term FP methods and referral for long acting methods and other reproductive and maternal services. Their support includes assessment of minimum standards using a checklist they developed, purchasing of small items of equipment, provision of FP counselling material, training for infirmary staff, follow-up Quality Assessment visits from the MSIC team and practical support in obtaining commodities. Nurses participate in small lunch time education sessions for workers on family planning methods.

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## *Joint activities*

The two NGOs have developed a referral directory for garment factories. These are binders with details about the public and private health care facilities near the factories that offer RNMH services. A copy is provided to the HR department and infirmary and, where applicable, the factory library. In addition, a one-page list of nearby facilities, the services they offer and the fees have been produced. To monitor the use of these tools,

In Cambodia about 8% percent of employed workers (aged between 15 and 64) worked in the textiles and apparel industry in 2012. There are 522 garment factories in Cambodia with 495,176 workers with 85% are female (Data obtained from the BW HQ in Geneva, the data as of December 2014). Textile and apparel factory workers in Cambodia are predominantly women (83%), mostly from rural areas. Workers in the textile and apparel industry tend to be younger than those in other industries. In 2012, the average age of the textile workers was about 26 years in Cambodia.

In Phnom Penh, about 15% of workers are in the textile and apparel industry; 26% of jobs in the sector are located in Phnom Penh.

In Cambodia, only a small proportion of textile and apparel workers has received education beyond the secondary level, and its share is proportionately smaller than that of non-textile and apparel workers.

From Interwoven: How the Better Work Program Improves Job and Life Quality in the Apparel Sector, World Bank, 2015.

infirmarys were given referral slips for workers to take to a service, but this appears to have not been widely used. An assessment of the referral directory is being conducted in November 2015.

Garment factory infirmaries are regulated through the Ministry of Labor and Vocational Training (MLVT) and not the MoH. Following discussions with UNFPA, ILO and USAID's new garment factory project on workers' health, PSL drafted a terms of reference for a process for developing guidelines factory infirmaries. With the promise of financial support from UNFPA, the non-government stakeholders presented the TORs to MLVT, which has embraced the proposal and indicated they want to incorporate the guidelines into the law governing infirmaries. NMCHC included this activity in their 2015 priority list and will support the process as a technical advisor.

## Relevance

Garment factories are a highly visible sign of the dramatic changes in gender roles and youth in Cambodia.

The baseline survey commissioned by PSL was very helpful in counteracting stereotypes about garment factory workers. A large minority are married and many unmarried women live under the protection of relatives. Given the acceptability of married women working, many of today's workers will probably be employed in factories all of their working life, suggesting many will need the full range of RNMH services at some point. With respect to family planning, unmarried garment factory workers may be more likely to have had sex than other unmarried women in Cambodia, but their knowledge of family planning methods and use of modern contraceptive methods is very high. Concern about side-effects is the main reasons for not using a modern method.

Both NGO partners participating in the garment factories component brought considerable strengths. MSIC has worked with garment factories for seven years and brings technical knowledge of FP service provision and practical experience from its own clinics in urban Cambodia. CARE has worked with Cambodia's garment factories, brands and retailers for over a decade. They support a network of managers from over 60 factories interested in workers' health; had pre-existing relations with major brands and retailers; been increasing their partnerships with media firms and NGOs; and, has a project on sexual harassment in the workplace.

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## Effectiveness and efficiency

The baseline survey indicated that workers did not go to the infirmary for reproductive health issues. However, most infirmaries do not offer FP services. The one PSL-supported factory we attended had many clients for short term FP and pregnancy testing. Staff had been trained in counselling and the provision of short term family planning methods through PSL. The costs of contraceptives and pregnancy tests were displayed and there were posters and a flip chart for education. The staff estimated that up to 35 workers a month obtain short term family planning methods from the infirmary and we saw one of the midwives involved in a lunchtime education session. In contrast, the infirmary without PSL support had no contraceptive supplies, the staff had not been trained and there was no educational material.

The effectiveness of the BCC activities is more difficult to assess but does not appear to be as beneficial. We were not convinced that the current workplace BCC strategies being trialled by CARE are likely to have enough reach to influence the large numbers of workers, given the very short times workers are available during working hours. Furthermore, the content primarily covers topics in which knowledge is very high or is addressed through many other mass media channels. The sessions conducted with the support of MSIC have similar shortcomings. Mass communication, coupled by some audio-visual displays at the factory and better information available at the infirmary and set stalls around the factory may be more effective. The midterm survey may not actually uncover any change since it does not actually capture women who have worked in the targeted factories and had already recorded fairly high rates of knowledge. Under other funding, CARE is conducting impact evaluations of BCC impact in individual factories. The intention is to work alongside management to demonstrate the benefits of BCC on workers' health, absenteeism and other issues of concern.

We understand that CARE and MSIC have found that peer educators are not able to reach many other workers regarding RMNH and are relying less on that method.

The referral directory was good initiative, but it is not user friendly for women seeking a service. It may be useful for infirmary staff if they have the capacity to offer RMNH advice and referrals. At present it has only been introduced in a few factories. One- page directories listing nearby services, if readily available in appropriate locations, may be more effective for workers and infirmary staff. We understand they are being trialled.

A progressive HR manager told us that addressing RMNH issues was very important for factories because it could reduce sickness and absenteeism by preventing unwanted pregnancies. He had incorporated the importance of seeking advice from the infirmary in workers' orientation and claimed that PSL activities had reduced the numbers of workers hospitalised as a result of unsafe abortions. He expressed a wish for PSL to expand into women's cancers and other health issues.

## Sustainability

Building the capacity of infirmaries to provide short acting FP methods and RMNH referrals helps to create an enabling environment for improving RMNH outcomes. However, major changes in the engagement of factories in RMNH will only come about with the support of government, factory managers and owners, retailers, brands and workers. The decade long support by CARE of a network of factory managers interested in promoting health of workers and the recent PSL work on MLVT guidelines for infirmaries are likely to have much more influence than supporting a handful of factories through PSL. National level partners, including MoH, noted the valuable role of PSL in the development of factory infirmary guidelines. Importantly, PSL created a mechanism for MoH to work with MLVT.

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We advisors were pleased to learn that both MSIC and CARE have received new funding to expand their factory work. Other donors and NGOs are seeking out the expertise of PSL NGOs to form partnerships, use their materials or seek advice. For example, one NGO that establishes reading rooms in Cambodian factories has asked to include PSL BCC materials.

## Recommendations for Years 4 & 5

Significant new funding becoming available for work in garment factories and the development of MLVT guidelines are likely to provide more opportunities. This is a great outcome for PSL. We believe that it is timely to ask if PSL has already made a significant contribution in these garment factories and whether PSL activities in this area should stop, scale back or refocus.

We recommend that starting in Year 3 and continuing in Year 4, the PSL partners should:

- 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.
- Except for the pilot, phase out PSL support for BCC activities delivered face-to-face in factories which focus on reproductive health knowledge.
- Work with MoH and non-government partners to support the development of MLVT guidelines for factory infirmaries.
- Cease support for peer educators as a BCC tool.

Consider the following actions in in Year 4 and/or Year 5, subject to available resources:

- Build the capacity of infirmaries to delivery short-acting FP methods and provide referrals for other RMNH services in the remaining PSL supported factories.
- Disseminate the results of the trends between the baseline and midterm surveys of garment factory workers, highlighting any learning for improving RMNH in factories.
- Explore potential synergies with PSL's experience in working with garment factories and DFAT's Ending Violence Against Women's program.
- 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.

## 5.5. Monitoring, evaluating, learning and advocacy

This section discusses the internal monitoring activities by PSL to measure and report on process and outcomes. It also examines the learning activities through internal review and reflection and commissioning of studies by researchers and consultants. After that, we look at PSL's impact on the development of national policies and practices in RMNH.

## Monitoring, evaluation and the MERI framework

PSL undertakes several M&E activities.

