COUNTRY REPORT

CAMBODIA

EVALUATION OF UNFPA SUPPORT TO MATERNAL HEALTH

Mid-Term Evaluation of the Maternal Health Thematic Fund

EVALUATION BRANCH
Division for Oversight Services
New York, October 2012

UNFPA

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COUNTRY REPORT: CAMBODIA

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EVALUATION OF UNFPA SUPPORT TO MATERNAL HEALTH

Including the contribution of
the Maternal Health Thematic Fund

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ADB	Asian Development Bank
AFD	Agence Français de Développement
ANC	Antenatal care
AOP	Annual operational plan
APRO	Asia and the Pacific regional office
ASEAN	Association of Southeast Asian Nations
AusAid	Australian Agency for International Development
AWP	Annual work plan
BCC	Behavior change communication
BEmONC	Basic emergency obstetric and newborn care
BTC	Belgium Technical Cooperation
CAC	Comprehensive abortion care
CAPPD	Cambodia Association of Parliamentarians for Population and Development
CAR	Council for Administrative Reform
CARE	CARE International in Cambodia
CBD	Community-based distribution
CC	Commune Council
CCA	Common country assessments
CDCF	Cambodian Development Co-ordination Forum
CEDAW	Committee on the Elimination of Discrimination against Women
CEmONC	Comprehensive emergency obstetric and newborn care
CHEMS	Cambodia Health Education and Media Services
CIP	Commune Investment Plan
CMA	Cambodian Midwives Association
CMC	Cambodia Midwifery Council
CMDG	Cambodia Millennium Development Goals
CMS	Central medical stores
COAR	Country office annual report
CO	Country office
CPA	Complementary Package of Activities
CPAP	Country programme action plan
CPD	Country programme document
CPII	Country programme II
CPIII	Country programme III

CPR	Contraceptive prevalence rate
CPRS	Cambodian Poverty Reduction Strategy
CSS	Community systems strengthening
CSWG	Contraceptive Security Working Group
D&D	Decentralization and deconcentration
DDF	Department of Drugs and Food
DfID	Department for International Development (UK)
DHD	District Health Department
DHS	Demographic Health Survey
DIC	Department of International Co-operation, MoH
DOCFR	Direct obstetric case fatality rate
DoLA	Department of Local Administration
DPHI	Department of Planning and Health Information
DRH	District Referral Hospital
EC	Emergency contraception
ECOSOC	Economic and Social Council
EDP	External development partner
EF	Equity Fund
EmONC	Emergency obstetric and newborn care
EmONC- IP	Emergency obstetric and newborn care Improvement Plan
EU	European Union
FDI	Foreign direct investment
FTIRM	Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality
GAVI	Global Alliance for Vaccines and Immunizations
GBV	Gender-based violence
GDCC	Government Donor Coordination Committee
GDP	Gross domestic product
GoC	Government of Cambodia
GPCC	General Population Census of Cambodia
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
HACT	Harmonized Approach to Cash Transfers
HC	Health Centre
HCMC	Health Centre Management Committee
HE	His or Her Excellency
HEF	Health Equity Fund
HIS	Health information system
HIV	Human Immunodeficiency Virus

HMIS	Health management information system
HQ	Headquarters
HRD	Human Resources Development Department
HWDP	Health Workforce Development Plan
HRH	Human resources for health
HSD	Health service delivery
HSP1	First Health Sector Strategic Plan, 2003-07
HSP2	Second Health Sector Strategic Plan 2008-2015
HSR	Health sector review
HSS	Health systems strengthening
HSSP I	First Health Sector Support Project
HSSP II	Second Health Sector Support Programme
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
IDP	Institutional Development Plan
IEC	Information, education and communication
IMCI	Integrated management of childhood disease
IMR	Infant mortality rate
INGO	International non-governmental organization
IPC	Inter-personal communication
IUD	Intrauterine device
JAPR	Joint annual performance review
JICA	Japan International Cooperation Agency
JMA	Joint management arrangements
JPA	Joint partnership arrangements
JPIG	Joint Partner Interface Group
KAP	Knowledge attitude and practice
KfW	Kreditanstalt fuer Wiederaufbau (German Development Bank)
KHANA	Khmer HIV/AIDS NGO Alliance
KYA	Khmer Youth Association
LMIS	Logistics management information system
LSS	Life-saving skills
MARP	Most at risk population
M&E	Monitoring and evaluation
M-CAT	Midwife Coordination Alliance Team
MDA	Maternal death audit

MDG	Millennium Development Goals
MDS	Maternal death surveillance
MEDiCAM	Membership organization for NGOs active in Cambodia health sector
MHTE	Maternal Health Thematic Evaluation
MHTF	Maternal Health Thematic Fund
MIS	Management information system
MISP	Minimum Initial Service Package
MMR	Maternal mortality ratio
MNbM	Maternal and newborn mortality
MoEF	Ministry of Economy and Finance
MoEYS	Ministry of Education, Youth and Sports
MoH	Ministry of Health
MoI	Ministry of Interior
MoP	Ministry of Planning
MoWA	Ministry of Women Affairs
MPA	Minimum Package of Activities
MSI	Marie Stopes International
MTR	Mid-term review
MWH	Maternity waiting home
NA	National assessment
NAA	National AIDS Authority
NCDD	National Council of Deconcentration and Decentralization
NCDM	National Committee on Disaster Management
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs
NCHP	National Centre for Health Promotion
NCPD	National Committee for Population and Development
NDCC	National Development and Coordination Center
NGO	Non-governmental organization
NHS	National Health Survey
NHPC	National Health Promotion Centre
NIPH	National Institute of Public Health
NIS	National Institute of Statistics
NMCHC	National Maternal and Child Health Centre
NPO	National Programme Officer
NRHP	National Reproductive Health Programme
NPP	National Population Policy
NSDP	National Strategic Development Plan

NSRSH	National Strategy for Reproductive and Sexual Health
OBGYN	Obstetric and gynecologist
OCM	Office of the Council of Ministers
OD	Operational district
ODA	Overseas Development Assistance
PATH	Programme for Appropriate Technology in Health
PBA	Programme based approach
PD	Personnel Department, MoH
PHC	Primary health care
PHD	Provincial Health Department
PMP	Performance monitoring plan
PMTCT	Prevention of mother-to-child transmission
PNC	Postnatal care
PO	Programme Officer
Pro-TWGH	Provincial Technical Working Group for Health
PSI	Population Services International
RACHA	Reproductive and Child Health Alliance
RHAC	Reproductive Health Association of Cambodia
RHCS	Reproductive health commodity security
RHIYA	Reproductive Health Initiative for Youth in Asia
RR	Reproductive rights
RTC	Regional training centre
SM	Safe motherhood
SOA	Special Operating Agencies
SOP	Standard Operating Procedure
SoW	Scope of work
SRP	Sector related programme
SWAp	Sector wide approach
SWiM	Sector wide management
TC	Technical Committee
TFR	Total fertility rate
ToR	Terms of reference
TOT	Training of trainers
TSMC	Technical School for Medical Care
TWG	Technical working group (H – health)
UNAIDS	United Nations Programme on AIDS

UNDAF	United Nations Development Assistance Framework
UNDMT	United Nations Disaster Management Team
UNESCO	United Nations Education, Social and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNSD	United Nations Statistics Division
USAID	United States Agency for International Development
VCCT	Voluntary counseling confidential testing
VHC	Village Health Committee
VHSG	Village Health Support Group
VSC	Voluntary surgical contraception
VSO	Voluntary Services Overseas
WCHC	Women and Child Health Committee
WHO	World Health Organization
WTO	World Trade Organization

1. Purpose and scope of the evaluation

Maternal health remains a major challenge to health systems worldwide. The world is on track to reach some targets of the Millennium Development Goals (MDGs) by 2015, but falling short on others; maternal health is the least likely to meet the 2015 target. A recent analysis found an annual rate of reduction of 1.3 per cent during the period of 1990–2008, well short of the 5.5 per cent needed to attain the MDG targe t by 2015. At the current rate of decline, it will take more than 188 years to meet the goal of 100 per 100,000 live births.

Given the current lack of sufficient progress in tackling maternal mortality, it is critical that effective interventions are implemented and monitored. Careful evaluation of these interventions is crucial for determining what works and for ensuring scarce resources are allocated effectively. This is particularly true for developing countries, where maternal mortality is highest and access to maternal health services is poor. For this reason, United Nations Population Fund (UNFPA) has launched the evaluation of its support to maternal health in the last eleven years and the mid-term evaluation of the Maternal Health Thematic Fund. Following the terms of reference, the evaluation covers the period from 2000 until 2010, and includes information related to a number of interventions implemented in 2011.

The aim of conducting both evaluations in parallel; i.e. the Maternal Health Thematic Evaluation (MHTE) and the Mid-Term Evaluation of the Maternal Health Thematic Fund (MHTF); is to take advantage of potential synergies in the evaluation portfolio of UNFPA and obtaining deeper and better substantiated insights on the thematic area of maternal and reproductive health as a whole, as well as on the MHTF individually.

1.1 Scope of the Maternal Health Thematic Evaluation

The MHTE assesses to what extent UNFPA support to maternal health has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health. The evaluation covers all programmatic interventions that have been directly relevant to maternal mortality and morbidity within UNFPA mandate, including all activities financed from core and non-core resources; and those financed through UNFPA Reproductive Health Thematic Funds.[1] MHTE focuses on key elements of reproductive health including family planning, skilled birth attendance and Emergency Obstetric and Newborn Care (EmONC), i.e. the "three pillars" of reducing maternal mortality. The thematic scope of the MHTE is defined by a list of twelve evaluation questions (a table with all evaluation questions and related judgment criteria is presented in Annex 6.3).

1.2 Scope of the Maternal Health Thematic Fund mid-term evaluation

The objectives of the mid-term evaluation of the Maternal Health Thematic Fund (MHTF) are to assess to what extent MHTF support has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health. The mid-term evaluation focuses on technical areas (midwifery, family planning and emergency obstetric and newborn care) and on the potential of the MHTF to act as a catalyst in these areas. The evaluation also covers the internal coordination and

1. I.e., the Maternal Health Thematic Fund, the Global Program to Enhance Reproductive Health Commodity Security and the joint UNFPA-UNICEF Female Genital Mutilation Program.

management processes of the MHTF (support to planning, programming and monitoring, coordination and management mechanisms, and the facilitation of the integration and use of synergies). Additionally, aspects of leveraging and visibility are assessed. The temporal scope of the mid-term evaluation covers the period since the launch of the MHTF in 2008.

The strategic framework of the MHTF (i.e., the MHTF business plan) provides a clear reference framework for the mid-term evaluation. The specific thematic scope of the mid-term evaluation of the MHTF is defined by a list of eight evaluation questions (a table with all evaluation questions and related judgment criteria is presented in Annex 6.3).

1.3 Geographical scope of the overall evaluation

The scope of this evaluation is limited to those 55 countries whose maternal mortality ratio in the year 2000 was higher than 300 deaths per 100,000 live births. The main rationale for this delimitation of the scope is to allow the evaluation to a) include those countries that have or have not made improvements in addressing maternal heath since the year 2000; and b) to focus the analysis on those countries that, relative to others, have experienced the greatest challenges in improving maternal health in accordance with MDG 5.

1.4 Purpose and structure of this country report

This country report has been prepared following the completion of the country case study in Cambodia and summarizes its findings and conclusions. The findings presented in this country report, together with nine other country reports, inform the final evaluation reports for the MHTE and the mid-term evaluation of the MHTF.[2]

The country report is structured as follows:

- Chapter 2 explains the case study methodology. It discusses:
    - The process and criteria for selecting case study countries overall, and the specific reasons for choosing Cambodia as a case study
    - The preparation and implementation of the case study
    - The limitations and constraints experienced by the evaluation team
- Chapter 3 provides a short description of the reproductive health sector in Cambodia, and describes the overall approach of UNFPA to supporting maternal health in the country
- Chapter 4 presents the findings of the country case study
- Chapter 5 presents the conclusions of the country case study drawing on the findings for each of the evaluation questions. While Chapter 5.1 draws conclusions for UNFPA overall maternal health support in the country, Chapter 5.2 focuses on the added value of the Maternal Health Thematic Fund
- Chapter 6 presents the annexes of this country report including a list of all documents consulted and a list of people interviewed for this case study. The annexes also contain key data for Cambodia, the methodological instruments utilized for this case study and a list of UNFPA interventions and activities in Cambodia

2. Final evaluation reports for MHTE and MHTF are available on the following web page: http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094.

2. Methodology of the case study

The methodology for the case study has been developed based on the overall methodology for the MHTE and the mid-term evaluation of the MHTF (see final reports for MHTE and MHTF). The purpose of the country case study is to use the field visit to collect data and information to verify the hypotheses developed during the desk phase of the evaluation and to further inform the answers to the evaluation questions.

2.1 The selection of country case studies

2.1.1 The process and criteria for selecting country case studies

The evaluators carried out a comprehensive staged sampling process to select the countries to be included in the field phase of both evaluations. The first sampling stage resulted in the selection of all 55 UNFPA programme countries with a maternal mortality ratio (MMR) higher than 300 deaths per 100,000 live births in the year 2000.[3] In the second sampling stage, 22 countries out of the initial 55 were selected for inclusion in the extended desk phase. In order to ensure that different types of country contexts were included in this second-stage sample, the countries were grouped and selected according to the following criteria (see Table below).

Criteria used to create a typology of desk phase countries

Selection criteria
Relative success of program countries in improving maternal health (to include "high-performing" and "low-performing" countries);
Average income level in the different program countries (to include countries with different poverty levels as one determinant of maternal health);
Quality of the public administration (to include countries with different administrative capacities to develop and manage maternal health programmes); and
Relative prevalence of HIV (to include program countries whose maternal health situation was interlinked with a high incidence of HIV).

In the third sampling stage, ten countries out of the group of 22 were selected for in-depth case studies (field phase);[4] eight of these countries were recipients of the MHTF. Case studies were selected so that each type was represented by two cases: One country that had made large improvements; and a similar country (according to the above selection criteria) that only

3. The sampling criterion has been selected to establish a close ling to the MDG5 indicators. The data have been taken from the H4 report "Trends in Maternal Mortality: 1990-2008" in agreement with UNFPA.
4. Burkina Faso, Cambodia, DRC, Ethiopia, Ghana, Kenya, Lao PDR, Madagascar, Sudan, and Zambia.

had made small improvements in reducing maternal mortality. Overall, this systematic approach to selecting countries for the field phase allowed for different types of country contexts to be equally covered by the evaluations.

2.1.2 Justification for selecting Cambodia

Cambodia is one of several programme countries in the sample that have made significant progress in reducing maternal mortality. Not all the reasons for progress in Cambodia are similar to other countries in the same category; for example, Ethiopia has reasonably effective public administration like Cambodia and high maternal mortality reductions. Cambodia had a maternal mortality ratio (MMR) of 437 deaths per 100,000 live births in 2000, which increased to 472 deaths in 2005 before showing a reduction by more than half to 206 deaths in 2010.[5] The MDG target for 2015 is 250 deaths per 100,000 live births. Reductions in the MMR are mostly attributed to monetary incentives provided to midwives in 2008-2010.[6]

Cambodia has a relatively high per-capita gross national income (GNI) of US$1,000.[7] The assumption for Cambodia was that the higher resource availability would influence the ability of the government and society to address certain bottlenecks in maternal health service provision with their own resources; and that this circumstance would change the demands made on UNFPA to support the efforts to reduce maternal mortality. However, Cambodia has scored 'medium' in quality of public administration quality. Again, this was interpreted to mean that Cambodia like Ethiopia would have a relatively higher capacity than Sudan and Burkina Faso (which scored low on this indicator) to take on many of its own challenges with greater support and co-operation from its development partners. The existence of a long-term programme based approach by the Health Sector Support Project (HSSP) in Cambodia, for example was seen as expression of this relatively greater national capacity and aid effectiveness. Cambodia significant progress in reducing MMR is almost on par with Ghana, Benin, Malawi and Madagascar (with high quality public administration). Like the aforementioned four countries in the sample, Cambodia is now below the threshold of 300 deaths per 100,000 live births.

Finally, Cambodia has relatively low HIV prevalence. This assumption made the task of reducing maternal mortality less challenging for the government as well as for UNFPA. Thus, it was expected that the UNFPA approach to maternal health support would need to be adapted as compared to other countries with high incidences of HIV.

2.2 Scope of the country case study

This country case study is one of several evaluation components used to collect evidence for answering the global evaluation questions and judgment criteria[8] of the two evaluations.[9] These evaluations draw on a number of different information sources. Consequently, this country case study provides only some of the information required to answer the global evaluation questions comprehensively.[10] The scope of the country case study is defined by the "issues to assess" that are listed at the

5. Cambodian Demographic Health Survey 2000, 2005 and 2010:
6. Almost all interviewees alluded to this fact but qualified it as the government had to do what was necessary and incentives have worked since it has achieved the results. Some were calling for better schemes supporting services in remote areas, others voiced concern about sustainability.
7. This puts Cambodia into a group of countries with per capita GNIs higher than US$1,000, along with Zambia, Ghana and Lao PDR.
8. During the inception phase of this assignment, the focus of each o f these global evaluation questions had been sharpened by defining a set of judgment criteria that specified which aspects of UNFPA associated support to maternal health should be at the center of attention for each evaluation question. These judgment criteria define in greater detail the specific conditions of success of UNFPA support in each of the thematic areas covered by the evaluation questions. For a more detailed explanation of judgment criteria, please see the final reports of the MHTE and MHTF evaluations.
9. I.e., the Maternal Health Thematic Evaluation and the MHTF mid-term evaluation; see Chapters 1.1 and 1.2 above.
10. 12 evaluation questions for the Maternal Health Thematic Evaluation and eight evaluation questions for the MHTF mid-term evaluation.

beginning of the findings-section for each evaluation question, together with the judgment criteria they correspond to. These "issues to assess" were defined after analyzing the global maternal health strategy of UNFPA and its underlying theory of change. Based on this analysis, the evaluation team determined which parts of this theory of change were the most important for the overall success of the UNFPA maternal health strategy. The global list of "issues to assess" was then adapted to the context of the case study country.[11] The country case study focused on collecting information on these specific issues. Its findings therefore do not amount to complete answers to the global evaluation questions.[12] Recommendations are not elaborated at this stage, as the overall conclusions to the evaluation questions will only be developed on the level of the final reports to the MHTE/MHTF evaluations.

Since the 20 global evaluation questions of the two evaluations[13] are designed to assess the relevance, efficiency, effectiveness, and sustainability[14] of the support to maternal health provided by UNFPA, the issues to assess that were derived from the evaluation questions are also related to these four DAC standard evaluation criteria.

2.3 Preparation of the country case study

The evaluation team prepared this country visit in cooperation with the UNFPA country office. The evaluation team mapped the relevant stakeholders, selected interviewees, identified data sources and selected data collection approaches to ensure that information on each particular issue would be collected

1. From different sources, such as from different stakeholders, to reflect potentially differing perspectives, or from different documents (data triangulation)
2. Using complementary data collection methods, i.e., a mix of quantitative and qualitative methods, such as the use of secondary data on maternal health from demographic health surveys; and the use of feedback from key informant interview and focus groups (methodological triangulation)[15]

An overview of the triangulation for each evaluation question is presented in Annex 6.2.

2.4 Data collection methods and analysis during the country case study Cambodia

The evaluation team used the following approaches for collecting data during the country visit to Cambodia:

- The evaluators conducted a series of interviews in Phnom Phen, i.e., with staff from UNFPA and with representatives of UNFPA main partners in the country, including governmental partners, non-governmental, development and other implementing partners. In these interviews, the team focused on the collection of qualitative data that would help to provide contextual information on UNFPA interventions, its contributions and roles in partnerships, etc

11. Issues addressed may vary from one country case study to the other. Only issues which have been addressed in this specific country case study are shown in the tables in front of each evaluation question and in the annex. This might lead in some occasions to difficulties in linking issues and judgment criteria but this is unavoidable as the methodology has been designed for the overall global evaluations.
12. See also the final reports of the MHTE and MHTF evaluations for more details on the methodological approach.
13. The Maternal Health Thematic Evaluation and the MHTF Mid-Term Evaluation.
14. I.e., four of five standard Development Assistance Committee (DAC) evaluation criteria.
15. E.g., semi-structured interviews, focus groups, document reviews.

- During the country visit, the team collected and reviewed additional documents that either had not been available during the desk phase; or that needed to be drevised to verify particular information that had been received during one of the interviews.[16] Evaluators focused in particular on the following types of documents:

  - Annual work plans (AWPs), in particular those AWPs that had not been available to the evaluation team during the desk phase
  - Relevant national strategic documents including policies and strategic frameworks for sexual and reproductive health policies, maternal health policies, family planning, EmONC and other relevant topics
  - Needs assessments and other inputs into the policy-making process that UNFPA had supported or implemented, covering all relevant maternal health topics
  - Documents that described and defined UNFPA relationship with its partners in the country, such as Memoranda of Understanding (MoUs) with development partners or government
  - Evaluations or assessments of UNFPA maternal health support in the country that had not been available to the evaluation team during the desk phase of this evaluation

- The team visited two operational districts out of 24 UNFPA target districts (in 2010) which were selected for the purpose of the evaluation by using key indicators of population density, rural and urban population, and proportion of women aged 15-21 years and duration of UNFPA programming in the operational districts. The two operational districts were Kralanh District in Siem Reap Province and Kampong Chhnang in Kampong Chhnang Province. One provincial referral hospital, one district referral hospital and one health center were visited as examples of basic emergency obstetric and newborn care (BEmONC) services and comprehensive emergency obstetric and newborn care (CEmONC) services. Battambang province hosts one of four Regional Training Centers (RTC) supported by UNFPA and was thus visited, too. Throughout the preparation and conduct of the case study, the evaluators ensured that they differentiated between maternal health support financed by UNFPA core funds, and support financed by the MHTF

At the end of the visit to Cambodia, the evaluation team did a preliminary analysis of their findings for each of the evaluation questions. These findings were presented to the UNFPA country office prior to the departure of the team. In addition, the team formulated conclusions on a number of topics that cut across the thematic areas covered by the evaluation questions. These conclusions constitute an assessment of selected aspects of UNFPA support to maternal health in Cambodia and on the added value of the MHTF. However, due to the selective nature of the case study, these conclusions do not necessarily form a comprehensive and complete assessment of UNFPA support of sexual and reproductive health in the country, as would have been the case in a country program evaluation of Cambodia. These conclusions are presented in Chapter 5.

2.5 Limitations and restrictions

During the country visit, the evaluators encountered the following challenges or constraints:

Challenges/constraints encountered	Reactions
The schedule preparation process for this mission took time because the selected key persons were busy with their core work, mission, meetings related to National Health Strategic Plan 2 (HSP 2) review and Joint Partner Interface Group (JPIG) meeting which took place on short notice at the same time as the first week of the country visit.	A couple of appointments had to be canceled at the last minute and rescheduled for another date; some appointments were finalized during the last week of the mission because of non-availability of the persons to be interviewed at an earlier date. With the exception of CHEMS, the evaluation team met with all listed interviewees.

16. A comprehensive list of interviewees is presented in the annexes.

3. Short description of the reproductive health sector

3.1 Country Background

Cambodia experienced regional and civil conflict from the early 1970s, which still affected the country in the late 1990s. The Khmer Rouge period from 1975 – 1979 was marked by genocide and starvation resulting in nearly two million deaths and the loss of skilled and educated people which, almost 30 years later, have only partially been replaced.[17] Peace and stability were progressively re-established throughout Cambodia following the Paris Peace Agreements in October 1991. The first national elections of the country were held in 1993, and subsequent multi-party elections followed in 1998, 2003 and 2008. With peace and macro-economic stability more firmly established, by 2004 Cambodia began focusing on long-term development including the health and social sector.[18]

According to the 2008 General Population Census of Cambodia (GPCC), the population was 13.4 million with a population growth rate of 1.54 per cent. While poverty has decreased substantially over the last 10 years, the benefits of growth have not been equitably distributed, resulting in increased inequality in the country where 33 per cent of the population is still living below the poverty line, with approximately 12 per cent facing hunger and food insecurity.[19] Economic decline (both internationally and nationally) is affecting the country's ability to meet the Millennium Development Goals (CMDG) target of reducing overall poverty to 19.5 per cent by 2015.

A secondary data analysis of the Cambodian Demographic Health Survey (DHS 2010) shows that 27 per cent of households are headed by women.

Table 1: Key economic data Cambodia

Total Population Cambodia (2009)	14,805,000
GDP (2009)	US$ 10.798 billion
GDP/per capita (2009)	US$ 729

Source: UN Statistical Service UNData. Cambodia

17. UNFPA Cambodia.
18. Cambodia at a Glance, Population, Gender and reproductive health, UNFPA, 2005.
19. CCA, UNDP, 2009.

