



**Evaluation of the UNFPA Sixth Country Programme of Assistance
to the Royal Government of Cambodia CP6 (2019-2023)**

**Final Report
Country Programme Evaluation (CPE)**

April 10, 2023

Cambodia Country Map



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Abbreviations and Acronyms

APRO	UNFPA Asia and Pacific Regional Office
ADM	Associate Degree of Midwifery
AFHS	Adolescent Friendly Health Services
AY	Adolescents and Youth
AYFS	Adolescent Youth Friendly Service
BSM	Bachelor of Science in Midwifery
CCWC	Commune Council for Women and Children
CO	Country office
CDHS	Cambodia Demographic and Health Survey
CP	Country programme
CP6	6th Country Programme
CPAP	Country programme action plan
CPD	Country programme document
CPE	Country programme evaluation
CSE	Comprehensive Sexual Education
DSA	Daily subsistence allowance
EmONC	Emergency Obstetrics and Neonatal Care
EQA	Evaluation quality assessment
EQAA	Evaluation quality assurance and assessment
ERG	Evaluation reference group
ET	Evaluation Team
GBV	Gender-based violence
GDP	Gross Domestic Product
GE	Gender Equality
HC	Health Center
HCMC	Health Center Management Committee
HCT	Humanitarian Country Team
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
M&E	Monitoring and evaluation
IECM	Information Education Communication Materials
ILO	International Labour Organization
LNOB	Leaving No One Behind
LSE	Life Skills Education
MDT	Multidisciplinary Team
MDG	Millennium Development Goal
MIC	Middle Income Countries
MISP	Minimum Initial Services Package
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MTR	Mid-term Review
MoEYS	Ministry of Education, Youth and Sport
MoWA	Ministry of Women's Affairs
NAPVAW	National Action Plan on Violence Against Women
NCCT	National Committee for Counter Trafficking
NGOs	Non-Governmental Organisations
NIS	National Institute of Statistics

NMCHC	National Maternal and Child Health Center
NSDP	National Strategic Development Plan
OECD/DAC	Organisation for Economic Cooperation and Development/Development Assistance Committee
ODA	Official Development Assistance
OSSC	One-Stop Service Centre
PO	Programme Officer
PD	Population Dynamics
PWD	Persons with Disabilities
PLHIV	People Living with HIV
PSEA	Prevention of Sexual Exploitation and Abuse
RG	Results Group
RRF	Results and Resources Framework
RBM	Results-based Management
RH	Reproductive Health
RHAC	Reproductive Health Association of Cambodia
RMNCH+A	Reproductive, Maternal, Newborn and Child Health + Adolescents
RGC	Royal Government of Cambodia
RTC	Regional Training Center
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-based Violence
SOGIE	Sexual Orientation, Gender Identity & Expression
SP	Strategic Plan
SPR	Standard Progress Report
SRH	Sexual and Reproductive Health
SRHR	Sexual and reproductive health and rights
SRMH	Sexual Reproductive and Maternal Health
SRMNAH	Sexual, Reproductive, and Maternal, Newborn and Adolescent Health
SSTC	South-South and Triangular Cooperation
STD	Sexual Transmitted Diseases
STI	Sexual Transmitted Infection
TA	Technical Assistance
TL	Team Leader
ToC	Theory of Change
TOR	Terms of Reference
TPO	Transcultural Psychological Service Organization
TSMC	Technical School of Medical Care
TWG	Technical Working Group
UBRAF	United Budget, Results and Accountability Framework
UHC	Universal Health Coverage
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund

UPR	Universal Periodic Review
VAWG	Violence Against Women and Girls
WHO	World Health Organization
WP	Work Plan

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5. Evaluation Matrix
6. Data Collection Tools

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Box 1. Structure of the Cambodia Country Programme Evaluation (CPE) Report

This report comprises an executive summary, six chapters, and annexes and follows the structure recommended in the evaluation handbook by the UNFPA Independent Evaluation Office.

Chapter 1, the **Introduction**, provides the background to the evaluation, objectives and scope, the methodology used, and the evaluation process including the limitations encountered. The **second chapter** describes the Cambodian country context, and the development challenges it faces in the UNFPA mandated areas. The **third chapter** refers to the response of the UN system and then leads on to the specific response of UNFPA through its country programme to the national challenges faced by the country in the areas of sexual and reproductive health and rights, health response to GBV, adolescents and youth, population change and data, gender equality and women's empowerment, including GBV/DV. The **fourth chapter** presents the findings for each of the evaluations question specified in the evaluation matrix (which is annexed); the **fifth chapter** discusses conclusions, and the **sixth chapter** concludes with strategic and programmatic level recommendations based on the conclusions.

Part 1 Annexes 1-6 contain the obligatory documents for CPE (terms of Reference, list of persons met, stakeholders map, list of documents consulted, and evaluation matrix and data collection tools). Part2 Annex contains additional information related to the report.

TABLE 1: KEY FACTS**Key Facts Table**

Indicator	Value	Source of information
Geographical Location	Cambodia is located in South East Asia neighboring to Lao, Vietnam and Thailand.	
Land Area	181 035 km ²	http://www.ccop.or.th/epf/cambodia/cambodia_profile
People		
Population	15,552,211	Census Data 2019
Urban Population	6,135,194	Census Data 2019
Total Fertility Rate	2.5	Census Data 2019
Type of government		
Type of government	Cambodia is a constitutional monarchy country with parliamentary democracy governed by prime minister. (http://www.ccop.or.th/epf/cambodia/cambodia_profile)	
% of seats held by women in national parliament (2021)	22%	World Bank Indicators, Accessed, 2023
Currency		
Currency	Riels	
GDP per capita (2021)	1625.2 US\$	World Bank Indicators, Accessed, 2023
GDP Growth rates (2021)	3%	World Bank Indicators, Accessed, 2023
Social indicators		
Human Development Index (2021) Rank (2021)	0.593 146 of 191 countries	UNDP, 2022
Gender Inequality Index (2021) Rank (2021)	0.461 116 of 191 countries	UNDP, 2022
Gender Development Index (2021)	0.926	UNDP, 2022
Gender Parity in Tertiary Education (GPI) (2021)	1.03	World Bank Indicators, Accessed, 2023
Adult Literacy Rate (15+ years) (2008-2019)	87.7% (total) 84.8% (female) 90.9% (male)	Census, 2019
Sex ratio at Birth (2008-2019)	1054 females per 1000 males at birth	Census, 2019
Child sex ratio (0-6 years)	998 females per 1000 males in the age group 0-6 years	Census, 2019
Poverty Rate- Proportion of population living below the National Poverty Line	17.8%	Asian Development Bank, Accessed 2023

(2019)		
Unemployment Rate (2021)	0.6%	World Bank Indicators, Accessed, 2023
Health expenditure (%of GDP) 2019	6.99	World Bank Indicators, Accessed, 2023
Life Expectancy at Birth (2019)	Women - 76.8 Men – 74.3	Census, 2019
Maternal Mortality Ratio (per 100,000 live births) (2020)	154	CDHS, 2021-22
Under-5 Mortality (per 1000 live births) (2019)	28	Census, 2019
Neonatal Mortality Rate (per 1000 live births) (2020)	12.831	UNICEF, Data Warehouse, Accessed 2023
% of births attended by skilled health personnel. (2020)	99%	CDHS, 2021-22
% of pregnant women received Antenatal Care 4+ ANC (2020)	86%	CDHS, 2021-22
Percent of births delivered by C-section (2009-2014)	6.3%	WHO Data Repository, Accessed 2023
Adolescent birth rate (15-19 years)	9.1	Census, 2019
Teenage pregnancy and motherhood	9% and 7%	CDHS, 2021-22
Contraceptive Prevalence Rate modern methods	45%	CDHS, 2021-22
Unmet need for family planning	11.8 %	CDHS, 2021-22
Prevalence of HIV, total (% of population ages 15-49) (2021)	0.6%	UNAIDS Global Report 2022
Ever married women 15-49 years who have experienced spousal violence (2014)	30.8%	CDHS 2014 Ending Violence against Women and Children in Cambodia.pdf (unicef.org)
Women aged 20-24 married before 18 years	19%	CDHS 2014

Executive summary

Overview

UNFPA in partnership with the Royal Government of Cambodia (RGC) implemented an external independent evaluation of its sixth Country Programme (CP6) 2019-2023 keeping in line with the United Nations Evaluation Group (UNEG) Norms and Standards, code of conduct and ethical guidelines, UNEG guidance on gender-and human rights-responsive evaluations, and international best practices in evaluation. With an amount of \$13 million, CP6 has \$8.3 million from regular resources and \$4.7 million planned from other resources. Adhering to the United Nations Population Fund (UNFPA) Evaluation Policy, this country programme evaluation (CPE) was conducted in 2022 (July to December) by a four member independent team, managed by the Country Office (CO) in close collaboration with the Asia and the Pacific Regional Office (APRO) M&E Adviser with oversight from the Independent Evaluation Office of UNFPA Head Quarters (HQ).

The main audience and primary intended users of the CPE are: (i) The UNFPA Cambodia CO and the implementing partners (IPs) (ii) the Royal Government of Cambodia (RGC) (iii) rights holders involved in UNFPA supported interventions and the organizations that represent them (in particular women, adolescents and youth) (iv) the United Nations Country Team (UNCT) (v) UNFPA Asia Pacific Regional Office (APRO) and (vi) donors. The evaluation results will also be of interest to a wider group of stakeholders, including: (i) UNFPA headquarters divisions, branches and offices (ii) the UNFPA Executive Board (iii) academia and (iv) local civil society organizations and international NGOs. The evaluation results will be disseminated as appropriate, using traditional and digital channels of communication.

The Purpose and the Objectives of the Evaluation

Key purposes are to: 1) Demonstrate accountability to stakeholders on the contribution of CP6 agreed results, 2) generate evidence and lessons to support evidence-based programming in UNFPA, and 3) provide necessary evidence to design UNFPA's next CP (CP7). Given these purposes, the **specific objectives of the evaluation are**: i. to provide an independent assessment of the relevance, coherence, effectiveness, efficiency and sustainability of UNFPA support, and in addition, coverage and connectedness in the humanitarian context, ii. to assess the ability of UNFPA to respond and adapt to changing contexts (including but not limited to COVID-19), new emerging issues, and national priorities, iii. to provide an assessment of the role played by the UNFPA Cambodia CO in the coordination mechanisms of the UNCT with a view to enhancing the United Nations collective contribution to the national development results and iv. to draw key conclusions from past and current cooperation (UNFPA assistance to the country) and provide a set of clear, forward-looking and actionable recommendations for the next programme cycle (CP7).