Data collection and analysis:

- Surveys of households and factory workers within the vicinity of supported HCs and factories at baseline, midterm and end of project
- Reanalysis of sub-set of survey results by substantive experts

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- Specialist studies to inform PSL and the wider RNMH sector on BCC strategies and messages for ethnic minorities in the northeast and garment factory workers in the Phnom Penh metropolitan area, and financial barriers to accessing RNMH services
- An exit survey of RMNH clients at supported HCs in the NE about how they were referred
- Several strategies for quality assessment as discussed above
- Cambodia's Health Information System

### Review and reflection processes

- Updated MERI indicators every 12 months
- Annual Review
- Regular meetings of technical officers involved in quality, M&E and garment factories
- Learning updates

Some of the external studies, and especially the surveys of householders and factory workers and the snapshot survey, will provide useful information on behaviour change, if they are well targeted to areas of PSL activity. If not, attribution of any changes (or absence of change) will be very difficult to interpret. For example, the baseline survey of women in the reproductive ages asks questions about knowledge of RMNH and use of services. Changes in use of services will be very helpful to monitor outcomes, but difficult to link to specific project support to strengthen demand or supply. The baseline survey found that knowledge of modern contraceptive methods was nearly universal in both NE and the other provinces but lower levels of knowledge about danger signs in pregnancy and neonatal distress. It would be helpful to ask about exposure to health education about danger signs to be able to link improved knowledge to program activities. Answers to questions about self-efficacy in using contraceptives or negotiating sex in hypothetical situations will be difficult to interpret: hypothetical questions produce unreliable answers and we are not aware of any BCC activities focusing on self-efficacy in the NE or other provinces.

The review and reflective practices are largely qualitative exercises. The quantitative data referred to in the annual plans and learning updates were almost all from the baseline and snapshot surveys. The PSL learning updates and the minutes of PSL meetings we read did not draw on other quantitative evidence generated by PSL partners outside of PSL or by other organisations.

We saw missed opportunities for useful monitoring or, what is often called, evaluative thinking. For example, the QA tools that MSIC have developed for factory infirmaries could be used to track improved capacity and give evidence to inform decisions about common weaknesses and the duration of support required before good processes were in place. (Adding information the numbers of commodities distributed in the previous period would give some indication of outcomes.) HIS data for supported and non-supported HCs will indicate what project inputs drive improvements. Results of supervision, coaching and mentoring activities could be tracked to understand which HCs improve under what circumstances. We understand that collecting this information will require collaborating with PHDs, ODs and HC who hold the data.

The MERI is the main tool for communicating PSL outputs and impacts but the current practice of reporting single figures, such as numbers of participants or services provided is not informative. The MERI reports do not include information necessary to understand the indicator such as numbers of HC, villages/communes/factories supported. More generally, the reporting should provide more narrative interpreting the indicators, including identifying where and how PSL was most effective.

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Some indicators, such as decrease in low-birth weight babies, are only aspirational—for example, PSL activities could not affect the proportion of low birth weight babies. In other cases, the targets are changed because PSL activities have changed even though the goal was for the activity to be sustained. An example of this is the tracking of HCMC meetings in supported HCs. HCMCs are an MoH policy and PSL supports them in some provinces. Although funding to support attendance has stopped, information should still be collected to track if the meetings continue to occur without PSL's financial support.

### Contributing to national policy development

PSL has contributed to national policy. We are confident aspects of PSL's experience are informing the final HSP3 and related RMNH documents. There have been two major successes in national advocacy:

- MCAT meeting guidelines where PSL played a key role in gathering the NGOs and other agencies involved in MCAT to discuss, get it on the NMCHC agenda for 2015 and hold a subsequent study tour as part of the joint effort to draft guidelines.
- Working with the MLVT in partnership with the MoH and other agencies, to develop guidelines for garment factory infirmaries.

Development partners said PSL's contribution was in bringing experiences encountered during the implementation of government policies. From the perspective of the leadership in the PSL NGOs and the CLU, PSL's contribution is assisted by DFAT's advocacy for their involvement and their own processes of review and research, dialogue, harmonising and disseminating which results in a deeper understanding of the issues and more meaningful input into national level processes.

We heard criticisms that PSL does not document and share the outcomes they have achieved so that others can learn from their experience. It may be premature to expect substantive findings. The results of the Baseline Survey for the NE and garment factories have been shared in many forums (one informant had heard the presentation four times). PSL should plan to disseminate the results of the midterm survey widely. These will provide evidence of how much change is feasible in a relatively short period.

One of the reasons for the lack of evidence about impact is that many project activities are relatively new. Two other reasons are that activities are not evaluated and learning from some PSL and non-PSL activities conducted by only one NGO is not incorporated into the collective body of evidence. There is a real risk that the outcomes and learning from PSL, no matter how significant, will not be documented or disseminated.

Governance structures are a vehicle for initiating policy discussion as well as ensuring that PSL is aligned with strategic directions. The proposal to discuss national guidelines for MCATs emerged from a PSL Technical Reference Group meeting in November 2014. At the national level, the CLU director has become the public face of PSL, but the three NGOs also participate in their own right and have their own input based on their experiences in PSL and other projects. Several stakeholders told us that at times the multiple PSL representatives and the multiple roles of those representatives created confusion.

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## Recommendations for Years 4 & 5

We would expect that in Years 4 and 5 PSL would increase its capacity for monitoring, evaluation, learning and advocacy in the following ways:

- 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.
- 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.
- As evidence becomes available through learning activities, disseminate results of PSL's evaluations of its impact.

## 6. Summary of the effectiveness of the PSL investment

Table 5 gives a high level summary of the PSL performance against the Aid Effectiveness Criteria: relevance, efficiency, effectiveness/impact and sustainability, adopted from the United Nations Development Assistance Committee Principles for evaluation of development assistance.<sup>4</sup> For each criterion, we describe the evaluation questions used to guide the MTR. We draw on the findings of the MTR to give an indicative rating of 1 - 6 to assist identifying areas of strength and weakness and providing a marker for assessing end-of-project outcomes. Table 5 is high level and does not appropriately reflect the complexities of the project. Specific issues are addressed in detail in Section 5.

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<sup>4</sup> The *DAC Principles for the Evaluation of Development Assistance*, OECD (1991).



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**Table 5:** High level assessment of aid effectiveness

Assessment	High level evaluation questions specific to PSL	Rating	Evidence
<p><b>Relevance</b></p> <p>Extent to which activity is suited/appropriate to the priorities and policies of target group</p>	<ul style="list-style-type: none"> <li>Are the program objectives and activities aligned with RGC and DFAT policies for RMNCH?</li> <li>Are the objectives and activities addressing priority needs for partners, health services, communities and other beneficiaries?</li> </ul>	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><b>Effectiveness</b></p> <p>A measure of the extent to which an aid activity attains its objectives and managing the risks.</p> <p>Includes social inclusion</p>	<ul style="list-style-type: none"> <li>Have program objectives been achieved or are on track to being achieved (as measured against the MERI indicators)?</li> <li>What additional or unintended benefits have occurred?</li> <li>What have been the enablers and barriers to achieving results?</li> <li>Were benefits directed towards communities and individuals with the greatest need?</li> </ul>	4	<p>Beneficiaries speak highly of individual PSL inputs and activities, especially support for MCAT, CAC, garment factory infirmaries and engagement of commune councils and VHSGs 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><b>Efficiency</b></p> <p>Qualitative and quantitative measure of outputs in relation to inputs (including resource inputs)</p>	<ul style="list-style-type: none"> <li>Were project objectives and achievements achieved on time; what facilitated or impeded timely delivery.</li> <li>Were program activities conducted in the most cost-effective and efficient manner, compared to alternatives?</li> <li>What additional financial and other resources were leveraged to achieve PSL objectives?</li> </ul>	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. MSIC 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>
<p><b>Monitoring and evaluation</b></p>	<ul style="list-style-type: none"> <li>Does the logic model drive program implementation and strategic review?</li> <li>Is the MERI plan appropriate and effective in monitoring process and outcomes?</li> <li>Have the program learning strategies been appropriate and effective in improving program impact?</li> </ul>	4	<p>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 commissioned external studies that they have used effectively to designed programs and several mechanisms to review and plan activities. However, information about service utilisation and service capacity is not routinely used to improve project implementation.</p>