Cambodia is a member of the World Trade Organization (WTO) and the Association of South East Asian Nations (ASEAN), which ensures the regional and international integration of the country but also poses challenges for growth and competiveness. The dependency on external factors, especially Overseas Development Assistance (ODA) remained high in 2008 and accounted for approximately half of the yearly budget of the government, or annual support per capita of US$39.[20]

3.2 Cambodia Health Sector

Reproductive health and the associated policy environment in Cambodia are defined by the International Conference on Population and Development principles and its programme of Action (ICPD 1994) as well as the Fourth World Conference on Women (Beijing 1995). These two international forums provided a basis for the establishment of the National Reproductive Health Programme (NRHP 1994-95), the Birth Spacing Policy 1995, the National Safe Motherhood (SM) Action Plan 2001-2005 that was updated in 2009, National Population Policy (NPP) 2003, and Cambodian Millennium Development Goals 2000 (updated in 2001, 2003, and 2006).

The National Strategy for Reproductive and Sexual Health (NSRSH 2006-2010) was undertaken by the national reproductive health programme with the Ministry of Health (MoH) providing a coordinated response for advocating priorities and a framework for annual planning and mobilizing resources. Reproductive health and maternal, newborn and child health are prioritized under the Health Strategic Plan I and II (2008-15). The Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality (FTIRM 2010-15) identifies priority areas such as emergency obstetric and newborn care (EmONC), skilled birth attendants, family planning, comprehensive abortion care (CAC), behavior change communication (BCC), removing financial barriers, and maternal death surveillance (MDS).[21]

There are many actors supporting the improvement of maternal health in Cambodia. To provide efficient, sector-wide support to the MoH, the Health Sector Support Project (2003 -2007, HSSP I) and currently the Health Sector Support Programme[22] (2008-2013, HSSP II) were initiated by four international donors. By 2010 the number of donors supporting these initiatives had increased to seven (UNFPA, Agence Française de Développement (AFD), Australian Agency for International Development (AusAID), Belgian Technical Co-operation (BTC), UK Department for International Development (DfID), UNICEF and World Bank).

However, a decade after starting health sector reform (linked to decentralization and deconcentration), public health services in rural Cambodia remain under-utilized for reasons related to financial, structural and personnel factors. Ineffectiveness of rural public health services has led to a significant increase in private providers, often the same staff from public facilities. Public health clinics are often viewed as low quality, with long waiting times and unexpected costs; in contrast, private clinics are seen to provide more convenient health care at an unregulated price. Several strategies, including contract management and Health Equity Funds, have been introduced to improve public sector performance and encourage utilization; these efforts are ongoing. However, the feasibility of these strategies remains in question, particularly in terms of cost-effectiveness and sustainability. [23]

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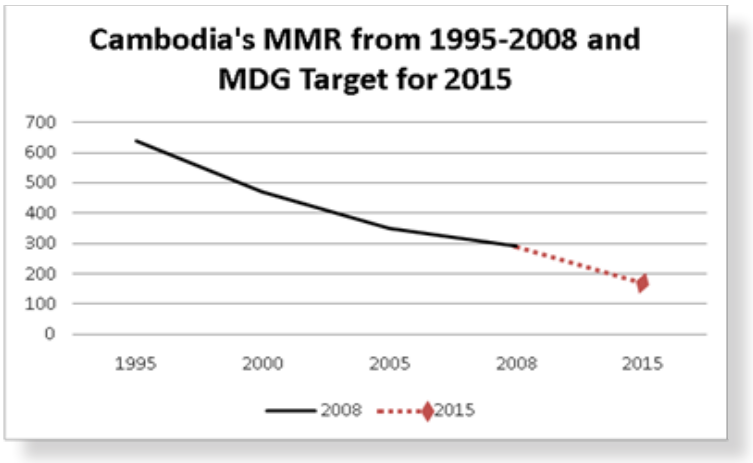
20. World Bank EA Update 2008.
21. UNFPA Cambodia Presentation to Evaluation Team, Nov. 2011.
22. HSSP II is a joint management mechanism for pooled resources to build capacity of health professionals, including midwives, and to strengthen service delivery. By coordinating a number of bilateral and multilateral development partners, HSSP strives to maximize impact and efficient use of health resources. UNFPA also operates a mechanism of funding outside of the pool but under HSSP II for the reproductive health component. From 2008 to 2015, HSSP II will disburse US$120 million from external development partners, including UNFPA. Funding in 2012 for reproductive health/maternal health remains a challenge as important donors like DfID and KfW Entwicklungsbank (KfW) move onto other priority regions and issues. The government is not prepared to take over some critical areas like procurement of contraceptives for public health sector distribution.
23. Original Research: Health Worker Effectiveness and Retention in Rural Cambodia; C. Chhea, N. Warren and L. Manderson, July 2010.

3.3 Health Indicators

In Cambodia today there are 77 operational districts (ODs; these are especially demarcated development areas), 1027 health centers, 80 referral hospitals and 4 national hospitals.[24] There has been significant progress in some indicators, but overall Cambodia is not on track to fully achieve MDG 5 (improve maternal health). There has been dramatic reduction in total fertility rate (TFR) which is now almost equal to the Cambodian MDG target of a TFR of 3. Family planning remains a critical issue. Modern contraceptive prevalence rate is 35 per cent in 2010 (12 per cent traditional methods, which is an increase from 2005). Some experts believe that abortion rate of 5 per cent (decrease from 8 per cent in 2000) is under-reported.[25] There has been a significant reduction in maternal mortality ratio from 510 per 100,000 live births in 2000 to 250 in 2010 (see figure 1). While antenatal care (ANC) of two or more visits has increased substantially to 83 per cent, antenatal care of four or more visits is only at 59 per cent, and delivery in health facilities is 54 per cent.[26](See table 2).

Figure 1: Maternal Mortality Ratio Cambodia, 1995-2008 and 2015 MDG 5 Target



Source: WHO Global Health Observatory Data Repository

There are many factors that affect the maternal mortality rate, namely:[27]

- Shortages, limited capacity, and uneven deployment/retention of midwives in rural/remote areas
- High-unmet need for family planning (17 per cent, DHS 2010)
- High levels of anemia among pregnant women
- Limited availability of EmONC services
- Financial obstacles to seeking care (service fees, transportation and opportunity costs)
- Prevalence of harmful practices and inappropriate care-seeking during pregnancy and with newborn
- Limited access to safe abortion services (comprehensive abortion care, CAC)
- Progressive weaknesses in throughout levels of health infrastructure
- Gender inequity and inequality despite of 90 per cent of women reporting having sole or joint decision-making power over their own health care (DHS 2010)
- The impact of poverty and poor nutrition on women's health also remains a cause for concern

24. Health Coverage Plan 2009-2010, DPHI, MoH.
25. Interviews.
26. Cambodian General Population Census 2008, CDHS 2010, MoH data from HIS 2008.
27. Talking points for Round Table Discussion on Cambodia World Population Day: Maternal Health, July 2010.

However, considerable progress has been made in the last three years:

- Rapid increase in access to ante-natal care, deliveries in health facilities, and births attended by skilled birth attendants resulting from increased availability of health facilities, increased deployment of midwives, increased coverage or introduction of some equity funds and incentives to midwives, especially at health centers and District Referral Hospitals
- A slow but steady increase in contraceptive prevalence rate (CPR) (1-2 per cent per year);
- Undertaking the National Assessment (NA) of EmONC and the development of the EmONC Improvement Plan (EmONC - IP 2010) and implementation (2011-15)

Table 2: Maternal Health Indicators. Cambodia Demographic Health Survey 2010

Maternal mortality ratio in 2010	206
Total fertility rate	3.4
% HIV prevalence rates (aged 15-49) in 2005	0.6
% Current use of contraception (modern method) in 2010	35
% Current use of contraception (any method) in 2010	51
% Women aged 15-49 years attended at least once by a health professional during pregnancy (2010)	89.1
% of births attended by skilled health personnel in 2010	71
% of currently married women with an unmet need for family planning in 2010	17.1

Source: Demographic Health Survey Cambodia (DHS) 2010

3.4 UNFPA response to maternal health in the country

Geographic coverage of UNFPA support:	Support to Health Sector Support Programme at national level
	Targeted support to different number of Operational Districts: • 14 ODs in 2004-5 (HSSP I); 18 ODs in 2007 (HSSP II); 24 ODs in 2009 (HSSP II); 24 ODs in 2010 (HSSP II).
Population covered by UNFPA support in 2010 (only focal regions)	6,589,682
% of total population in Cambodia covered by UNFPA support in focal provinces	44.82
Total spending regular sources 2004-2010[28]	19,702,353.34 US$
Total spending regular sources per capita (based on total population)	1.34 US$
Total spending regular sources per capita (based on regions only)	2.99 US$
Total spending other sources 2004-2010[29]	6,351,198.36 US$
Total spending other sources per capita (based on total population)	0.43 US$
Total spending other sources per capita (based on focal provinces only)	0.96 US$
Allocation according to CPD 2006-2010	Total: 27,000,000.00 US$ (CPD 2006-2010) Regular Sources: 18.000.000,00 US$ Other Sources: 9.000.000,00 US$ reproductive health Component: 18.000.000,00 US$ population and development Component: 6,000,000,00 US$ Gender Component: 2,000,000,00 US$ Programme coordination and assistance: 1,000,000.00 US$
Total spending MHTF (started in 2008, funding in 2009) and GPRHCS	Approved/Expenditure MHTF: US$74,900/72, 760 (2009); US$337,419/334,161 (2010) GPRHCS: US$389,821 (2009).[30]

28. ATLAS data.
29. ATLAS data.
30. UNFPA, MHTF Progress Report Cambodia, 2009 and 2010.

UNFPA Cambodia has completed three cycles of assistance: the first country programme (1994-2000), the 2nd country programme (2001 – 2005) and the 3rd country programme (2006-2010 extended to 2011). While the reproductive health programme is delivered entirely through the sector-wide management/programme-based approaches (SWiM/PBS) of HSSP II, population and development and gender are programmed directly through implementing partners such as national and sub-national government entities, research agencies and civil society.[31] During the current evaluation, preparations were ongoing for the 4th country programme (2011-2015) with an approximate budget of US$24 million.[32]

In 2000-2003, UNFPA provided project support to the National Reproductive Health Programme under the safe motherhood and birth spacing component. In 2003, the SWiM approach (sector-wide management) was introduced to improve efficiency and co-ordination. In 2004-5, UNFPA supported 14 ODs together with National Reproductive Health Programme through the SWiM modality under HSSP I.

By 2010 the reproductive health component of 3rd country programme operated in 24 ODs and supported: i) HSSP II/ MoH; ii) Inter-departmental Committee for HIV/AIDS and Drugs, (ICHA/Ministry of Education, Youth and Sports – MoEYS); iii) youth-friendly clinical services and information (NGOs and youth organizations), and; iv) decentralization and deconcentration of health through Department of Local Administration (DoLA) and Ministry of Interior (MoI). The Maternal Health Thematic Fund (MHTF) was introduced in 2008 with partial implementation in 2009, full implementation in 2010-11, and funding was extended to 2013.

31. There was no evaluation of 2nd country programme but there was an evaluation of the 3rd country programme. The findings of the latter were not ready for dissemination during the time of this evaluation.
32. UNFPA Cambodia presentation to evaluation team, Nov. 2011.

4. Findings of the country case study

The following section presents the findings of the country case study.

4.1 Findings related to the MHTE

4.1.1 Evaluation question 1: Relevance/Coherence

Evaluation question 1

To what extent is UNFPA maternal health support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?

Judgment criteria	Issues to address (field phase)
1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/ vulnerable groups	To what extent do UNFPA/implementing partner-monitoring tools include indicators to capture the specific situation of the most vulnerable?
	To what extent do UNFPA country offices utilize information from needs assessments other than the common country assessments?
1.3. Needs orientation of planning and design of UNFPA supported interventions	To what extent are country offices using means alternative to UNDAF process for needs-oriented planning and the identification of the most vulnerable groups?

Judgment criterion 1.2

- (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/ vulnerable groups

UNFPA Cambodia has supported the disaggregation of national-level survey data for use in planning, programming and measuring trends in information and services for the poor and disadvantaged groups. Availability of such disaggregated data at the operational district (OD) level has increased.

UNFPA pledged to increase access to high quality, comprehensive, client-oriented and gender-sensitive reproductive health information and services for the rural poor and vulnerable groups in priority areas in the country programme action plan (CPAP 2006-10). The term 'vulnerable' is used only in reference to HIV/AIDS and describes the most at-risk populations (MARP), but is being expanded to sections of the population (mainly women) facing gender-based violence. An inter-agency

assessment on vulnerability and sexual reproductive health was conducted in 2011, which has implications for expanding maternal health services to MARP.[33]

The 2008 census provided trends in total fertility rate (TFR) by province for the first time and examined factors related to the social and economic status of women that affected fertility. The census also provided trends for the maternal mortality ratio, infant mortality rate (IMR) and under-five mortality rate (U5MR) based on administrative, geographic, income and remote area differentials. The Demographic Health Surveys 2005 and 2010, supported by UNFPA, provide disaggregated data about a number of reproductive health and maternal health indicators. UNFPA supported the dissemination of Cambodian DHS data at OD level in the past two surveys (2005 and 2010). It also funded the training of 144 staff members of the National Institute of Statistics (NIS) to conduct secondary analysis of both the census and DHS data disaggregated by urban/rural, gender and wealth quintile.[34]

A high-level annual conference of provincial governors and district health authorities in five regions conducted by the National Committee on Population and Development helped to disseminate and utilize reproductive health/maternal health data at district level. More recently, issues of vulnerability were explored in order to tackle gender-based violence.

Judgment criterion 1.3

- Needs orientation of planning and design of UNFPA supported interventions

UNFPA is strategic in how it conducts and utilizes needs assessments/reviews to highlight the planning and design of its pro-poor interventions. Issues of access to maternal health services remain a critical issue in rural and remote areas.

UNFPA has afforded high priority to geographic areas with poor maternal health indicators by, amongst other things, promoting the rapid expansion of both the National Safe Motherhood Action Plan (2001-2005) and the Community-Based Distribution Programme [35] to small towns and rural and remote areas. The country office has also frequently utilized the Midwifery Review (2006) to advocate for funding and the extension of the midwifery programming. UNFPA efforts focused on numbers, skills and placement of midwives in 14 (out of 18 in 2007-9) of the poorest operational districts in order to boost access and utilization of district hospitals and health centers.[36] The progress in improving maternal health, illustrated in the Cambodian Demographic Health Survey (DHS) in 2010, provided motivation for the government to sustain its efforts to reach the MDG targets by 2015. The government supports the Fast Track Initiative Road Map (FTIRM) for Reducing Maternal and Newborn Mortality (2010-2015) which targets all peri-urban and rural ODs showing poor performance.[37]

By working closely with the government, UNFPA interventions targeted the 40 per cent of women and their families who seek primary healthcare through the public health system, who are usually from the poorest wealth quintiles (DHS 2010).[38] Allocation of resources by the Commune Council (CC) for local development, including health, is based on three criteria: equal share (30 per cent), population size (35 per cent) and poverty index (35 per cent).[39] These criteria also apply to UNFPA funding.

With support from UNFPA, the National Reproductive Health Programme has developed costing tools to expand services to rural, remote and poor areas, and to fund Health Equity Funds for the poor (HEF) and voucher schemes. However, access to services is still an issue, as illustrated during a focus group discussion with poor and disadvantaged community women conducted[40] during the country visit. There are still large differences in access to maternal health services between rural and urban areas, as reflected in all the disaggregated national access indicators (DHS 2010).

33. Interview with external development partner.
34. Interview with Government partner.
35. Interview with UNFPA Cambodia.
36. Reproductive Health Costing 2006-2015, MoH, National Reproductive Health Programme, 2007.
37. Interview with NGO partner.
38. Cambodia 2010 DHS Key Findings.
39. Cambodian Aid Effectiveness Report, RGC 2010.
40. Which took place approximately 10 kilometers from a health center and provincial hospital.

4.1.2 Evaluation question 2: Harmonization and coordination of maternal health support and partnerships

Evaluation question 2

To what extent has UNFPA successfully contributed to the harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?

Judgment criteria	Issues to address
2.1. Harmonization in maternal health partnerships between UNFPA and United Nations (UN) organizations and World Bank (including H4+)[41] at country level	Compatibility of UNFPA rules, regulations and procedures with design and planning procedures of health SWAps it is participating in (or other joint implementation arrangements, i.e., in countries where no SWAp exists).
	What is the significance of H4+ country teams for country level MNH harmonization and coordination?
	To what extent do functioning mechanisms for coordination and harmonization of planning and implementation (e.g., common work plan) in UN joint programmes exist?
	What is the extent of use of pooled funding in UN joint programmes?
2.2. Harmonization of maternal health support through partnerships at country and South-South/regional	Does donor community consider national MNH road maps to be viable components of national health policy that allows them to use it as a focal point for aligning their support with government structures and mechanisms?
	Is UNFPA financing activities to facilitate the adoption and implementation of MNH Road Maps? (including activities that identify and address existing bottlenecks in MNH road map operationalization and implementation at country level)
2.3. UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda	Comprehensive list of "partnerships for evidence creation"
	What kind of evidence-related deliverables that were meant for adaptation at country level have these initiatives produced?

41. UNFPA, UNICEF, World Bank, World Health Organization (WHO), UNAIDS.

Judgment criterion 2.1

- Harmonization in maternal health partnerships between UNFPA and UN organizations and World Bank (including H4+) at global; regional and country level

The contribution by UNFPA to increased harmonization of maternal health support has been relatively high, in part because the country office has used its membership of key coordination committees to influence pro-actively the maternal health agenda. H4+ is functional, but UNFPA, UNICEF and WHO often meet under a variety of coordinating mechanisms. Development partners do not see an urgent need to have H4 mechanism at the national level.[42]

Cambodia does not have a sector-wide approach (SWAp)[43] but there is a Health Support Sector Project I (2003-2007) and Health Systems Strengthening Programme (HSS) II (2008-2013) coordinated by the Ministry of Economy and Finance (MoEF) and World Bank. HSSP II has mechanisms for joint planning, programming and monitoring. At the time of the country visit, UNFPA served as the Chair of HSSP II.

UNFPA Cambodia began contributing funding to HSSP II in 2006, using its own funding mechanism. In 2010, UNFPA began contributing to "the common donor funding" mechanism. This decision was being reconsidered at the time of the country visit as UNFPA internal accountability and reporting requirements[44] could not be applied to this mechanism.[45] This suggestion to leave the common donor funding mechanism had drawn a lot of criticism from UNFPA partners who expressed frustration that UNFPA let its own procedural challenges on the use of funds determine its ability to participate in a joint effort.[46]

UNFPA annual work plans (AWP) for the reproductive health component[47] have reflected the agreed UNDAF and country programme objectives and were implemented only through HSSP II (2008-2013).[48] The HSSP II criteria for resource allocation are an alternative for under-funded priority areas in maternal, newborn and child health, the poorest performing districts and results of evidence-based assessments. In accordance with its mandate, UNFPA has been taking the lead in reproductive health/maternal health financing and alignment under HSSP II, and has successfully advocated for "40 per cent of pool funds to be allocated for reproductive health/maternal health".[49] UN agencies in Cambodia collaborate in various sectors of reproductive health, with UNFPA and WHO focusing on maternal health, UNICEF and WHO working in newborn health, and UNICEF and UNFPA primarily addressing family planning. However, the H4+ concept has not yet led to more harmonized maternal health support among the partners because other coordination mechanisms existed. So far, H4+ is utilized only for special events, such as the UN Secretary General Joint Plan of Action on Reducing Maternal Mortality (2010) and the First Lady's role as a national champion for maternal health as coordinated by the Parliamentarian Forum (2010-11). The efficacy and efficiency of such initiatives has not yet been assessed.[50]

42. Interview with external development partner.
43. Interview with UNFPA Cambodia.
44. I.e. quarterly advances to government agencies with justification of the use of funds in the previous quarter.
45. Guidance Note on HSSP II Support to the 2012 AOP.
46. The country office stated that it intended to continue influencing the reproductive health/maternal health process through its membership in the Joint Partnership Interface Group (JPIG) led by WHO and argues that this group has several other large donors who were not contributing any resources to the pool, and in some cases were not even funding the HSSP II through discrete mechanisms. The country office also intended to use its membership in the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality for this purpose.
47. The reproductive health sub-programme has accounted on average for about 60 per cent of UNFPA budget.
48. UNFPA Cambodia, AWP HSSP II, 2009, 2010.
49. Interview with development partner.
50. Interview with development partner.

Judgment criterion 2.2

- Harmonization of maternal health support through partnerships at country and South-South/regional

UNFPA is member of various technical working groups and is the lead of the maternal, newborn and child health taskforce within the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality (FTIRM 2010-15). At the sectoral level, UNFPA has gained credibility through its experience of working with MoH and key line ministries.

The United Nations Development Assistance Framework (UNDAF) coordinates 23 agencies that are linked to the achievement of Cambodia MDG targets, based on the country National Strategic Development Plan (NSDP) 2006-2010. The government-led Cambodian Development Cooperation Forum (CDCF) is overseeing the development of instruments within UNDAF. UNDAF contains 19 Technical Working Groups (TWGs), nine of which are facilitated by UN agencies, including the TWG for Health. The Government-Donor Coordination Committee (GDCC) coordinates the TWGs, provides guidance, and resolves problems. UNDAF has five pillars,[51] and 11 coordinating mechanisms.[52] UNFPA is a member of the TWG for Health, is the lead agency for the TWG sub-group for Maternal Health, and member of the TWG Human Resource for Health (HRH). Its leadership has helped, in particular, to improve the performance of the TWG sub-group for Maternal Health.[53] The active role played by the former UNFPA Representative and the reproductive health advisors was highly recognized among the government and development partners.

The FTIRM, under the leadership of the National Maternal and Child Health Center (NMCHC), includes midwifery, EmONC, family planning and comprehensive abortion care. UNFPA is an active member of the RMNCH Task Force 1, and has contributed to capacity development activities. There are also joint milestones for the implementation of the upgraded Minimum and Complimentary Packages of Activities.[54] However, at the time of the country visit, it was too early for the FTIRM to be assessed.

As part of its South-South partnerships, UNFPA supported high-level policy makers and strategic technical staff to attend advocacy conferences and skills development workshops. UNFPA also supported training of trainers (ToT) in a variety of topics, including midwifery, EmONC and BCC.[55]

Judgment criterion 2.3

- UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda

The government of Cambodia emphasizes the need for donor support for maternal health research and documentation, including UNFPA. Donors recognize Cambodia as a well-researched country that continues to use evidence in the policy-making process, and public health debates at various levels show increased improvement. The UNFPA country office has contributed to these achievements.

At the sectoral level, UNFPA has gained credibility by producing evidence for reproductive health/maternal health policy debates and prioritization. The corresponding discussions and negotiations are facilitated by UNFPA on a long-term basis and involve trusted partnerships with MoH and other key line ministries, such as Planning, Women Affairs, Interior, Education, Youth and Sports, Cambodian Association of Parliamentarians for Population and Development (CAPPD) and National Committee for Population and Development (NCPD) at the Office of the Council of Ministers.

51. UNFPA participates in four (health, education, gender and governance).
52. UNFPA participates in all of these (UNDAF 2011-2015).
53. Maternal health as a sub-group was not operational at policy and budgeting levels, but through discussions, UNFPA has brought it to a higher level" (Interview with external development partner).
54. MPA-does not include surgery and CPA-includes surgery.
55. Unfortunately, the effect of knowledge-sharing seminars and skills training workshops have not been assessed beyond the usual pre-post evaluations.

The MoH has introduced wide-reaching regulations on midwifery that are well-researched and based on evidence collected during the Midwifery Review in 2006. UNFPA has supported policy research and guidelines related to multi-sectoral approaches to reproductive health/maternal health/HIV. In the last five to six years, the Cambodian Parliament, with the support of UNFPA and other UNDAF partners, has helped to pass important legislation related to prevention of mother-to-child transmission (PMTCT), Health Equity Funds, maternal health incentive schemes, domestic violence, trafficking, safe abortion and cross-border migration. The government has ratified CEDAW (Committee on the Elimination of Discrimination against Women), ICPD and MDGs and passed legislation to enable the National Committee on Population and Development to conduct a high-level Midwifery Forum every four years (2005, 2009 and 2013). The Midwifery Forum has raised the prestige of midwives and increased investment in midwifery programming based on research evidence provided by UNFPA. In addition to providing support to the macro/micro MoH data system, UNFPA has supported several participatory assessments i.e. the National Strategy for Reproductive and Sexual Health (2006-10), National EmONC Assessment (2009), EmONC Improvement Plan (2010-15), and evaluation of community-based distribution (2010).

4.1.3 Evaluation question 3: Community involvement / demand orientation and civil society organizations partnerships

Evaluation question 3

To what extent has UNFPA support contributed to a stronger involvement of communities that has helped increase current levels of demand and utilization of services, in particular through its partnerships with civil society?