The Country Programme

Given the middle-income country status of Cambodia, UNFPA supports the consolidation of earlier achievements as well as 'upstream' policy development, advocacy, evidence generation and knowledge management in line with the strategic focus of UNFPA's interventions. This Country Programme has three outcomes addressing Sexual Reproductive Health and Rights (SRHR), Adolescents and Youth (AY) SRH via Comprehensive Sexual Education (CSE) and SRH services, and Population Dynamics (PD), with each of these outcomes having an output. Gender-based violence (GBV) has been integrated into outcome 1 as UNFPA has focused more on health sector response to GBV. With a rights-based and an inclusive approach addressing interventions in development and humanitarian contexts, gender equality and women's empowerment cross-cut the three outcomes. Working closely with the government counterparts at the national level, with an advocacy role and support forming policy and strategy upstream at a programmatic level, UNFPA focuses on eight provinces (Kampong Cham, Kratie, Mondulkiri, Oddar Meanchey, Preah Vihear, Ratanakiri, Stung Treng, Tboung Khmum and upstream work in Phnom Penh) where there is a high need for SRHR, AYSRH and Data related programmes and services. With strategies to address gender inequality integrated across all the programmes, four out of these eight provinces have a focus on health sector response to GBV. Interventions on CSE, and policies and strategies on gender equality and violence against

women (VAW) are expected to address and contribute to prevention of GBV. UN joint programme was implemented in three provinces to address the health needs of returning migrants during the pandemic.

Evaluation Scope

Based on the Terms of Reference (ToR, Annex 1) the Evaluation covers UNFPA's work at both the national level and priority locations which include the eight provinces mentioned above and in the capital city of Phnom Penh for specific interventions as defined by the Country Programme. The Evaluation looked at both interventions implemented by UNFPA Country Office (policy and advocacy) and implementing partners which included the CP6 thematic areas: SRHR including health response to GBV, CSE among adolescents and youth and population dynamics and cross cutting issues such as gender equality and rights-based approach to programme design and implementation in the development as well as humanitarian context. CPE covers the period from Jan 2019 to June 2022. Given that the CP6 cycle is from 2019-2023, and part of the period was affected by the Covid-19 pandemic, the final achievements and results of the CP6 are most likely not seen within the scope of the exercise.

Methodology

Structured around seven evaluation criteria, Relevance, Coherence, Effectiveness, Efficiency, Sustainability, and criteria Coverage and Connectedness specifically in the humanitarian context, the evaluation used purposive sampling method, applying mixed method approach for data collection both from secondary and primary sources. This included field visits to collect primary data in sampled provinces Kampong Cham and Ratanakiri and Oddar Meanchey (virtual data collection), and Phnom Penh for national level data, documentary review of CP6 related publications, research, monitoring and evaluation (M&E) reports, financial and operations system; semi-structured individual and group face-to-face interviews, phone and on-line interviews, informal and focused group discussions, and field observations. Applying a gender and rights-based approach and triangulating the sources and methods of data collection, the evaluation adopted an inclusive approach involving a broad range of partners and stakeholders. Totalling 168 respondents, represented by 80 females, UNFPA CO staff, national and local level development partners, donors, UNCT, service beneficiaries and providers, contributed their input to this evaluation. The evaluation design was validated by APRO and the evaluation reference group (ERG) and CO staff. For validation of the preliminary findings, conclusions and recommendations, a workshop was held with CO staff and ERG, and the final conclusions and recommendations were presented to CO and a larger stakeholder group for their input. Their feedback has been integrated in the report and evidence has been reported using triangulated data.

Main Findings

CP6 design stayed relevant to the national strategies and priorities, aligned with UNDAF, and UNFPA mandate. The design met the needs of the intended populations incorporating the vulnerable groups. Implementation of CP6 adapted and stayed relevant to the changes in the national development context, emerging needs and priorities of local context, especially during COVID-19 pandemic and post-pandemic period. UNFPA, working closely with RGC, other development partners and relevant UN agencies, contribute to sustainable development goals (SDGs) in particular Goal 3 on health, Goal 4 on education, Goal 5 on gender equality, and Goal 17 on partnerships that includes data and accountability.

UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT by actively contributing to UNCT working groups, results group, and joint initiatives, ensuring synergy and maximizing and optimizing results, both in development and humanitarian contexts. UNFPA added value to the results of other development actors' interventions specifically in SRHR, AYSRH via CSE, and health response to GBV, Data and rights advocacy. Supporting the national government to complete several policies/guidelines, UNFPA successfully contributed to the development of advocacy and knowledge products at upstream level. However, efforts to translate these into implementation on the ground are limited. Engagement of CSOs at sub-national levels could have been more than what is currently observed. Institutional capacity building has been accomplished, especially related to the production and analysis of national data, however, there are still some challenges to be addressed and key agencies still need support in data generation from UNFPA.

Improvements are observed in the quality of the emergency obstetric and newborn Care (EmONC), pre-service for midwife workforce, in-service training and family planning service reducing unwanted pregnancy. With the support of the ministry of health (MoH), Ministry of Women's Affairs (MoWA), and CSOs, health sector response to GBV and VAW has been addressed, but with room to improve the services to reach more survivors and women and girls in general on awareness and prevention (development setting). Adolescent and youth-friendly health services are set up and scaled up with support from the Ministry of Education, Youth and Sport (MoEYS) with public schools providing sexuality education, reproductive health and reproductive rights to Adolescents and Youth (AY). UNFPA contributed to developing the national strategy for both in and out-of-school CSE. However, so far, there is less focus on out-of-school population with regards to health service response in many needy areas.

Working in coordination with other UN Agencies, IPs and government counterparts, UNFPA contributed to the integration of population dynamics, reproductive health, and gender equality (GE) into development planning at national, sectoral and local levels. Joint programming results show evidence of coherent approach to programme implementation and maximizing the comparative advantage of each partner to reach development results. In CP6, GE does not have a separate outcome or output although GE is integrated across all programmatic areas. Measuring how GE is assured in programme outcomes as well as how the expected changes in gender norms are measured is less obvious. Targeted population groups were reached and disaggregated data were available by geographic locations at healthcare service points. However, specific data on socially disadvantage groups are limited. Reproductive health services were available to address related needs in humanitarian settings. With the available human resources, CO was able to find additional funding resources partnering with other agencies and development partners to deliver uninterrupted services, adapting to the changes triggered by the COVID-19 pandemic to serve the needy populations. Results reporting, in general, are focused more on outputs of target achievements, often in quantitative numbers and information on immediate or intermediate outcomes and quality improvements are limited. Sharing of experience via South-South and Triangular Cooperation (SSTC) was limited. Although plans were included in CP6, the implementation was not evident.

Main Conclusions

With a high degree of relevance to the national priorities and plans, UNFPA strategic plans (2018-2021 and 2022-2025), international treaties, and commitments, CP6 has followed the business model that is relevant to an "orange" country, working mainly at upstream and where necessary at downstream, working with relevant IPs, to contribute to strengthening the national ownership and sustainability of the programme interventions. As a knowledge broker and partner in successfully bridging and facilitating various players engaged in the development as well as humanitarian contexts, UNFPA has employed gender-sensitive and human rights approach in work advocating for the rights of the male and female youth, marginalized populations and GBV and DV survivors and men and women in their reproductive ages. CP6 has focused on vulnerable populations through its choice of priority provinces (e.g. the choice of Ratanakiri) however; there is more room for improvement in disability inclusion and services those living in remote areas.

Strategically, UNFPA has maintained its strong presence in all policy and key decision functions related to UNFPA's mandate. UNFPA contributed positively towards coordination mechanisms, both internal as well as external partners and agencies. UNFPA's corporate strengths are well recognized and acknowledged by other UN members for UNFPA's contribution to improving the UNCT coordination mechanism. As for the internal coordination, UNFPA actively contributed to the UNCT working groups, results groups, and joint initiatives in the development as well as in the humanitarian context. Externally, UNFPA coordinated well and implemented the CP with the support of the participating ministries as well as the non-governmental IPs and other development partners in delivering the programme. Although active in GBV working groups, UNFPA engagement with CSE working group is observed to be limited.

Responding to and meeting the needs of important emerging issues in the country, especially in floods and COVID-19 pandemic, UNFPA mobilized funds and human resources in a timely manner. High relevance to the RGC needs has been a key facilitating factor in the CP6 achievements. UNFPA's trusted working relationship/collaboration with key government partners has contributed towards greater national ownership while simultaneously helping UNFPA broker collaborative arrangements to achieve results. Collaborating with other UN agencies, the comprehensive and holistic approach to the humanitarian work in the selected three provinces appeared to be effective and would be considered as a good model for scaling up and replicating in other provinces in humanitarian context.

While partnerships established at the national as well as provincial-level have been a factor in accomplishing development results, there is limited engagement with private partners. Similarly, if linkages with more local CSOs/ downstream development organizations (working towards similar objectives) present in the UNFPA priority provinces were established, effectiveness and efficiency of programme interventions could have been enhanced. This gap may have been partly due to the nature of CP6 design that is based on the strategy plan 2018-2021 business model, maintaining more focus on policy, advocacy, capacity development, data generation and knowledge management at the national level.

As for the implementation, planned interventions of CP6 under the outcome areas (SRHR, AY & PD with GE) as a cross-cutting theme) are found to be highly relevant to the national priorities, the (National strategies), UNDAF/UNSDCF, UNFPA mandate, ICPD POA, 2030 Agenda, and the needs of the beneficiaries. However, in the design of CP6, the alignment with UNFPA Gender Strategy 2018-21 was not fully reflected as there was no dedicated outcome or output on gender equality and empowerment of women under the Gender equality and women's empowerment outcome (SP outcome 3). Although there is no separate output for Gender equality and women's empowerment, GE is integrated into all thematic areas with most of the indicators measuring GE (mainly focusing on GBV as per CPAP design) interventions reported under SRH. Policy and advocacy support has been achieved as planned. While disaggregated data by age and sex are reported to be available in most data bases providing a data for gender analyses at national and provincial levels, there is room for gender analysis to further understand gender norms and to include more gender-transformative approach to programming. CP6 emphasised on health response to GBV (including policy support to MoWA) and achieved positive results. However, ground level interventions seem to miss the opportunity to consider and address how multiple socio-cultural and structural dimensions (i.e., strong intersectionality) may be impacting women.