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<p><b>Sustainability</b></p>	<ul style="list-style-type: none"> <li>• How probable is it that program benefits continue at the end of donor funding?</li> <li>• What are the major factors contributing to sustainability of program?</li> <li>• What strategies or actions need to be continued or put in place to increase the likelihood of sustainability?</li> </ul>	4	<p>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.</p> <p>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.</p>
<p><b>Gender Equality</b></p> <p>How does the investment address gender equality and women's empowerment?</p>	<ul style="list-style-type: none"> <li>• How have program objectives and activities addressed gender equality and women's empowerment, including reduction in risk of gender-violence?</li> <li>• What benefits have been achieved or are on track to being achieved?</li> <li>• What, if anything, could be done within the program to enhance gender equality and women's empowerment?</li> </ul>	5	<p>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.</p>
<p><b>Risk Management</b></p> <p>What else is at stake?</p> <p><b>And Safeguards</b></p> <ul style="list-style-type: none"> <li>• Child protection</li> <li>• Displacement and resettlement</li> <li>• Environment</li> <li>• Other</li> </ul>	<ul style="list-style-type: none"> <li>• Has the program put into place effective risk identification and minimisation strategies?</li> <li>• What, if any, negative incidences or consequences have arisen and how effectively were they addressed?</li> <li>• Have safeguards been put in place?</li> <li>• What continuing and new risks are foreseeable in the future if the project were to continue and how should they be managed?</li> </ul>	4  5	<p>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.</p> <p>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.</p>
<p><b>Innovation and Private Sector</b></p> <p>Innovative development approaches?</p>	<ul style="list-style-type: none"> <li>• What are the aspects of innovation and private sector involvement demonstrated by this program?</li> <li>• Have the innovative and private sector activities been appropriate and effective?</li> <li>• What new or current innovation and private sector activities should form part of the program if continued?</li> </ul>	5	<p>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.</p> <p>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.</p>
<p>Quality rating: poor– 1,2; less than adequate – 3; Adequate – 4; Good quality – 5, 6; N/A not able to be assessed</p>			

# PSL MIDTERM REVIEW

## 7. Conclusions

*Cambodia has now entered a period where the consolidation of existing and proven interventions is the most pressing need. Further experimentation and piloting of completely new interventions are no longer required. The process of research and evaluation, however, will continue as existing programmes are tested and scaled up.*<sup>5</sup>

The conclusion of the MTR is that PSL should continue to Years 4 and 5. It is making progress towards its five year objectives and providing assistance in areas of high priority for the MoH.

### 7.1. Relevance

PSL is an appropriate response to the poor RMNH status of women and newborns in Cambodia and to the MoH policy directions as described in the Health Strategic Plan 2008-2015 and FTIRMN. PSL engages in joint planning and problem-solving with MoH officials at every level and is diligent in following MoH guidelines.

Furthermore, PSL is meeting the expectations of the Australian Government for development assistance in the health sector. By improving RMNH, PSL is empowering women and reducing poverty. It has engaged private garment factories and trialled several innovative approaches to BCC and community engagement.

Development partners stressed PSL supported RNMH activities that very few other donors were involved: specifically, comprehensive abortion care and the NE provinces. Our interviews in the NE confirmed this; only UNICEF and UNFPA, and some small NGOs gave other external assistance for RMNH.

### 7.2. Effectiveness and impact

The depth and breadth of PSL, as originally designed and implemented in Years 1, 2 and 3, was extensive but highly variable. Funding constraints, unrealistic expectations and uncoordinated implementation has meant that inputs and outcomes are distributed unevenly across the project and across the country. In some areas PSL has worked intensively in a few sites and in others have offered more diluted support across many sites. This is one of the factors that make attributing impact to project activities difficult.

During our field visits, it was obvious that in many cases PSL's impact has benefited from the NGOs' historical and contemporaneous activities. This is particularly true of CARE's work with garment factories and in ethnic communities in the NE and of MSIC's work supporting skills development in CAC and FP in many provinces.

Halfway through PSL, these are the highlights of PSL:

- 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 MCAT in the NE. 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 NE until PSL.
- Improving the capacity of some HCs in the NE to offer long acting family methods, conduct safe deliveries and give women pre- and post-natal care.

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<sup>5</sup> PL Annear, J Grundy, Por Ir et al, The Kingdom of Cambodia Health System Review *Health Systems in Transition*, vol 5, no. 2, 2015, p 157.

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- Reaching women and communities in the NE who have not previously used the public health system.
- Increasing willingness between the NGO partners share information and approaches and to develop joint activities within and outside of PSL.

There has been less progress to date in:

- Supporting a coherent and sustainable approach to PHDs and ODs conducting quality assessments and quality improvements for RMNH in NE and elsewhere.
- Demonstrating that BCC and community engagement strategies are targeting the communities in greatest need. There is no 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. Some evidence of effectiveness may be available from the mid-term survey which has just been commissioned.

### 7.3. Sustainability

There are 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. We observed 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 methods.
- PSL teams on the ground are responsive to operational challenges. Informants told us that PSL staff members were always available to meet and problem-solve any difficulties.

The greatest weakness to sustainability is the lack of a clear vision and specific targets of what the project can achieve on the ground, coupled with regular collection and review of data about progress. There is little effort made to monitor the strengths and weakness of particular HCs or communities and direct resources accordingly. There is no regular review of data coming from the HIS on supported facility and no comparison of supported and non-supported facilities. PSL staff will find it difficult to support PHDs and ODs to strategically manage for quality improvement if they do not adopt these practices themselves.

We acknowledge that one reason for the lack of attention to sustainability 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. Year 3 planning was affected by the uncertainty of Years 4 and 5. Early certainty of funding levels is very important.

### 7.4. Recommendations for Years 4 and 5

The funding available for Years 4 and 5 will determine which MTR recommendations can be actioned. We recommend that DFAT continue to fund PSL at approximately the same level of expenditure in Years 2 and 3. Although we recommend phasing out some activities, transitioning out of project activities can involve additional costs in the short term. The current investment of approximately AUD4.5 million in

## PSL MIDTERM REVIEW

Years 2 and 3 seems appropriate and justifiable, especially in light of the current exchange rate of an Australian dollar under USD0.75. The anticipated amount of AUD5.75 million for Years 4 and 5 based on a total five-year budget of AUD19.75 million, would require a constriction of project activities. If that was all of the money that is available, it would be advisable to have a larger spend in Year 4.

The thrust of our recommendations are to enhance the likelihood that PSL benefits would be sustained by focusing on building capacity to achieve and maintain improved service delivery and increased community demand. Regardless of the funding allocated for Years 4 and 5, the MTR advisors recommend that PSL should undertake the following actions, which are summaries of recommendations detailed in Section 5:

- Greater unified, transparent and strategic decision-making regarding which activities are supported.
- More sharing of skills and resources by NGOs to deliver PSL activities.
- 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.
- 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.
- Implementing a single model of coaching and mentoring for RMNH skills across all PSL sites, aligned with Level 2 assessments and to be delivered with PHDs and ODs.
- Phase out of supply-side financing of long acting FP and the mobile team model of QI.
- Find more sustainable models of BCC activities, including phasing out support for VSLA and delivering information on long acting FP within all PSL health education.
- Do not pilot a combined program of funding mechanisms to reduce financial obstacles to RMNH service utilisation.
- Continue to support CAC training and PHD-implemented model of CAC QI visits.
- Work with partners to find a solution for compensating CAC facilitators or their employers
- Work towards phasing out the need for donor support for assessing, training and supportive supervision for long acting FP methods. This may involve supporting new national curriculum or training of trainers.
- Phase out support of BCC activities in garment factories after the results the CARE BCC pilot.
- Continue to work with MLVT, MoH and other stakeholders on guidelines for factory infirmaries.
- Cease any existing PSL support for peer educators in garment factories.
- Increase use of routinely collected data to monitor the outcomes of PSL activities.
- Incorporate questions about exposure to RMNH messages as part of the midterm or endline surveys.
- Disseminate evidence of the effectiveness of PSL activities and strategies based on mixed-methods evaluations and population surveys.

We also recommend that, depending on the resources available, PSL should consider the following actions:

- Greater role of CLU, especially in coordinating and managing PSL activities in the NE and liaising with MoH at a national and provincial level to define targets for capacity building.
- 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.
- Upgrade capacity of infirmaries to provide RMNH services and referrals in all PSL supported factories.

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- Extend selected support to HCs in the NE that are not currently supported by PSL or other donor-funded organisation.
- 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.
- Greater engagement with commune councils to promote RMNH behaviours and demand for services.
- Increase capacity of all PSL supported infirmaries to provide RMNH services and referrals.
- Explore potential synergies with PSL’s experience in working with garment factories and DFAT’s Ending Violence Against Women’s program.
- 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.

### Annex 1. Advisors

The Midterm Review Team advisors were contracted by DFAT through the Specialist Health Service.

Team Leader Ann Larson has a PhD in demography from Australian National University and 30 years’ experience in researching and evaluating reproductive, maternal, newborn and child health programs in Asia, West Africa, Pacific Islands and rural, remote and Indigenous Australia. She is based in Geraldton, Western Australia.