Judgment criteria	Issues to address
3.1. Government commitment to involve communities translated in sexual reproductive health and maternal health strategies through UNFPA support	Examples of policy advocacy and other UNFPA support to create legal frameworks, regulations and guidelines to facilitate full participation of communities and CSOs in policy and programme development
	Can civil society organization/community participation in policy/programme formulation (if occurring) be linked to greater awareness, and demand for MNH services?
3.2. Civil society organization involvement in sensitization on maternal health issues and facilitating community based initiatives to address these issues supported by UNFPA	Examples of UNFPA human resource mobilization and institutional capacity development for CSOs to overcome weaknesses in transparency, service accountability and responsiveness to national civil constituencies at local level (including local public institutions outside ministries and departments).
	Example of how UNFPA has allocated funds to civil society and communities and how it overcomes the lack of financial support to civil society due to its own dependence on external funding which often leads to increased competition by government to lay claim to donor funds (in the name of Health Systems Strengthening (HSS) and Community Systems Strengthening (CSS)).
	Examples of UNFPA coordination among implementing partnerships to bring together governments and CSOs at local level to generate social capital through community participation.

Judgment criterion 3.1

- Governments commitment to involve communities translated in sexual reproductive health and maternal health strategies through UNFPA support

UNFPA work with communities in Cambodia has been a long-term commitment. It also closely reflects the influence of the government decentralization and deconcentration strategy that favors the engagement of Commune Councils' (local government entities) for raising community awareness on maternal health.

In 2001-2005 UNFPA helped develop a national framework and tools for civil society involvement related to community-based distribution (CBD), counseling, and behavior change communication (BCC). These protocols, guidelines and training curriculum and materials have been accredited by the MoH and all NGOs and Commune Councils are required to utilize them. Between 2010 and 2011, guidelines have been designed for maternity waiting homes.

Between 2002-2008, UNFPA supported a joint communication initiative (using non-core funds) between MoH and Cambodian Health Education and Media Services (CHEMS).[56] This initiative included behavior change interventions to increase awareness and utilization of reproductive health/maternal health services.[57]

Over time, UNFPA has placed greater emphasis on engaging Commune Councils in creating awareness and demand for maternal health services through organized community-based groups. Multilateral and bilateral funds for sensitizing community groups are increasingly coordinated by Commune Councils.

UNFPA sought synergies with the government-led Decentralization and Deconcentration Strategy that supports local commune authority and development.[58] By the 3rd Country Programme, UNFPA was working with 446 Commune Councils in 14 provinces. In the area of reproductive health/maternal health, UNFPA currently interacts with community-service organizations (CSOs) mostly through the Fast Track Initiative Road Map on Reducing Maternal Newborn Mortality, and with communities as part of the wider Commune Investment Plan (CIP), which includes support to Commune Councils (CC), Village Health Support Group (VHSG), Village Health Committee (VHC), Health Center Management Committee (HCMC), the Women and Child Health Committee (WCHC). Community-based distribution mechanisms are being consolidated and expanded. UNFPA has developed communication and advocacy materials to bridge community and policy change related to decentralization and deconcentration in the implementation of reproductive health-related activities

However, it was noted that UNFPA is too reliant on the Commune Councils and Health Center Management Committee to raise awareness and create demand, when in reality NGOs play an active role in communication.

Judgment criterion 3.2

- CSOs involvement in sensitization on maternal health issues and facilitating community based initiatives to address these issues supported by UNFPA

UNFPA used to collaborate closely with NGOs and civil society to implement reproductive health interventions, in particular, adolescent reproductive health. Since HSPP II, the Cambodian government's confidence in its capacity to expand the delivery of maternal health information and services has led UNFPA to shift its support towards the public health sector, instead of channeling support through NGOs. Currently UNFPA does not have direct programme partnerships in reproductive health/maternal health with independent CSOs but they are contracted for specific activities related to awareness-raising and sensitization.

56. 2008 Progress Report on "Support for Cambodian MDG five", MoH and CHEMS.
57. Interview with NGO partner.
58. Interview with external development partner.

The involvement of civil society (NGOs) in reproductive health/maternal health programming in the past has been acknowledged by UNFPA but continued government commitment resulted in UNFPA becoming an integral part of HSSP II in 2008. From that point on, UNFPA channeled all its reproductive health funds through this mechanism. HSSP II mostly funds national and sub-national public sector entities.

The 2nd UNFPA country programme (2001-5) saw the highest level of funding of NGOs (through non-core earmarked funding) with 62 per cent funded by the European Union for five years (Reproductive Health Initiative for Youth in Asia - RHIYA 2001-2005). By the 3rd country programme (2006-10), non-core reproductive health funding to NGOs had been significantly reduced to 13 per cent and core funding to 9 per cent. UNFPA still coordinates its work with NGOs at the district level[59] and contracts independent CSOs for specific activities related to awareness-raising and sensitization on an ad hoc basis. UNFPA considers this approach to be a more strategic and flexible arrangement. At the same time, some major bilateral donors, such as USAID, and international private foundations have expanded their involvement with NGOs and INGOs, counteracting this trend.

Whilst major reproductive health NGOs did not necessarily need the financial support provided by UNFPA, they did need UNFPA to comment on critical sexual reproductive health issues[60] in places that most NGOs cannot access.[61] The small and non-reproductive health NGOs funded by UNFPA felt they lacked support for capacity development during implementation.[62] Youth NGOs felt under-utilized by UNFPA and criticized the Adolescent Sexual and Reproductive Health interventions for focusing more on nutrition than on preventing teenage pregnancy.

4.1.4 Evaluation question 4: Capacity Development - human resources for health

Evaluation question 4

To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal health?

Judgment criteria	Issues to address
4.1. Development/strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)	What mechanisms had UNFPA applied to ensure that policy makers include reproductive health in national human resource plans; and to what effect?
	To what extent was UNFPA involved in supporting the development of regulatory frameworks for reproductive health cadres in the HRH plans?
4.2. Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual reproductive health/maternal health needs	To what extent was UNFPA involved in supporting capacity development in management skills of policy makers and health administrative staff?
	Which mechanisms did UNFPA utilize to ensure applicability and usability of training; and to what effect?

59. If UNFPA is there, NGOs will not support and vice versa, it is quite efficient" (NGO partner).
60. For instance on rights-based approaches in reproductive health/maternal health service delivery.
61. We feel we are not getting this kind of support" (NGO partners).
62. Interview with NGO partner.

Judgment criterion 4.1

- Development/strengthening of national human resources for health policies, plans and frameworks (with UNFPA support)

UNFPA has made a clear contribution to the strengthening of national human resources for health policies, plans and frameworks and in particular ensuring that issues related to reproductive health/maternal health staffing are taken into consideration. The country office has actively participated in the development of the National Health Workforce Development Plan, and supported the Human Resources Development Department in designing strategies aimed at maintaining midwives in remote areas. This intensive advocacy role in promoting midwives has resulted in high recognition of skilled attendance at birth in Cambodia.

The Cambodian genocide in the mid to late 1970s decimated the number of skilled health workers in the country. Many of the surviving professionals left the country in the following decade. Systematic efforts to redevelop national human resources for health in Cambodia only began from 2000 onwards.[63]

Between 2002-2003, UNFPA financed the full-time position of an human resources for health (HRH) adviser in the Human Resource Development Department (HRD) of the MoH. This adviser served as the focal point in the government to represent UNFPA interests in a coordinated manner.[64]

The Health Workforce Development Plan 2006-2015 (HWDP) was the second national plan for the health workforce, and preceded the formulation of the Health Sector Programme II (2008-2015).[65] WHO is the lead supporting agency for the Health Workforce Development Plan. UNFPA plays a key role and is focused specifically on the areas of reproductive health/maternal health and participates in Technical Working Group for Health sub-groups on human resources for health. Key activities included the formulation of policies outlining the vision and support for the development of the health workforce within the National Strategic Development Plan 2006-2013, the Serving the People Better Policy 2006, Regulations for Private Practice 2007 and integration into the Fast Track Initiative Road Map for Reducing Maternal and Newborn Health (2010-2015).[66]

The recommendations of the HWDP have led to increases in the salary of MoH civil servants since 2006, including 20 per cent annual increase in the base pay for midwives and obstetricians. The government is committed to repeating these increases until 2013, with the hope of slowing down dual practice by health workers.[67] A projection tool is also used to bring planning information in line with the Health Coverage Plan staffing standards, compensation data, attrition rates and health facility deployment. This has contributed to reaching the target of having at least one primary midwife in every health center by 2010.

Important achievements by UNFPA Cambodia have been the high-level Midwifery Forum in 2005 (repeated every four years), the Midwifery Review in 2006, and the launch of a wide-reaching national midwifery programming that led to policy change that helped promote the status of midwives, and enabled the training and incentives scheme that in turn has improved maternal health indicators. This policy change gave focus to the critical role of midwives and high-level promotion on assisted delivery.

HSSP II development partners, including UNFPA, continue to monitor MoH standard operating assessments, which have introduced rural-level incentives in about 20 per cent of the health system. The MoH Personnel Department has also

63. However, UNFPA had started to support the re-development and strengthening of national human resources for health in 1998.
64. Interview with government partner.
65. Second National Health Work Force Development Plan, HRD, MoH, 2006. Those with * supported by UNFPA.
66. Health Workforce Development Plan 2006-15, MTR, 2011.
67. Interview with external development partner.

maintained a recruitment and transfer policy, which limits recruitment and transfers to Phnom Penh, enabling an intensification of resources in the provinces.[68] Furthermore, UNFPA has played a role in influencing placements of midwives. However, issues related to deployment and replacement of health workers remain.

Judgment criterion 4.2

- Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual reproductive health/maternal health needs

UNFPA provides a range of skills and tools for strengthening competencies for in-service and pre-service midwives. It also provides additional support for the overall development and engagement of reproductive and maternal health workers. However, there are many challenges related to appropriateness of the pre-service curriculum and the quality of teaching,

UNFPA support for human resource development has been specific to reproductive and maternal health. Safe motherhood trainings in maternal health services took place until 2004, when UNFPA began supporting national and sub-national cascade training on related subjects including Minimum and Complimentary Package of Activities[69] for reproductive and maternal health in health centers, and district and provincial hospitals. Training for EmONC and skilled birth attendants started in 2002-3 but remained unsatisfactory until the Midwifery Review (2006) which highlighted the low capacity of the MoH staff as well as the challenges in public health facilities due to the lack of incentives and remuneration.[70]

Technical assistance has been provided to the Human Resource Department of the MoH (2002-2008) to develop and harmonize midwifery curriculum development, pre-service education and in-service training of midwives (upgraded in 2000, 2005 and 2009). UNFPA has provided support for four of the five Regional Training Centers (RTC) by training teachers, and providing their fees, daily service allowance for students, infrastructure support, training materials and equipment. HSSP II has recently placed limitations on funding scholarships for training, which has been problematic for the enrollment of trainees from remote areas in the Regional Training Centers. Issues such as accountability in the candidate recruitment process and the appropriateness of the revised curriculum for teachers with low technical capacity were identified during the country visit.

UNFPA also supported the National Health Promotion Center in conducting trainings on behavior change and inter-personal skills for midwives. Support for supervision has been provided through HSSP II with UNFPA technical support. Currently, the focus is also on registration and licensing of trained midwives, and there is an ongoing process to develop ethics, standards and regulations for trained midwives.[71] The MoH is confident that it will reach the numbers of midwives required by 2015, but the applicability of the pre-service curriculum and the quality assurance process for midwives post-training and follow-up remains problematic.[72]

The Fast Track Initiative Road Map on Reducing Maternal and Newborn Mortality will provide trainings on EmONC services, family planning and Comprehensive Abortion Care, but the national and subnational in-service trainings have not yet benefited from the improved EmONC curriculum for doctors, because the national trainers (surgeons) have not been available.[73]

68. MoH Reproductive Health Costing 2006-2015, UNFPA and WHO HRD Review 2010.
69. Minimum Package of Activities involve no surgery and Complimentary Package of Activities involves surgery.
70. Interview with UNFPA Cambodia.
71. Interview with government partner at national and sub-national level.
72. We do not have qualified teachers and degree holders are difficult to find. I have recommended (and UNFPA agrees) that we slow down on new recruitment and focus on the quality side of teaching and the practical upgrading in pre-service education." (Government partner).
73. These challenges will be further discussed in section 4.2. Findings Related to mid-term evaluation of MHTF.

To support the capacity development of Commune Councils in reproductive and maternal health promotion, UNFPA designed and developed reference tools for mainstreaming six areas of reproductive and maternal health, which included a gender and population perspective. These reference tools are currently used by all levels of government through local administration during training and supervision.

4.1.5 Evaluation question 5: Maternal health in humanitarian contexts (relief, emergency/crisis, post-emergency/-crisis)

Evaluation question 5

To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?

Judgment criteria	Issues to address
5.1. Inclusion of sexual reproductive health in emergency preparedness, response and recovery plans	How does UNFPA monitor the effectiveness of MNH mainstreaming activities?
5.2. Accessibility of quality EmONC, family planning and reproductive health/HIV services in emergency and conflict situations	To what extent do UNFPA mechanisms/procedures facilitate timely/flexible response to MNH needs in humanitarian situations?
5.3. Accessibility to medical products in emergency and conflict situations	How does UNFPA ensure equitable commodity provision in humanitarian settings, and to what effect?

Judgment criterion 5.1

- Inclusion of sexual reproductive health in emergency preparedness, response and recovery plans

and

Judgment criterion 5.2

- Accessibility of quality EmONC, family planning and reproductive health/HIV services in emergency and conflict situations

UNFPA has ensured that accessibility to critical EmONC and family planning services are included in emergency preparedness and response plans through providing support to the Joint Plan of the National Committee for Disaster Management, MoH, providing Minimum Initial Service Package training. UNFPA also participated in the UN-government cooperation for disaster management. Emergency preparedness and response (including access to reproductive health services) is institutionalized in the health sector as it is integrated in the HDDPII.

UNFPA was an active participant in responses to post-conflict challenges, which the government of Cambodia and Ministry of Health appreciated.[74] UNFPA Cambodia took a prominent role in supporting two censuses on post-emergency issues and re-construction in 1998 and 2008. In 2002, UNFPA coordinated with MoH and helped fund CARE International to provide emergency preparedness protocols related to sexual reproductive health. In 2008, UNFPA pioneered the use of Global Positioning systems (GPS) to deal with unmapped terrain and to identify areas prone to annual flooding,[75] in cooperation with the National Institute for Statistics.[76]

74. Interview with UNFPA Cambodia.
75. The main disaster faced by the Cambodian Government.
76. UNFPA website.

At the sectoral level, the government of Cambodia has no technical working group for emergency preparedness. There is, however, a UN inter-agency Disaster Management Team (UNDMT), led by WHO, of which UNFPA is a member. UNFPA provided inputs into the UNDMT Disaster Management Plan, which is coordinated with National Committee for Disaster Management (NCDM). UNFPA has provided small seed-funding on an annual basis to the NCDM Secretariat, which has given it leverage in mainstreaming sexual reproductive health activities.[77] UNDMT has supported an application to the Central Emergency Response Fund (UN-CERF) to provide greater support to immediate, medium and longer-term natural disasters in Cambodia. The UNDMT uses UN-CERF funding to meet basic needs for food, agriculture, water, sanitation, health, shelter and education, and UNFPA can request access to this support.[78] During the recent flood response by the health sector (which mainly consisted of releasing funds to allow staff from health facilities in flood-affected areas to conduct outreach activities by boat to deliver basic services) UNFPA participated in an assessment mission to look at integration of reproductive health and maternal health issues.

UNFPA also has interacted closely with the Department of Preventive Medicine, MoH, which is responsible for emergencies. It supported the development of a joint plan by NCDM and MoH on disaster preparedness that includes accessibility of critical EmONC and family planning services during emergencies. Implementation of the NCDM-MoH Joint Plan should have started in 2010, but was hampered by capacity bottlenecks within NCDM. However, the NCDM-MoH Joint Plan was integrated into HSSP II in 2011. Stakeholder meetings (including UNFPA) are held on an ad-hoc basis, and reproductive health integration is led by MoH. Now the NCDM-MoH Joint Plan in place, government funds can be immediately requested when a disaster occurs, and an additional request can be made through HSSP II. UNFPA is in a position to ensure that sexual reproductive health issues are included in the request as it chairs HSSP II.

UNFPA has supported staff from NCDM, MoH and UNFPA to attend trainings on Minimum Initial Service Package (MISP) in Australia and further trainings on Disaster Preparedness and Management in Malaysia and Thailand.

Judgment criterion 5.3

- Accessibility to medical products in emergency and conflict situations

UNFPA has not supported any particular provision of medical commodities for emergencies as the government is responsible through HSSP II.

The Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) does not include medical products for emergencies, for example, the assessments performed on contraceptive security did not include commodities for emergencies. UNFPA and MoH consider HSSP II funding to be sufficient for any foreseen or unforeseen emergency support for commodities in the present context of Cambodia. There is currently no request for further donor contributions for commodities in cases of emergency.

77. Interview with UNFPA Cambodia.
78. Interview with UNFPA Cambodia.

4.1.6 Evaluation question 6: Sexual and reproductive health services – family planning

Evaluation question 6

To what extent has the UNFPA contributed to the scaling up and increased utilization of and demand for family planning?

Judgment criteria	Issues to assess
6.1. Increased capacity within health system for provision of quality family planning services in UNFPA programme countries	Are (UNFPA-supported) national reproductive health strategies geared towards integration of family planning services in all service delivery points?
	Are the capacity development interventions designed strategically i.e. taking into account national strategies and orientations, supervisory mechanisms, potential for replication?
	Are capacity development interventions accompanied by interventions ensuring an environment where trained health care providers can practice their newly acquired skills once they are back in their health facilities (equipment, material, and infrastructure)?
6.2. Increased demand for and utilization of family planning services in UNFPA programme countries, particularly among vulnerable groups	How has UNFPA supported community-based distribution of family planning commodities translated into sustainable national strategies?
	What are the monitoring and evaluation tools in place to measure the impact of these communication initiatives?
	Are UNFPA supported initiatives contributing to the increase of Family planning utilization among vulnerable groups?
6.3. Improved access to contraceptives (commodity security)	What are the mechanisms in place to monitor and follow up MOH/responsible line ministry supply chain?
	What are the mechanisms in place to sustain actual achievements and governments' commitment to RHCS?

Judgment criterion 6.1

- Increased capacity within health system for provision of quality family planning services in UNFPA programme countries

UNFPA has pioneered family planning services in a number of ways, including support to various policies and strategies. These include the Birth Spacing Policy of 1995 and National Strategy for Reproductive and Sexual Health (NRSH 2006 -10) ensuring that capacity-building activities for family planning services are planned and implemented and modern contraceptive methods are promoted and provided. Although UNFPA has supported the provision of family planning services, including diversification of methods on a long-term basis, some opportunities were missed, such as stronger integration in maternal health services and in adolescent sexual and reproductive health programme.

In 2000, UNFPA and WHO developed the Minimum Package of Activity (MPA), which includes pre-natal, antenatal (ANC) and family planning as part of maternal health services. In 2003, the first National Population Policy (NPP) was implemented with UNFPA support.[79] The NRSH, also supported by UNFPA, reflects the difficult environment for family planning in Cambodia and explicitly mentions the need to expand existing family planning services and available methods and build the capacity of specific cadres of health workers. Both WHO and UNFPA support the National Health Workforce Plan (2006-15), which specifies the training of nurses, midwives and other relevant health professionals (including on family planning).[80]

The need to increase the capacity of national policy and programming in family planning is reflected in the upgrade of the Minimum Package and Complimentary Package of Activities (2008). The upgrade includes new long-term and permanent contraceptive methods and defines which health cadres can apply the different methods of contraception.[81] The Fast Track Initiative for Reduction of Maternal and Newborn Mortality also includes trainings on family planning.[82]

In the area of unwanted pregnancy and birth spacing, UNFPA has worked with both NGOs and the government. Since 2004, UNFPA has played a leading role in the introduction of the community-based distribution (CBD), the introduction of long-term family planning methods (such as Implanon procured in 2009 by the GPRHCS), and in training health care providers. UNFPA partnered with the Reproductive and Child Health Alliance (RACHA) for the provision of intrauterine devices (IUD) and voluntary surgical contraception (VSC) and the introduction of emergency contraception. The contraceptive prevalence rate (CPR) in Cambodia has increased from 19 per cent in 2000 to 27 per cent in 2005 and 35 per cent in 2010.[83] This is a steady increase in CPR of about 1-2 per cent per year but with an unmet family planning need of 17 per cent, Cambodia will not to reach its MDG CPR target of 60 per cent.[84]

Despite UNFPA efforts, gaps identified during the country visit included insufficiencies in family planning in the adolescent sexual and reproductive health programme[85] and no public health sector family planning assessments or updating of clinical practices by MoH. Access to a mix of family planning methods at health centers, the ability of midwives to discuss family planning issues during antenatal or postnatal care, and record family planning use, is still problematic. Difficulties recording family planning care, in particular, have limited the accurate monitoring of an important indicator for procurement, the rate of couple year protection, and the ability of UNFPA and national partners to project contraceptive demand.[86]

79. Interview with government partner.
80. Health Workforce Development Plan 2006-15, MTR, 2011.
81. Interview with government partner.
82. Interview with government partner.
83. UNFPA presentation to evaluation team based on Cambodian DHS 2000, 2005 and 2010.
84. "Cambodia is expected to reach a CPR of only 45 percent in 2015 with sharp rural – urban differentials and with youth forming a large part of the population that remains un-served" (NGO Partner).
85. Interview with NGO partner.
86. Interview with NGO partner and external development partner.

Some development partners and NGOs reported that, in the last five years, UNFPA had focused too much on trainings for skilled attendance during childbirth and not enough on trainings for family planning services and sexual health, which is not consistent with full implementation of the NRSH Strategy. It was also reported that UNFPA had been hesitant to provide support for comprehensive abortion care, even when requested by the government.[87] The evaluation team was informed that this was due to directives from UNFPA headquarters, as Cambodia abortion laws are some of the most liberal in the region.[88]

Judgment criterion 6.2

- Increased demand for and utilization of family planning services in UNFPA programme countries, particularly among vulnerable groups

A key UNFPA contribution in the field of family planning has been the introduction of the community-based distribution (CBD) of contraceptives, which aided the expansion of family planning provision in remote areas and for poor populations. However, coverage needs to be improved. Communication initiatives undertaken in collaboration with the Communication in Health Education and Media Services (CHEMS) had good coverage levels but have not fully realized results.

The National Strategy for Reproductive and Sexual Health (2006-10) states that combining CBD with communication activities will increase demand for family planning services and help address the issue of access for the poor in priority areas. The UNFPA CBD programme began implementation in 2004 in areas located significant distances from health centers (10 kilometers or more). CBD agents received basic training in 2004 and 2005 and are permitted to sell contraceptive pills and condoms on a commission basis. In 2006, UNFPA discussed and developed a five-day training manual for CBD with the National Center for Health Promotion (NCHP). All programme implementers now use the accredited CBD manual, and the National Maternal and Child Health Center (NMCHC) is responsible for all CBD programming.[89] UNFPA and USAID also updated the CBD guidelines in 2008.

In 2010, UNFPA and USAID supported a review of CBD.[90] It highlighted the increased use of contraceptives in the focus areas, in particular among usually under-served populations and the poor. However, the review also noted issues around uneven coverage and poor monitoring. This programme is critical for UNFPA performance and the country office has been too reliant on the government's HSSP II monitoring and has not sufficiently considered the findings from its own evaluation and oversight exercises. For example, while partner NGOs adopted the recommendations of the 2010 UNFPA-supported CBD evaluation and updated their programmes, neither UNFPA nor the government did so.[91] Furthermore, the role of the CBD programme is not emphasized in the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality. This lack of support at the national level contrasts with the appreciation of the role of CBD agents by local health professionals at the district level.

Communication initiatives were carried out through NHPC (2002-8) and Communication in Health Education and Media Services (CHEMS). NCHP included two topics, behavior-change communication and inter-personal communication, for health workers in maternal and child health/family planning. NHPC provided direct trainings in 18-targeted operational districts in 14 provinces. CHEMS extensively utilized electronic media, with support from German cooperation channeled through UNFPA. Knowledge, attitude and practice (KAP) baseline and end-line surveys indicated that family planning messages reached the target communities, but that messages were not sustained, especially in rural and remote areas.[92]

87. Interview with Government partner.
88. Interview with NGO partner and external development partner.
89. Interview with government partner.
90. Review of the community-based distribution of contraceptives – for the Ministry of Health- National Reproductive Health Programme- October 2010.
91. UNFPA reliance on the leadership of Commune Councils to create demand for family planning, without first implementing the 2010 CBD recommendations, came under criticism from several NGO partners.
92. "The only time one heard about UNFPA and family planning was in 2008-10 when there was German funding or when a new method is being introduced, apart from that, the whole range of issues around family planning is hardly discussed from a perspective of enhancing

Judgment criterion 6.3

- Improved access to contraceptives

Historically, UNFPA has been strongly involved in contraceptive supply. After the German Development Bank (KfW) took over responsibility of family planning commodity security, UNFPA shifted support towards advocacy, technical support through its participation in the Contraceptive Security Working Group (CSWG), and procurement of specific methods (Implanon) in anticipation of commodity shortfalls. Although there are signs that the government will take over the procurement of contraceptives, modalities have not yet been clearly defined. Furthermore, gaps in technical support led to issues concerning the sustainability of the logistics system.