Despite limited funds from regular resources, UNFPA has been able to mobilize other resources and shown tremendous effort in terms of its efficiency in achieving planned results. Some inefficiency, which is beyond the country office control, was observed due to limited human resources to take maximum use of UNFPA supported interventions, mainly related to downstream interventions. Joint programmes and working on government requested interventions have shown to be efficient and effective.

UNFPA's leadership in UN joint programmes as well in partnership with development partners, contributions to the joint UN response to the COVID-19 pandemic has been significant, including preventing/addressing GBV through media and strengthening services at one stop centres, in the context of COVID-19. While the contribution to promoting a focus on young people and rights issues is well recognized, UNFPA has demonstrated its added value to the national RMNCH+A programme by bringing to the foreground rights perspectives, particularly in the context of family planning (FP), midwifery services, maternal health service delivery and health response to GBV. Quality of service varies and is an issue to address. However, UNFPA's efforts to address this are apparent from the study delegated to understand the quality of health services in the priority/focus provinces.

UNFPA together with the development partners worked closely to support RGC to strengthen national capacity to implement the SDGs that were localized and endorsed by the country. Overall, UNFPA has performed well – at the national level UNFPA has done an excellent job (in all thematic areas) contributing to policy, advocacy and data generation, however the need to strengthen institutional capacities on production of quality data through

census and national surveys still remain. A missing link between policies to their implementation on the ground is observed. Covering all thematic areas, SRHR including GBV, AY, PD and Gender, support to relevant national IPs in terms of policy guidelines, strategies, studies and surveys, UNFPA has been an ardent supporter at the national level. However, given the nature of the work plan and the allocation of human as well as financial resources, follow-up on the implementation of these on the ground level is limited. To reiterate, establishing stronger engagement with the IPs working closely with the targeted populations could expand the reach as well as for more opportunities for translating the policies into action on the ground.

Recommendations:

UNFPA to continue to operate through strategic partnerships as the key mode of engagement and continue to strengthen partnerships and innovations (CP6 through CP7). Leverage innovation across the organization and with strategic partners to amplify the impact and try to engage private partners who can be effective. Given the mode of engagement and the programme needs, UNFPA to maintain its current leadership in SRHR, AYSRHR, PD and response to GBV and continue to support and assist the government with strategy and policy development. **Continue the focus on priority (target) provinces with key interventions, especially focusing on those that are directly contributing to three zeros** by contextualizing the interventions to suit the ground level. To accelerate the achievement of the three transformative results, UNFPA to continue to build on the successes in developing human capital and the achievements in improving the quality of life of women, girls and adolescents. **As for coordination, CP7 to be more focused on integrated programming with a more synergetic approach across development programme components that aim for similar objectives and same targeted populations** by coordinating well with participating development partners. Include theories of change (TOC) that encompass the entire results chain, ensuring adequate skills and capacity of staff that participate in the formulation of the results framework and implementation. Include where feasible, ex-ante evaluations and update TOC as new interventions are planned with a clear agreement on indicators for results achievement. **Include joint programming and monitoring:** More joint programmes with a clear theory of change and indicators to achieve final planned outputs (strong design and clear roles and responsibilities agreed upfront). Scale up (roll out) the experience gained from the joint programme in the three provinces (after a quick assessment of how the system is working) to other areas addressing similar issues as relevant to the local context. **Given the complexity of the GBV and violence against women (VAW), Gender Equality and Women's Empowerment to be considered as a stand-alone outcome.** Response to GBV to be a more comprehensive and intersectional approach as it entails much more than the health sector response to GBV. Maintain rights-based approach to gender equality, and engage with other ministries, going beyond current strategic partners. Focus on mainstreaming gender applying gender-transformative principles and approaches in programme design, implementation and reflect these in monitoring and reporting. **Ensure and enhance the quality and availability of essential SRHR services to reach out to the communities, targeting marginalized groups that are left behind (not reached)** from current SRHR services, especially those women and men with disabilities and adolescents and youth living in remote rural areas and those from minority populations. Both twinning approaches, either mainstreaming disability issues into the current services or implementing disability specific programme may be suitable. Rights-based approaches to be strengthened in SRHR services. **UNFPA to consider updating the existing working group, or initiating new CSE Technical Working Group (CSE-TWG).** **Continue to strengthen institutional capacities on production of quality data** through census and relevant national surveys, data analysis, and dissemination, especially on large dataset management and analyses using more robust and rigorous advanced statistical models and continue strengthening the availability of quality data to guide policymaking, planning, and programming is a precondition. This will also help evidence-based advocacy for the rights of left-behind populations and advocate for gender equality.

Chapter 1: Introduction

1.1 Purpose and Objectives of the Country Programme Evaluation

In accordance with the 2019 UNFPA Policy, this independent evaluation of CP6 is implemented to generate evidence to: (a) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources (b) support evidence-based decision-making and (c) contribute important lessons learned to the knowledge base of the organization as a whole. The CPE draws conclusions and provides a set of actionable recommendations for the next programme cycle (CP7) 2024-2028.

The main audience and primary intended users of the CPE are: (i) The UNFPA Cambodia CO (ii) the Royal Government of Cambodia (RGC) (iii) implementing partners (IPs) of the UNFPA Cambodia CO (iv) rights holders involved in UNFPA supported interventions and the organizations that represent them (in particular women, adolescents and youth) (v) the United Nations Country Team (UNCT) (vi) UNFPA Asia Pacific Regional Office (APRO) and (vii) donors. The evaluation results will also be of interest to a wider group of stakeholders, including: (i) UNFPA headquarters divisions, branches and offices (ii) the UNFPA Executive Board (iii) academia and (iv) local civil society organizations and international NGOs. The evaluation results will be disseminated as appropriate, using traditional and digital channels of communication.

Specific Objectives

With the broader objectives as mentioned above, the specific objectives of this CPE are:

- i. To provide an independent assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support.
- ii. To assess the ability of UNFPA to respond and adapt to changing contexts (including but not limited to COVID-19), new emerging issues, and national priorities.
- iii. To provide an assessment of the role played by the UNFPA Cambodia CO in the coordination mechanisms of the UNCT, with a view to enhancing the United Nations collective contribution to national development results.
- iv. To draw key conclusions from past and current cooperation (UNFPA assistance to the country) and provide a set of clear, forward looking and actionable recommendations for the next programme cycle.

1.2 Scope of the Evaluation

Based on the Terms of Reference (ToR, Annex 1)¹ the Evaluation covers UNFPA's work at both the national level and priority locations which include the provinces of Kampong Cham, Kratie, Mondulkiri, Oddar Meanchey, Preah Vihear, Ratanakiri, Stung Treng, Tboung Khmum, and in the capital city of Phnom Penh for specific interventions as defined by the Country Programme. The Evaluation looked at both interventions with direct interaction of UNFPA² Country Office and those implanted by implementing partners which included the CP6 thematic areas: Sexual Reproductive Health and Rights (SRHR) including health response to Gender-Based Violence (GBV), Comprehensive Sexual Education (CSE) among adolescents and youth and Population Dynamics (PD) and cross cutting issues such as gender equality (GE) and rights-based approach to programme design and implementation in the development as well as humanitarian context. The time period this CPE covered is from Jan 2019 to June 2022³. Given that the CP6 period covers 2019-2023, and part of the period

¹ToR is attached (obligatory annex)

² Advocacy and policy dialogue refers to the direct interaction of UNFPA with national policy decision-makers and other stakeholders toward the development, improvement, reform, and monitoring of policies, legislation, strategies, plans, budgets and programmes.

³Although the ToR specified May 2022, due to the delay in starting the CPE, the evaluation covered up to June 2022.

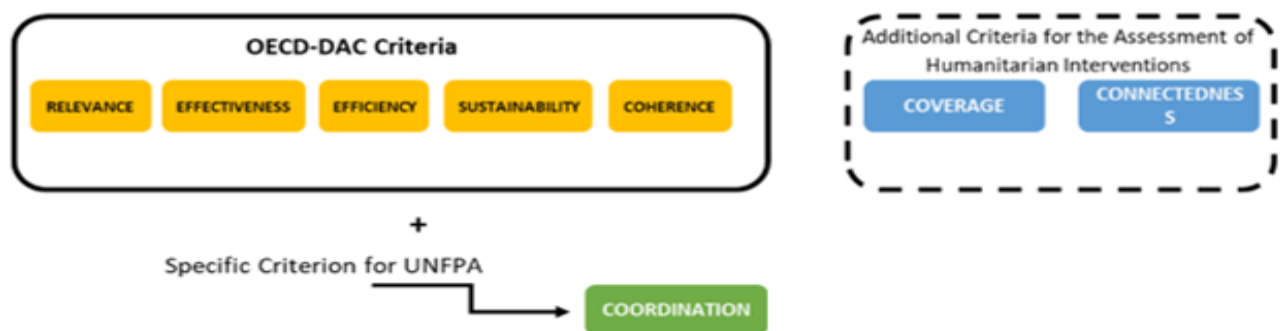
affected by the Covid-19 pandemic, the final achievements and results of the CP6 are most likely not seen within the scope of the exercise.

The Evaluation applied the UNEG and UNFPA guidelines on Disability and Rights Approach, UN Women and WHO guidelines, and as the main reference, the UNFPA Handbook “Evaluation handbook how to design and conduct a country programme evaluation at UNFPA” in informing the whole evaluative process.

Methodology and Process

Evaluation criteria⁴ and evaluation questions: CPE evaluated the programme outcome areas using ECD/DAC evaluation criteria of **Relevance, Coherence, Effectiveness, Efficiency and Sustainability**. UNFPA specific evaluation criterion Coordination and Added value come under Coherence and assessed UNFPA’s contribution to the existing coordination mechanisms and strategic positioning in the country with a focus on UNCT Coordination and UNFPA’s comparative advantage in the development agenda within the development community and national partners in responding to national needs. Evaluation team (hereafter referred to as ET) assessed how UNFPA has been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to achieve planned results, ensure ownership and the sustainability of effects.