Dr Ok Amry gained his medical qualifications from University of Health Sciences (UHS) in Phnom Penh. He also holds a Master’s degree in Management from Pannasastra University of Cambodia (PUC). He has twelve years of working experience in social development and seven years’ experience in project research and M&E, mostly on health-related projects for government ministries, national and international NGOs, UN agencies and donors in Cambodia.

We were assisted by translator Mr. Sorn Dara for the first week of field visits to Pursat and the Phnom Penh garment factories and Ms. Lina Khoun during the field visit to Ratanakiri and Kratie. Our driver, Mr Pa Sophan, got us to our appointments safely, on time and with a smile.

# EVALUATION PLAN

## Annex 2. Evaluation plan

## PARTNERING TO SAVE LIVES MIDTERM REVIEW 2015

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17 September 2015

**Specialist  
Health  
Service**

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## Acronyms

ANC	Antenatal care
BCC	Behaviour change communication
CAC	Comprehensive abortion care
CDHS	Cambodian Demographic and Health Survey
DFAT	Department of Foreign Affairs and Trade
FP	Family Planning
FTIRMN	Fast Track Initiative to Reduce Maternal and Neonatal Mortality
HMIS	Health Management Information System
PSL	Partnering to Save Lives
NE	Northeast
MCAT	Midwifery coordination alliance teams
MERI	Monitoring, Evaluation, Reporting and Improvement framework
MoH	Ministry of Health
MSIC	Marie Stopes International Cambodia
OD	Operational Districts
PHD	Provincial Health Department
PNC	Postnatal care
RGC	Royal Government of Cambodia
RMNCH	Reproductive, Maternal, Newborn and Child Health
RMNH	Reproductive, Maternal and Newborn Health
ToR	Terms of Reference

# EVALUATION PLAN

## 1. Document purpose

This evaluation plan was prepared by mid-term review consultants Dr Ann Larson (Team Leader) and Ok Amry (Team Member) in consultation with the DFAT Cambodia office and technical advisors at Specialist Health Service, in Canberra. It is based on the project ToR, and forms the basis for the schedule of visits, interviews and other data collection activities.

## 2. Program being evaluated

Partnering to Save Lives (PSL) is a key element of the Australian aid program's assistance to Cambodia's health sector. While reproductive, maternal and infant health indicators in Cambodia have improved considerably in the past 5-10 years, progress been uneven across the country and neonatal death rates remain unchanged. Reproductive, maternal and neonatal health (RMNH) is a priority for the Royal Government of Cambodia (RGC). It is one of the four health priorities in the National Strategic Development Plan, was one of the three strategic program areas in the Health Strategic Plan 2008-2015 and is being discussed as a continuing priority in preparations for the Third Health Strategic Plan (HSP3) 2016-2020. Within PSL documents, RMNH refers to the following technical areas: family planning (FP), quality improvement for comprehensive abortion care (CAC), antenatal care (ANC), safe delivery and post-natal care (PNC). It also addresses the demand side through Behaviour Change Communication (BCC) and reduction on financial barriers to using RNMH services.

PSL focuses on holistic RMNH service provision and demand creation in the underserved north-eastern provinces of Kratie, Mondulkiri, Ratanakiri and Stung Treng. PSL supports family planning services and training on safe abortion in an additional 14 provinces across the country along with BCC and reduction of financial barriers. PSL also works to improve access to RMNH information and services for vulnerable young women working in garment factories in Phnom Penh and Kandal.

PSL is a partnership between the Australian Government, the Cambodian Ministry of Health (MoH) (particularly the National Reproductive Health Programme), and three NGOs (CARE Australia, Marie Stopes International Australia and Save the Children Australia). The initiative is a partnership designed to draw upon and leverage the skills and roles of all partners in order to achieve better outcomes. It links funding from the Australian Government, implementation experience of the three NGOs, and policy leadership of the Ministry of Health to improve maternal, neonatal, and reproductive services in Cambodia.

## 3. Purpose of evaluation

The Project Design Document anticipated that the project would have a 3 + 2 year design, with the activities and budget frontloaded into the first three years. This would maximise the prospect of achieving outcomes against multiple objectives in the early years and provide the opportunity for reflection and re-direction in response to project learnings and changes in the policy landscape.

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 MoH's reproductive health services in target areas.

The specific purposes of the mid-term review of PSL are to:

- Make a recommendation regarding whether to proceed to the final two years of the program, pending budget availability.

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- 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 RGC health priorities.

## 4. Focus and scope of the review

### 4.1. Overall

The mid-term review will encompass all PSL program activities within the broader context of MoH and DFAT health priorities and policies. As PSL has an innovative partnership model, another important dimension of the mid-term review is to ascertain if this has been effective and efficient. Finally, PSL has been designed as a program to initiate learnings in the RMNH sectors in Cambodia, and the mid-term review will gather and analyse evidence of the programs performance translating knowledge and experience into policy and practice.

### 4.2. Australian policies on international aid

The evaluation plan has been designed to ascertain the extent that PSL conforms to the follow the aims of Australian aid as expressed in recent police documents: Making Performance Count (2014) and Health for Development Strategy (2015).

Making Performance Count is central to the purpose of Australia's aid program: promoting Australia's national interests by contributing to sustainable economic growth and poverty reduction. The 10 targets are:

1. Promoting prosperity
2. Engaging the private sector
3. Reducing poverty
4. Empowering women and girls
5. Focusing on the Indo-Pacific region
6. Delivering on commitments
7. Working with the most effective partners
8. Ensuring value-for-money
9. Increasing consolidation
10. Combatting corruption

The targets for Australian aid described in the document are subsumed in the aid effectiveness criteria which create the framework for this mid-term review and discussed in detail in section 6, with specific attention to the effectiveness and efficiency. As a health project targeting access and utilisation of reproductive, maternal and newborn health in Cambodia through a partnership model, targets 4, 5, 7, 8 and 9 are directly relevant. PSL is also engaged with the private sector garment factories which employ women (target 2), many of whom are economically or socially vulnerable. Improving women's and newborns' health also has an immediate relevance for increasing economic prosperity and poverty reduction (target 1 and 3).

The power of health programs to enable development is the subject of DFAT's Health for Development Strategy 2015-2020. In the health sector, Australia's core priority for aid is to influence partner country decisions on health policy, strategy, and domestic resource allocation for more efficient and effective use of resources. The PSL program has been designed to achieve this in RMNH areas through demonstrating

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innovative and cost-effective methods and providing technical assistance at the national and provincial levels.

The mid-term review of PSL will incorporate the strategies for measuring performance described in Health for Development. Firstly, the mid-term review support country-wide systems by using RCG's Health Management Information System (HMIS), Cambodian DHS, guidelines and assessment tools to answer evaluative questions related to relevance, effectiveness and efficiency of the PSL investment. Secondly, the review focuses on the key questions to measure strategic performance. In fact, all of the key questions in the document are relevant to the PSL objectives and are incorporated in this plan. This linkage is made explicit in Section 6 of this plan.

### 4.3. Changes in the RNMH landscape post program design

In addition to recent changes in Australian aid policy, the landscape for RMNH in Cambodia has undergone some changes since project design. One of the most significant changes has been the release of preliminary results of the 2014 Cambodian Demographic and Health Survey (CDHS) in February 2015. This survey has found that nationally, Cambodia is continuing its spectacular improvements in women's and children's health. Cambodia has met all of its Millennium Development Goals in these areas, except for the modern methods contraceptive prevalence rate, which was not met both in the NE and in key RH focus provinces. Maternal, neonatal and child death rates have all declined at the national level. Fertility has declined, nearing replacement level fertility in urban areas, although there was a striking increase in teenage fertility. Nearly all pregnant women attend antenatal care at least once and give birth in the presence of a skilled birth attendant. Despite the excellence progress in women's and children's health nationally, there is considerable variability with much weaker progress among some particularly vulnerable groups. For example, those living in the NE provinces, where PSL is activity, have significantly worse indicators of family planning and health care utilisation and health outcomes.