UNFPA activities related to commodities and contraceptives date from 1994-1995, which included support for essential medicine and the introduction of Birth Spacing Programme. In 2001, the MoH created the Contraceptive Security Working Group (CSWG) with the support and involvement of multilateral, bilateral and private donors. UNFPA was initially responsible for contraceptive supply, with complimentary support from other donors, such as KfW. This continued until 2004 when KfW took over responsibility for procurement and the Logistic Management and Information System (LMIS), which collects information from national to the district level. UNFPA helped to address some contraceptive shortfalls in the public health sector.[93] In 2009 the Global Fund to Enhance Reproductive Health Commodity Security (GPRHCS) supported the procurement of Implanon by the central medical store.

UNFPA is an active member of CSWG and is currently involved in the projection of contraceptive needs. UNFPA technical support is generally considered to be of good quality and that the procurement system is effective.[94] UNFPA also plays an advocacy role in helping to address commodity shortfalls.

KfW will phase out its support in 2012. AusAid has agreed to take over support on the condition that the government would become responsible for the procurement of contraceptives from 2015 onwards and develop a phase-in plan. However, at the time of the country visit, the agreement with AusAID had not yet been signed. In addition, there are outstanding important issues on how to maintain and manage the computerized logistics system which have not been anticipated by the CSWG. There is currently no exit strategy or government phase-in plan leading to 2015.[95]

choice and quality" (NGO partner).

93. They (UNFPA) are the ones who always help us" (External development partner).
94. "We feel we can work through their system" (External development partner).
95. Interview with external development partner.

4.1.7 Evaluation question 7: Sexual and reproductive health services – EmONC

Evaluation question 7

To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and EmONC services in programme countries?

Judgment criteria	Issues to assess
7.1. Increased access to EmONC services	What elements in UNFPA EmONC support were meant to ensure sustained commitment of the MoH to integrate EmONC services in the national planning and budgeting?
	Did these elements contribute to a (more) sustained commitment of MoH to EmONC?
	Which mechanisms has UNFPA applied to ensure most efficient use of resources of support to EmONC providing facilities?
7.2. Increased utilization of EmONC services	What mechanisms is UNFPA utilizing to mobilize the communities to support women in accessing EmONC; and to what effect?

Judgment criterion 7.1

- Increased access to EmONC services

UNFPA has contributed to increased access to EmONC services in Cambodia through a number of initiatives, including technical assistance at the national level, training of service providers, and strengthening EmONC service provision and referral systems in selected provinces. This contribution has increased in particular since the start of MHTF due to the EmONC needs assessment, the preparation and implementation of the National EmONC Improvement Plan, and the introduction of maternal death surveillance system.

During the 2nd country programme UNFPA supported the National Reproductive Health Programme on issues including birth spacing and safe motherhood through the placement of technical staff in the MoH. UNFPA also supported midwifery training and the provision of EmONC services in selected provinces.

A national assessment for EmONC (NA-EmONC) was discussed by UNFPA in 2003-4, but attempts to introduce the assessment were unsuccessful due to weak MoH capacity. The UNFPA-supported Midwifery Review (2006) highlighted the low capacity of MoH staffing and the poor state of emergency care in health centers and district hospitals.[96] The planning and budgeting for NA-EmONC was initially due to be funded by the MHTF (late 2008 and early 2009). Funds from the German Development Bank to UNFPA supported the national assessment, but MHTF provided the assessment tool and technical assistance from the Regional Office. The NA-EmONC was completed in mid-2009, with the process accelerated due to MoH cooperation with the National Institute for Public Health.[97] The assessment covered all hospitals and one-third of the health centers. The results helped to raise awareness among other donors to view EmONC as a priority issue.

96. UNFPA Cambodia.
97. Government partner.

In the latter half of 2009 and early 2010, MoH, with the support of UNFPA, engaged in activities related to the development and costing of the EmONC Improvement Plan (2010-2015). In 2010, the US$19 million EmONC Improvement Plan was adopted by the Fast Track Initiative for Reducing Maternal and Newborn Mortality. The National Maternal and Child Health Center is overseeing the national implementation of the EmONC Improvement Plan with MHTF-funded technical assistance. The EmONC Improvement Plan includes upgrading facilities in terms of renovation, supplies, data management, training, and research. The EmONC Improvement Plan has also been prioritized within HSSP II.[98]

In late 2009, the UNFPA country office recruited an EmONC Officer with the support of MHTF. His role is to interact with government representatives (national and sub-national) on technical issues, including the monitoring of the EmONC Improvement Plan, to mobilize community stakeholders in support of the Plan, and help remove operational barriers in the implementation process.

In 2009, equipment such as manual vacuum extractors and heart foetal detectors were procured by the GPRHCS as part of the EmONC Improvement Plan. Support to midwives' education (see evaluation question 3) and the introduction of maternal death audits also contributed to improving EmONC services.

Judgment criterion 7.2

- Increased utilization of EmONC services

With UNFPA support, the Cambodian government has set up mechanisms at different levels to increase the involvement of community representatives in supporting women to access maternal health services including EmONC (for instance through the provincial Women and Child Health Committee or the Health Center Management Committee). The Health Equity Fund, designed with UNFPA support, contributes to increasing financial access to services for poor women. At the time of the country visit, the EmONC Improvement Plan had not yet been implemented in remote rural areas.

The national assessment for EmONC (NA-EmONC) is part of the MoH response to high maternal and neonatal mortality, which affects in particular Cambodians living below the poverty line, many of whom are located in remote areas. These individuals are most likely to utilize health centers and district referral hospitals. For this reason, the NA-EmONC placed special emphasis on 230 health centers (one third of total health centers), 77 public hospitals and 40 private hospitals in 24 provinces of Cambodia. UNFPA is key coordinator alongside Ministries of Health, Women, Youth and Sports and Interior, which enables UNFPA to access community working groups at all levels of the system to increase utilization of EmONC services.[99] At commune level, the chair of the Women and Child Health Committee (under the Ministry of Interior) is the designated EmONC focal point. The EmONC focal point is a member of the Health Center Management Committee[100] (HCMC), which is led by the chair of the Commune Council who in turn oversees the Health Equity Fund,[101] which can be used by registered members of the community in case of emergency. UNFPA has played an active role in the design of the Health Equity Fund. The CBD agent (funded by UNFPA through the HSSP pool or discrete funds) and the chair of the Village Health Support Group are also members of HCMC. These mechanisms to increase community mobilization are useful for increasing health facility utilization and referral and, in particular, promoting skilled birth attendance.

The MoH Health Center Utilization Plan places strong reference on EmONC referrals and incentives to midwives for safe delivery. The incentive scheme for health center midwives was introduced in 2008 for safe delivery and referral. The rapid reduction in maternal mortality is greatly attributed to the success of this scheme. There are free services at health centers

98. UNFPA has helped fund the EmONC assessment and the quality is good so we are using them. This applies to B-EmONC only. We came to know about it because of UNFPA involvement in the Technical Working Group on Health" and "with MoH and HSSP II support now sustainability of the Plan is assured" (External development partner).
99. Interview with government partner.
100. Which also plays a role Maternal Death Audits Committee at the provincial level.
101. The Health Equity Fund provides transportation cost to pregnant women at the community level, and government provides free service to pregnant women at the Health Center.

for all pregnant women. As part of the pilot in 2010, EmONC services were initially not rolled out in remote areas, but only introduced in health centers and district referral hospitals where there was a minimum level of infrastructure. Roll-out of EmONC services to remote areas was planned by MoH for 2011, and the government is committed to scale-up (as per the EmONC Improvement Plan).[102] However, the roll-out to remote areas without health centres has not yet taken place and there is a danger that the implementation of the EmONC Improvement Plan may be slowing down.[103]

4.1.8 Evaluation question 8: Results/evidence orientation of UNFPA maternal health support

Evaluation question 8

To what extent has UNFPA use of internal and external evidence in strategy development, programming and implementation contributed to the improvement of maternal health in its programme countries?

Judgment criteria[104]	Issues to address assess
8.2. Consideration and integration of relevant maternal health/sexual reproductive health evidence and results data during development of country strategies	What process have country offices gone through to use lessons from past support for future programming?
8.3. Results- and evidence based management of individual projects throughout project life	To what extent did UNFPA take into account capacity gaps in M&E among its implementing partners and its own staff when developing its M&E calendars?

Judgment criterion 8.2

- Consideration and integration of relevant maternal health/sexual reproductive health evidence and results data during development of country strategies

and

Judgment criterion 8.3

- Results- and evidence based management of individual projects throughout project life

UNFPA programming is partially based on the evidence produced through regular monitoring. There are concerns from the government regarding UNFPA evaluations, which are perceived as duplicating joint evaluations of sector programmes.

The UNFPA internal monitoring system uses indicators listed in the CPD as a baseline and uses the CPAP Monitoring Tool for programme tracking and the Results and Resource Framework as a basis for financial reporting. The national programme officers (NPO) track the CPAP outputs and the finance officer provides the absorption and implementation rate on a month-by-month basis. Both meet regularly under the aegis of the Assistant Representative who is responsible for M&E.[105] Tracking implementation rates is often the only means of monitoring.

102. UNFPA Cambodia.
103. Interview with NGO partner.
104. The previous judgment criterion 8.1 was deleted; the assessment of the operationalization of UNFPA support in annual work plans was put together with the development of UNFPA country strategies (CPD/CPAP).
105. UNFPA Cambodia.

UNFPA did not evaluate the 2nd country programme as UNFPA was part of the monitoring arrangements for the joint health sector programme. However, an evaluation of the 3rd country programme was conducted due to requests from UNFPA HQ. In addition, there have been a number of ad hoc evaluations conducted by UNFPA Cambodia. This raised concerns from the government that too many evaluations were carried out that were parallel to the joint evaluation exercises associated with sector programmes,[106] and placed unnecessary additional strain on government capacity.[107] Internal and external monitoring systems are in place for HSSP II, but it is still questionable whether they provide real assessment of UNFPA interventions, and if the recommendations they propose are appropriate.[108]

4.1.9 Evaluation question 9: Integrating maternal health into national policies and development frameworks

Evaluation question 9

To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its programme countries?

Judgment criteria	Issues to assess
9.1. UNFPA support improved comprehensiveness of analysis of causes for poor maternal health and of effectiveness of past maternal health policies/strategies	Do relevant policy frameworks (PRSPs, health policies, etc.) reference maternal health-relevant disaggregated data (i.e. from UNFPA-supported censuses or other data collection exercises)?
9.2. Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process	How coherent are efforts under the different relevant initiatives for MNH policy making and policy dialogue: CARMMA, Maputo/MNH road maps and UNFPA participation in SWAp fora?
	What are the principal mechanisms by which UNFPA advocacy and awareness raising campaigns contribute to the development/revision/integration of MNH issues into national policies?
9.3. Monitoring and evaluation of implementation of sexual reproductive health/maternal health components of national policy framework and development instruments	To what extent have M&E tools, which were developed with UNFPA support been adopted to monitor national MNH/sexual reproductive health policies and programmes?
	To what extent are MNH indicators included in the monitoring (and evaluation) systems of national policies?

106. "The government asks us why donors are having so many evaluations when the sector and strategic evaluations are happening every year" (UNFPA Cambodia).
107. "The system works well and too many evaluations burdens the government especially given the limited capacity of government" (Government partner).
108. The CBD evaluation in particular was alluded to as a case in point (NGO partner; External development partner).

Judgment criterion 9.1

– UNFPA support improved comprehensiveness of analysis of causes for poor maternal health and of effectiveness of past maternal health policies/strategies

Maternal and reproductive health in Cambodia are well-documented, partly due to noticeable efforts by UNFPA who has supported policy development, assessments, and upgrades of technical documents to improve the effectiveness of reproductive and maternal health planning and programming.

Several analytical documents were cited as evidence of the effective support provided by UNFPA. These documents were perceived by interviewees to be building blocks developed specifically for reproductive and maternal health programming and which have been effectively utilized by the government. Two policies were highlighted in particular: the Birth Spacing Policy 1995[109] and the National Population Policy 2003.[110] Several strategic plans were also developed including the National Safe Motherhood Action Plan 2001-2005,[111] the Health Workforce Plan 2006 – 2015,[112] Health Strategic Plan, 2003-2007, 2008-2015,[113] the Midwifery Action Plan 2007-2010,[114] the National Strategy for Reproductive and Sexual Health in Cambodia, 2006-10 (and current review),[115] the Strategic Plan for HIV/AIDS and STI prevention and Care (2001-2005),[116] the National Strategic Plan for Adolescent–Friendly Reproductive and Sexual Health Services (2005-10),[117] the Mother-to-Child Transmission of HIV (PMTCT) Policy, Strategy and Guidelines,[118] and lastly the EmONC Improvement Plan (2010 – 15).[119]

Several national surveys supported by UNFPA provided evidence for programming. For example, the Cambodia Population and Household Census, 2008 Cambodia Inter-censual Population Survey (2004) and the Cambodian Demographic Health Surveys (2000, 2005 and 2010) are milestone monitoring documents which provide trends and up-to date information on all the relevant indicators for reproductive health/maternal health, as noted in the National Population Policy Indicators that feed into the Cambodian MDGs. Specific assessments, such as the Midwifery Report 2006[120] and the National Assessment – EmONC (2009),[121] were the basis for planning the improvement of maternal health services.

109. That legalized family planning services and its integration with maternal and child health services.
110. That for the first time envisioned rights based approach to sexual reproductive health and promoted partnership between central and local government in collaboration with civil society and private sector to remove barriers to reproductive health/maternal health.
111. Its aim was to promote the health of the woman and her newborn and was highly targeted to meet the needs of the poor and the disadvantaged.
112. identified priority areas in reproductive health/maternal health (among others) that needed to be addressed so that MoH understands causes for poor maternal health from the perspective of the supplier and to guide, monitor, regulate the production and deployment of midwives through sound governance, training and quality management.
113. both have defined and elaborated on the Minimum and Complementary Packages of Activities for reproductive health/maternal health/family planning.
114. focuses on increased coverage by competent midwives, increases in midwives education and training capacities, improvement of deployment and retention of midwives in remote and rural areas and increases the attractiveness of midwifery as a profession.
115. That is the cornerstone for maternal health programming in Cambodia, which has through HSSP II sought to improve policy and resource environment, increase availability of skilled personnel and strengthen delivery of services, include communities and expand evidence base to inform policy.
116. That for the first time identified the most at risk population (MARP) and prescribed various partnerships for prevention of mother child transmission (PMCT).
117. The first multi-sectoral document of its kind to analyze barriers faced by youth in accessing sexual reproductive health services, prevention of teenage pregnancy and contraceptive education.
118. Developed by NMCHC in collaboration with NCHADS.
119. Which seeks to improve the readiness of reproductive health/maternal health outlets especially Health Centers and District Referral Hospitals to provide quality service to the poor and disadvantaged.
120. Which highlighted MoH weaknesses because of low capacity of its health workforce and the poor state of emergency care in health centers and district hospitals and instigated the far-reaching Midwifery Programming.
121. Which determined the availability, functioning, quality and utilization of EmONC services, identified barriers and established a baseline for the first time to monitor progress.

Judgment criterion 9.2

– Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process

High priority has been given to maternal health in a number of policy documents, for example the Health Sector plan, the HSSP II, and in the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality 2010 – 2015. The UNFPA contribution to policy and regulatory initiatives has focused on a combination of high-profile political advocacy and public relations. UNFPA logistical, financial and communication support to the National Committee on Population and Development (NCPD) within the Council of Ministers, the Cambodian Association of Parliamentarians for Population and Development (CAPPD) and the High Level Midwifery Forum has translated into a coordinated and coherent effort to strengthen the integration of maternal health into the Cambodian health policy framework. It is too early to gauge the effect of the H4+ event associated with the Secretary General Action Plan on Maternal Health.

Through NCPD, UNFPA has consistently engaged in evidence-based advocacy with high-level politicians and national policy-level decision-makers including the Prime Minister, the Council of Administration Reform (CAR) and the Ministry of Economy and Finance. In response to the need for additional political commitment in support of midwifery, UNFPA and MoH approached NCPD to conduct a small campaign on Midwifery for All (2004), which culminated in a Midwifery Forum (2005), the two campaigns "Giving Birth with Skilled Attendants" and "No One Should Die Giving Birth" (2009). MoH has continued to support these forums every four years. In 2010, MoH increased health funding by 13 per cent, and a large part of this funding is to be allocated to reproductive and maternal health.[122]

The Cambodian Midwife Council (CMC) has a Code of Ethics that was produced through intensive consultations with a broad range of stakeholders. The Midwife Council is seeking to establish the Code of Ethics in law and has already received the support of Council of Administrative Reform. This initiative has been facilitated by the trusted relationship UNFPA has with the Cambodian government.[123]

Within CAPPD, the contributing role of UNFPA has been recognized. Over the past fifteen years, "co-operation between UNFPA, UN and relevant ministries and Parliament has helped to pass important laws relevant to expanding maternal health activities".[124] Key Parliamentarians who are members of the Health, Women and Children Committees have participated in developing strategies and policies that were presented in various co-ordination meetings, NGO forums and public gatherings. The Minister of Women's Affairs attended the Women Deliver conference held in Washington DC. When government halted new recruitment into the civil service in 2007, CAPPD helped to increase trainings and recruitment of midwives and nurses. Currently, each health center has at least one midwife. In response to the parliamentary decree calling for a minimum of two midwives per health center, parliamentarians have increased the salaries of midwives and helped to increase the status of the positions to attract additional staff members. Advocacy by CAPPD has also resulted in a 10 per cent increase in health budgets annually from 2011. UNFPA took part in dialogue regarding policies such as incentives for health providers and the Health Equity Fund.[125] In addition to these advocacy initiatives, UNFPA supports the annual population and development meetings by NCPD with Governors, Provincial, District and Commune Councilors (five meetings in each region). In the last five years, the selected topics have been policy briefs, fact sheets and policy tools on the integration of midwifery services, the National EmONC Assessment and the EmONC Improvement Plan. Dialogue with the Parliamentarians Forum on reproductive and maternal health occurs twice a year at the national level and includes policy review and discussion. UNFPA also helps organize maternal health workshops for parliamentarians and Public Health Directorates, communes, primary beneficiaries (community men and women) and NGOs. The Annual Commune Council Forums are considered to be an important avenue for communication, particularly as the Ministry of Women Affairs (MoWA), MoI and MoH are jointly promoting messages on utilization of health centers, the importance of assisted birth, antenatal care and postnatal care and increasing staff such as midwives. High-level policy discussions on population and health (2008), and three debates

122. Interview with government partner.
123. Interview with external development partner.
124. Interview with Government partner.
125. Interview with Government partner:

on increasing utilization of health facilities (2009), were facilitated by UNFPA and the Cambodian Health Education and Media Services (CHEMS).[126]

Judgment criterion 9.3

- Monitoring and evaluation of implementation of sexual reproductive health/maternal health components of national policy framework and development instruments

In addition to the long-term national health surveys, HSSP II (2008-13) monitoring system is the main monitoring mechanism. Both the UNFPA country office and government partners consider the monitoring arrangements for HSSP II to be appropriate but there are still capacity gaps. Moving from a project-based approach to a programme-based approach had been slow, but there has been steady change in performance monitoring within HSSP II.

UNFPA has had successes in policy change for family planning and midwives programming (incentives, salaries and placement/deployment) through the conduct of a NA-EmONC and the rapid implementation of the EmONC Improvement Plan.[127]

All implementing partners are subject to annual reviews, including MoH, and the performance indicators are reviewed for all provinces. UNFPA is subject to the External and Joint Monitoring System by peers of the Annual Operation Plan (AOP).[128] This system analyzes supply and demand, insurance schemes, gender review and human resources. Once this assessment is complete, the Annual Health Sector Review is conducted. In addition, the Joint Annual Performance Review for HSSP II reports on progress of achievements. Annual Operational Plans are prepared by all implementing partners and compiled as one under HSSP II to minimize chance of duplication. The NMNCH Center performs a supervisory role, but is limited by the size of their team.[129] The Ministry of Planning leads the annual monitoring of the National Strategic Development Plan and Health Sector Programme 2 linked to the MDGs, and UNFPA participates closely. However, the system is not yet performing adequately due to capacity gaps.

126. With regard to public relations, UNFPA performs the following:

    -The development of television and radio spots on the important role of men in maternal care. Migration and informed choice, lessons learned, the critical role of the Reproductive Health Equity Fund (both for beneficiary and policy), and seminars on positive views of midwifery, in partnership with UNESCO, UNDP HRD and Alliance Française. Criteria on how to advocate for services for the poor has been developed between MoH, RAC and UNFPA.

    -Campaigns and public events with the Khmer Youth Association (poor and migrant youth), NCPD (high-level policy makers), such as the State of the World Population Day, whose focus for the last three years has been on improving maternal health, SG Plan of Action on maternal health and International Midwives Day.

127. Interview with external development partner and government partner.
128. UNFPA Cambodia, AWP 2007-10.
129. Interview with government partner.

4.1.10 Evaluation question 10: Coherence of sexual reproductive health/maternal health support with gender and population and development support

Evaluation question 10

To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other programme areas?[130]

Judgment criteria	Issues to assess
10.1. Linkages established between programmes (Reproductive Health with Gender and Population and Development) in intervention design	To what extent has UNFPA identified specific gender constraints as affecting and impeding reproductive health programme objectives at country level in its planning?
	Have these gender constraints (as described) been adequately addressed by the current government; UNFPA? (reflections on CPAP document, explore gender mainstreaming at policy and programme level)
	Is the UNFPA adequately addressing the gender-based constraints to access to MNH services faced by poor and vulnerable women and the most at risk young people?
10.2. Integration of Monitoring and Reporting of UNFPA operations	How has population and development widened the utilization of its data in the last three years by government/ UNFPA and other partners in the reproductive health/ maternal health interventions?

Judgment criterion 10.1

- Linkages established between programmes (reproductive health with gender and population and development) established in intervention design

Only a small number of interventions have recently addressed gender-related challenges to maternal health. On the national level, population and gender still operate separately because of different funding streams but synergetic mechanisms are starting to evolve. At sub-national level, UNFPA is more successful at integrating gender, population and development and reproductive health. Many initiatives at the sub-national level are funded through a common pool that is managed by the Provincial Governor, who has a wide authority on health and development.

At policy and programme level, UNFPA Cambodia has lobbied the government on gender concerns, especially in poorly performing operational districts where traditional gender attitudes and relations continue to influence the health practices of women and their families. These attitudes impede the utilization of health centers and District Referral Hospitals. A gender approach to the Health Equity Funds, supported by the EmONC focal point, has helped to empower communities to increase the access to funds for poor women and to provide a "buddy system" when visiting health facilities.[131] UNFPA and the Ministry of Women Affairs (MoWA) have insisted that priority is given to girls and women within the Health Strategic Plan I and II through a multi-sectoral approach. The UNFPA-supported National Reproductive and Sexual Health Strategy (2006-10) is women-oriented; however, there has been a realization that "there has to be more balance in the ongoing review and update of the strategy so there is greater male involvement in services and by youth, especially adolescents."[132]

130. Gender (including female genital mutilation/cutting (FGM/C), gender-based violence (GBV), HIV-PMTCT (Prevention of Mother-to-Child HIV Transmission); Population and development.
131. UNFPA Cambodia.
132. Interview with NGO partner.

UNFPA supports a database in which information is increasingly disaggregated to improve gender analysis for health. As reflected in the more recent census and DHS,[133] the Cambodia Gender Assessments of 2004 and 2008, jointly funded by UNFPA, UNDP and several other donors, benefited from a number of UNFPA-supported surveys including the Cambodian Inter-census Population Surveys (CIPS, NIS 2004). The Gender Assessments included a review of the National Strategic Development Plan, and comments were received from the national CEDAW Committee. UNFPA supported two chapters of this assessment.[134],[135] A Gender Team from the Ministry of Women's Affairs (MoWA), supported by UNFPA, worked with the MoH Gender Team to develop (within MoH health strategy) a sub-strategy on gender mainstreaming. MoH, like other ministries and departments, has gender focal points and MoWA provided a curriculum for them on gender mainstreaming, technical tools for gender analysis, skills for integrating gender and health during programming, and on advocacy.[136],[137] MoWA also has a gender focal person at provincial level.