FIGURE 1: EVALUATION CRITERIA FOR THE CPE



Source: Handbook UNFPA Evaluation Guidelines (2019 version) – modified by CPE team to add Coherence

Coverage and Connectedness evaluation criteria were applied in the humanitarian context. Besides having two dedicated evaluation questions under these two criteria, most of the evaluation questions assessed integrated response to humanitarian context, especially reference to the COVID-19 pandemic. During CP6, Cambodia had not faced any major humanitarian emergencies other than COVID-19, except in one instance where floods took place. Evaluation team assessed how UNFPA has been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to achieve planned results, ensure ownership and the sustainability of effects.

As there was no major limitation for the evaluation team to travel to the provinces where UNFPA supported work is implemented to conduct the evaluation, face-to-face interviews were conducted where feasible, adhering to safety measures, in addition to the virtual interviews and meetings.

Upon selection of the EQs, ET attended to desk review of key documents and specific details were clarified by CO staff members. ET prepared evaluation design matrices (Annex 5) covering all evaluation questions with assumptions, indicators, and data sources and data collection methods. Stakeholder map (Annex 3) was prepared upon identifying the sources for interviews, discussions, and feedback. The methods for data

⁴ A brief description of each of these terms is given in Part 2 Annex-Additional Information.

collection and analysis were determined by the type of evaluation questions formulated to test the assumptions. Table 2 below shows the questions specific to the above evaluation criteria. While these were the questions proposed in the TOR, ET did a minor change by merging sub-questions under the Relevance criteria into one while keeping the content same, as it was deemed more appropriate. In addition to the key evaluation questions stated below, CPE drew lessons learned, what worked and what did not, factors that facilitated or hindered in achieving planned results, and what the unintended consequences are in the implementation processes.

Evaluation Methodology

As proposed in the ToR, following are the 12 evaluation questions specific to above criteria discussed. Initially, ET selected seven (7) key questions out of the 12 questions (mainly due to the number of days allocated to the evaluation for each team member), however, based on the feedback and comments from the reviewers on the design/inception report, ET decided to address all the questions possible, although the time allocated for the CPE was limited. There were overlapping questions and, in those cases, these questions were included as sub-questions thus not leaving any question out as requested by the reviewers.

The methods for data collection and analysis were determined by the type of evaluation questions formulated to test the assumptions developed (see Evaluation Matrix, Annex 5).

Taking into consideration the tasks of the evaluation as well as time and budget constraints, a non-experimental design was used to answer the evaluation questions. This type of design was relevant given that most of the key evaluation questions and sub-questions were descriptive and normative in nature. Experimental and quasi-experimental designs cannot be applied in this case, as they require creating a control group and this was not taken into consideration at design stage of CP6. It would have been possible to apply a quasi-experimental design by comparing with a non-intervention area with UNFPA intervention area; however, these methods are time-consuming and costly. Furthermore, there are other donors and IPs operating in most other provinces and to find an area or a population without any similar interventions would have been difficult and there could be contamination due to that.

TABLE 2: THE EVALUATION CRITERIA AND CORRESPONDING EVALUATION QUESTIONS

Evaluation Criteria and Evaluation Questions	
Relevance	EQ1-: 1.To what extent did the programme (i) adapt to the needs of the population (in particular, the needs of vulnerable groups), (ii) align with government priorities (iii) align with the priorities and strategies of UNFPA(leaving no one behind and reaching the furthest behind), and (iv) align with the UNDAF2019-2023? 2. To what extent was the country office able to respond to changes in the national development context and priorities?
Coherence	3. To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT? 4. To what extent have issues pertaining to sexual and reproductive health and rights (SRHR) and GBV, been adequately integrated and addressed in joint COVID-19 response and recovery programming with UNFPA's leadership?
Effectiveness	5. To what extent have the expected outputs and outcomes of the programme been achieved or likely to be achieved? What were unintended results of the programme? 6. To what extent were gender equality, equity and human rights and disability dimensions effectively incorporated into the CP design, implementation and monitoring iii) what were the factors (external and internal) that facilitated or hindered the achievement of intended results?

Efficiency	<p>7. To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the outcomes defined in the UNFPA country programme in a timely manner? Including during COVID 19 pandemic.</p> <p>8. To what extent did UNFPA systems, processes and procedures (particularly in terms of finance, partnerships, logistics, procurement and human resources) foster or, on the contrary, impede the adaptation and efficiency of the country programme to changes triggered by the COVID-19 pandemic?</p>
Sustainability	<p>9. To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects across the development-humanitarian continuum, including during the COVID-19 pandemic?</p> <p>10. To what extent has UNFPA been successful in mitigating the threats to the sustainability of results caused by the COVID-19 crisis?</p>
Coverage	<p>11. To what extent have UNFPA humanitarian interventions systematically reached the affected populations, especially the most vulnerable and marginalized groups (including young people and women with disabilities; those of racial, ethnic, religious, and national minorities; LGBTQI populations)</p>
Connectedness	<p>12. To what extent has UNFPA contributed to developing the capacity of local and national actors (government line ministries, youth and women’s organizations, health facilities, communities, etc.) to better prepare for, respond to and recover from humanitarian crises?</p>

The Evaluation utilized a theory-based approach. The Theory of Change (ToC) reflected the conceptual and programmatic approach taken by UNFPA over the period under evaluation including the most important implicit assumptions underlying the change pathway. ET did not have to reconstruct the ToC as there were no changes to the programme design, except additional interventions undertaken as response to Covid-19 Pandemic. The evaluation took into consideration these additional interventions and the mode of operation that had to be changed due to the pandemic. ToC was used during the field and data collection phase. The analysis of the theory of change served as the basis for the ET to assess how relevant, effective, efficient and sustainable the support provided by the UNFPA CO was in CP6.

Participatory Approach:

Stakeholder Participation: An inclusive approach, involving a broad range of partners and stakeholders, was followed. The evaluation team did a stakeholder mapping in order to identify both UNFPA direct and indirect



VALIDATION-CPE DESIGN STAGE

partners (i.e. partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic areas in the national context). The stakeholders included representatives from the Government, civil-society organizations, academics, the private sector, UN organizations, other multilateral organizations, bilateral donors, and the beneficiaries of the programme (the detail list of stakeholders shows the representation). Engagement of private partners was limited in CP6. Key stakeholders were involved in several vital stages of the evaluation providing input to the design of the evaluation, validating the findings, and contributing to the future recommendations. Rights holders at the ground level were

not engaged in validation processes due to logistical reasons.

Integration of Gender Equality, Disability, and Human Rights Approach in the evaluation: GE, disability dimensions, and HR approach were integrated in the design, evaluation questions, selection of interview participants, in the overall evaluation methodology and analyses as well as in the conclusions and recommendations. GEWE is considered cross-cutting in CP6 and the team attempted to answer all the evaluation questions with a reflection on gender, disability inclusion and HR concerns.

Evaluability Assessment and Reconstruction of the programme logic: The team reviewed the TOC to understand the logical linkages and the objectives behind the interventions. Programme officers responsible for each thematic area and cross-cutting areas presented the CP6 programme in detail to the ET, clarifying the links from strategic intervention to outputs and in turn to outcomes. All sessions ended with a Q&A session. This provided the team with an in-depth understanding of the programme prior to field visits to understand the TOC.

CP6 spanned two strategic plan periods, 2018-2021 and 2022 -2025. However, there were no major changes (or no change) that called for realignment of CP6 to the new SP 2022-2025, since the CP6 approach was already in line with the new SP. What is needed is to strengthen, or focus more on some areas that are already included in CP6. ET examined the country office results frameworks to check if the changing context and country realities due to the pandemic as well as emerging programme needs have changed or not during CP6 implementation. Annual review meeting minutes and the updated RRF were taken into consideration when evaluating CP6.

Brief overview of the project areas: At the outcome level, covering all thematic areas (SRHR including health response to GBV, AY and PD with GE integrated in all these areas, UNFPA works at the national level addressing policy and strategy review, update and development and national data. CP outcome on SRHR has moved to the ground at provincial, district, and community levels for the implementation of policy, strategy, and guidelines, and engaging with target populations in the selected provinces. PD is engaged in institutional capacity development at the national level as well as to some extent provincial level. AY has a presence at policy level as well as subnational level working with youth networks and schools, mainly on CSE and out of school populations on AYSRH. The geographic prioritization at subnational level had been based on an in depth evaluation and analysis of several key indicators across the country selecting locations that are performing poorly in comparison to the national averages where existing partnerships and resources can be leveraged and where thematic convergence is possible. As the map (figure 4, in chapter 3) illustrates, UNFPA supported interventions are targeted on provinces in high needs for SRHR including Gender and GBV, covering 8 provinces (Kampong Cham, Kratie, Mondulakiri, Oddar Meanchey, Preah Vihear, Ratanakiri, Stung Treng, TboungKhmum and upstream work in Phnom Penh) with a varying degree of maturity, concentration and focus. The eight target provinces covered SRHR interventions, including adolescents and youth friendly services, with four of them (Kampong Cham, Tbong Khmum, Preah Vihear, and Stung Treng) focusing on gender equality and GBV interventions.

In addition to these interventions, migration projects were implemented in three provinces mainly as a response to and recovery on the COVID 19 situation. As per the CPE ToR, the Evaluation covered UNFPA's work at the national level as well as in priority locations which include the eight target provinces mentioned above and the capital city of Phnom Penh for specific interventions as defined by the country programme.

Selection of the Sample for field visits and stakeholder interviews

CP6 development has been guided by the country needs as well as UNFPA corporate priorities and strategies. Using the programme knowledge and further discussions with CO staff, a purposive sample was drawn from the stakeholder map (Annex 3) to reflect all CP6 interventions and input. Programme beneficiaries were selected based on the availability, given the Covid19 environment. ET included a wide range of stakeholders to reflect multiple views to fully assess the human rights and gender dimensions. ET could not meet with people with disability in the provinces during field visits. However, the lens of disability was adopted by asking questions around disability.