Indicator	2000	2005	2010	2014	CMDG
Total Fertility Rate (avg number of births per woman)	4.0	3.4	3.0	2.7	
Maternal Mortality Rate (per 100,000 births)	437	472	206	170	250
Neonatal Mortality Rate (per 1,000 births)	37	28	27	18	22
Infant Mortality Rate (per 1,000 births)	58	66	45	28	50
Under 5 Mortality Rate (per 1,000 live births)	124	83	54	35	65
Percentage of Births Preceded by ANC	38%	69%	89%	95%	90%
Percentage of births Preceded by four ANC visits	9%	28%	59%	76%	90%

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Percentage of Births Delivered by Trained Attendant	32%	44%	70%	89%	87%
Percentage of Births Occurring in Health Facility	10%	22%	52%	83%	80%
Married Women using Modern Birth Spacing	19%	27%	35%	39%	60%
<b>Source:</b> Cambodia Demographic and Health Surveys: 2000, 2005, 2010, 2014 and CMDG Targets					

PSL was designed to address reproductive, maternal and newborn health, one of the four health priorities in the National Strategic Development Plan of Cambodia. It was also one of the three strategic program areas in the Health Strategic Plan 2008-2015. PSL strategies and activities addresses six out of the seven priorities for the country's Fast Track Initiative to Reduce Maternal and Neonatal Mortality 2010-2015 (FTIRMN). The next National Health Plan, which is under-development, will almost certainly include reproductive, maternal and newborn health; however, priorities and targets are likely to be different.

#### 4.4. As related to objectives of program being evaluated

The goal for PSL is: Save the lives of women and neonates in Cambodia through improved quality, access and utilisation of RMNH services. The MERI plan has six 5-year objectives which are listed in Table 2 along with the high level indicators of success. The consultants have summarised the principle strategies by the project to meet each objective. Progress to-date on the objectives will be completed when PSL's final year 2 annual report is submitted on 30th September.

**Table 2: Summary of Partnering to Save Lives objectives, indicators, strategies and progress**

Original 5-year PSL objectives	5-year indicators from final MERI plan	Principal strategies employed	Progress to date (to be completed during mission)
Improved quality RMNH services for target populations	Increase in facilities offering comprehensive abortion care and comprehensive modern contraceptive methods (NE and RH provinces); % of pregnant women delivering in a health facility; increase application of active management of labour practices; reduction in % of low birth weight babies	Clinic infrastructure, training and supervisory visits / coaching, commodity management support in the four NE provinces and RH focus provinces; reducing barriers to service utilisation including costs and referral pathways	

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Greater equity of access to appropriate RMNH services for target populations	Increase in women using modern contraceptive methods in NE and RH provinces. Increase in garment factory workers seeking FP and RH information, services and referrals from factory infirmaries	FP service delivery capacity building and quality improvement activities, BCC on FP and financial barriers approaches for FP in the NE and RH focus provinces. Supporting selected factory infirmaries to provide FP and appropriate referral services for reproductive health. BCC activities in FP and reproductive health for garment factory workers. Garment factory referral system.	
More responsive RMNH services meet the needs of target populations	Greater capacity to counsel and deliver short, long and permanent family planning methods post abortion and at post-natal care; women's satisfaction with FP services	Assessment of needs, training, quality improvement supervision, long-acting and permanent FP service delivery days, improving supply chain Community scorecards	
Improved RMNH behaviours amongst target population	Increase in women using FP who are using long acting methods; increase in four ANC and 2 PNC visits; greater knowledge of pregnancy danger signs	Community non-emergency referrals; reduction of financial barriers to accessing services; BCC	
Evidence- based innovation and learning that contributes to improved policy and practices	Number of national policies and guidelines that have been developed or strengthened due to the participation of PSL partners in key forums, meetings, workshops, working groups, etc.	Facilitating high-impact, cost-effective solutions for RMNH through technical advice on policies guidelines and training material, piloting and testing innovative approaches and conducting formative research. Development and implementation of learning agenda and advocacy action plan.	The four learning agenda themes are technical harmonisation, community referral systems, garment factory RMNH and financial barriers.
A partnership model that demonstrates high impact, cost effective methods for achieving RMNH outcomes	Effective and efficient program governance and management leading to greater influence on RMNH outcomes; enhanced learning and innovation	Establishing governance and management structures and systems, coordination and harmonisation of mechanisms between the partners	



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## 5. The audience

### 5.1. Primary user

The primary user of the mid-term review is the DFAT First Secretary, Development Cooperation, Ms Benita Sommerville, Australian Embassy, Cambodia. DFAT is the funding agency for PSL.

### 5.2. Key stakeholders directly affected by the report

The other key stakeholders are the senior representatives of the other partners: Cambodian Ministry of Health (Prof Tung Rathavy, Director National Maternal and Child Health Centre), CARE Australia, Marie Stopes International Australia and Save the Children Australia and PSL's Coordination and Learning Unit (CLU).

### 5.3. Broader audience

The broader audience will be at DFAT's discretion but may include bilateral donors and multilateral organisations involved in the RNMCH sector; local and international organisations advocating for or delivering RNMCH services; technical advisors and other experts within Cambodia and international involved in improving RNMCH outcomes in Cambodia and the region; private sector representatives (including garment brands and manufacturers).

## 6. Evaluation questions

### 6.1. Key evaluation questions (based on information from objectives in 4.4)

The key evaluation questions for this mid-term review are:

1. Has the PSL program achieved positive reproductive, maternal and newborn health outcomes through supporting improved service delivery and demand creation?
2. Has the PSL program influenced the strengthening reproductive, maternal and newborn health system in Cambodia through its learning, communication and advocacy activities?
3. Which strategies were the most relevant, effective and cost-efficient?
4. Was the partnership model of PSL effective and cost-effective compared to alternatives?
5. Based on program achievements and RCG's and DFAT's current needs and priorities, which aspects of the program should continue and in what form and with what resources?

### 6.2. Aid Effectiveness criteria

Using the Department of Foreign Affairs and Trade Aid Effectiveness criteria to structure the review, the following table provides the program-wide questions which will be addressed by the mid-term review.

Assessment	<i>Health for development (DFAT) strategic performance measurement</i>	Proposed questions to be addressed to evaluate criteria, specific to PSL
<b>Relevance</b> Extent to which activity is suited/appropriate to the priorities and policies of target group	<ul style="list-style-type: none"><li>• Are we focusing on the right issues to promote economic growth, reduce poverty, and maintain regional health security?</li><li>• Are we investing adequately in the right countries and targeting the right populations?</li></ul>	<ul style="list-style-type: none"><li>• Are the program objectives and activities aligned with RCG and DFAT policies for RMNCH?</li><li>• Are the objectives and activities addressing priority needs for partners, health services, communities and other beneficiaries?</li></ul>
<b>Effectiveness</b> A measure of the	<ul style="list-style-type: none"><li>• Are we achieving the impacts we intended?</li></ul>	<ul style="list-style-type: none"><li>• Have program objectives been achieved or are on track to being achieved (as measured</li></ul>

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<p>extent to which an aid activity attains its objectives and managing the risks.</p> <p>Includes social inclusion</p>	<ul style="list-style-type: none"> <li>• Are our investments effective and efficient?</li> </ul>	<p>against the MERI indicators)?</p> <ul style="list-style-type: none"> <li>• What additional or unintended benefits have occurred?</li> <li>• What have been the enablers and barriers to achieving results?</li> <li>• Were benefits directed towards communities and individuals with the greatest need?</li> </ul>
<p><b>Efficiency</b> Qualitative and quantitative measure of outputs in relation to inputs (including resource inputs)</p>	<ul style="list-style-type: none"> <li>• Are our investments effective and efficient?</li> <li>• Are we working with appropriate partners and using appropriate modalities?</li> <li>• Do we have the appropriate resources and systems to deliver impact and demonstrate results?</li> </ul>	<ul style="list-style-type: none"> <li>• Were project objectives and achievements achieved on time; what facilitated or impeded timely delivery.</li> <li>• Were program activities conducted in the most cost-effective and efficient manner, compared to alternatives?</li> <li>• What additional financial and other resources were leveraged to achieve PSL objectives?</li> </ul>
<p><b>Monitoring and evaluation</b></p>	<ul style="list-style-type: none"> <li>• Is there high quality monitoring and evaluation to assess the strategic performance of the investment?</li> </ul>	<ul style="list-style-type: none"> <li>• Does the logic model drive program implementation and strategic review?</li> <li>• Is the MERI plan appropriate and effective in monitoring process and outcomes?</li> <li>• Have the learning strategies employed by the program been appropriate and effective in improving program impact?</li> </ul>
<p><b>Sustainability</b></p>	<ul style="list-style-type: none"> <li>• Are we responding appropriately to context and to changes in the development environment?</li> </ul>	<ul style="list-style-type: none"> <li>• How probable is it that program benefits continue at the end of donor funding?</li> <li>• What are the major factors contributing to sustainability of program?</li> <li>• What strategies or actions need to be continued or put in place to increase the likelihood of sustainability?</li> </ul>
<p><b>Gender Equality</b> How does the investment address gender equality and women's empowerment?</p>	<ul style="list-style-type: none"> <li>• Are we contributing to gender-equality outcomes?</li> </ul>	<ul style="list-style-type: none"> <li>• How have program objectives and activities addressed gender equality and women's empowerment, including reduction in risk of gender-violence?</li> <li>• What benefits have been achieved or are on track to being achieved?</li> <li>• What, if anything, could be done within the program to enhance gender equality and women's empowerment?</li> </ul>
<p><b>Risk Management</b> What else is at stake?</p> <p><b>And Safeguards</b></p> <ul style="list-style-type: none"> <li>• Child protection</li> <li>• Displacement and resettlement</li> <li>• Environment</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Has the program put into place effective risk identification and minimisation strategies?</li> <li>• What, if any, negative incidences or consequences have arisen and how effectively were they addressed?</li> <li>• Have safeguards been put in place?</li> <li>• What continuing and new risks are foreseeable in the future if the project were to continue and how should they be managed?</li> </ul>