As part of the above process, UNFPA has supported quarterly meetings of all the gender focal points in relevant line ministries. UNFPA also provided a master trainer who developed a manual, guidance notes and tools on gender analysis, and provided practical training on gender analysis of health budgeting. In the provinces and districts, the gender focal point is the chair of the Women and Child Health Committee (WCHC), which is part of the structure of the Department of Local Administration under the Ministry of the Interior. This same department is responsible for the process of decentralization, deconcentration and the Commune Investment Plan. The WCHC Chair is the Gender Adviser to the Commune Council and a member of the Health Center Management Committee, and receives training from UNFPA.

Judgment criterion 10.2

- Integration of monitoring and reporting of UNFPA operations

There is a close coordination between UNFPA staff and government institutions in formulating and harmonizing indicators in the Health Strategic Plan, population polices and National Strategy for Reproductive and Sexual Health.

UNFPA has collaborated closely with several public institutions regarding the population and development component of the country programme[138] to create an enabling environment for reproductive health. However, the UNFPA reproductive health component provided budget support to the DHS, as there were insufficient funds available within the population and development component.[139] With regard to gender, population and development component utilizes statistics on gender and helps the Ministry of Planning formulate their gender sub-strategy, with the assistance of MoWA, including the collaborative formulation of gender indicators for health.[140] The UNFPA population and development component also provides support to MoH to analyze the DHS and compare results with MoH data. MoH has its own system of indicator tracking for each year, including trend analysis and review of the reliability of data collected through the system. In other regards, technical assistance in M&E from the population and development component relates to reproductive health and gender programming, data processing, analysis, policy implications, and integration of results in performance monitoring and midterm review of HSSP II.

UNFPA, in collaboration with public health authorities at district level and the Department of Local Administration, has helped to increase demand for maternal health services but the supply side (especially the health centers) still has major delivery gaps. The biggest challenge is gaps in reproductive and maternal health data at the community level.

133. UNFPA Cambodia.
134. Interview with Government partner.
135. A Fair share for Women, Cambodian Gender Assessment 2008, MoWA 2008.
136. I.e. talking points on the relationship between gender and health, how to lobby at sector level and multi-sectoral level.
137. Interview with Government partner.
138. Ministry of Planning, National Institute of Statistics, MoH, Ministry of Women Affairs, Parliamentarians Forum, National Committee on Population and Development, National Committee for Decentralization and Deconcentration, the Department of Local Administration (that overseas communes).
139. UNFPA Cambodia.
140. Interview with Government partner.

4.1.11 Evaluation question 11: Coherence between country, regional, global programmes

Evaluation question 11

To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?

Judgment criteria	Issues to assess
11.1. Clarity of division of labor and delineation of responsibilities between UNFPA global, regional and country offices	Are there specific agreements on division of labor between COs and regional offices?
	Does staff in country offices have a clear idea what kind of support they can expect from regional offices and UNFPA globally?
11.2. Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities	How time consuming was the recruitment of reproductive health expert into country offices? Could all required positions be filled?
	Are gaps in technical reproductive health/MNH staff capacity remaining that keep country offices from reaching their full potential?
11.3. Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level	To what extent has GP guidance for maternal health service up scaling; midwifery up scaling been applied at country level/was relevant for programming/ implementation support at country level?

Judgment criterion 11.1

- Clarity of division of labor and delineation of responsibilities between UNFPA global, regional and country offices

The country office has received adequate support from UNFPA headquarters and the Asia Pacific regional office (APRO), both in terms of technical assistance and support for advocacy events.

The regional office (RO) provides technical and programmatic assistance at two levels: i) to improve aid effectiveness through the CCA/UNDAF and ii) to support the UNFPA country office in the development of CP/CPD/CPAP. Additionally, the regional office has provided technical assistance on specific initiatives, such as UNFPA-ICM Midwives Programme and the National EmONC Assessment, and has supported long- and short-term consultancies for various evaluations related to the CCA. UNFPA headquarters has greater involvement during special events such as the State of the World Population campaign (an annual event), the Women Deliver Conference and the Secretary-General's Joint Action Plan. Tools provided by UNFPA headquarters for the Midwifery Review 2006 and National EmONC Assessment 2009, and related briefing materials, have been appreciated by the country office.[141] Both regional office and headquarters are sometimes involved in operational trainings related to administration, finance, and security,[142] and roles and responsibilities are clearly delineated.

141. UNFPA Cambodia:
142. "Headquarters, through the regional office, can also request country evaluations as they did with CP III, or as in 2004 ordered UNFPA to co-ordinate with SWAP/SWiM or as in 2011 make it improbable for the country office to stay in the HSSP II pool" (UNFPA Cambodia,

Judgment criterion 11.2

- Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities

The country office has experienced major changes in terms of human resources, which have affected its capacity to lead and make interventions in a timely and consistent manner.

The country office has experienced major delays in the replacement of senior management posts, including the Representative. A number of key long-time senior programmatic staff related to reproductive health, population and development, as well as the NPO for Gender, have also recently left the country office. Under the previous Representative, UNFPA management was active in terms of coordination and strengthening of systems during HSSP I and II. "UNFPA was the first chair of HSSP II, with strong technical leadership as well as being astutely political in the process of harmonization and alignment". [143] UNFPA was contributing only 2 to 3 per cent to the pool fund but had significant influence due to the strong combination of the Representative, reproductive health manager and international midwife expert, who were all active participants in debates and in influencing outcomes for the three UNFPA mandate areas.[144]

The country office has begun to resolve staffing problems through the appointment of a new Representative, who is also the chair of HSSP II.[145] In 2009, when the Midwives Programme was consolidated and the National EmONC Assessment commenced, the international midwife expert was replaced by an EmONC officer. A new reproductive health manager and a population and development manager were also recruited. The gender position has been upgraded, and the recruitment process was ongoing at the time of the country visit. However there are shortages of skilled technicians in Cambodia, and there are many agencies and NGOs competing for the same small pool of skilled personnel.

Judgment criterion 11.3

- Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level

The Asia Pacific regional office has offered on-demand support and has involved country office staff in capacity development events. The challenge of implementing key concepts in the country office and country-level programming has been shared by the two offices.

APRO is considered to be supportive and provide timely inputs. The APRO Reproductive Health Adviser is often available to respond to specific demands from the country office; when unavailable, a suitable substitute is identified. Also, the sub-regional office played a critical role during the introduction of the EmONC assessment and improvement plan.[146]

In 2008, the main support received by the country office for the mid-term review of the country programme (MTR) was from APRO, who supported the process, provided technical inputs, and participated in the high-level review meeting.[147] In 2009, the country office and APRO were involved in the formulation of the new UNDAF and 4th country programme, which encountered both facilitating and constraining factors. Overall, the process worked well as both APRO and the

Government Partner and EDP).

143. Interview with external development partners.
144. "If the Representative and the reproductive health team are strong they can influence at policy level. This is what has suffered rather than the programme which had consolidated well under the past leadership" (Government Partner).
145. "However, it was noted that UNFPA has no financial significance in HSSP II. " There is now an institutional issue as withdrawing from the pool as it is not perceived well by the some partners" (External Development Partner).
146. "If we compare to the days of Country Support Team we have to sometimes juggle for attention now but the quality of technical assistance has improved" (UNFPA Cambodia).
147. "Support from GD was generally good with some gaps during transition to Regional Office, but full support was available again" (COARS, 2008).

country office had a clear understanding of key concepts such as equity and knowledge of sectoral issues.[148]

APRO has provided country office staff with the opportunity to attend workshops on issues such as results-based management and financial management, which was appreciated by country office staff.

4.1.12 Evaluation question 12: Visibility

Evaluation question 12

To what extent did UNFPA maternal health support contribute to UNFPA visibility in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?

Judgment criteria	Issues to assess
12.2. UNFPA leadership of maternal health advocacy campaigns at national level	What approaches has UNFPA used to lead MNH advocacy vis-á-vis the national governments and the national public? (Based on concrete examples of how UNFPA displays it is convening power, where, how and who utilize its technical expertise, etc.)?
	What are the top technical assistance products and technical resources from global and regional offices best utilized by the country office?
	How does UNFPA fill its leadership role in institutional capacity development, advocacy on policy and political level, creation of a critical mass of public support for its programme and promoting empowerment (this is a new budget line since 2004).
12.3. Increased financial commitments of partner governments to sexual reproductive health and maternal health	What are the tools, information and evidence provided by UNFPA country office that has been utilized in reproductive health/maternal health resource mobilization (non-cash) and fundraising (cash) by partner governments?
	In what way did these tools improve the ability of governments to raise additional funds for MNH; or the willingness of governments themselves to devote more funds to MNH?

Judgment criterion 12.2

- UNFPA leadership of maternal health advocacy campaigns at national level

UNFPA leadership in maternal health advocacy at the national level has been strategic within the UN framework in terms of relationships with other donors and advocacy activities in their mandate areas. At the sectoral level, UNFPA contributes a broad understanding based on many years of experience, which UNFPA uses on behalf of reproductive and maternal health issues.

148. Interview with external development partner.

UNFPA is deeply involved in the health sectoral framework and in the Technical Working Groups on Health and the sub-group on maternal health. UNFPA remains a key player in maternal health advocacy and demand-creation campaigns through government and NGO channels. The Ministry of Planning is responsible for M&E, supervised by the National Strategy Development Plan, and UNFPA has maintained involvement. UNFPA has ensured balanced reporting on Cambodian MDGs, the census, and DHS by government in various aid and assistance forums and has supported national workshops to discuss "achievement and gaps and ensured dissemination of results".[149]

UNFPA is well-positioned to provide quality data sets that are well maintained, and can provide evidence to support reproductive and maternal health arguments.[150] With regard to planning and programming, UNFPA support is based on experiences with the National Reproductive and Sexual Health Strategy and chairmanship of HSSP II, and has lobbied for these issues in the UNDAF and HSP II.[151]

Judgment criterion 12.3

- Increased financial commitments of partner governments to sexual reproductive health and maternal health

UNFPA has been successful in leveraging funding and additional support using new initiatives and concepts in maternal and reproductive health through a programme-based and integrated approach to joint programming, especially through HSSP II.

Prior to 2006, the majority of UNFPA funding was received from the European Union to expand the adolescent health programme (RHIYA 2001-2005). In 2006, UNFPA joined HSSP II and was appointed the chair. By 2010, 40 per cent of the total pool fund (over $100 million) was allocated for reproductive and maternal health, due partly to the evidence from the Midwifery Review (2006), Midwives Programme (2007-10), National Assessments on EmONC (2009) and the EmONC Improvement Plan (2010-2015).[152] UNFPA Cambodia has received funding from both the German Government and AusAID for its Midwives Programme and EmONC assessments which replaced MHTF support, which in turn has been used for other maternal health activities.

MoH has contributed additional resources for health, with 13 per cent earmarked for maternal health.[153] In 2010, Parliament committed to an increase of 10 per cent annually in health budgets and agreed on a proportion for maternal health at sub-national level.[154] Full attribution is difficult, but MoH staff and Parliamentarians suggested that the advocacy role of UNFPA had been influential.[155] UNFPA has been less successful in its advocacy with regard to government funding of contraceptives but, in light of UNFPA procurement expertise, further support has been received from AusAID.

149. Interview with Government partner.
150. Interview with External development partner.
151. Interview with External development partner.
152. Interview with External development partner.
153. Interview with Government partner.
154. Interview with Government partner.
155. After the SG visit last year, UNFPA and MoH requested additional funds. NCPD had access to the Council of Ministers. The Minister asked the Deputy Prime Minister for a meeting, and as the chair of Council of Administrative Reform, the latter helped to push for a successful increase for the Initiative (according to information from government partners and external development partners).

4.2 Findings related to the mid-term evaluation of MHTF

4.2.1 Evaluation question 1: Relevancey

Evaluation question 1

To what extent is MHTF support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?

Judgment criteria	Issues to assess
1.1. MHTF countries selection processes support the role of MHTF as strategic instrument to improve maternal health among the most vulnerable populations	What was the rationale that guided the selection of the 25 initial "high priority countries" by the H4 group? Do the selection criteria and their processing capture the most vulnerable?
	How/to what extent has the global agreement on the division of responsibilities among the H4/IHP+ partners been translated into concrete cooperation agreements among the agencies at country level?
	To what extent do the project portfolios that MHTF supports at country level correspond to the core functions of UNFPA that were agreed by the H4/IHP+ and enhance UNFPA strategic response group?
1.2. MHTF supported national assessments yield sufficient and disaggregated data for needs orientation planning, programming and monitoring targeting the most vulnerable groups (including underserved groups)	To what extent do the MHTF supported needs assessments consider the needs of the most vulnerable groups in the programme countries; and identify the gaps that have prevented the addressing of their needs to that point?
	To what extent are MHTF supported needs assessments (see output 2 of the MHTF business plan) sufficiently "owned" by national governments to guide the subsequent planning and implementation of national MNH support?
1.3. National policies and sub national level sexual reproductive health/maternal health planning and programming priorities the most vulnerable groups and underserved areas	To what extent is the MHTF support targeted to address the identified gaps and needs of the most vulnerable (look at focus upon geographical areas with the highest MMR, focus on remote areas, deployment and retention of health care providers, outreach…)? How is it translated increased budget allocation for staff, equipment…)?

Judgment criterion 1.1

- MHTF countries selection processes support the role of MHTF as strategic instrument to improve maternal health among the most vulnerable populations

At the time of the country visit, the selection of Cambodia as a country to receive MHTF support had not yet fully translated into improved coordination and cooperation among H4+ partners. However, H4+ was active in 2010, with a number of individual high-level advocacy events. None of the relevant external development partners saw H4+ as an important technical co-ordination mechanism, as they were already involved closely in many other mechanisms and initiatives.

H4+ was established in Cambodia in 2009. The division of labor among UN agencies in Cambodia reflects the Memorandum of Understanding of the Secretary General's Joint Action Plan: UNFPA and WHO are responsible for maternal health, UNICEF and WHO are responsible for newborn health, and UNFPA and UNICEF are responsible for family planning.[156] However, the three partners and World Bank had not met as H4 until June 2010, when they came together to support the preparation of the country delegation for the Women Deliver Conference in Washington DC, which had been funded by MHTF.[157] The project portfolio that MHTF introduced to Cambodia, including EmONC Assessment and EmONC Improvement Plan, closely corresponds to the core functions of UNFPA and has helped enhance strategic position of UNFPA in Cambodia, but not necessarily as a H4+ member.[158] For example, there were efforts to introduce a national EmONC assessment in 2003-2004, but there was a lack of interest from MoH. MHTF introduced the EmONC Assessment tool (through the regional office), which was due to be funded by MHTF. However, with the growing interest from the World Bank, UNICEF and WHO, who regarded the tool as a strategic instrument to improve maternal health for poor and disadvantaged groups, it was agreed to jointly promote the National EmONC Assessment to MoH. AusAID funds were made available through UNFPA for a national assessment in early- to mid-2009, and HSSP II funding was made available for the development and implementation of the Improvement Plan (2010-2015).

However, the rapid decline of maternal mortality ratio from 437 in 2008 to 206 per 100,000 live births in 2010 means that Cambodia is no longer eligible for MHTF funding.

Judgment criterion 1.2

- MHTF supported national assessments yield sufficient and disaggregated data for needs orientation planning, programming and monitoring targeting the most vulnerable groups (including underserved groups)

MHTF was successful in leveraging funds for the National EmONC Assessment and the Improvement Plan as noted in judgment criteria 1.1. The assessment tool that MHTF provided was well received by MoH. The orientation, planning, design and execution of the assessment were highly consultative and participatory. The process is considered an example of the practical use of a technical research tool, knowledge transfer and sharing, inter-agency cooperation and government participation. For this reason, the findings of the EmONC assessment, while very critical of public health facilities, were fully accepted by MoH and recommendations were scaled-up to feed into the development and implementation of the EmONC Improvement Plan.

An EmONC assessment tool was introduced to Cambodia by MHTF in collaboration with Averting Maternal Deaths and Disability (AMDD) Programme of Columbia University, and was fully supported by UNFPA headquarters, WHO and UNICEF. This tool, which includes maternal health indicators commonly known in Cambodia as the UN EmONC indicators, provided a framework to assess the quality and readiness of EmONC services in the country. The assessment report has been accepted by MoH as the first baseline study on EmONC.[159]

156. Interview with external development partner.
157. UNFPA Cambodia, Annual Joint Reporting for the Thematic Funds, Jan-Dec. 2010.
158. Interview with external development partner.
159. Interview with UNFPA Cambodia and NGO partner.

The National EmONC Assessment was conducted by the National Institute of Public Health, with technical support from the National Maternal and Child Health Center and the National Reproductive Health Programme. UNFPA staff facilitated and coordinated the technical, administrative and logistical arrangements, partly using MHTF resources. AusAID resources to UNFPA supported the technical consultant on the design, data monitoring, data analysis, interpretation and report writing. The assessment was completed in 70 public hospitals, most at the district level, one-third of Health Centers (230) as a sample of facilities used by the poorer sections of society in rural areas, and 40 private hospitals that are used by the general population and served as a point of comparison of services. All 24 provinces were represented in the sample. Provincial health directors, operational district directors, hospital directors, health center chiefs, doctors, midwives, nurses and technicians in each study site provided inputs throughout the process.

The National EmONC assessment identified several bottlenecks on the supply side related to availability, functionality and utilization of EmONC. Many of the gaps discovered related to lack of quality assurance in the public health system. The assessment also highlighted critical barriers including user fees and the affordability of what should be a free/low-cost health care service for the poor. All 10 UN EmONC indicators were included in the assessment, and the findings were compared to the established UN standard for EmONC services. The National Maternal and Child Health Center added two "poverty-related" indicators: i) very early neonatal death rate and ii) proportion of maternal deaths due to indirect causes. The EmONC assessment found that while a general health infrastructure was in place, there is a need for EmONC service expansion in some rural and many remote areas, and upgrade of facilities is needed in other areas. The rapid agreement on the assessment report and the development and implementation of the EmONC Improvement Plan were seen as widely participatory processes, and the first changes were implemented within six-seven months of planning. This is surprising "given the fact that the approval process can be very long and protracted in Cambodia. It shows the commitment of MoH to improve the quality of its health facilities."[160]

Judgment criterion 1.3

- National policies and sub national level sexual reproductive health/maternal health planning and programming priorities the most vulnerable groups and underserved areas

MHTF supported two main interventions aimed at improving access to vulnerable groups: i) expansion of the Health Equity Fund and ii) the development of guidelines and the implementation of maternity waiting homes (MWH) in pilot areas. Although the dissemination of guidelines were delayed, MWH proved to be successful and are being replicated. The Health Equity Fund was absorbed within HSSP II and MHTF funds were therefore not utilized.

MoH perceives both the National EmONC Assessment and EmONC Improvement Plan to be good examples of pro-poor interventions. Circumstances dictated that these two critical instruments were funded by external donors: AusAID and HSSP II respectively. MHTF resources had been budgeted for the expansion of the Reproductive Health Equity Fund, which UNFPA had piloted in five ODs. However, in 2009, MoH decided to move towards universal coverage/ universal package for Health Equity Funds (by 2015), which meant that existing efforts were to be funded from the HSSP pool in 2010/11. This led to under-utilization of MHTF resources in 2009-10.

MHTF fully contributed to the initial installation of five maternity waiting homes (MWH) in two remote provinces that were operational in 2009, utilized by 47 high-risk pregnant women from remote villages. By 2010, seven MWH were established in four remote provinces, caring for 1,268 pregnant women with high-risk symptoms and 111 pregnant women from remote communities identified as high-risk.[161]

The first guidelines for establishing and operating MWH were developed and approved by MoH and disseminated in 2010. The guidelines provided clear, step-by-step guidance on how to set up, operate and expand MWH at a designated public health facility. In 2011, NGOs were beginning to support the building of MWH and are now required to follow these guidelines.

160. UNFPA Cambodia.

161. UNFPA Cambodia MHTF Progress Report 2009, 2010.

Scholarships for enrolling students from remote districts as candidates for midwife pre-service training were under discussion at the time of the country visit.

4.2.2 Evaluation question 2: Capacity Development - human resources for health

Evaluation question 2

To what extent has, the MHTF contributed towards strengthening human resources planning and availability (particularly midwives) for maternal health and newborn health?

Judgment criteria	Issues to assess
2.1. Programme countries midwifery education upgraded based upon ICM (International Confederation of Midwives) essential competencies through MHTF support	How does the MHTF support improved mechanisms for: • long term national midwifery education funding, • country wide integration of new curricula and • monitoring of effective uptake of new knowledge / training?
	What follow up mechanisms are instituted by the MHTF to assess the relevance of the training content, the trainers' capacities and the appropriate utilization of the training equipment?
2.2. Strategies and policies developed to ensure the quality of midwifery services provision in programme countries through MHTF support	To what extent does the MHTF support the relevant national institutions to address deployment, motivation and retention policies for health care workers (particularly midwives)? (Which activities? what are the changes adopted by the government?)
	How does MHTF support programme countries to define the most urgent needs/priorities of midwifery scaling-up within the financial and political constraints?
2.3. Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support	What approaches is the MHTF considering to enabling midwives' associations, to take on the role envisioned in the programme (capacity to advocate for and implement the scaling up of midwifery services)?

Judgment criterion 2.1

- Programme countries midwifery education upgraded based upon ICM essential competencies through MHTF support

MHTF provided support to the midwifery education, focusing on upgrading in-service EmONC trainings and pre-service curriculum through introducing ICM competencies. In 2009-10, in addition to the implementation of the revised curricula, MHTF provided training materials and supported teachers and clinical practice activities in four training institutions as a complement to external sources of funding. However, the curricula was inadequately adapted and not readily usable..

The Midwifery Review (2006) and Midwifery Programme and Action Plan (2007-2010) was supported by German funding. In 2009, MHTF supported the review of EmONC training curricula for midwives and doctors with a view to transforming the fragmented system of trainings into one coherent framework as part of the support to the EmONC Improvement Plan.

A standard EmONC training curriculum for midwives at health centers and a diploma/certificate course in EmONC for medical doctors/physicians (24 weeks) was developed with the support of external technical assistance. In 2010, hands-on training of trainers and coaching, again facilitated by an international expert on EmONC training, was conducted for 18 midwives and 18 medical doctors. These trainees then provided the first 12-week EmONC training course for 10 medical doctors.[162] The training took place in late 2010 to help contribute to the urgent need for skilled midwives at health facilities selected for upgrade to either comprehensive EmONC (with surgery) or basic EmONC (without surgery) services.

The essential competencies for midwifery services (based on ICM competencies) were adapted to the Cambodian context through four consultation workshops. ICM competencies and standards were introduced in 2010-2011 with MHTF support, without pre-testing of the in-service and pre-service training curricula. However, the process was slow, and the integrated ICM curriculum was criticized due to poor adaptation to the Cambodian context. Teachers reported that the curriculum difficult to use because of language issues. There has been no post-integration testing of the curriculum and no supervision guidelines had been developed at the time of the country visit, although this is planned for 2011 if technical support is available.[163]

The first curriculum for a bachelor degree in midwifery was developed in 2010, with technical support from an international expert. This degree was considered highly useful by the Department of Human Resources Development who wish to implement it in appropriate training institutions. It is a major step towards assisting midwifery lecturers, as well as addressing the current shortage of professionals. [164]

In 2010, all five regional training centers (RTCs) provided midwifery training to a total intake of 835 students (continuing the increase from 335 students in 2008 to 830 in 2009). The training of most students have been supported by the German Fund, but the equipment and training materials were provided by MHTF alongside support for midwifery teachers and clinical practice activities in the four RTCs. The midwifery training programme has since been scaled up and receives HSSP II pooled funding.

The refresher course for anesthetists (nurses or doctors) for emergency obstetric care was not implemented in 2009 due to the lack of financial approval by the Ministry of Economy and Finance. In 2010, the training was again not implemented as planned, due to a government policy change banning all forms of payment of incentives to government staff. The change negatively affected staff motivation, leading to further delays and suspension of the training.[165]

Judgment criterion 2.2

- Strategies and policies developed to ensure the quality of midwifery services provision in programme countries through MHTF support

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UNFPA sought to influence the quality of midwifery services using MHTF resources through midwife in-service and pre-service curricula review, supporting midwifery education, as well as the development of midwifery standards. Although support for the implementation of the EmONC Improvement Plan will contribute to improving the provision of midwifery services, ensuring the needs-based deployment of new midwives and the retention of those already employed remains a key challenge.

MHTF started operations in Cambodia in 2009 when the fully-funded UNFPA Midwifery Programme (2007-10) was already being implemented. UNFPA sought to influence quality using MHTF resources through upgrading EmONC in-service curriculum, supporting service curriculum development, and strengthening training institutions (as described in judgment

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162. Maternal Health Thematic Fund Cambodia, Progress Report 2009 and 2010.
163. Interview with external development partner.
164. Interview with government partner.
165. UNFPA Cambodia and NGO partner.

criterion 2.1). Since 2008, there has been a large increase in midwifery students, largely attributable to the three-year direct entry midwifery-training programme that is funded by the German Trust Fund and the Government Midwifery Incentive Programme. This increase in numbers contributes to the MoH commitment to achieve its target of at least one midwife working at each health center (EmONC Improvement Plan target). It is planned that the Ministry will increase coverage to at least two midwives per health center, as reflected in the Health Workforce Plan 2006 – 2015 projections. UNFPA has not been involved in any quality assessments or supported the deployment or retention of midwives, but this is anticipated for the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality.