For field data collection the team visited only a few selected sites, however, the document review covered all the interventions in the priority provinces. Site selection for the CPE was based on the in-depth knowledge gained by discussions with POs, ERG and the strategic direction that is presented by the country office staff. ET selected interventions for evaluation based on certain criteria. Based on a purposive sampling method, site selection for the CPE depended on the in-depth knowledge gained by related documents, vulnerability surveys,

discussions with POs, ERG and the strategic direction that was presented by the country office staff. In addition, as explained below, ET applied certain criteria for selecting the geographic locations for field visits. Given the number of reviews and evaluations completed by the CO, and other agencies, visit to field sites was based on the need to collect new information. The selection of stakeholders depended on the actual relationship of the stakeholders to UNFPA outputs and contribution to outcomes. Based on the stakeholder map (Annex 3) stakeholders who have been closely working with UNFPA and contributing to CP6 results were selected in the sample. This is not a statistically representative sample, only a purposively drawn an illustrative sample that, from our understanding, could provide the optimum information related to the programme. From the beneficiary side, a convenient sample of the service users was chosen during the field visits. Due to logistical considerations, and the lack of team’s understanding of the physical feasibility in reaching the locations, CO assisted in selecting the schools and clinics to visit. School administration provided students for interviews and when in the field, ET selected convenient samples to interview, on the spot. At the health clinics, ET interviewed, with consent, mothers who received services and their husbands who accompanied the women. GBV survivors were selected by the GBV support group working with PDOWA.

The following table provides a summary of persons interviewed representing the sample selected from the stakeholder map and the additional sources of information identified in the process of the evaluation in line with the purpose of the exercise. Furthermore, in addition to the information gathered from the stakeholders and other relevant persons, information were elicited from the recently conducted relevant reviews and evaluations to support and strengthen the findings as well as to fill the gaps where details were not possible to collect due to the limited number of days in the provinces. Based on the CP6 interventions ET can safely ensure that the information collected covered the interventions and the stakeholders identified by the country office as well as ET. However, as described above the sample selection was purposive and judgemental and not a statically representative sample. The team took great effort to cover the CP6 interventions and include a sample of stakeholders that would compare well with the sampling universe.

TABLE 3: LIST OF REPRESENTING INSTITUTIONS AND NUMBER OF STAKEHOLDERS MET

Number of Respondents and Representing Institutions	Male	Female	Total
UNFPA	10	5	15
UN agencies (ILO, IOM, UNAIDS, UNICEF, UNDP, UN WOMEN, WHO) and RCO	6	11	17
National Government Level (CDC, MoEYS, MoH, MoP/NIS, MOWA)	15	12	27
Provincial and District Levels (Provincial Health Department, Provincial Planning Office, Provincial Department Of Women’s Affairs, Education)	23	30	53
Development Partners (ACCESS, ADB, EU, GIZ, JICA, SIDA)	5	1	6
NGOs and CSOs (FHI360, GreenLady, RHAC, UNYAP Members)	6	4	10
School level (school Principals, teachers, students)	11	10	21
Other (women/men visiting clinics, GBV survivors)	12	7	19
Total	88	80	168

Detailed list of persons interviewed (data sources) in Annex 2.

Data Sources, Collection and Analysis

Data Sources:

The data sources, collection and analysis methods were designed around the assumptions and indicators proposed in the evaluation matrix, considering the most effective ways to collect and analyze the needed information to answer EQs in the given country and programmes’ context and limited timeframe. The data sources are shown in the above table. Field data collection in the 2 provinces was confined to 4 days; 2 days in each province. The National level data were collected, spread across for over four weeks depending on the availability of the selected interviewees. Virtual data collection of the provinces took place simultaneously. Repeat interviews with a few selected stakeholders had to be done to ask questions to close the gaps as well

as for validation of the findings. When the physical visits to the field sites were not possible, wherever feasible, interviews were held remotely.

Based on the selected evaluation questions and the theory of change model, the sources of data were both secondary and primary. The type of data was based on a mix of quantitative and qualitative, derived from multiple sources.

The evidence in this evaluation included data collected from the field, desk review of documents, direct observations, semi-structured interviews, key informant interviews (KII), informal group discussions, and secondary sources such as the evaluation and review reports and other sources. Desk review included CP-related documentation, relevant national policies, strategies and action plans, national statistics, evaluation and review reports, minutes of UNCT meetings, and monitoring reports (quarterly reports, project-specific reports, annual reports, and trip reports) submitted by IPs and UNFPA staff. A detailed list of documents reviewed is attached to the report (Annex 4). The evaluation triangulated data sources, data types, and data collection methods.

Primary data sources included UNFPA CO staff, IPs, government officials, other UN agencies and donors at the national level, and IPs/CSOs and beneficiaries at sub-national level.

Qualitative data, secondary quantitative data and other evaluation findings from existing reports were triangulated in making conclusions from the findings. The triangulation of data collection is expected to minimize the weaknesses of one method, offset by the strengths of another, enhancing the validity of the data. Validation of the findings was achieved through stakeholder meetings, such as debriefing meetings with UNFPA staff, ERG members and Implementing Partners.

Data Collection Methods:

Primary data were collected at the national (including IPs, non-IP government and non-government partners, UNFPA CO staff, other UN agencies and donors) and sub-national levels as needed through semi-structured interviews (face-to-face and online, phone, zoom and skype) focus group discussions, informal group discussions, key informant interviews (KII) and direct observations as appropriate. Interviews adopted an inclusive and participatory approach. The respondents (e.g., implementing partners, civil society, programme participants, representatives of vulnerable and marginalized groups, donors etc.) were given the opportunity to discuss freely about the programme and to propose what works for them to make the programme better in their own context.



GROUP INTERVIEW WITH STAKEHOLDERS

Secondary data were collected through desk review of existing literature (evaluations, research and assessments conducted by UNFPA CP6 and other partners in the country), annual reviews/progress reports, and other monitored data.

Specific ethical as well as safety standards were employed/considered when interviewing stakeholders and are discussed in a section below.

Based on the evaluation questions and the source, tools were prepared and used for data collection. The rationale for selecting these tools depended on the type of question to answer, stakeholder and the interventions. Tools were structured and adapted to the situation to gather the information on the key questions as per the assumptions and the sources indicated in the evaluation matrix. Data Collection tools are attached (Annex 2). The main method was face-to-face interviews and group discussions using the semi-structured questions. Virtual interviews were held with individuals as well as groups, when in-person meeting was not possible. Observation method was used in addition to interviews, in combination when functioning

facility bases (health centers, schools etc.) were visited. A check list was used for direct observation (clinics, schools, and interaction during group meetings).

Semi-structured data collection tools were used in most of the cases keeping in mind the time considerations and the easy flow of thought process to answer the questions. Some stakeholders requested for an outline of the questions for them to prepare in advance and using a semi-structured questionnaire tool facilitated the flow of information ET needed and some flexibility as the conversation and the rapport was built up in the interview process. With the rights-bearers at ground level, a few questions were asked followed by an informal conversation and with group discussions that helped them to build up on each other's feedback on the questions asked.

Data Analysis:

The Evaluation matrix provided a guiding structure for data analysis for all components of the evaluation and the evaluation questions determined the method of data analysis. The team used descriptive analysis to identify and understand the contexts in which the programme has evolved, and to describe the types of interventions and other characteristics of the programme. This heavily depended on the availability of secondary data and time to collect new data. Descriptive analysis was used to interpret quantitative data, in particular data emerging from programme annual reports, studies and review reports.

Content analysis of documents, interviews, and group discussions enabled identifying emerging common trends, themes and patterns and provided a basis for preliminary observations and evaluation findings. Given the nature of the key data collection method in this CPE, major data analysis was mostly limited to content analysis to interpret qualitative data with some quantitative analysis using secondary data. The list of documents consulted is attached (Annex 4).

Conclusions and recommendations show evidence of consistency and dependability in data, findings, judgments and lessons learned appropriately reflecting the quality of the methodology, procedures, analysis and interpretation of data. As described earlier, the questions, data collection and analysis ensured that gender concerns, disability inclusion, and human rights-based approach were integrated.

Contribution analysis was done to assess the extent to which the country programme contributed to the expected results. The team attempted to gather evidence to confirm the validity of the theory of change, and to identify any logical and information gaps that it contained.

Retrospective and Prospective Analysis and the Evaluation Criteria: ET assessed the extent to which results have been sustainable, and in cases where expected results have already been generated, ET assessed the prospects for sustainability, i.e., the likelihood that the effects of UNFPA interventions will continue once the funding comes to an end. Questions were formulated to elicit this information; however, this was based on respondents' perceptions. Where interventions have been in effect for over several cycles (maturity), actual effects were observed. Previous evaluation findings and programme documents, CO monitoring and performance data, and field observations were combined with interview data to substantiate findings. Relevance and Efficiency evaluation criteria were assessed mainly by reviewing the related policy and strategy documents, financial documents and face-to-face interviews with relevant stakeholders. Special consideration was made, where feasible, to include and reflect how boys, girls, men and women, and those belonging to marginalized groups, including people with disabilities during CP6 design and implementation.

Data Quality and Validation Mechanisms: All evaluation findings were supported with evidence. Data was triangulated across sources and methods by cross-comparing the information obtained via each data-collection method (desk study, individual interviews, discussion groups, focus groups) and double-checking the results of the analysed data. Thus, data quality was maintained by triangulating the data sources and methods of collection and analyses. Validation took place at different stages in the evaluation process. Design



UNFPA ANNUAL REVIEW MEETING INCLUDED CPE NATIONAL TEAM

stage, preliminary findings stage, draft conclusions and recommendations and final stage of reporting. Validation of preliminary findings, by key stakeholders, enhanced the quality of data collected

ensuring absence of factual errors or errors of interpretation and no missing evidence that could materially change the findings. The draft report was shared with CO staff, ERG members⁵ and selected stakeholders for their comments and feedback. The final draft was shared with a larger stakeholder group and discussed at the annual review meeting. The CPE national team participated at the meeting to answer any questions or clarifications.

Ethics and Maintaining the Quality of Evaluation: Ensuring the protection of respondents’ rights, an informed consent was sought before all interviews were made. In schools where students under 18 years were engaged, the school principal gave the permission as they are authorized to do so. The data collected were confidentially kept, with no identifiers. Where written consent was not applicable or feasible, verbal agreement was sought. UNFPA CO informed the respondents about the evaluation purpose and the rights and confidentiality of those participating in the evaluation and it was voluntary participation by those agreed to provide feedback. The team followed UNEG and UNFPA guidelines and standards, as well as UNFPA’s Handbook on “How to Design and Conduct a Country Programme Evaluation at UNFPA” in carrying out the CPE to ensure its quality.