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<ul style="list-style-type: none"> <li>• Other</li> </ul>		
<b>Innovation and Private Sector</b> Innovative development approaches?	<ul style="list-style-type: none"> <li>• Are we engaging appropriately with the private sector?</li> <li>• Are we investing adequately in innovation and research?</li> </ul>	<ul style="list-style-type: none"> <li>• What are the aspects of innovation and private sector involvement demonstrated by this program?</li> <li>• Have the innovative and private sector activities been appropriate and effective?</li> <li>• What new or current innovation and private sector activities should form part of the program if continued?</li> </ul>

These program-wide questions are the basis for component specific questions, which can be found in Annex 1 of this Evaluation Plan. The components, which vary slightly from the program objectives for ease of data collection, are in Table 3.

Importantly the evaluation questions address not only the relevance, effectiveness and efficiency of current project activities. The mid-term review will also explore what should happen in the future, based on achieved and probable success of PSL strategies for creating improved service delivery and heightened demand for sustained FP and RMNH outcomes. They incorporate DFAT's performance measures for health investments.

**Table 4: Key evaluation questions by PSL program components.**

PSL Components (from MERI framework)	Evaluation components for mid-term review	Summary of key questions for the review (complete list by component in Annex 1)
1) Improving health service delivery  2) Community strengthening and engagement	Service quality improvements in the Northeast	Have PSL activities resulted in improved quality of FP and RMNH in the NE provinces? What have been the effective strategies and is the change likely to be sustained?
	Service quality improvements (FP/CAC) in selected provinces outside of the NE	Have the PSL activities to demonstrate high-impact, cost effective strategies to improve FP and RMNH services in other provinces been effective and cost-efficient in increasing utilisation and leading to sustainable improvements throughout the provinces and in national policies? Are the activities still relevant for Cambodia given the mix of providers and improved health outcomes?
	Increasing access to reproductive health services for garment factory workers	Has PSL been able to increase the availability and use of FP services and RMNH referrals from factory infirmaries? Can this program be scaled-up, including through other workplaces that employ women?
	Behaviour change communication and improved financial access in the Northeast	Have the BCC strategies, community referral systems and mechanisms to reduce financial barriers been effective and efficient? Can they be scaled-up through the Northeast?
	Behaviour change communication for garment factory workers	Has the behaviour change strategy been appropriate to the target group, has implementation been efficient and is there evidence of its effectiveness?
3) Knowledge into policy	Learning activities to demonstrate	Are the learnings based on robust data?

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	high impact and cost-effective RMNH solutions	Have the learnings been effectively communicated to stakeholders and is there evidence that they have influenced PSL's implementation and the policies and practices of other stakeholders?
	Project governance and management	Have the partners been able to harmonise their approaches and activities in an effective and efficient manner to maximise RMNH sustainable outcomes?

## 7. Methodology

The evaluation methodology will be pragmatic and employ mix-methods to gain a detailed, holistic and robust assessment of program performance and outcomes from which recommendations about future implementation priorities and modalities can be drawn with confidence.

The consultants will seek evidence from representatives of all stakeholder groups including those directly involved as PSL partners, those with expertise or practical knowledge of RMNH sector in Cambodia, provincial, district, commune and village officials and intended beneficiaries. The consultants will observe the settings where the program operates and where possible observe service delivery. Information will be collected through semi-structured and structured interviews and small group discussions, structured observations (including facility check-lists), and review of documentation including program outputs, policy documents, research findings and HMIS indicators. Analysis methods are described in section 7.3. Translators and note-takers will be used as necessary.

When making conclusions about program current and potential contribution to impact the consultants will attempt to provide counterfactuals. Given the short period of the review it will not be possible to visit sites that have not had the program in order to compare. The review will draw on existing data including PSL's baseline studies and national data such as HMIS and DHS to see if PSL sites have improved more rapidly than comparable areas. The consultants will also ask informants about their reasons for attributing change to PSL including the timing and amount of inputs, activities that reinforced or enabled change and their views of what would have happened without PSL.

Analysis will triangulate sources of evidence to create plausible results chains leading to likely contribution of the project to outputs and intermediate outcomes. Conclusions will document the degree of confidence we have in the main conclusions related to relevance, effectiveness, effectiveness and sustainability.

Table 5: Methodological considerations for drawing conclusions concerning contribution of programs

Principle	Application for mid-term review
Reliability	PSL mechanisms mentioned frequently and considered important by a range of stakeholders in different positions and sites
Internal reliability	Stakeholders opinions about PSL contribution is consistent with each other and quantitative indicators
Triangulation	The evidence for PSL contribution emerges from different data methods and sources
Chronology	PSL contribution is plausible because the activities were prior to changes in service delivery or behaviour
External validity	Stakeholders and consultants own profession expertise consider PSL contribution to be plausible given its composition and size
Internal validity	Gains attributed to PSL are present in program sites and absent or weak in non- program

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	sites without similar support from other programs
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## 7.1. Data collection

The consultant team will conduct interviews with partner representatives and other stakeholders in their workplaces. Site visits to observe the effects of program activities, interview representatives at the provincial, district, commune and village level and interview. Use of data collection frameworks (as described above), comparison of high performing sites with those that are not in the program or performing at a lower level and case studies of knowledge translations (see ‘Learning activities’ in Table \*) will add specificity and rigour to the mid-term review.

The consultants will collect and analyse qualitative and quantitative data from many sources. These are described by broad program area in Table 3. In many cases the same people will be interviewed about a number of PSL activities.

The detailed evaluative questions for each program area in Annex 1 will be the basis of semi-structured interview guides and analysis templates.

	Data			
	Qualitative	Quantitative	Site visits	Respondents
Service delivery and behaviour change in the NE	Key informant interviews; small group discussions with women in childbearing ages; review of policies and program documents	PSL activity reports and indicators; Cambodian HMIS; Cambodian DHS 2015 preliminary findings; facility assessment checklists	4 clinics and associated communes in each of Kratie and Ratanakiri Provinces; one of the sites in each province will be of a commune/clinic not supported by PSL. Sites will include those near the provincial capital and more remote	CLU and other PSL team members; representatives of PHD, OD and health clinic staff; Commune council women’s focal point, village health management committee, VHSGs, VSLAs or community based distributors; Small group discussion with women of child-bearing age in sites with PSL activity
FP and CAC Service capacity building outside of NE	Key informant semi-structured interviews; small group discussions with women in childbearing ages; review of policies and program documents	PSL activity reports and indicators; Cambodian HMIS; Cambodian DHS 2015 preliminary findings; facility assessment checklists	In Pursat Province: PHD, 3 clinics and their communes in at least 2 districts. One clinic will have had little or no involvement in PSL supported activities	MSIC representatives, representatives of PHD and OD, clinic managers and midwives; Commune council women’s focal point, village health

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				management committee or community based distributors; Small group discussion with women in reproductive ages.
RMNH in garment factories	Key informant semi-structured interviews; small ground and individual interviews with garment workers using hypothetical scenarios	PSL activity reports; infirmary statistics; relevant facility checklist	Three garment factories involved with PSL, demonstrating a range of activities and engagement levels (2 highly engaged, 1 less engaged)	Garment factory infirmary personnel and managers; Small group discussions with factory workers over 18 years; Private clinics or pharmacies located near factories(minimum of 12 workers in total)
Learning activities	Key informant semi-structured interviews; review of PSL documents including minutes and annual plans and other relevant documents to show evidence of policy dialogue. Case studies of two areas of learning for PSL, selected in consultation with DFAT, to trace the pathways PSL influences policy and practice through the system, at the national, provincial and OD levels. Possible examples are improving availability of modern contraceptive commodities, BCC or MCAT training curricula	PSL activity reports; evidence of adoption through RCG indicators. Use of a scale-up framework to assist in measuring comprehensiveness of efforts to expand and sustain high-impact, cost effective solutions	Site visits to work places In Phnom Penh and provinces.	PSL quality team members, CLU staff and TRG and PMG members; PHD representatives; other stakeholders
Partnership governance & management	Interviews with; review of PSC minutes and PMG minutes, TRG minutes. Reviews of annual reports and plans and other evidence of other evidence of harmonisation of strategies and processes.	PSL activity statistics; budget; partnership assessment tool	Site visits to work places In Phnom Penh and provinces	CLU, other PSL team members and partner representatives and representatives of PHD, OD and clinics. Commune council representatives if relevant.