As German funding ended in 2010, MHTF support is sought for four areas related to human resources for maternal health: [166]

- Participation in international and regional conference
- Support for training workshops on reproductive and maternal health and midwifery
- Support to midwifery training in four RTCs
- Support to roles and functions of the Cambodian Midwives Council and Association

MoH requested support from the Cambodian Midwives Council (CMC) for the development of standards through introducing ICM protocols and aligning with ASEAN standards, as well as the elaboration of a Code of Ethics (see judgment criterion 2.3.).

Judgment criterion 2.3

- Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support

The Cambodian Midwives Council (CMC) is fully operational and receives support from German funding and MHTF resources. However, the Cambodian Midwives Association (CMA) will require further support from MHTF in order to evolve as an independent organization with the ability to advocate on behalf of the profession, fulfill the necessary role of 'watchdog', and help the public health sector scale-up of quality services.

UNFPA supported the creation of the Cambodian Midwives Council (CMC). Institutional capacity development of the Cambodian Midwives Council (CMC) and the Cambodian Midwives Association (CMA) was carried out by a local organization, funded by the German Trust Fund (from late 2009 to mid-2010) to address basic capacity development and institutional needs such as the Strategic Plan (2010-2015) and internal regulations.[167] The CMC is now fully operational with a new Executive Committee, and permanent institutionalization by the government is anticipated.

MHTF has supported a full-time programme assistant to assist both CMC and CMA, particularly in the formulation of the Code of Ethics and Standards as well as to help organize advocacy events. However, this support was not equally distributed between the two organizations, nor of an adequately technical level. A VSO midwife has now joined and further improvements are expected.[168] Core competencies for midwives (based on ICM competencies) have been defined by CMC within guidance for all midwives and training institutions to improve the quality of teaching and the skills of graduate midwives.

MHTF supported the 2009 and 2010 International Midwives Day, organized jointly by the CMA and CMC. The event included participation of approximately 400 midwives over two years, health professional organizations, and provincial and district representatives, with high-level support from the Minister of Health. As a consequence of this event, MoH offered to host the secretariat of both these organizations and to include CMA and CMC activities in its annual operating plan.

166. Updated Planned Activities and Budget Required for 2011 for reproductive health component, taken from ATLAS.
167. UNFPA Cambodia MHTF Progress Report 2009, 2010.
168. UNFPA Cambodia.

Both these organizations are reliant upon volunteers who recognize the importance of remaining independent but have expressed concerns about the sustainability of their long-term involvement.[169] A database of registered midwives is being maintained but needs further software support. Accreditation and licensing are being discussed with the Department for Human Resources to help define responsibilities. CMA members are involved in coaching newly-trained midwives once they are deployed. However, it appears that the CMA needs further organizational and management support from UNFPA to evolve into an independent and sustainable organization that can assist the scale-up of midwifery services.[170]

Additional issues

MHTF activities began with one international EmONC consultant, recruited in late 2008. In mid-2009, a full time maternal health staff was hired who had sole responsibility for EmONC. This position to support to the implementation and monitoring of the EmONC Improvement Plan was appreciated by partners. However, MHTF support for the midwifery component was not as strong as previous support due to the absence of the AusAID-funded midwifery advisor position. In summary, MHTF has supported technical assistance for specific interventions e.g. development of curricula, support to EmONC training implementation.

4.2.3 Evaluation question 3: Sexual and reproductive health services – family planning

Evaluation question 3

To what extent has the MHTF contributed towards scaling-up and increased access and use of family planning?

Judgment criteria	Issues to assess
3.1. Creation of enabling environment to facilitate scale-up of quality family planning services in priority countries through MHTF support	What were the specific family planning activities funded through MHTF (categorize between fully or partly MHTF funded)? How do they fit within the overall UNFPA strategy?
3.2. Demand increased for family planning services in MHTF priority countries, particularly among the vulnerable groups through MHTF support.	What is the rationale of MHTF support to community-based family planning distribution interventions and demand creation/communication initiatives?
	Are the monitoring and evaluation mechanisms to measure the appropriateness of the MHTF funded family planning communication initiatives coordinated with the other UNFPA sources of funding?

Judgment criterion 3.1

- Creation of enabling environment to facilitate scale-up of quality family planning services in priority countries through MHTF support

MHTF has so far only provided partial support to the UNFPA Midwifery Programme, the conduct of the National EmONC Assessment and the implementation of the EmONC Improvement Plan. Overall the range and number of activities to improve access to family planning services financed with MHTF funds have been limited.

169. Interview with government partner.
170. Interview with NGO partner.

Until 2009, family planning activities were supported by UNFPA core funds and by other partners such as USAID, DFID, Options/IPAS, KfW and UNFPA (contraceptive security) and PSI (social marketing), all of whom have helped create an enabling environment. In 2009, GPRHCS procured contraceptive commodities to support the introduction of a new contraceptive method and 4,500 sets of sub-dermal implants were ordered. However, MHTF support for the revision of existing family planning policies and guidelines to ensure availability of family planning services in referral hospitals and facilities providing abortion services was replaced by DFID (through Options/IPAS).

Judgment criterion 3.2

- Demand increased for family planning services in MHTF priority countries, particularly among the vulnerable groups through MHTF support

MHTF supported the peer review of the evaluation of the Contraceptive Community-Based Distribution Programme, with a focus on informing and expanding future programming in rural/remote areas. The recommendations of the review have been integrated by relevant NGOs but have not been followed up by UNFPA Cambodia.

The evaluation of the Contraceptive Community-Based Distribution Programme was jointly financed by UNFPA and USAID. In 2010, MHTF supported an international consultant to facilitate a workshop for the peer review of the evaluation findings. The findings and recommendations of the peer review were disseminated in October 2010, with participation by national and international partners and national and sub-national health personnel. The evaluation was considered key to informing future directions for the programme, particularly to expand services and increase family planning utilization and acceptance by women in rural/remote areas. To date, there has been no formal response from the government to the evaluation recommendations or integration into the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality.[171] NGOs working in community-based distribution programming, however, have successfully integrated many of the recommendations.[172]

171. UNFPA Cambodia.
172. Interview with NGO partner and external development partner.

4.2.4 Evaluation question 4: Sexual and reproductive health services – EmONC

Evaluation question 4

To what extent has the MHTF contributed towards scaling up and utilization of EmONC services in priority countries?

Judgment criteria	Issues to assess
4.1. Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support	What mechanisms does the MHTF support to upgrade/ provide continuous EmONC education in remote areas?
	How does the MHTF ensure that its EmONC services quality control mechanisms (including institutionalizing supportive supervision) are adopted by the programme countries?
	What mechanisms does the MHTF apply to motivate and sustain the MoH commitment to strengthen and scale up EmONC services based on the bottlenecks identified?
4.2. Utilization and access of EmONC services improved through MHTF support	What are the mechanisms in place to explore the barriers to EmONC services in countries supported by the MHTF?
	What are the mechanisms put in place with MHTF support to address the identified barriers and to increase demand of quality EmONC services (communication activities, social mobilization…)? What are the results?

Judgment criterion 4.1

- Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support

The EmONC Improvement Plan will remain an initiative for UNFPA Cambodia regardless of different funding sources. MHTF has contributed to the implementation of the EmONC Improvement Plan by strongly supporting the MoH EmONC coordination team and the EmONC training component of the Improvement Plan as well as by supporting the dissemination of EmONC guidelines.

The EmONC Improvement Plan (2010-2015) provides an opportunity to create an enabling environment to help accelerate and sustain the reduction of maternal and newborn mortality and morbidity. The EmONC Improvement Plan is implemented simultaneously at national and provincial level as an ongoing process. The National Reproductive Health Programme (NRHP), under the umbrella of the National Mother and Newborn Child Health Center, is responsible for overall management, coordination and execution of the Improvement Plan. EmONC focal points have been established and are part of the referral system.[173] In 2010, an EmONC Unit was established with a national coordinator, four technical staff and two support staff appointed to the Unit. This team is responsible for monitoring and supervision in accordance with MoH guidelines. The Unit is closely supported by a full-time UNFPA national programme officer for maternal health who is employed with MHTF funds and works only on the EmONC Improvement Plan. MHTF support to strengthening the

173. Interview with external development partner.

EmONC Unit has been crucial for the implementation and monitoring of the EmONC Improvement Plan. This support involved many joint visits with national staff to the EmONC facilities in the country for supportive supervision.[174]

The plan to support the NRHP in building the capacity of EmONC data collection and monitoring through recruiting a national technical assistant was not successful despite two rounds of recruitment. [175]

From 2009, MHTF supported the development of training curricula for EmONC teams based on training assessments undertaken with international technical assistance. MHTF supported training of trainers for both midwives and doctors. In 2010, MHTF provided support for the training of health professionals (facilitated by the trained master trainers) selected on the basis of the EmONC Improvement Plan (as seen under judgment criterion 2.1).

In 2009 and 2010, MHTF supported the first National Maternal Health Symposium on EmONC services quality to disseminate guidelines and technical updates with 400 health professionals. This was a useful forum for experts and health professionals to share experiences and learn about the EmONC assessment, Improvement Plan, the master training for midwives and doctors, new EmONC guidelines and technical updates.

Judgment criterion 4.2

- Utilization and access of EmONC services improved through MHTF support

Through its support for the implementation of the EmONC Improvement Plan, the MHTF partially addresses EmONC service utilization through strengthening linkages with communities. MHTF support to the Health Equity Fund for Maternal Health and to maternity waiting homes (MWH) has also contributed to improved utilization. Currently, initiatives such as MWH are very limited and will require scale-up to increase effectiveness.

The purpose of the EmONC Improvement Plan (2010-2015) is to improve coverage and utilization of quality EmONC services and skilled care, particularly among the poor and vulnerable. This is aligned with the MHTF objective to facilitate equitable access to key reproductive and maternal health services for the poor.[176] The expected results are improved minimum standards, access, skills, utilization, referrals, provincial and district health department plans, and strengthened links with communities. The latter is related to improved linkages through Health Center Management Committee and Commune Councils, upgrading referral support and providing transport schemes, as well as strengthening the traditional birth attendant midwifery alliance. However, MHTF inputs to community linkages remain weak, as the MHTF focus has predominantly been on EmONC trainings for midwives, doctors and the CMC/CMA.[177] Moreover, assessments undertaken prior to MHTF did not focus on exploring barriers to accessing EmONC services and this remains an under-researched area. However, the financial barriers to accessing services are well-known and the MHTF involvement in Health Equity Funds was based on an intention to address these barriers. Furthermore, MHTF support to developing 'Guidelines for Establishing and Operating Maternal Waiting Homes' and to piloting MWHs in selected provinces (see evaluation question 1) allowed MoH to build on existing experiences to address barriers related to remoteness, although this is reliant on documentation and feedback at policy level.

The EmONC Improvement Plan has been adopted by the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality. However, there are indications that implementation is slowing and the lack of incentives for higher-level health professionals to participate in trainings, lack of support to community groups and community-based distribution have been highlighted as challenges.[178]

174. UNFPA Cambodia.
175. Interview with government partner.
176. Cambodia EmONC Improvement Plan, MoH 2010-15.
177. Outcomes of the group discussion (Annex 6.4) suggest that access and utilization of health outlets by poor and uneducated community women (who still form a large part of the population) is limited; also based on information from NGO partner.
178. Interview with UNFPA Cambodia and NGO partner.

4.2.5 Evaluation question 5: Support to health planning, programming and monitoring

Evaluation question 5

To what extent has the MHTF contributed to improve planning, programming and monitoring to ensure that maternal and reproductive health are priority areas in programme countries?

Judgment criteria	Issues to assess
5.1. Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support	How have the advocacy campaigns/activities supported by the MHTF been translated into national policies and strategies (that include family planning, skilled care in pregnancy and childbirth, emergency obstetric and neonatal care, obstetric fistula and sexual reproductive health and reproductive health/HIV linkage)?
	Do the sexual reproductive health coordination bodies established in countries (facilitated by MHTF) provide a coordination framework to address sexual reproductive health/maternal health issues?
5.2. National plans consider sustainable funding mechanisms for sexual reproductive health/maternal health through MHTF support	Do national health budgets include dedicated budget lines for family planning, skilled care during pregnancy and childbirth, emergency obstetric and neonatal care and obstetric fistula in MHTF supported countries? What are the prospects for sustainability?
5.3. National and sub-national health plans include clear monitoring and evaluation frameworks for family planning, skilled care in pregnancy and child birth, EmONC, obstetric fistula and reproductive health/HIV linkages	Are key internationally agreed sexual reproductive health/ maternal health indicators integrated in HMIS in MHTF countries and properly measured and used for programming?
	To which extent are the M&E plans, mechanisms (developed with MHTF support) adopted, and lessons learnt integrated in sexual reproductive health/MNH annual programming?

Judgment criterion 5.1

- Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support

MHTF has had a synergistic effect when combined with the strategic position of UNFPA Cambodia in national coordination mechanisms, such as Health Sector Support Programme II, and active participation in Health Strategic Plan and the Fast Track Initiative Roadmap on Reducing Maternal and Newborn Mortality. Its support to high-level advocacy has contributed to promoting maternal health.

MHTF has supported a high-level international advocacy conference (Women Deliver Conference) and the Secretary General's Joint Plan of Action. These two initiatives demonstrated UNFPA commitment to maternal health and youth through advocacy and helping to increase public awareness of maternal health. In late 2010, UNFPA involved the Cambodian First Lady as a national advocate and champion for maternal health.[179]

179. Interview with external development partner.

There are three coordination bodies, which provide a framework for the MHTF project portfolio and promote innovative ideas for maternal health:

- The MoH Second Health Sector Strategic Plan (HSP2 2008-2015) identified reproductive health, maternal, newborn and child health as priorities, and the second Health Sector Support Programme (HSSPII 2008-13), which is jointly funded by seven development partners including UNFPA, has also aligned its priorities with HSP2, placing reproductive maternal newborn and child health as the top priority for support
- UNFPA is a member of Technical Working Group (TWG) for Health, the lead on TWG sub – group for Maternal Health and member of TWG Human Resource for Health (HRH)
- The RNMCH taskforce, one of the three main programmes of the NSP II, was established by MoH and to improve access to quality reproductive and maternal health services and reinforce quality improvement at referral hospitals and health centers. UNFPA is a member of the RNMCH Task Force, which is recognized by the government

Judgment criterion 5.2

- National plans consider sustainable funding mechanisms for sexual reproductive health/maternal health through MHTF support

Development partners supported the development of the EmONC Improvement Plan and its costing. It is funded through HSSP II which enhances its sustainability. MHTF funds were not used for this process but MHTF support for implementation helped to develop national capacity in managing the improvement of the EmONC system.

National health budgets in Cambodia have dedicated budget lines with maternal health activities, midwifery programming, and the EmONC Improvement Plan reflected in the budget of the National Reproductive Health Programme.[180] The EmONC Improvement Plan was budgeted with support from UNFPA and development partners, and will mostly be funded through HSSP II. MHTF has provided technical assistance to the government for the implementation of EmONC and contributed to developing MoH capacities.

Judgment criterion 5.3

- National and sub-national health plans include clear monitoring and evaluation frameworks for family planning, skilled care in pregnancy and child birth, EmONC, obstetric fistula and reproductive health/HIV linkages

Key internationally-agreed reproductive and maternal health indicators are integrated into the Cambodian Health Management Information System (HMIS). The Annual Progress Report publishes country indicators as reflected in DHS 2010 and MoH (HMIS) for 2009 and 2010. The country office uses the MHTF Result Framework indicators and there is growing interest within MoH on the qualitative indicators of the MHTF Business Plan.

At the level of operational districts, UNFPA relies on annual tracking by the Health Information System (HIS) for all the major indicators, as reflected in the Basic and Comprehensive Package of Activities.[181] The reproductive and maternal health national indicators (MMR, CMR, IMR, TFR and CPR) are tracked via the DHS, three of which have been undertaken in Cambodia. Indicators from the Result Framework of the MHTF Business Plan were shared with national partners when UNFPA prepared the 2009 progress report and during Fast Track Initiative Road Map discussions. These are qualitative indicators which MoH has shown an interest in using in its own reporting.[182]

Monitoring and supervision of the implementation of EmONC activities and facilities is carried out by the EmONC coordination team of the National Maternal and Child Health Center with the support of the MHTF-funded national programme officer for maternal health (EmONC officer). The EmONC Improvement Plan and its log-frame form the basis for monitoring and evaluation of EmONC activities.

180. Interview with government partner.
181. MHTF Progress Report 2009, 2010.
182. UNFPA Cambodia.

4.2.6 Evaluation question 6: Management of MHTF

Evaluation question 6

To what extent have the MHTF management mechanisms and internal coordination processes at all levels (global, regional and countries) contributed to the overall performance of the MHTF in fulfilling its mission?

Judgment criteria	Issues to assess
6.2. Instruments and mechanisms developed by the MHTF to strengthen country office capacities to manage the fund at global and regional level	To what extent country offices MHTF/RHTF planning process is facilitated by the tools provided at global level?
	To what extent country offices MHTF/RHTF planning process is facilitated by the review system in place?
6.3. Monitoring and evaluation of the MHTF supported proposals including financial monitoring	What are the mechanisms in place for regular financial monitoring of MHTF support in countries, at regional and global level?

Judgment criterion 6.2

- Instruments and mechanisms developed by the MHTF to strengthen country office capacities to manage the fund at global and regional level

The country office has received support for the Asia Pacific Regional Office (APRO) and headquarters for the design of MHTF-funded interventions in order to harmonize these interventions with the country programme and government priorities. The flexibility of MHTF as an instrument has allowed adjustment of interventions in response to the changes to government and other development issues.

The final proposal for MHTF was prepared by the country office with close support from APRO and UNFPA headquarters. The country office now reports directly to headquarters, which accelerates communications.[183] MHTF activities are part of national and regional meetings to review annual work plans, and receives feedback from headquarters. This has helped to ensure that MHTF requirements are well-integrated and help to strengthen the capacities of the country office.

Analysis of UNFPA annual work plans (AWP) indicate that the MHTF project portfolio is closely linked to the reproductive health outputs for the 3rd country programme, and that planned activities reflect MoH priorities, based on MoH annual operational plans (AOP) for 2009 and 2010. MHTF has introduced and defined four areas of operations which are in line with the MHTF Business Plan.

MHTF funds are flexible but less predictable, and programme implementation is therefore less smooth than programmes supported by other funds. Implementing partners (IPs) must integrate new activities from external donors into mainstream activities, which tend to be more structured.[184] When IPs receive new donor funds, MHTF funds are usually re-allocated, as MHTF resources are perceived as internal funding and hence more flexible. Planned activities are not adversely affected but are assigned to a new funding source. High Operating Fund Account (OFA), such as MHTF, is a challenge particularly in the context of the programme-based approach and HSSP II, but recent financial training has helped integration.

183. UNFPA Cambodia.
184. UNFPA Cambodia MHTF Progress Report 2010.

Judgment criterion 6.3

- Monitoring and evaluation of the MHTF supported proposals including financial monitoring

Monitoring of MHTF activities is integrated into the internal M&E system of the country office. MHTF reporting tools are useful to track progress as the result-based framework does not reflect specific MHTF contributions. Activities undertaken to strengthen financial monitoring helped to reinforce country office capacity.

In late 2010, MHTF supported the monitoring and supervision of the implementation of EmONC activities and facilities carried out by the EmONC co-ordination team of the National Maternal and Child Health Center. Monitoring support from UNFPA is provided jointly by the national programme officer for sexual reproductive health and the EmONC officer (supported by MHTF), supervised by the UNFPA reproductive health manager. The long-term reproductive health manager resigned in April 2011 and a new reproductive health manager was assigned six months later. This was not viewed as having an adverse effect on MHTF activities, although representation at policy dialogue level was not as strong.[185]

The internal M&E system is integrated within the country office system for all sources of funding. However, improvements were noted as a result of the reporting template for the MHTF that is helpful to track progress, particularly EmONC and midwifery developments.

MHTF uses the FACE system to monitor financial expenditure. The UNFPA finance associate was trained on MHTF and the harmonization approach of cash transfers training (HACT), and provided training to UNFPA offices in Lao PDR and South Africa.[186]

As seen in evaluation question 5, the MHTF results-based framework is considered useful by national partners for following-up progress in maternal health but has some limitations with regard to providing information on the actual contribution of MHTF.

Development, implementation and monitoring of the MoH annual operational plan are still weak and not sufficiently flexible to embrace new ideas. This is challenging for UNFPA when new funding is available on short notice as in the case of the late approval of MHTF resources.

185. UNFPA Cambodia.
186. UNFPA Cambodia.

4.2.7 Evaluation question 7: Coordination/coherence

Evaluation question 7

To what extent has the MHTF enhanced and taken advantage of synergies with other UNFPA Thematic Funds e.g. the Global Programme to Enhance Reproductive Health Commodity Security, the Campaign to End Fistula and the UNFPA-ICM Midwives Programme and HIV-PMTCT in order to support maternal health improvements?

Judgment criteria	Issues to assess
7.1. Integration of the components of the Campaign to End Fistula into maternal health programmes after the integration in MHTF	Do MHTF supported countries include obstetric fistula in their advocacy campaign for sexual reproductive health/ MNH?
7.2. Joint and coordinated planning at country level with GPRHCS	What are the mechanisms in place between GPRHCS and MHTF to harmonize pharmaceuticals, medical supplies and medical equipment lists in programme countries?
7.3. Integration of Midwife Programme strategic directions in MHTF plans in countries	What is the role of ICM regional advisor in supporting country offices?
	Is partnership with ICM sufficient to boost midwifery in programme countries? Are there other potential partners that can contribute to this aim?
7.5. MHTF plans integrate HIV activities in synergy with core funds, Unified Budget and Work plan (UBW) and other resources	To what extent national and sub-national service health delivery plans have an integrated sexual reproductive health/HIV component (with MHTF support)?
	Do the revised midwifery curricula include PMTCT in country with high HIV prevalence supported by MHTF?

Judgment criterion 7.1

- Integration of the components of the Campaign to End Fistula into maternal health programmes after the integration in MHTF

Obstetric fistula is a potential area for funding by MHTF, but so far has only been partially addressed with UNFPA core funds.

Obstetric fistula is not a well-known phenomenon in Cambodia, and no assessment on obstetric fistula has been performed in Cambodia.[187] UNFPA country office has received reports of a small number of cases from the NGO Children Surgical Center (CSC). UNFPA Representative recently received a request for funds to contribute to an assessment of obstetric fistula.

187. UNFPA Cambodia.

In 2011, the country office began a small campaign on fistula in remote provinces through radio broadcasts and providing leaflets to healthcare providers through the provincial health department.[188] Using core funds, UNFPA also started a pilot partnership with an NGO clinic that performs re-constructive surgery free of charge.

Judgment criterion 7.2

- Joint and coordinated planning at country level with GPRHCS

MHTF coordination with GPRHCS contributed to the EmONC Improvement plan through the procurement of equipment for EmONC services.

In order to support the development of the EmONC Improvement Plan and to meet critical needs for improving maternal health services, in late 2009 GPRHCS provided manual vacuum extractors and fetal heart detectors. All equipment and commodities were distributed to health facilities by the time the implementation of the Improvement Plan began, in line with MoH distribution procedures. Sub-dermal implants (Implanon) were procured by GPRHCS to support the improvement of family planning services through the introduction of a new contraceptive method.[189] Procurement activities to support contraceptive security were planned for 2010, but no request for support was received from MoH.

Judgment criterion 7.3

- Integration of Midwife programme strategic directions in MHTF plans in countries

ICM tools have been integrated into pre-service curricula and training institutions, supported by MHTF. The Cambodian Midwifery Council and Cambodian Midwives Association have the potential for partnership if organizational and management issues can be resolved.

Support to midwifery in Cambodia began with the appointment of a UNFPA midwifery adviser in 2007 to mid-2009. Integration of strategic directions from the Midwifery Programme into the MHTF project portfolio included the following support from MHTF:

- Support for a short-term consultant in 2010 to facilitate the Department of Human Resource Development, MoH to develop a Bachelor Degree in Midwifery, EmONC curricula review based on ICM competencies, and master training (ToT) and coaching of in-service midwives on-site
- Support for the implementation of midwifery training in regional training centers (see judgment criteria 2.1)
- Support for clear roles and functions of Cambodian Midwives Council and Association. Issues around their dependency to external support are still acute (see judgment criteria 2.3)
- Support for the review and update of the National Strategy on Reproductive and Sexual Health to incorporate key findings from the Midwifery Review (2007), monitoring reports of the Midwifery Action Plan (2007-10), key findings on midwifery in the National EmONC Assessment, and integration of midwives' role and responsibilities in the EmONC Improvement Plan. (This activity has been postponed)

Judgment criterion 7.5

- MHTF plans integrate HIV activities in synergy with core funds, Unified Budget and Workplan (UBW) and other resources

In Cambodia the integration of sexual reproductive health/HIV component has been supported by various donors but MHTF has not been involved.