When GBV survivors were interviewed, they were provided a comfortable environment where they feel safe and free to express their opinions. Only female team members interviewed the survivors and they were allowed to sit together during the interview, only after they requested and gave the consent to be together. When they knew each other before, they felt more comfortable to share their stories with ET. Interview took place in a closed room providing privacy. The GBV working group provided the contact information of these survivors.

ET followed a “do no harm” principle and meeting national and sub-national level key stakeholders face-to-face was not a problem as there were no major restrictions, however, where stakeholders’ preferred virtual meetings, ET conducted the interviews using zoom or other methods of connectivity. All planned meetings were kept based on stakeholders selected. Although the team hoped to meet non-beneficiaries of UNFPA interventions, it was not possible, but it did not affect the planned evaluation as this was something in addition that ET hoped to do if it was possible only. If the team wished to record the interview, permission was sought and only upon their consent the interviews were recorded only for the use by the ET.

Limitations and Mitigation Measures: Sample is a purposive one and not a representative sample thus we cannot generalize the findings. Limited time duration in field sites, probable socially desirable responses, inadequate number of meetings with non-beneficiaries and PWDs, may have been some limitations. Given the situation on the ground, the time availability and the logistical feasibility it was not conducive for conducting methodologically sound FGDs. To mitigate this, ET depended on informal group discussions and for assessing the quality of SRHR services, ET used the recent study report on client feedback based on qualitative methods that included several FGDs.

⁵ List of ERG members and their TOR included as an annex to the main TOR provided by the country office.

Engaging PWDs in the field interviews was limited. Moreover, UNFPA disability inclusion was intensified only in 2020 and disaggregated data on populations with disabilities (PWDs) was limited. However, ET was able to interview a few UNYAP members that included persons with disability, and those with diverse sexual orientation.

Triangulation of different data sources and data collection methods mitigated the limitations caused by the tight time period available for the field visits to the provinces. The selection of interventions was covered across three provinces to understand the full spread of work CP6 had implemented. The fourth province selected was only to understand the process and status of the migration project and ET depended on virtual interviews. ET, when appropriate, divided the interview visits based on their expertise to cover more ground and when feasible combined visits were made to achieve the maximum out of the visits. Several rounds of meetings with CO staff and repeat interviews with selected stakeholders helped clarify CP6 work programme and its implementation as well as to fill the gaps and to validate the findings.

Process Overview

The evaluation unfolded in five phases. Of the CPE five phases i) preparation, ii) design, iii) field, iv) reporting, and v) management response, dissemination and follow up, the preparatory phase was completed by the CO. The Design Phase included desk review of key documents; stakeholder mapping; analysis of the programme/intervention logic and reconstruction of the TOC, finalization of the evaluation questions, development of data collection and analysis strategy, and a plan for field phase; preparation of the evaluation matrix and presentation of the design report to the ERG and CO. ET met with UNFPA CO programme teams to go over the outputs and expected results in detail to agree on the indicators to be used and the list of key stakeholders for interviews. Upon approval of the design report by CO, APRO and ERG⁶ data collection tools (Annex 6)⁷ were refined, and field work started.

The Implementation Phase/Data collection and Analysis Phase: After the Design Phase, the team-initiated data collection in the selected provinces and districts.

Reporting Phase: Upon completion of preliminary analysis of data and the debriefing session, the first draft report was shared for review by CO staff, ERG, APRO and Evaluation Manager for feedback. The final draft, updated upon taking the feedback into consideration, was shared with the national stakeholders and CO staff for validation and the finalization of the CPE report was done based on the stakeholder feedback.

Preparation of the Management Response and the Dissemination of the final recommendations will be the CO responsibility. The CPE findings and recommendations will inform the development of CP7. The final report and evaluation quality assessment (EQA) will be posted in the UNFPA evaluation database and the country office will have the results and recommendations uploaded in their website.

⁶ List of ERG members in the TOR.

⁷ Annex 6 attached

Chapter 2: Country Context

Cambodia, since transitioned from a lower-income country (LIC) to a middle-income country (LMIC), there has been a steady increase in mean annual per capita income over a number of years. The economy grew at an annual average of 5.4% from 2010-2019⁸. Cambodia was able to achieve the Millennium Development Goals (MDG) targets in a number of areas such as eradicating extreme poverty and hunger (1), reducing child mortality (4), improving maternal health and forging global partnerships for development (5). Under the leadership and strong commitment of the Ministry of Health (MoH) with support from health partners, the MoH has taken strong leadership in improving the health outcomes of its own population. The country's progress in health system strengthening and quality improvement contributed to the achievement of the MDGs of reduction in maternal mortality and child mortality. The improvement has been seen through the investment in health infrastructure and human resources for health, particularly upgrading the skills of midwives through pre-service and in-service education to contribute to the quality of Sexual, Reproductive, Maternal, Newborn and Adolescent Health (SRMNAH) services across the country. In line with the above strategies and plans, the Ministry of Planning has conducted its voluntary national review (VNR) on the implementation of Cambodia SDG 2030 agenda. The process started in 2018 and results showed that the majority of CSDG targets were rated as "ahead" or "on track"⁹.

While the country has made progress in improving the situation of the RMCH service in the past two decades, the progress has been shown through the achievement of major RMCH indicators, including the reduction of Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMR), and unmet need of family planning and increase of the use of modern family planning methods among the population. The MMR has reduced from 472 in 2005 to 174 in 2014¹⁰ and this trend continues to level off to 154 in 2021- 22¹¹. The IMR has also made progress as it fell from 95 to 28 between 2005 and 2014. By 2021-22, the IMR continues to fall further to 12.¹²

The contraceptive prevalence rate (CPR) among currently married women has increased from 24% in 2000 to 62% in 2021–22. Similarly, the trend of modern contraceptive use among current married women was 19% in 2000 and it increased to 45% in 2021-22. However, more women in urban areas are more likely to use any contraceptive methods (66% versus 59%) and women in rural areas are more likely to use modern contraceptive methods (47% versus 41%). The use of traditional methods has reduced from 18% in 2014 to 17% in 2021–22. The use of the traditional method of contraception among currently married women is higher in urban areas (24%) than in rural areas (12%).

Antenatal Care (ANC) is crucial to prevent adverse effects of pregnancy-related issues. By 2021-22, almost all women (99%) reported receiving antenatal care from a skilled provider for their most recent live birth. Women who made ANC visits four or more times have increased almost 10 times in the last 2 decades (9% in 2000 vs. 86% in 2021-22). Similarly, the trend of delivery by skilled health providers has also increased within the same period. The percentage of live births assisted by a skilled health provider has increased remarkably over this period. It increased from 34% in 2000 to 99% in 2021–22.

With a total population of 15.5 million in 2019¹³, those aged 24 years and below comprised 46.6%¹⁴ while young people aged 10-24 years made up approximately 17% of the total population. The total fertility rate (TFR) or the average number of children per woman was declined from about 3.1 children¹⁵ in 2008 to 2.5

⁸ Cambodia Voluntary National Review 2019 (CSDG 2019) by Royal Government of Cambodia

⁹ Cambodia's voluntary national review 2019 on the implementation of 2030 agenda for sustainable development

¹⁰ Cambodia Demographic and Health Survey, 2014, Ministry of Health, Royal Government of Cambodia

¹¹ Cambodia Demographic and Health Survey, 2021-22, Ministry of Health, Royal Government of Cambodia

¹² *ibid*

¹³ Cambodia Population Census 2019

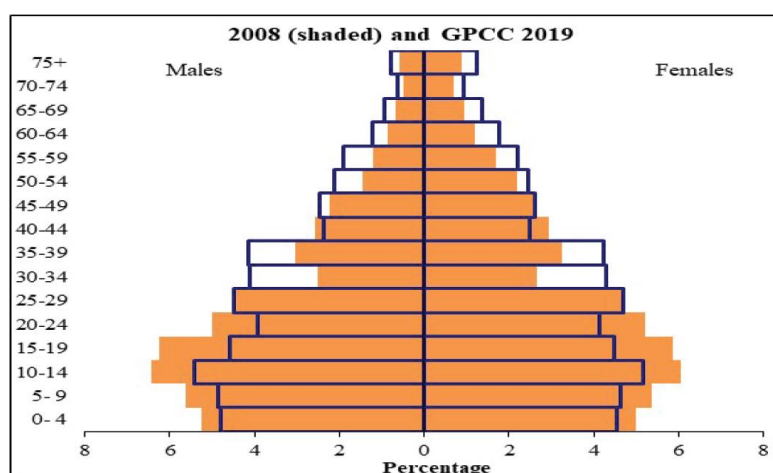
¹⁴ *ibid*

¹⁵ Cambodia Population Census 2008

children in 2019 with a trend of decrease in the coming years. In 2008, life expectancy for Cambodians was 60.5 years and 64.3 years¹⁶ for males and females respectively. There is an improvement one decade later. In 2019, the average life expectancy¹⁷ was 76 years. Women (77 years) live longer than men (74 years).

The population was distributed into four main regions: Central Plane region comprised 49.2% (7,644,295), Tonle Sap region (31.2%), Plateau and Mountains region (11.3%), and Coastal and Sea region (6.9%). In total, 60.6% of the entire population was from rural areas. The population density in 2019 showed that there were 87 persons per square kilometer, a 12-person increase from 75 persons per square kilometer in 2008. The Central Plane region had the highest population density at 305 persons per square kilometer. The age distribution of the population (between 2008 and 2019) is shown in figure 2 below.

FIGURE 2: POPULATION PYRAMID (2008 AND 2019)



Source: National Institute of Statistics of Ministry of Planning, General Population Census of the Kingdom of Cambodia, National Report on Final Census Results, 2019, October 2020.

As for the literacy rate, the proportion of those aged seven and above was 88.5% in 2019¹⁸ compared to only 78.4% in 2008¹⁹ with not many differences in the proportion of literacy between the female (86.2%) and male (91.1%) populations. About education, 86.1% completed primary education²⁰, 47.6% completed lower secondary education²¹, and 31.1% completed secondary²² education. This percentage showed better improvement than the level of education in 2008. For labor and employment²³ is 98.5%, the proportion of the economically active population was 62.0% in 2019 slightly higher than the data in 2008 (58.7%). 78.7% of the employed population worked in local private enterprises, 12.8% in foreign enterprises, 4.9% for civil services and 3.6% for all other sectors. For migration, 78.5% of the total population did not migrate and only 21.5% of the total population was considered migrants.