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## 7.2. Tools and frameworks

Partnership assessment tools. The consultant team is currently reviewing tools to determine the most appropriate one for assessing PSL.<sup>6</sup> The team will discuss its final choice (or top two choices) with DFAT before proceeding.

Sustainability framework. A framework on best practices in scaling-up RMNCH health interventions in LMIC by the Team Leader is about to be published. This draws on the experience of 18 scale-up national programs and an extensive literature review. As scale-up is ultimately about sustaining high-impact interventions, the framework will be used to construct interview guide and analytical tools concerning the sustainability of the PSL outcomes.

Facility assessment tools. To the extent practicable, we will use the relevant PSL/MoH facility assessment tools where appropriate to ground our observations of clinic infrastructure and capacity.

## 7.3. Data management and analysis

Notes will be taken during all interviews and checked and expanded as soon as practicable. With the verbal consent of the respondents, interviews will be recorded as a back-up for the notes and to confirm quotations. The interviews will not be transcribed and recordings destroyed at the end of the review.

The consultant team will review information at the end of each day to keep track of the evidence for the evaluation questions and to form, test and refine conclusions. Issues to be clarified will be incorporated in future interviews.

From the notes and quantitative data, all information will be entered into Excel matrices structured by evaluation area, aid effectiveness criteria, respondent and site (if relevant). The interview responses and quantitative findings will be entered individually and then summarised to identify themes and patterns. The summaries (including exceptions) will be progressively aggregated so that the data supporting conclusion can be traced back to original data sources. Analysis will also highlight exemplary cases and quotations from all interview types to include in the report. The final data sets will be compiled and checked for consistency by the team members.

Analysis will take into account issue based findings comparing and contrasting distance from the provincial centre e.g. close to provincial headquarters, far away from provincial headquarters and very remote from provincial headquarters.

## 7.4. Ethical considerations in data collection, analysis and reporting

Everyone approached for interviews will be given a single page information sheet about the mid-term review. The information will be in English and Khmer and will be submitted to DFAT Cambodia for approval before finalising. The information will be read aloud, and translated into relevant ethnic minority languages, for those who do not read English or Khmer. In addition to explaining the purpose of the mid-term review, the information sheet will explain that what respondents tell us will be kept confidential. The report will name them and their position in a list of people consulted but their opinions and words will not be attributed to them in a way they could be identified.

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<sup>6</sup> Tsou et al, An exploration of inter-organisational partnership assessment tools in the context of Australian Aboriginal-mainstream partnerships: a scoping review of the literature. *BMC Public Health* 2015, 15:416 [online]

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Verbal permission will be sought from all respondents prior to the interview and after reviewing the information sheet. Permission will also be sought for recording the interview. Extensive notes will be taken during all interviews, regardless of whether they are recorded.

A small gift of gratitude will be given to beneficiaries and village level informants and garment factory workers who agree to be interviewed. These will be to express gratitude and not an inducement for participation. The gifts will be the responsibility of the consultants and it will be made clear they are from the consultants and not DFAT or PSL.

The consultant team will not have any contact with children under age 18 except incidentally while they are in the presence of their mother or other carer.

## 7.5. Limitations and constraints

The consultants have identified two limitations for this plan.

First, PSL is still a new program. Implementation started in mid-2013 and the mid-term review will be conducted after only two years of implementation. Much preliminary work, including staff recruitment, relationship building, needs assessment had to be undertaken prior to starting activities that could be expected to lead directly to outcomes. The consultants will be cognisant of this and, to the extent possible, make assessments based on progress which will plausibly be achieved by the end of the third year of the project.

Second, although we will conduct as rigorous as possible an evaluation, time and other constraints will limit the amount of data to be collected and analysed. Techniques described in 7.2 will assist in making conclusions based on reliable and valid information. Inevitably there will be key people who will not be available and a limited number of sites we will be able to observe. We will not be able to verify all of the information provided to us. Our report will indicate the level of confidence we have in our conclusions and we will also welcome the feedback provided by partners during the aide-memoire presentation and in response to the draft report to correct errors of fact or interpretation.

## 8. Schedule of activities

### 8.1. Proposed activity plan

Monday	21 Sept	AM - Meetings with DFAT PM – Phnom Penh meetings	Phnom Penh
Tuesday	22 Sept	AM – Phnom Penh meetings PM – travel to Pursat	Phnom Penh / Pursat
Wednesday	23 Sept	Activities in Pursat province	Pursat
Thursday	24 Sept	Public Holiday AM – Travel to Phnom Penh PM – Phnom Penh meetings (PSL NGOs willing to work on PH)	Pursat/ Phnom Penh
Friday	25 Sept	AM and PM - Garment factories	Phnom Penh
Saturday	26 Sept	AM or PM Phnom Penh meetings (if needed)	Phnom Penh
Sunday	27 Sept	Travel to Ratanakiri	Ratanakiri
Monday	28 Sept	RTK	Ratanakiri
Tuesday	29 Sept	RTK	Ratanakiri
Wednesday	30 Sept	Travel to Kratie	Ratanakiri / Kratie
Thursday	1 Oct	KRT	Kratie
Friday	2 Oct	KRT	Kratie
Saturday	3 Oct	Travel to PP	Kratie /Phnom Penh

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Sunday	4 Oct	Prepare Aid Memoire	Phnom Penh
Monday	5 Oct	Meet MoH in Phnom Penh/Prepare Aid Memoire / SHS review	Phnom Penh
Tuesday	6 Oct	Present Aid Memoire	Phnom Penh

### 8.2. Agreed dates for deliverables

Date (working days)	Activity	Responsibility
6 October	Present Aide-memoire	Team Leader
19 October	Final draft of mid-term review report	Team Leader
13 November	Final mid-term review report	Team Leader

## 9. Documents reviewed

Final five-year Monitoring, Evaluation, Reporting and Improving Framework, PSL, 2013.

Cambodia Demographic and Health Survey 2014. Key Indicators Report. February 2015.

Health for Development Strategy, 2015–2020. DFAT, June 2015.

Making Performance Count: enhancing the accountability and effectiveness of Australian aid. DFAT, June 2014.

Partnering to Save Lives (PSL): Australia-Cambodia Reproductive, Maternal and Neonatal Health Program. Program Design Document (PDD) [Draft], 2013.

PSL year 1 joint annual report final

PSL final year 2 6-month joint report

PSL yr2 learning update 1 technical harmonisation

PSL yr2 learning update 2 Community referrals

PSL yr2 Learning update 3 Garment factories

PSL yr2 Learning update 4 financial barriers

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Aid Effectiveness Criteria	PSL mid-term review guiding questions (summary)	Service quality improvements& BCC in NE	Service quality improvements outside of the NE (FP/CAC)	RNMH for garment factory workers	Monitoring, evaluation and learning	PSL governance & management
<p><b>Relevance: Extent to which activity is suited/appropriate to the priorities and policies of target group</b></p>	<p>Are the program objectives and activities aligned with RGC?and DFAT policies for RMNCH? Are the objectives and activities addressing priority needs for partners, health services, communities and other beneficiaries?</p>	<p>Were the criteria for selecting the sites for program activities appropriate considering the needs of the PHD and the provincial populations, particularly remote and ethnic minority communities? Were the program objectives and activities to enhance services in the NE needed and appropriate for the RCG health facilities in the NE?</p>	<p>Are the assessment, training and support activities aligned with RCG priorities and using tools and material that are appropriate for the Cambodian context? Are PSL training and support activities targeted at the areas of greatest need?</p>	<p>Are factory infirmaries and appropriate site for family planning and other reproductive health services for their workers? Are BBC activities targeted at workers appropriate and relevant to their needs?</p>	<p>Was PSL's learning and advocacy activities well targeted? Did they address information gaps and were they a credible source of learning evidence?</p>	<p>Are the program goals and activities aligned with and contributing to partner's organisational goals? Are the MERI indicators and logic model appropriate to measure program impact?</p>