188. UNFPA Cambodia.
189. See judgment criterion 6.3.

Under the National Reproductive Health Programme (NRHP), PMTCT has been part of the integrated Minimum and Complimentary Package of Activities from 2001, supported by JICA and UNICEF. As part of the package, midwives were trained in PMTCT. However, it was noted that the HIV aspect of the package was not functioning systematically.[190] The MoH regards VCT as an important intervention and an entry point for PMTCT, which was expanded from 65 PMTCT sites in 2006 to 98 by 2007. By 2010, PMTCT services reached 921 sites.[191] However, UNFPA has not provided support for PMTCT.

A UN MARP assessment led by UNICEF, with UNFPA UNESCO and WHO as partners, found that reproductive health services are meaningful to most at-risk populations, and that there is a need for primary prevention of pregnancy, i.e. family planning counseling and contraceptive services.[192] These are potential areas for MHTF funding under reproductive health component output two (strengthening capacity).

4.2.8 Evaluation question 8: Leveraging and visibility

Evaluation question 8

To what extent did the MHTF increase the visibility of UNFPA sexual reproductive health/maternal health support and help the organization to leverage additional resources for maternal health at global, regional and national level?

Judgment criteria	Issues to assess
8.2. Effect of MHTF on (increased) external financial commitments to UNFPA/MHTF for maternal health support (at global, regional, country level)	How do programme countries benefit from regional MNH related initiatives (conferences, workshops) supported by MHTF?
	What kind of mechanisms are in place to support programme countries to increase their efforts to leveraging additional resources with external donors (CARMMA, UN SG initiative, especially Canada, France grants, etc)?
	To what extent the MHTF support contributed to an increase in the share of external financial commitments earmarked to support maternal health at country level?
8.3. Effect of MHTF on (increased) financial commitments of partner governments to sexual reproductive health and maternal health	To what extent programme countries governments intended/committed to allocate additional resources for MNH with MHTF support?

Judgment criterion 8.2

- Effect of MHTF on (increased) external financial commitments to UNFPA/MHTF for maternal health support (at global, regional, country level)

The strong presence of UNFPA in the field of maternal health, as well as the discussions initiated for the MHTF launch in Cambodia, led to donor involvement in interventions initially planned with MHTF funds. MHTF support for the participation of national counterparts in international maternal events added to the existing momentum.

190. Interview with government partner (sub-national).
191. National PMTCT programme report.
192. Interview with external development partner.

MHTF resources in 2009-10 were under-utilized due to the impetus created by the country office's strong presence in maternal health and its success in leveraging external funds for MHTF activities. For example, support planned under MHTF for the National EmONC Improvement Plan and Health Equity Fund were funded by AusAID, DfID and HSSP II.

MHTF supported national participation in international and regional technical workshops on reproductive and maternal health and high-level advocacy conferences, for example, the Women Deliver Conference in Washington DC in June 2010. The country delegation included senior parliamentarians, government officials, civil society representatives and the UNFPA Representative. As a result, parliamentarians signed a petition requesting that the First Lady became the national advocate for maternal and child health, which was accepted. In mid-2011, in an effort to implement the Secretary General's Joint Plan of Action for Women and Child Health and at the request of H4+, the UN Country Team also invited the First Lady to become the champion for the Joint Plan of Action.

Judgment criterion 8.3

- Effect of MHTF on (increased) financial commitments of partner governments to sexual reproductive health and maternal health

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MHTF support for the EmONC Improvement Plan, combined with the long-term involvement of UNFPA in maternal health advocacy, has contributed to increased national commitments for maternal health.

UNFPA was able to leverage funding by being an active part of sector plans and HSSP II (40 per cent of funds to maternal health in 2010) and participating in the pool funds, in addition to intensive advocacy at different levels (see MHTE evaluation question 12). National Committee on Population and Development, engagement by parliamentarians, and Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality has led to funds being provided on an ad-hoc basis by the government in response to requests from MoH for extra activities in maternal health. There was a 10 per cent annual increase in 2011 compared to the regular health budget over the previous year, which will be continued until 2015. The extent to which MHTF has contributed to increased commitment for maternal health is clear in the strong support by government and donors to the National EmONC Assessment and EmONC Improvement Plan in Cambodia and MHTF helped to increase national financial commitments to maternal health.

5. Conclusions

Based on the findings on the issues to assess for each of the evaluation questions, the evaluation team has drawn some cross-cutting conclusions which are presented below. These are country-specific conclusions and are not to be confused with the conclusions of the MHTE/MHTF final reports. The conclusions presented in this section are based on the selective analysis of UNFPA maternal health support in Cambodia only, and as such do not provide a judgment on the quality of UNFPA country program in Cambodia overall, which would only be provided by a comprehensive country program evaluation. The conclusions cover the overall maternal health interventions of UNFPA in Cambodia and the specific added value of MHTF in the country.

5.1 Conclusions on UNFPA overall maternal health portfolio in Cambodia

1. UNFPA was able to advance the reproductive and maternal health agenda due to its long experience in Cambodia, which has given the agency a unique position vis-á-vis the government. This position was further consolidated after 2006 through UNFPA contribution to the Health Sector Support Programme II (HSSP II) and the technical leadership role it provided. Maintaining this strong position may be a challenge considering recent turnover in UNFPA staffing[193]

    - Government officials, both at national and sub-national level, have praised UNFPA for its continued and consistent effort in reproductive and maternal health and recognized its contribution to capacity enhancement
    - UNFPA ability to engage closely with MoH and government and its active participation in policy and technical forums has significantly facilitated progress at the policy level. This was possible due to strong leadership and recognition of UNFPA expertise. This strong position was further reinforced by UNFPA participation in the Health Sector Support Programme II, which allowed critical agenda issues to be advanced
    - UNFPA advocacy efforts with high-level officials and parliamentarians have greatly contributed to increased government commitment
    - At the same time, temporarily severe staffing issues have demonstrated the importance of the country office retaining sufficient numbers of well-qualified staff members in order to maintain this influence

2. UNFPA is perceived as being pro-poor in all its related programming and its advocacy efforts. However, addressing all the maternal health issues specifically faced by the poor and vulnerable groups is a remaining challenge[194]

    - UNFPA involvement in the discussions related to the Health Equity Fund in relation to reproductive and maternal health helped to ensure those issues are taken into consideration
    - Increasing the number of midwives in order to deploy them in remote areas as planned in the EmONC Improvement Plan and providing them with incentives as per the Human Resource Development Plan are measures that will ensure greater availability of skilled birth attendance and EmONC for isolated populations
    - Initiatives such as community-based distribution (CBD) of contraceptives and maternity waiting homes (MWH) are important steps towards addressing barriers to access to services linked to distance and remoteness
    - The recent MARP assessment (supported by UNICEF, UNFPA and UNAIDS) has implications for UNFPA if it adopts the finding to jointly address primary prevention of unwanted pregnancy and safe delivery among identified vulnerable groups in already prioritized operational districts and in more in remote/rural areas
    - However, assessing to which extent the above measures will effectively address all the barriers will require close

193. Based on evaluation question 2, 4, 6, 7, 8, 9 and 12.
194. Based on evaluation question 1, 3, 6, and 7.

monitoring. In addition, insufficient analysis of the access barriers to maternal health services may lead to gaps in focusing on appropriate issues

3. Institutional capacity development and training for reproductive and maternal health has formed the core of UNFPA Cambodia support for a number of years. This contribution has been notable in reinforcing the national reproductive health programme and midwifery through increasing numbers of midwives, emphasizing appropriate qualifications and establishing minimum number of midwives in health centers[195]

    - UNFPA (with other partners) has contributed significantly to reinforcing the National Reproductive Health Programme and the National Maternal, Newborn and Child Health Center (NMNCH) as a training centre which has become backbone for reproductive health activities in Cambodia
    - UNPPA inputs for midwifery from 2006 (together with the EmONC Improvement Plan) have been essential for promoting skilled attendance at birth. As a result, the government, thorough HSSP II, plans to scale-up midwifery including in the most remote areas of the country
    - Transparency and accountability issues in recruitment, deployment, placement, retention and quality remain, particularly in rural/remote areas.[196] UNFPA funded the upgrade of curricula but gaps remain in applicability, quality assurance, utilization and follow-up

4. Strategic and multi-sectoral partnerships are key areas for UNFPA. UNFPA has gained experienced in advocacy, policy, monitoring, communicating and profiling within joint partnerships such as HSSP II. However, plans to leave the pooled funding mechanism for administrative reasons may put these achievements at stake[197]

    - UNFPA Cambodia has based its work on priorities defined by the government. As part of the pool fund UNFPA had a strong voice to advocate for reproductive and maternal health agenda and demonstrated legitimacy in these areas
    - Since UNFPA has chosen to leave the pool funding mechanism because of administrative procedures there are some concerns that this strong legitimacy and its influencing power will diminish

5. While UNFPA has been praised for its work in midwifery programming, the EmONC needs assessment, and implementation of the EmONC Improvement Plan, criticism was received in the area of family planning services, which was viewed as an issue that UNFPA has neglected since 2006[198]

    - National Maternal and Child Health Center is over-burdened with many donor requests and the pace of implementation of the EmONC Improvement Plan in 2011 may be slowing down in spite of its adoption by the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality
    - UNFPA has not taken the lead on the challenges to MDG 5 (universal coverage of reproductive health services including family planning), and the difficult issues of quality of care, protocols and quality assurance surrounding family planning services and safe abortion have yet to be addressed
    - The procurement and management of the LMIS remains an outstanding issue. There is no exit strategy or sustainability for continued donor support in the area of contraceptive security

195. Based on evaluation question 4, 6, 7, and 9.
196. External development partner.
197. Based on evaluation question 2, 9, 11 and 12.
198. Based on evaluation question 4, 6 and 7.

5.2 Conclusion on the added value of MHTF in Cambodia

6. The first MHTF initiatives were catalytic as they led to government adoption of some initiatives and other initiatives were taken on by development partners.[199]

   - The Cambodian context is favorable to maternal health with regard to the following policies and strategies: i) The Health Strategic Plan 2008-15 (HSP II); ii) the Health Sector Support Programme II (HSSP II), and; iii) the Fast Track Initiative Road Map on Reducing Maternal and Newborn Mortality. These were all conducive to the introduction of MHTF support
   - MHTF support to training institutions paved the way for other donors to be involved in midwifery education
   - The EmONC Improvement Plan was catalytic in ways that are now included in the Fast Track Initiative Road Map on Reducing Maternal and Newborn Mortality (FTIRM) and funded under HSSP II. In addition, there are topics such as family planning, safe abortion care and quality assurance within FTIRM that are not readily funded by other donors but which may be consistent with MHTF
   - Interventions such as maternity waiting homes initiated by MHTF have been adopted by the government. Their implementation will follow the guidelines that have been developed with MHTF support

7. MHTF has added value to maternal health by its strong focus on the implementation the EmONC Improvement Plan that proved to have catalytic effects[200]

   - Support to the development and the costing of the EmONC Improvement Plan resulted in its inclusion in HSSP II, thus improving the likelihood of sustainability
   - The recruitment of a national specialist to support the EmONC unit in the National Maternal and Child Health Centre helped to strengthen capacities at the central level for the implementation and the monitoring of the EmONC Improvement Plan
   - Strengthening the supervision of the EmONC facilities by the EmONC unit was valuable support to increasing the quality of EmONC services

8. Within the context of existing UNFPA support to midwifery, MHTF contributed to strengthening human resources for maternal health based upon the Midwifery Action Plan through supporting in-service and pre-service midwifery education and advocacy. Nevertheless, ongoing support is still needed to address quality issues[201]

   - MHTF added value to the ongoing Midwifery Programme by upgrading in-service trainings and pre-service curricula based on ICM competencies. This was a strategic entry point to help create an enabling environment for raising the status of the midwifery profession. However, the process was slow, and the ICM integrated curriculum was not fully adapted to the Cambodian context
   - Through supporting training institutions, in partnership with other development partners, MHTF helped to improve the quality of midwifery education although additional inputs are required in the future
   - Support to the Cambodian Midwives Council to develop a Code of Ethics and standards was a useful contributions to improving quality of services
   - Cambodian Midwives Council and Association have been utilized as advocates in events aiming at promoting midwifery and skilled attendance at birth, which complemented UNFPA advocacy interventions at different levels
   - The MHTF Midwifery Adviser was active in 2008 to mid-2009 as a co-ordinator and helped the Midwifery Programme to become established. However, the failure to replace this adviser meant that UNFPA could not maintain its leading role in midwifery

199. Based on evaluation question 1, 2, 4, 5 and 8.
200. Based on evaluation question 2, 4, 5, 6, 8.
201. Based on evaluation question 2, 4, 5, 6.

9. MHTF project portfolio focuses on the poor and disadvantaged as demonstrated by issues such as maternity waiting homes and the Health Equity Fund. Barriers to accessing maternal health services however are not fully addressed

    - MHTF support to maternity waiting homes and interest in the Health Equity Fund demonstrated willingness to address some of the barriers to access to maternal health services
    - However, doubts were expressed on the roll-out of community linkage schemes in the EmONC Improvement Plan, and there are questions about support for the poor and disadvantaged with regard to transportation and user fees

6. Annexes

6.1 Key data of Cambodia

CAMBODIA		
Summary Statastics		
Region	2000	South-eastern Asia
Currency	2008	Riel (KHR)
Surface area (square kilometers)	2008	181035
Population (estimated, 000)	2008	14562
Population density (per square kilometers)	2008	80.4
Largest urban agglomeration (population, 000)	2007	Phnom Penh (1466)
Economic indicators		
GDP: Gross domestic product (million current US$)	2008	11193
GDP: Gross domestic product (million current US$)	2005	6293
GDP: Growth rate at constant 1990 prices (annual %)	2008	6.0
GDP per capita (current US$)	2008	768.6
GNI: Gross national income per capita (current US$)	2008	659.7
Gross fixed capital formation (% of GDP)	2008	21.0
Exchange rates (national currency per US$)	2008	4077.00
Balance of payments, current account (million US$)	2008	-1053

CPI: Consumer price index (2000=100)	2008	126 (Phnom Penh)
Agricultural production index (1999-2001=100)	2008	161
Food production index (1999-2001=100)	2007	163
Unemployment (% of labor force)	2005	7.1*
Employment in industrial sector (% of employed)	2000	8.4*
Employment in agricultural sector (% of employed)	2000	73.7*
Labor force participation, adult female pop. (%)	2008	74.5
Labor force participation, adult male pop. (%)	2008	86.5
Tourist arrivals at national borders (000)	2008	2125
Energy production, primary (000 MT oil equivalent)	2007	4
Telephone subscribers, total (per 100 inhabitants)	2008	29.4
Internet users (per 100 inhabitants)	2008	0.5
Exports (million US$)	2004	2797.5
Imports (million US$)	2004	2062.7
Major trading partners (% of exports)	2004	United States (46.9), China, Hong Kong SAR (22.0), Germany (8.5)
Major trading partners (% of imports)	2004	China, Hong Kong SAR (19.9), China (16.5), Thailand (11.2)
Social indicators		
Population growth rate (avg. annual %)	2005-2010	1.6
Urban population (%)	2007	20.9
Population aged 0-14 years (%)	2009	33.3
Population aged 60+ years (women and men, % of total)	2009	6.9/4.5
Sex ratio (men per 100 women)	2009	95.8

Life expectancy at birth (women and men, years)	2005-2010	62.6/59.0
Infant mortality rate (per 1 000 live births)	2005-2010	62.3
Fertility rate, total (live births per woman)	2005-2010	3.0
Contraceptive prevalence (ages 15-49, %)	2005	40.0
International migrant stock (000 and % of total population)	mid-2010	335.8/2.2 (foreign citizens)
Refugees and others of concern to UNHCR	end-2008	225
Education: Government expenditure (% of GDP)	2005-2008	1.6
Education: Primary-secondary gross enrolment ratio (w/m per 100)	2005-2008	74.7/83.4
Education: Female third-level students (% of total)	2005-2008	34.4
Seats held by women in national parliaments (%)	2009	16.3
Environment		
Threatened species	2009	201
Forested area (% of land area)	2007	56.7
CO2 emission estimates (000 metric tons and metric tons per capita)	2006	4071/0.3
Energy consumption per capita (kilograms oil equivalent)	2007	104.0

Source: UN World Statistics Pocketbook

Figure 2: Map of Cambodia

6.2 Data Triangulation

Table 3: Data and methodological triangulation – Maternal Health Thematic Evaluation

Evaluation question - Maternal Health Thematic Evaluation	Country Office	Nat. Government (MoH)	Sub-national Government	Civil Society	Development Partners	Implementing Partners[202]	Beneficiaries	Data collection methods
1. Relevance	▲ O	▲	▲	▲	▲ O	▲	▲	Document analysis (strategic and planning documents), interviews
2. Harmonization, coordination, partnerships	▲ O	▲ O	▲	▲	▲ O	▲		Document analysis (e.g. joint programmes, documentation of coordination structure), interviews
3. Community involvement and demand orientation	▲ O	▲	▲	▲	▲ O	▲	▲	Document analysis (e.g., Government. strategies), interviews capital, field visit (focus groups, interviews)
4. Capacity development – Human Resources in Health (HRH)	▲ O	▲ O	▲	▲	▲ O	▲		Data and document analysis (strategic documents, needs analyses), interviews, field visits (focus groups, inter views) field visits (focus groups, interviews)
5. Maternal Health in humanitarian contexts	▲	O			O			Interviews, plan document, CERF request
6. Sexual and reproductive health services – family planning	▲ O	▲ O	▲	▲	▲	▲	▲	Data and document analysis, interviews, field visits (focus groups, interviews)
7. Sexual and reproductive health services – EmONC	▲ O	▲ O	▲ O	▲	▲	▲	▲	Data and document analysis (e.g., scale up plan, Annual Work Plans (AWPs)), interviews, field visit (interviews, focus groups)
8. Results/evidence orientation	▲ O	▲ O	▲		▲			Document analysis (monitoring reports, tools), interviews
9. Integrating maternal health in national policies and frameworks	▲ O	▲ O			▲ O			Document analysis (policies and frameworks), interviews
10. Coherence of maternal health support with Gender and Population and Development	▲ O	▲ O	▲		▲			Document analysis (review of AWPs, Country Programme Document (CPD), COARs, interviews
11. Coherence between country, regional, global programmes	▲ O	▲			▲			Document analysis (review of AWPs, Country Programme Document (CPD), COARs, interviews
12. Visibility	▲ O	▲	▲	▲	▲	▲		Interviews, document analysis (visibility tools and strategies)

▲= Primary Sources (Interviews, Focus Groups), O = Secondary Sources (Evaluations, project reports, planning documents, etc.)

202. Other than national Government (in particular the Ministry of Health (MoH)) or sub-national Governments.

Table 4: Data and methodological triangulation – mid-term evaluation of the MHTF

Evaluation question - Maternal Health Thematic Evaluation	Country Office	Nat. Government (MoH)	Sub-national Government	Civil Society	Development Partners	Implementing Partners[203]	Beneficiaries	Data collection methods
1. Relevance	▲ O	▲ O	▲	▲	▲	▲		Document analysis (strategic and planning documents), interviews
2. Capacity Development – HRH	▲ O	▲ O	▲		▲	▲		Document analysis (e.g., curricula, strategic documents), interviews
3. Sexual and reproductive health services – family planning	▲ O	▲ O		▲		▲	▲	Document analysis, interviews capital, field visit (focus groups)
4. Sexual and reproductive health services - EmONC	▲ O	▲ O	▲			▲	▲	Document analysis, interviews, field visits (interviews)
5. Health planning, programming and monitoring	▲ O	▲			▲	▲		Data and document analysis, interviews
6. Management of MHTF	▲ O	▲				▲		Document analysis, interviews
7. Coordination and Coherence	▲ O	▲	▲			▲		Document analysis, interviews
8. Leveraging and Visibility	▲ O	▲	▲	▲	▲	▲		Document analysis, interviews

▲= Primary Sources (Interviews, Focus Groups), O = Secondary Sources (Evaluations, project reports, planning documents, etc.)

203. Other than national government (in particular MoH) or sub-national governments.

6.3 Data collection result matrix

Evaluation question 1 To what extent is UNFPA maternal health support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?	
Judgment criteria	1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/vulnerable groups
	1.3. Needs orientation of planning and design of UNFPA supported interventions
Evaluation question 2 To what extent has UNFPA successfully contributed to the harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?	
Judgment criteria	2.1. Harmonization in maternal health partnerships between UNFPA and United Nations (UN) organizations and World Bank (including H4+ [204]) at global, regional and country level
	2.2. Harmonization of maternal health support through partnerships at country and South-South/ regional
	2.3. UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda

204.UNFPA, UNICEF, World Bank, World Health Organization (WHO), UNAIDS.

Evaluation question 3 To what extent has UNFPA support contributed to a stronger involvement of communities that has helped to increase current levels of demand and utilization of services, in particular through its partnerships with civil society?	
Judgment criteria	3.1. Government commitment to involve communities translated in sexual and reproductive health and maternal health strategies through UNFPA support
	3.2. Civil society organization involvement in sensitization on maternal health issues and facilitating community-based initiatives to address these issues supported by UNFPA
Evaluation question 4 To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal health?	
Judgment criteria	4.1. Development strengthening of national human resources for health policies, plans and frameworks (with UNFPA support)
	4.2. Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual and reproductive health/maternal health needs
Evaluation question 5 To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?	
Judgment criteria	5.1. Inclusion of sexual and reproductive health in emergency preparedness, response and recovery plans
	5.2. Accessibility of quality EmONC, family planning and reproductive health/HIV services in emergency and conflict situations
	5.3. Accessibility to medical products in emergency and conflict situations

Evaluation question 6 To what extent has the UNFPA contributed to the scaling up and increased utilization of and demand for family planning?	
Judgment criteria	6.1.Increased capacity within health system for provision of quality family planning services in UNFPA programme countries
	6.2 Increased demand for and utilization of family planning services in UNFPA partner countries, particularly among vulnerable groups.
	6.3. Improved access to contraceptives (commodity security)
Evaluation question 7 To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and EmONC services in programme countries?	
Judgment criteria	7.1. Increased access to EmONC services
	7.2. Increased utilization of EmONC services
Evaluation question 8 To what extent has UNFPA use of internal and external evidence in strategy development, programming and implementation contributed to the improvement of maternal health in its programme countries?	
Judgment criteria	8.2. Consideration and integration of relevant maternal health/sexual and reproductive health evidence and results data during development of country strategies
	8.3. Results- and evidence based management of individual interventions throughout project life

Evaluation question 9 To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its programme countries?	
Judgment criteria	9.1. UNFPA support improved comprehensiveness of analysis of causes for poor maternal health and of effectiveness of past maternal health policies/strategies
	9.2. Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process
	9.3. Monitoring and evaluation of implementation of sexual and reproductive/maternal health components of national policy framework and development instruments
Evaluation question 10 To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other programme areas?[205]	
Judgment criteria	10.1. Linkages established between programmes (reproductive health with gender and population and development) in intervention design
	10.2. Integration of monitoring and reporting of UNFPA operations

205. Gender (including female genital mutilation/cutting, gender-based violence, HIV-PMTCT (prevention of mother-to-child HIV transmission), population and development.