The main reason for migration was to move with families or individually, for employment purposes. The dominant stream of movement was from rural to urban areas, as well as international migration to the bordering countries, Thailand being one of the key recipient countries.

¹⁶ Ibid

¹⁷ Cambodia Population Census 2019

¹⁸ Ibid

¹⁹ Cambodia Population Census 2008

²⁰ Education Congress 2021

²¹ Cambodia Voluntary National Review 2019

²² Education Management Information Systems (MoEYS) 2021

²³ Cambodia Population Census 2019

2.1 Development Challenges and National Strategies

2.1.1 Development Challenges

(Development challenges discussed here are limited mainly to those related to the UNFPA mandate)

Despite the overall improvement of the key RMCH (Reproductive, Maternal, and Child Health) indicators, accessibility and utilization of RMCH service and information²⁴ among vulnerable groups and across the geographical areas, particularly among the north and north-east province remain a challenge²⁵. Although overall Contraceptive Prevalence Rate (CPR) improved from 56% in 2014 to 62% in 2021-22²⁶, the unmet need for family planning (FP) among married women fell by only 1% between over 2014 and 2021-22. There was also inconsistency in the unmet need across the age groups and populations in different geographic areas. Teenagers have higher unmet need for FP. The unmet need among 15-19 is 19%, compared to 12% among the women between 45-49 years. The women living in rural areas were facing higher unmet needs compared to those in urban areas²⁷. Overall, prevalence of using traditional methods is 17.2% and more women in urban area using the traditional methods compared to their peers in rural area. The health care needs of women and girls in remote areas on health care, hygiene, and nutrition is still a priority for the national agenda²⁸.

According to the recent analysis of the youth situation in Cambodia²⁹, limited knowledge on sexual and reproductive health and safe abortion services have become challenging for teenagers. Among the young aged 15-24 years only 50% understood that a woman can get pregnant with one exposure to intercourse and only 35% had the basic knowledge of the menstrual cycle and the fertile period one can get pregnant. Regarding teenage pregnancy, about 9% have their first pregnancy at 16 or 17, which leads to complications as most of these teenage mothers lack antenatal care, and ultimately leading to potential post-delivery and newborns complications³⁰. Pregnancy complications and unsafe abortions are the leading causes of death among 15-19 year-old girls. Many barriers such as social norms to provide abortion services to young and single women, unstructured abortion fees, lack of highly trained providers, and stigma, rumors and women's fear of ill-treatment were noted. These led to many adolescent girls and women seeking unsafe abortion services elsewhere³¹.

The main challenge of population dynamics lies within the coordination and collaboration between different ministries and institutions to produce official statistical figures. Some feedback from key informants was the CDHS findings on key indicators to achieve the SDGs 2030 are underutilized among the development partners. Relevant stakeholders are doing their own ad-hoc surveys in silos producing confusing population data and statistical figures. The online data sharing platform (CAMSTAT) is not up to date. Although NIS has significantly increased its capacities, internal management and operation of NIS, at both national and sub-national levels, need to improve³² to be in par with new developments. Funding support from development partners for statistical work is decreasing as Cambodia is progressing into an upper middle income country. The technical working group on Data for Development (D4D) is still in need for more technical support and collaboration with and from DPs. While the technical working groups on Planning and Poverty Reduction which is co-chaired by MoP and UNDP under the leadership of the Cambodian Development Council (CDC) for statistics and data

²⁴ Clients' Feedback on Sexual Reproductive and Maternal Health Services in Cambodia: A qualitative study (draft report, September 2022)

²⁵ National Strategy for Reproductive and Sexual Health in Cambodia 2017-20, National Maternal and Child Health Centre, MoH

²⁶ CDHS 2020-21

²⁷ *ibid*

²⁸ Neary Rattanak V: Five Years Strategic Plan for Gender Mainstreaming and Women's Empowerment 2019-2023

²⁹ Youth Situation Analysis in Cambodia (December 2020), UNFPA

³⁰ CDHS 2021

³¹ field interviews

analysis did not function well, D4D did enable the interaction between data user and data producer³³.

The COVID-19 pandemic delayed the CDHS planned for 2020 to be conducted in 2021 and subsequent raw data could not be produced until 2022. Though Cambodia has made some progress in improving the health outcome of the population, gender equality remains a big challenge for the country to reach. The country ranks 12th of the 20 countries in the region in 2021³⁴, compared to the 10th in 2020³⁵ and the global gender gap index for Cambodia is 103 out of 156 countries.

Gender Equality and Women's Empowerment

While laws and policies to achieve gender equality exist, dominant social norms support male authority, including the toleration of violence against women, and hinder gender equality. Cambodia ranks low on the global gender inequality index (112 out of 188). The acceptance of violence against women from intimate partners is high; 27% of men and 50% of women believe that a husband beating his wife for specific reasons is justified. It is estimated that only 24 per cent of women who experience physical or sexual intimate partner violence seek help from formal service providers. Efforts to improve services had significant advances in the health sector response but low coverage and quality remain challenges.

Gender equality and violence against women (VAW) are human rights issues and according to CO documents, they remain one of the major public health issues as well, in Cambodia³⁶. Thus, CP6 included health response to GBV as a key intervention under SRHR. Almost 20% of women in Cambodia experienced all types of violence. A study in 2015 illustrated that approximately 1 in 5 women (21%) aged 15-64 (N=3043) reported ever experiencing of physical and sexual violence, or both, by intimate partner at least once in their lifetime and about one third of these women had reported that their children were present at least 2-5 times when violence took place. According to this study, about 8% of women had experienced some forms of sexual violence by intimate partner in the past 12 months.³⁷ Furthermore, the same study also reported that the prevalence of violence was higher in remote areas, compared to urban area.

The trend of GBV globally has been increased during the COVID-19 pandemic and Cambodia has experienced the same. Evidence of accessing for help through the number of calls to hotline from GBV survivors had increased 7 times higher during the lockdown period (March 2021) compared to the before the lockdown (November 2020)³⁸. The number of searches for information for GBV survivors through internet also had increased by 52% compared to a year before COVID-19 community outbreak in Cambodia³⁹.

As for political participation, the proportion of seats held by women in legislative institutions in 2018 remains low 19.7%, (CSDG, 2019). And the women in commune/Sangkat council were 16.8% in 2017. The critical challenges are the social norms, the limited capacity, education level and the limited social and gender empowerment. For the youth participation and rights also the main challenges are that only 11% be able to talk about their opinion and exchange ideas in the group of people (UNFPA, 2020). responding to this, MoWA developed Neary Rattanak V 2019-2023⁴⁰ - the five years strategic plan for strengthening gender mainstreaming and women's empowerment through five specific strategies; women's economic empowerment, education of women and girls, health of women and girls, legal traction of women and girls, women in public leadership and politics, gender climate change.

³³ KII feedback

³⁴ Global Gender Gap Report, 2021, World Economic Forum

³⁵ Global Gender Gap Report, 2020, World Economic Forum

³⁶ CPAP document for CP6

³⁷ National Survey on Women's Health and Life Experiences in Cambodia, 2015, Ministry of Women's Affairs

³⁸ Abuse of women and children increasing during Covid-19 crisis - Khmer Times (khmertimeskh.com)

³⁹ Ibid

⁴⁰ Neary Rattanak V 2019-2023 by Cambodia Ministry of Women's Affairs

In Cambodia, youth between ages 15-35 years represented 35.8% (46.8% female) of the total population amounting to around 16 million⁴¹. The labor force participation rate of population age 15-59 years is 81.7%; however the unemployment rate of population aged 15-59 years is 1.2%. In general male got married at the aged 27 and female 24.

Given the global trends of young people's issues and situation, Cambodian young people are likely to face many of the same challenges. Based on the previous study of young people's situation conducted by CDRI in 2009, around 300,000 Cambodian young people get pushed out of their education early in order to look for work. Since there were not enough jobs for adolescents and youth, it resulted in continued pressure on public services and resources in education and health. The rural-to-urban migration of young people for employment and education contributes to their exposure to sexual reproductive health risks, such as increased risk-taking behaviour associated with HIV infection and other health development risks, including drug abuse and gender-based violence. Additionally, access to information and communication technology influences attitudes and introduces new lifestyle possibilities throughout the country.

Cambodia has made extensive progress in implementing climate change and disaster risk management interventions over the last decade. According to the UN assessment, Cambodia continues to be highly vulnerable to natural disasters and climate change. Disaster risk and climate changes remained the critical issue, as in 2016 it was 43% of commune/Sangkat vulnerable to climate change (CSDG, 2019). They limited the budget, technology and human resource on implementation the disaster and climate change adaptation. In 2020, the impact of flood on social, agriculture and infrastructure was around 371 million USD⁴². In the same report, Cambodia government set the strategy to prevention and migration before, during, and after disaster with the official committee structure at national, provincial and unofficial structure at commune and district levels. The country capacity to effectively respond and coordinate during emergencies was limited as recognized by the World Index Report 2016 and pointed to an urgent need to strengthen the capacity of the health system to respond to emergencies.

Emerging Issues COVID-19: Challenges in development

Across the globe, the impact of the COVID-19 pandemic on adolescents and youth education has centered on school closures, implemented as a necessary measure to control the spread of the virus. The impact of COVID-19 on education globally is so profound and it is not different in Cambodia.

In general, COVID-19 pandemic, to a certain extent, has disrupted access to essential life-saving information and services, particularly for sexual and reproductive health and rights (SRHR), response to GBV, as well as continuity of education for essential health care providers, and has exacerbated existing inequalities among vulnerable populations⁴³.

The impact of COVID-19 on young people has resulted in Interruptions in the rollout of the programme affecting the learning opportunity of CSE and disruption in opportunities to access SRHR knowledge for young people during the pandemic due to the suspension of school in-person. The findings from a recent situation of young people in Cambodia led by UNFPA in partnership with the National Youth Development Council (NYDC) showed that parents and schools were the main sources of information for young people aged 15-24 about sexual and reproductive health. 33% of males and 29% of female respondents got information on sexual and reproductive health from the formal education, while 18% of female and only 5% of male respondents learned from their mothers. The information lacked input of fathers to the children, especially to sons.