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Aid Effectiveness Criteria	PSL mid-term review guiding questions (summary)	Service quality improvements & BCC in NE	Service quality improvements outside of the NE (FP/CAC)	RNMH for garment factory workers	Monitoring, evaluation and learning	PSL governance & management
<p><b>Effectiveness: A measure of the extent to which an aid activity attains its objectives and managing the risks. Includes social inclusion.</b></p>	<p>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?</p>	<p>Were program activities effective in improving FP and RNMH services in selected sites?            What were the most effective strategies?            Has there been an increase in adoption of FP methods, and increase in ANC and PNC visits, safe deliveries in the targeted communities?            What strategies have been effective in increasing utilisation?            What barriers still address and what are strategies to address these?</p>	<p>Has PSL contributed to an increase in women using modern contraceptives in the selected sites and province?            Has the quality and range of short and long term family planning services increased as a result of PSL?            Has PSL contributed to improved supply of short and long term family planning methods in Cambodia and selected provinces?            Has PSL contributed to improved obstetric and newborn care practices? Which strategies were most effective in producing change?            Has PSL contributed to improving abortion care in the selected provinces / sites?</p>	<p>Are garment factory workers able to access increased family planning and reproductive health services?            Are factory workers more aware about the importance for family planning and antenatal care and more likely to use services as a result of the project?</p>	<p>What has been PSL influence on MoH RNMH policies, guidelines and implementation at the national and provincial levels? What strategies have been most effective in influencing change?</p>	<p>What have been the benefits of the partnership model to the partners' capacity and RNMH outcomes? What have been the most successful aspects of the partnership? What, if anything, has been an obstacle to impact and how have they been addressed?</p>

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Aid Effectiveness Criteria	PSL mid-term review guiding questions (summary)	Service quality improvements& BCC in NE	Service quality improvements outside of the NE (FP/CAC)	RNMH for garment factory workers	Monitoring, evaluation and learning	PSL governance & management
<b>Efficiency: Qualitative and quantitative measure of outputs in relation to inputs (including resource inputs)</b>	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?	Did the program activities in the NE introduced as expected in the project design and annual plans? Have the program activities been delivered in a cost-effective manner compared to alternatives? Have there been sufficient financial and other resources to deliver the planned activities in the NE? If not, what was done to deliver the program?	Have the project activities been cost effective in demonstrating high impact cost effective solutions? Have the number of sites been manageable for PSL delivery? Have PSL activities added a unique value to efforts to improve FP and abortion care in Cambodia keeping in mind RCG and other donor-supported activities?	Is the program strategy for supporting garment factory workers' needs for family planning and reproductive health care the most cost effective option compared to alternatives? What are the options for leveraging additional resources?	Are the evidence gathering methods used by PSL cost effective / efficient? Have the learnings influenced the delivery of PSL? (covered in other sections as well) Are the communication strategies efficient so that the learnings are reaching the appropriate decision-makers?	Have the partners' efforts been harmonised to maximise efficiency of program delivery? Were the assumptions in the project design regarding the efficiency of the partnership model accurate? Has the partnership arrangements contributed positively or negatively to the timely, efficient and transparent progress of objectives?

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Aid Effectiveness Criteria	PSL mid-term review guiding questions (summary)	Service quality improvements & BCC in NE	Service quality improvements outside of the NE (FP/CAC)	RNMH for garment factory workers	Monitoring, evaluation and learning	PSL governance & management
<b>Monitoring, evaluation and learning</b>	Does the logic model drive program implementation and strategic review? Is the MERI plan appropriate and effective in monitoring process and outcomes? Have the learning strategies employed by the program been appropriate and effective in improving program impact?	How have learnings from the NE activities been gathered, disseminated and translated into learnings for PSL and other stakeholders in the NE and other parts of Cambodia? Do stakeholders consider the learnings relevant and useful?	Has PSL gathered and disseminated meaningful learnings regarding high-impact and cost-effective strategies regarding provision of modern contractive methods and abortion care? Has PSL learning strategies impacted on the policies and practices of MoH and other Cambodian service providers nationally and in these provinces?	How has monitoring and evaluation informed the strategies for working with garment factories and workers.	Have learnings of learning activities been incorporated into the MEL agenda?	How effectively has the partnership used information to make strategic decisions and adapt to new circumstances?
<b>Sustainability</b>	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?	What is the evidence that there has been lasting changes to health facility capacity to deliver improved RNMCH services? What mechanisms were most effective in enhancing the likelihood of sustainability? What would need to be done in the future to sustain (and expand) the benefits for the program in the NE	Will the technical and capacity building activities lead to sustained change in service delivery? What has been the successful (and unsuccessful factors) contributing to sustainability at the clinic, OD, province and national levels—either now or likely by the end of the project What would be the impact on	Are factory infirmaries likely to continue to provide family planning services after PSL? If so, what has assisted them?	Have MEL activities contributed to increased capacity in MEL within the partner organisations?	What aspects of the partnership are likely to remain at the end of PSL? What will be the legacy of PSL within partnership organisations as a result of the partnership model?

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Aid Effectiveness Criteria	PSL mid-term review guiding questions (summary)	Service quality improvements& BCC in NE	Service quality improvements outside of the NE (FP/CAC)	RNMH for garment factory workers	Monitoring, evaluation and learning	PSL governance & management
		provinces?	sustainability if these activities were to end or be altered?			
<b>Gender Equality : How does the investment address gender equality and women’s empowerment?</b>	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?	How has PSL activities promoted gender equality, women's empowerment and addressed gender-based violence in the NE?	How have the activities incorporated gender equality and women's empowerment? To what extent has PSL addressed gender-based violence as part of its work in FP and abortion care? What strategies are feasible for greater incorporation of these issues in strategies and activities?	How did the interventions in garment factories further gender equality and women's empowerment?	Have the learning activities highlighted issues related to gender equality, women's empowerment and gender-based violence? If so, have their inclusion contributed to the impact of the learning activities?	Has the program instituted policies and processes that promote gender equity and women's empowerment within the PSL team and the partner organisations?



## EVALUATION PLAN

Aid Effectiveness Criteria	PSL mid-term review guiding questions (summary)	Service quality improvements & BCC in NE	Service quality improvements outside of the NE (FP/CAC)	RNMH for garment factory workers	Monitoring, evaluation and learning	PSL governance & management
<b>Risk Management and Safeguards (includes child protection, displacement and resettlement, and environment)</b>	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?	How has PSL identified and managed the risks to reproductive health rights, including service quality, in the NE? What strategies to safe guard rights have been successful?	How has PSL identified and managed the risks to reproductive health rights, including service quality, in the RH provinces? What strategies to safe guard rights have been successful?  How effectively does PSL address issues related to potential threats to reproductive rights? Which strategies have been employed to address these risks? What are the risks involved in changing the PSL strategies and activities in these areas and how can they be minimised?	What risks to reproductive human rights and other risks have been identified and addressed in relation to garment workers in the program?	How have the learning activities addressed risks of evidence quality, relevance and ethical considerations while conducting baseline research and trials and in disseminating results?	Have the partners harmonised a risk management approach to PSL and to the Cambodian RNMH sector more generally? What safeguards have been put into place to safe guard risks to human rights in program activities and in the RNMH sector in Cambodia? How did the program manage the challenges of per diem rates in relation to program activities in the field?

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<b>Innovation and private sector involvement</b>	<p>What are the aspects of innovation and private sector involvement demonstrated by this program?</p> <p>Have the innovative and private sector activities been appropriate and effective?</p> <p>What new or current innovation and private sector activities should form part of the program if continued?</p>	<p>What have been the innovative practices trialled by PSL in the NE and what has been the experience? Are these practices appropriate for scaling up through PSL or other programs?</p>	<p>What have been the innovative practices trialled by PSL in the RH provinces and what has been the experience? Are these practices appropriate for scaling up through PSL or other programs?</p>	<p>What are the lessons learned from working with factories? Have nearby health clinics and pharmacies been involved?</p>	<p>What have been the innovative practices or issues championed by PSL? How has the learning team worked with private sector as research contractors and as users of the information (private health care providers, garment factory owners)?</p>	<p>What has been the partners' appetite for innovation and working with the private sector? Has the PSL partnership enabled greater innovation and private sector engagement than would have occurred by the partners without PSL?</p>