Evaluation question 11 To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?	
Judgment criteria	11.1. Clarity of division of labor and delineation of responsibilities between UNFPA global, regional and country offices
	11.2. Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities
	11.3. Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level
Evaluation question 12 To what extent did UNFPA maternal health support contribute to the visibility of UNFPA in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?	
Judgment criteria	12.2. UNFPA leadership of maternal health advocacy campaigns at national level
	12.3. Increased financial commitments of partner governments to sexual reproductive health and maternal health

Overview evaluation questions MHTF	
Evaluation question 1 To what extent is MHTF support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?	
Judgment criteria	1.1. MHTF countries selection processes support the role of MHTF as strategic instrument to improve maternal health among the most vulnerable populations
	1.2. MHTF supported national assessments yield sufficient and disaggregated data for needs orientation planning, programming and monitoring targeting the most vulnerable groups (including underserved groups)
	1.3. National policies and sub national level sexual reproductive health/maternal health planning and programming priorities the most vulnerable groups and underserved areas
Evaluation question 2 To what extent has the MHTF contributed towards strengthening human resources planning and availability (particularly midwives) for maternal health and newborn health?	
Judgment criteria	2.1. Partner countries midwifery education upgraded based upon International Confederation of Midwives (ICM) essential competencies through MHTF support
	2.2. Strategies and policies developed to ensure the quality of midwifery services provision in partner countries through MHTF support
	2.3. Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support

Evaluation question 3 To what extent has the MHTF contributed towards scaling-up and increased access and use of family planning?	
Judgment criteria	3.1. Creation of enabling environment to facilitate scale-up of quality family planning services in priority countries through MHTF support
	3.2. Demand increased for family planning services in MHTF priority countries, particularly among the vulnerable groups, through MHTF support.
Evaluation question 4 To what extent has the MHTF contributed towards scaling-up and utilization of EmONC services in priority countries?	
Judgment criteria	4.1. Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support
	4.2. Utilization and access of EmONC services improved through MHTF support
Evaluation question 5 To what extent has the MHTF contributed to improve planning, programming and monitoring to ensure that maternal and reproductive health are priority areas in partner countries?	
Judgment criteria	5.1. Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support
	5.2. National plans consider sustainable funding mechanisms for sexual and reproductive health/maternal health through MHTF support
	5.3. National and sub-national health plans include clear monitoring and evaluation frameworks for family planning, skilled care in pregnancy and child birth, EmONC, obstetric fistula and reproductive health/HIV linkages

Evaluation question 6 To what extent have the MHTF management mechanisms and internal coordination processes at all levels (global, regional and countries) contributed to the overall performance of the MHTF in fulfilling its mission?	
Judgment criteria	6.2. Instruments and mechanisms developed by the MHTF to strengthen country office capacities to manage the fund at global and regional level 6.3. Monitoring and evaluation of the MHTF supported proposals including financial monitoring
	6.3. Monitoring and evaluation of the MHTF supported proposals including financial monitoring
Evaluation question 7 To what extent has the MHTF enhanced and taken advantage of synergies with other UNFPA thematic funds e.g. the Global Programme on Reproductive Health Commodity Security (GPRHCS), the Campaign to End Fistula, the UNFPA-ICM [206] Midwives Programme and HIV-PMTCT [207] in order to support maternal health improvements?	
Judgment criteria	7.1. Integration of the components of the Campaign to End Fistula into maternal health programmes after the integration in MHTF
	7.2. Joint and coordinated planning at country level with GPRHCS
	7.3.Integration of Midwives Programme strategic directions in MHTF plans in countries
	7.5. MHTF plans integrate HIV activities in synergy with core funds, Unified Budget and Work plan (UBW) and other resources

206. International Confederation of Midwives.
207. Preventing Mother-to-Child Transmission.

Evaluation question 8 To what extent did the MHTF increase the visibility of UNFPA sexual and reproductive health/maternal health support and help the organization to leverage additional resources for maternal health at global, regional and national level?	
Judgment criteria	8.2. Effect of MHTF on (increased) external financial commitments to UNFPA/MHTF for maternal health support (at global, regional, country level)
	8.3. Effect of MHTF on (increased) financial commitments of partner governments to sexual and reproductive health/maternal health

6.4 Focus Group report template

FOCUS GROUP	Evaluation team member		Date
	Topic/issues to be addressed	Place	
Participants (type, number, etc.)			
Issues discussed			
Findings			
Other Observations by evaluator			

6.5 List of documents consulted

Title	Year	Type of Document
AGEG, Dorei Research and Consulting: Health Sector Support Project 1 End of Project Assessment	2010	Assessment Report
Background for Launchers: The State of World Population 2009: Facing a changing world on Women, Population and Climate	2009	Report
BANK-UNDP: Technical Briefing Note on Child and Maternal Mortality Estimates	2011	Report
Cambodia Council of Ministers: Rectangular Strategy for Growth, Employment, Equity and Efficiency Phase II	2008	Strategic Document
Cambodia Health Education and Media Services (CHEMS): FINAL PROGRESS REPORT-Support for Cambodia MDG five: Improve Maternal Health	2010	Report
Cambodia Health Education Media Service: Knowledge, Attitudes and Perceptions 2010- End line Study for Improving Maternal Health through Behavior Change Communications	2010	Evaluation Report
Cambodia Health Education Media Service: Knowledge, Attitudes and Perceptions 2008- Baseline Study for Improving Maternal Health through Behavior Change Communications	2008	Evaluation Report
Cambodia Midwives Council: Strategic Plan 2010-2015 for Midwives Council	2010	Planning Document
Cambodian Rehabilitation and Development Board of the Council for the Development of Cambodia: The Cambodia AID Effectiveness Report 2010	2010	Report
Claes Örtendahl, Martine Donoghue, Mark Pearson, Catharine Taylor, Joseph Lau: Health Sector Review 2003-2007 in Cambodia	2007	Evaluation Report
Department of Information Cooperation: Report on External Assistance to Health Sector 2007-2009	2008	Report
DFID, UNFPA, and World Bank: AIDE MEMOIRE-Cambodia Health Sector Support Project, Joint Review Mission	2009	Review Report
Dorei Research and Consultant: Health Facilities Assessment	2010	Assessment Report
Dorei Research and Consultant: HSSP End-of-Project Evaluation: Health Equity Household Survey 2010	2010	Evaluation Report

Human Resource Department, Ministry of Health: First Biennial Review of the Health Workforce Development Plan 1996-2005	1999	Review Report
Human Resource Department, Ministry of Health: Needs Assessment of Cambodian Public Midwifery Training Institutes and Clinical Practice Sites	2010	Needs Assessment Report
Human Resource Department, Ministry of Health: Second National Health Workforce Development Plan 2006-2015	2006	Planning Document
JSI : Evaluation of the UNFPA Reproductive Health, Birth Spacing and Sexual Health Project	2000	Report
Ministry of Education, Youth and Sport: Mid-Term Review Report of the Education Strategic Plan and Education Sector Support Programme 2006-2010 implementation.	2009	Planning Document
Ministry of Education, Youth and Sport : Policy for Life Skills Education	2006	Strategic Document
Ministry of Health : Cambodia EmONC Improvement Plan 2010-2015	2009	Strategic Document
Ministry of Health : Health Sector Strategic Plan 2003-2007 and Health Sector Support Project 2003-2007	2005	Strategic Document
Ministry of Health : Mid Term Review Report Health Sector Support Project 2003-2006	2006	Report
Ministry of Health : National Strategy for Reproductive and Sexual Health in Cambodia 2006-2010	2008	Strategic Document
Ministry of Health : National Strategy for Reproductive and Sexual Health in Cambodia 2006-2010	2008	Strategic Document
Ministry of Health: Complementary package of activities: Guidelines for the Referral Hospital for 2003-2007	2003	Guideline Document
Ministry of Health: Guidelines on Minimum Package of Activities for Health Center Development 2008- 2015	2007	Guideline Document
Ministry of Health: Health Sector Strategic Plan 2003-2007	2002	Planning Document
Ministry of Health: Health Sector Support Programme I	2010	Report
Ministry of Health: Health Strategic Plan 2008-15: Accountability Efficiency Quality Equity	2008	Strategic Plan document
Ministry of Health: National Guidelines on Complementary Package of Activities for Referral Hospital Development 2006- 2010	2006	Guideline Document

Ministry of Health: Second Health Sector Support Programme, 2009-13: 2010 Annual Performance Monitoring Report	2011	Monitoring Report
Ministry of Health: Second Health Sector Support Programme, 2009-13: 2009 Annual Performance Monitoring Report	2010	Monitoring Report
Ministry of Health: Second Health Sector Support Programme, 2009-13: Operational Manual	2008	Operational Manual document
Ministry of Health: Terms of Reference for the Reproductive, Maternal, Newborn and Child Health Task Force	2011	Task Force document
Ministry of Interior: Commune Committee for Women and Children Capacity Assessment	2009	Report
Ministry of Planning/UNFPA : National Population Policy	2005	Report
Ministry of Planning/UNFPA : National Population Policy	2003	Report
Ministry of Planning: Achieving Cambodia Millennium Development Goals	2010	Report
Ministry of Planning: Achieving Cambodia Millennium Development Goals	2005	Report
Ministry of Planning: Cambodia Population Census 1998	2002	Report
Ministry of Planning: Cambodia Population Census 2008	2009	Report
Ministry of Planning: Cambodia Millennium Development Goals	2003	Report
Ministry of Women and Veteran Affairs: Promoting Gender Equality in Reproductive Health: Best Practices and Lessons Learned		Report
Ministry of Women Affaire: Executive Summary of Cambodia Gender Assessment: A Fair Share for Women	2008	Report
Ministry of Women Affaire: Cambodia Gender Assessment: A Fair Share for Women	2008	Assessment Report
Ministry of Women Affairs: Neary Rattanak II- Five Year Strategic Plan 2005 - 2009	2004	Planning Document
Ministry of Women and Veteran Affairs /UNFPA : Annual Report Gender/Reproductive Health Advocacy Project CMB/02/PO6	2003	Report
Ministry of Health: Fast Track Initiative- Road Map for Reducing Maternal & Newborn Mortality	2010	Strategic Document

National Committee for Population and Development, Council of Ministers: Cambodia National Population Policy Review Report 2010	2010	Policy Document
National Committee for Population and Development, Council of Ministers: Reference Tool, National Population Policy.	2010	Policy Document
National Institute of Public Health, Ministry of Health: National Emergency Obstetric and New born Care Assessment	2009	Report
National Institute of Statistics, Ministry of Planning: Cambodia Demographic and Health Survey 2010	2011	Survey documents
National Institute of Statistics, Ministry Planning: Cambodia Demographic and Health Survey 2010	2011	Evaluation Report
National Institute of Statistics, Ministry Planning: Cambodia Demographic and Health Survey 2005	2006	Evaluation Report
National Institute of Statistics, Ministry Planning: Cambodia Demographic and Health Survey 2000	2001	Evaluation Report
National Reproductive Health Programme: Reproductive Health Costing 2006-2015	2007	Planning Document
National Reproductive Health Programme: National Strategy for Reproductive and Sexual Health in Cambodia 2006-2010	2006	Strategic Plan Document
Nhem Sothun, Ly Sensonlyla and Mariolein Coren: Cambodia at a Glance: Population, Gender and Reproductive Health	2005	Evaluation Report
Ralph Hakkert, UNFPA-Cambodia: Population and Development Branch Technical Division, Questions and Answers on the Estimation of Maternal Mortality: An Updated Technical Note	2011	Report
Royal Government of Cambodia: National Strategic Development Plan Updated 2009-2013	2010	Strategic Plan Document
Safiye Cagar, UNFPA-Cambodia: Them for World Population Day (WPD)	2007	Report
Second Health Sector Support Programme II: Obstacles to deliveries by trained health Providers to Cambodian Rural women	2006	Report
Secretariat of National Committee for Population and Development, Council of Ministers: National Population Police : Reference Tool	2010	Policy Document
Secretariat of National Committee for Population and Development, Council of Ministers: National Population Police--Reference Tool	2007	Policy Document

The Cambodian Rehabilitation and Development Board of the Council for the Development of Cambodia: The Cambodia AID Effectiveness Report 2010	2010	Report
The National Statistical System in Cambodia: Annual Report 2010	2011	Report
Thung Rathavy : Maternal Mortality in Cambodia	2010	Presentation
UNFPA : Minutes of the Mid Term Review Meeting of UNFPA Third Country Programme of Assistance to the Royal Government of Cambodia (2006 – 2010)	2008	Minutes
UNFPA : Preliminary Progress Report Support for Cambodia MDG five: Improve Maternal Health	2009	Report
UNFPA Cambodia: Communications and External Relations Strategic Plan, January-December 2010	2009	Strategic Plan Report
UNFPA Cambodia: Communications and External Relations Strategic Plan, January-December 2009	2008	Strategic Plan Report
UNFPA Cambodia: Communications and External Relations Strategic Plan, January-December 2008	2008	Strategic Plan Report
UNFPA Cambodia: Communications and External Relations Strategic Plan, January-December 2007	2007	Strategic Plan Report
UNFPA Cambodia: Communications and External Relations Strategic Plan, January-December 2006	2006	Strategic Plan Report
UNFPA Cambodia: Country Programme IV, 2011-2015: Communications and Advocacy Strategic Plan	2011	Strategic Plan Report
UNFPA Cambodia: Talking Points for the Roundtable Discussion on the World Population Days: Maternal Health	2011	Report
UNFPA Cambodia: Talking Points on the World Population Day 2010	2010	Report
UNFPA : Annual Report UNFPA Supported Birth Space/Safe Motherhood Project CMB/01/PO2	2001	Report
UNFPA : Cambodia at a Glance	2005	Report
UNFPA : Maternal Health Thematic Fund – 2009 Budget Revision	2009	Report
UNFPA : Maternal Health Thematic Fund Cambodia	2009	Report
UNFPA : Mid Term Review National Reproductive Health Programme	2008	Report
UNFPA : Mid Term Review Report 2006-2010	2008	Report

UNFPA : Project Document Birth Spacing/Safe Motherhood 2001-2003	2001	Strategic Document
UNFPA : Project Document Birth Spacing/Safe Motherhood 2004-2005	2004	Strategic Document
UNFPA : Report on the Review of Adolescent/Youth Friendly Sexual & Reproductive Health Services in Cambodia	2006	Report
UNFPA : Review Annual Reports 2009/AWP 2010	2010	Report
UNFPA : Sub-Programme Reproductive Health	2001	Strategic Document
UNFPA : The Cambodia Country Brief	2003	Report
UNFPA : Updated Planned activities and required budget for 2010 - Reproductive Health Component	2010	Strategic Document
UNFPA-Cambodia: Briefing Kit.	2009	Programme Document
UNFPA-Cambodia: Country Programme Action Plan 2011-15 for Programme of Cooperation between The Royal Government of Cambodia and United Nations Population Fund	2011	Action Plan document
UNFPA-Cambodia: Second Health Sector Support Programme II/UNFPA 2010 AWP Budget Revision	2010	Budget Review Report
UNFPA-Cambodia: UNFPA and the 2008 Population Census of Cambodia"	2008	Report
United Nation in Cambodia: Cambodia Common Country Assessment 2009	2010	Assessment Report
United Nation in Cambodia: United Nations Development Assistance Framework 2011-2015	2010	Framework document
United Nation: Country programme document for Cambodia	2005	Programme Document
United Nation: Final Country programme document for Cambodia	2010	Programme Document
United Nation: HIV/AIDS Joint Support Programme and Operational Plan and Budget 2011-2015	2011	Operational Plan document
United Nations in Cambodia: United Nations Development Assistance Framework 2006-2010	2005	Framework Document
United Nations : Situation Analysis of Youth in Cambodia	2009	Report
Annual Work Plans (AWP)		
Annual Work Plan : MHTF	2010	Strategic Document

Annual Work Plan : UNFPA Support to Reproductive and Maternal Health Priorities of the Ministry of Health Annual Operational Plans through the Health Sector Support Programme II (HSSP2)	2009-2010	Strategic Document
Annual Work Plan : UNFPA Support to Reproductive Health Component of Health Sector Support Project (HSSP)	2006-2008	Strategic Document
Annual Work Plan: Communication	2008-2010	Strategic Document
Annual Work Plan: Reproductive Health- RHAC, CARE, and PFD	2007-2009	Strategic Document
Annual Work Plan: Reproductive Health-Cambodia Health Education Media Service	2008-2010	Strategic Document
Annual Work Plan: Reproductive Health- Khmer Youth Association	2006-2011	Strategic Document
Annual Work Plan: Reproductive Health-Ministry of Education, Youth, and Sports/Inter Departmental committee for HIV/AIDS	2006-2011	Strategic Document
Annual Work Plan: Gender	2006-2011	Strategic Document
Annual Work Plan: Ministry of Health	2006-2011	Strategic Document
Annual Work Plan: Population and Development-DoLA	2006-2011	Strategic Document
Annual Work Plan: Population and Development-Ministry of Planning	2006-2011	Strategic Document
Annual Work Plan: Population and Development-National Committee for Population and Development	2006-2011	Strategic Document
UNFPA Key Documents (COAR, CPAP, CPD)		
UNFPA : Country Office Annual Report (COAR)	2004-2010	Strategic Document
UNFPA : Country Programme Action Plan (CPAP)	2001-2005, 2006-2010, 2011-2015	Strategic Document
UNFPA : Country Programme Documents (CPD)	1997-2000, 2001-2005, 2006-2010, 2011-2015	Strategic Document

6.6 List of people interviewed

Organization/Unit	Name	Position
ArLaeng Village, Chrey Bak commune, Kampong Chhnang District, Kampong Chhnang province	Ms Pao Chuom	Women in the community (18)
AUSAID	Ms Chi Socheat	Health Advisors
Council of Ministers, National Committee for Population and Development (NCPD)	HE. Katika Chamroeun Dr. Maneth Nhem	Under Secretary General Head of Training Department
Health Center Chrey Bak, Chrey Bak commune, Kampong Chhnang District, Kampong Chhnang province	Mr. Sokun Meas Ms. Sothear Rath Ms. Sothear Rath Kong Mr. Leng Channe Ms Chhum Pao Mr. Yoeum Keo Mr. Im Koeun Mr. Piny Phuok Ms. Sao Sambor	Head of health center Vice head of health center Health center staff Commune Chief, and health staff of health center Health Center Management team and Women and children focal point
Hospital of National Maternal and Child Health Center	Ms. Thavy Heing Ms. Sophornnary Say Ms. Bou Rum Bun	Chief of OPD and Midwives of national maternal and child health center hospital
Kampong Thkov Health Center, Kralanh district, Siem Reap Province	Mr. Muong Lay Ms. Hearn Hoeun	Head of Health Center Commune Based Distribution (CBD)
Khmer Youth Association (KYA)	Ms. Chansen Sun Mr. Kosal Phan Pheab	President of KYA Project Coordinator
Kralanh Operation District, Siem Reap Province	Dr. Siravuth Long Ms. Neary Reak Duong	Director of Operational District Director of maternal and child health of Operational District
MARIE STOPES INTERNATIONAL (MSI)	Ms. Che Katz, Dr. Antoinette Pirie Mr. Thou Chum Ms. Socheat Chhoeur Mr. Lan Mao	Programme director Health Advisor Director Grants EC Project Manager USAID Project Manager

Ministry of Health	Prof. Huot Eng	Secretary of State, Director of Health Sector Support Project
Ministry of Health	Dr. Sokhan Chhoung	Vice Rector of department of Drug and Food (DDF)
Ministry of Health /Department of Human Resource and Development (HRD)	Dr. Sam Song Phom	Deputy Director of HRD
Ministry of Health, Health Sector Support Programme 2009-13 (HSSP2)	Dr. Veasan Kiri Lo	Programme Coordinator of HSSP2
Ministry of Health, Personnel Department (PD)	Mr. Sambor May/ Dr. Sary Vannark Oeng Dr. Sony Lay	Director/Deputy Director of PD Head of staff management unit
Ministry of Health/Cambodia Midwives Council (CMC)	Mrs. RadaIng Mr. Pros Nguon	President of CMC
Ministry of Health/Department of International Cooperation (DIC)	Dr. Or Vandine	Director of DIC
Ministry of Interior	Mr. Malyna Yin Mr. Meng Sean Yam Mr. Sopheak Say	Director, deputy director, and officer of Department of local administration
Ministry of Planning	HE. Sy Than San	Director general of National Institute of Statistics
Ministry of Women Affairs	Ms. Nirmita Hou Ms. Danine Sengphal Mr. Hak Chhun The	Director of women and health department HIV technical officer of women and health department Deputy director of women and health department
National Center for Health Promotion, Ministry of Health	Ms. Sokun Ouk	Deputy Chief of Technical Bureau of National Center for Health Promotion
National Maternal and Child Health Center	Prof. Rathavy Tung	Deputy Director of national maternal and child health center and National Reproductive Health Programme Manager
National maternal and child health Center, JICA Project	Ms. Yasuyo Osanai	Chief Advisor

Parliamentary Commission	H.E. Damry Ouk Mr. Vannak Heng	Secretary-general and 6thCommission National Assembly Programme Coordinator
Provincial Health Department (PHD) of Siem Reap	Dr. Kheng Darasy	Deputy of maternal and child health Midwife
Provincial health department of Kampong Chhnang province	Ms. Sam Maly	Chief of maternal and child health
Provincial hospital of Kampong Chhnang province	Dr. Tirathany Sorin	Director of provincial hospital
PSI	Mr. Sokun Sok	Deputy Country Representative
PSI	Ms. Yasmin Madan	Country Representative
Regional Training Center (RTC) (for Midwifery training), Battambang Province	Mr. Chhor Vaeng Ouk, Mr. Sophea Meak Ms. Channary Moeung	Deputy of RTC Head of administration Head of training unit
Regional Training Center (RTC) (for Midwifery training), Battambang Province	Ms. Ladar Kiev	Teacher and Students
Reproductive and Child Health Alliance (RACHA)	Ms. Chan Theary Dr. Sun Nasy	Executive Director Programme Implementation Advisor
The World Bank, Cambodia country office	Mr. Timothy A Johnston	Senior Health Specialist
UN Resident Coordinator, UNDP	Ms Ann Lund	Senior UN Coordination Specialist
UNAIDS	Mr. Tony Lisle	Country Coordinator
UNFPA Country Office	Dr. Marc Derveeuw	Representative
UNFPA Country Office	Ms. Sarah Knibbs	Deputy Representative
UNFPA Country Office	Mr. Tum May	Assistant Representative
UNFPA Country Office	Mr. Pon Rieng	Finance Associate

UNFPA Country Office	Mr. Muong Sopha	Programme Associate-EmONC, UNFPA Country Office
UNFPA Country Office	Dr.Vandara Chong	National Programme Officer Youth sexual reproductive health and HIV
UNFPA Country Office	Ms. Sophanara Pen	Communications Associate
UNFPA Country Office	Ms. Sochea Sam	National Officer of maternal and child health
UNFPA Country Office	Mr. Yi Soktha	National Officer of Population and Development
UNFPA Country Office	Dr. Marc Derveeuw,	Representative
UNFPA Country Office	Dr. Sathiarany Vong	reproductive health Specialist
UNICEF/ Cambodia	Ms. Viorica Berdaz	Chief of Health and Nutrition
USAID/ Cambodia	Dr. Sophea Narith Sek	Development Assistance Specialist
WHO	Ms. Ann Robins	Human Resource of WHO
WHO	Dr. Howard Sobel	Team Leader of maternal and child health

6.7 Overview of UNFPA interventions in Cambodia (2006-2010)

Annual Work Plans (AWP)		
Programme name	**Year of expenditure**	**Volume in US$**
Reproductive Health Component	2010	628,400
Reproductive Health Component	2010	628,400
UNFPA Support to Reproductive Health Component of Health Sector Support Project II (HSSP II), Ministry of Health	2010	3,501,971
UNFPA Support to Reproductive Health Component of Health Sector Support Project II (HSSP II), Ministry of Health	2009	4,968,682
UNFPA Support to Reproductive Health Component of Health Sector Support Project (HSSP), Ministry of Health	2008	1,795,350
UNFPA Support to Reproductive Health Component of Health Sector Support Project (HSSP), Ministry of Health	2007	1,221,000
UNFPA Support to Reproductive Health Component of Health Sector Support Project (HSSP), Ministry of Health	2006	833,000

Note: These are not necessarily complete expenditures for the mentioned period, but just an indicative overview about the activities based on available AWPs.

Source: Annual Work Plans Cambodia

Table 5: UNFPA interventions in Cambodia 2004-2010

Programme name	Sectors/Issues Addressed	Time Period	Volume in US$ (paid in time period)
ARH	ARH	2004 - 2006	8,518
BCC Intervention		2008 - 2010	617,382
Birth Spacing/Safe Motherhood	maternal health		2,685,574
Cambodia BSB Management	Management	2008 - 2010	1,610,892
		2006 - 2008	425,639
		2006 - 2008	103,229
Gender /reproductive health Advocacy	Gender, reproductive health	2004 - 2005	92,065
Gender Mainstreaming and Advocacy	Gender	2004 - 2006	188,635
Health Sector Support Project	reproductive health		4,219,531
HSSP	reproductive health	2008 - 2010	3,042,473
IEC/BCC Interventions		2004	3,996
Improving Data in the NIS	Data	2004 - 2006	948,962
Increased Access to High Quality RHS	RHS Access	2006 - 2008	762,354
Increased Awareness of Women	Gender, Awareness	2006 - 2008	980,591
Intensified Response to HIV/ AIDS Prevention	HIV/AIDS	2006 - 2008	79,473
Intensified Response to HIV/ AIDS Prevention	HIV/AIDS	2008 - 2010	192,212
Promote Gender Equality	Gender		1,055,529

Reproductive Health Project	reproductive health	2004 - 2006	379,085
Strengthening the MoWA in reproductive health	reproductive health	2004 - 2005	31
Strengthened Capacity	Capacity Building	2006 - 2008	672,325
Strengthened National and Local Capacities	Capacity Building	2006 - 2008	873,996
Strengthened National Capacity	Capacity Building	2006 - 2008	406,878
Support to D&D			864,807
Support to LSHE			1,040,493
Support to Population Census 2	Population, Data	2008 - 2010	4,074,789
Thematic Trust Funds for RHCS	RHCS	2006	6,775
UNFPA Support to Young People	Adolescents		526,982
YFSRH and HIV/AIDS	reproductive health, HIV/AIDS		190,321
Total			26,053,551

Source: ATLAS data