Population surveys in Cambodia (2020) have estimated the percent of disabled persons in the country to range from 2% to 9.5%, over the past decade. . Their access to rehabilitation centres has decreased, and they are

⁴¹ General Population Census of the King of Cambodia 2019, NIS of Ministry of Planning

⁴² Lost and Damage Report 2021, National Committee for Disaster Management (NCDM)

⁴³ documentary reviews related to impact of COVID-19 in Cambodia and interview feedback

often excluded from communication and decision-making due to inaccessibility of information. They have less access to social insurance based on employment than others. The lack or reduction of income may have put a disproportionate burden on people with disabilities, as their households typically face extra costs and expenditure related to disability. Women and girls with disabilities face higher rates of abuse. People with disabilities may be more severely affected by the pandemic due to their health conditions.

Although the country was making economic progress, during Covid-19 impact, there was an economic drop from 5.5% in 2019 to 2.5% in 2020⁴⁴. During Covid-19, 260,000 Cambodia migration workers returned from abroad that impacted on their family income, debt payments, food security and their children's education⁴⁵. The capture of the data for migrant workers, informal sector workers and indigenous communities remained challenging. There is a need to intensify the data collection efforts to produce coherent data and evidence for these groups of people. Specifically, the data collection should be focused on ageing, migration, and VAW and ethnic minority groups. CSDGs (2019) claimed that the proportion of Cambodia population in rural areas with access to safety managed and clean water supply service is 16% in 2018. And the proportion of rural population using improved/basic sanitation is 71.2%. Another challenge on the employment sector is the youth in factories who were temporarily laid off. Based on country office feedback, 90.9% of them could hardly find employment (UNFPA, 2020). They face challenges in getting hired during the economic contraction while adding burdens to families who may already be struggling.

2.1.2 National Strategies

The Royal Government of Cambodia (RCG) and Ministry of Health (MOH) have committed to improve the health and well-being of the country's population by making services accessible and equitable by leaving no one behind. The recent commitment was made by the RGC in the Nairobi ICPD25 in 2019 where the country aims to make progress toward achieving the Three Zero's by 2030 (zero preventable maternal mortality, zero unmet need for family planning, and zero harmful practices and GBV)⁴⁶.

Various policies and national strategies have also been developed to advance the achievement toward the UN Sustainable Development Goals (SDG), particularly good health and well-being (SDG3), SDG4 and the achievement of gender equality and the empowerment of women and girls (SDG5). Education Strategy Plan 2019-2023: CSE was integrated into the core curriculum (2019) based on CSE pilot supported by UNFPA in seven provinces. 2030 Roadmap of Cambodia's SDG 4, Education to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all: Priority 3 Ensuring equal access for all people to affordable and quality technical, vocational and tertiary education, including university. Priority 4: Increasing lifelong learning opportunities for all youth and adults to achieve literacy and numeracy, and learners in all age groups as well. Ministry of Education Youth and Sports (MoEYS) Gender Mainstreaming Action Plan provided education about sexual and reproductive rights in formal education for both male and female students.

Education policy has focused successfully on increasing access to and participation in education opportunities. Importantly, in addition to enrollment and participation in formal education, the priority is to ensure life-long learning opportunities for all youth including technical vocational training. While the Gender Mainstreaming Action Plan only promotes education about sexuality and reproductive rights in formal education for males and females, good practices show that linking out of school CSE to these efforts is most successful.

⁴⁴ Project Information Document (PID) 2020, The World Bank

⁴⁵ Rapid Assessment on Social and Health Impact of Covid-19 Among Returning Migrant Workers in Cambodia, November 2020, UN Cambodia

⁴⁶ Mid-term Review of UNFPA Cambodia, 6th Country Programme, Final Report, UNFPA, 2021

The CSDG framework 2016-2030 was approved by the government in 2018. CSDG places high emphasis on leaving no one behind and provides the basic for development of government strategies. The CSDG has 18 goals, 88 targets, and 148 indicators⁴⁷. Out of these 18 goals, health issues and gender equality are clearly the Cambodia's priorities to address.

The National Strategic Development Plan (2019-2023) set out plans for the implementation of the government rectangular strategies phase IV and to contribute to the realization of the goals set in the CSDG. NSDP focuses on the maintaining of growth, promote global trade, improve financial sector, reap benefits of demographic dividend, maintain peace, and address environmental issues. The Rectangular Strategies (RS) of the government focus on the themes of growth, employment, equity, and efficiency. The RS focuses on good governance and includes 4 main policy rectangles: 1) human resource development, 2) economic diversification, 3) private sector development and 4) inclusive and sustainable development⁴⁸. Cambodia RS⁴⁹ focused on improving the youth quality through skills training, health facilities accessibility to job market, working conditions and opportunities to achieve "One youth has at least one skill in life".

Gender mainstreaming in the education sector is also a key action to implement the Rectangular Strategy Phase 4 of the Royal Government and Neary Ratanak Strategic Plan, in particular, eliminating gender gaps in the education sector. MoEYS has been executing the Gender Mainstreaming Action Plan in the Education Sector 2016-2020 and mainstreaming some issues into the educational policies of all sub-sectors, including the Education Strategic Plan 2019-2023 and the Teacher Policy Action Plan.

In line with the above strategies and plans, the Ministry of Planning has conducted its Voluntary National Review on the implementation of its CSDG 2030 agenda. The process started in 2018 and results showed that majority of CSDG targets were rated as "ahead" or "on track"⁵⁰. The National Strategy for the Development of Statistics (2019-2023) was also developed by NIS of the MOP to provide evidence and data supports for national policy development as well as to provide accurate official statistical figures against the CSDG and NSDP indicators⁵¹. The Profile of Demographic and Gender Dividend was also completed by General Secretariat for Population and Development of the MOP in 2021 to provide evidence-based policy and strategic direction to help the government with its development efforts as well as its international commitments such as ICDP25, CSDG, NSDP, and more⁵².

The National Population Policy (2016-2030) was developed and approved in 2016 to provide more information about the demographic population issues and development. The policy aims to further improve the quality of life and well-being of the people to reflect all the development efforts carried out by the government as specified in the ICDP25, CSDG, NSDP and more. The policy also discussed about the roles and responsibilities of relevant line ministries and development partners as MOP is the lead for this policy implementation⁵³.

The Cambodia Digital Economy and Society Policy Framework (2021-2035) was also developed in 2021. The framework lays long term foundations for digital transformation in all sectors to build a future vibrant digital economy and society. The objective is to build a digital economy by promoting economic productivity and efficiency and to improve the economic welfare of Cambodia's digital society⁵⁴.

The National Ageing Policy (2017-2030) was jointly developed between Ministry of Planning and Ministry of Social affairs veterans and youth rehabilitation (MoSVY) and approved in 2017 by the government. MOP is

⁴⁷ Cambodian Sustainable Development Goals (CSDGs) Framework (2016-2030)

⁴⁸ National Strategic Development Plan, 2019-2023

⁴⁹ Rectangular Strategy Phase IV 2019-2023, Royal Government of Cambodia

⁵⁰ Cambodia's voluntary national review 2019 on the implementation of 2030 agenda for sustainable development

⁵¹ National strategy for the development of statistics (2019-2023)

⁵² Profile of demographic and gender dividend of Cambodia (2021)

⁵³ National Population Policy (2016-2030)

⁵⁴ Cambodia Digital Economy and Society Policy Framework (2021-2035)

taking the lead in the implementation of this aging policy in collaboration with other relevant ministries. The purpose of the policy is to promote the well-being of the older persons. The policy discussed about the general demographic information for aging population as well issues and challenges faced by the older persons. The ministry of social Affairs is the lead implementing agency for this policy to contribute to the well-being of elderly people in the country with support from all relevant line ministries and development partners⁵⁵.

The guiding policy in the health sector is the Health Strategic Plan (HSP) where MOH has developed the HSP 2008-2015 which aimed to enhance the “Accountability, Efficiency, Quality and Equity”⁵⁶ and the HSP2016-2020 was more focused on “Quality, Effective and Equitable Health Service”⁵⁷. To specifically address the gaps in maternal and child health, the National Maternal and Child Health Center (NMCHC) under the MOH with support from various development partners has developed various policies and guidelines to address the maternal and child health issues in Cambodia. These include the updated National Strategy for Sexual and Reproductive Health and Rights (2017-2023) which fully takes into account the National Commitments to the ICPD25 at Nairobi Summit, and the Fast Track Road Map for Reducing Maternal and Newborn Mortality (2016-2020)⁵⁸.

Addressing gender inequality and VAW are on the top agenda of the RGC but currently, out of the relevant ministries, only MOWA and MOH are more responsible for VAW and health service responses to GBV survivors. To address VAW, a multi-sectoral approach is needed and the major policies to address the GBV issues in Cambodia are the constitutional law, Law on Prevention of Domestic Violence and Protection of Victims, draft national policy on gender equality, Neary Ratanak (MoWA), and National Action Plan on Violence against Women (NAPVAW). Health sector response to GBV is a priority agenda across relevant ministries, including MOH and the Ministry of Women’s Affairs. While the health sector response is needed, to be meaningfully effective, it needs to be aligned to justice, counselling, shelters and other services including building women’s trust on these services. The policy and guidelines have been jointly developed to respond to the GBV, this includes the National Guidelines for Managing Violence Against Women in the Health System, and the Clinical Handbook for Healthcare for Women Subjected to Intimate Partner and Sexual Violence, Guideline on Healthcare Response for VAW/GBV survivor 2017 and Guideline for Health Facility Manager for healthcare of VAW/GBV survivors 2020. However, the enforcement of the policy and guidelines for the GBV response is not fully realized, resulting in inconsistent quality of the response for GBV survivors⁵⁹.

2.2 The Role of External Assistance

With the achievement of lower middle-income country status, ODA to Cambodia is likely to decrease, however it will still be a source for complementing other financing sources for key development programmes. ODA has played a less important role in the country’s development and funds have been reduced dramatically in the last decade. As a percentage of GDP, ODA has been decreasing since 2011 (9%) to 2016 (5%) and slight increase is observed in 2019 about 6%. (Cambodia CCA, UN Cambodia, May 2021).

On the contrary, domestic resources (tax and non-tax revenues), remittances and FDI continue to increase to finance rising investment demands for development. In Cambodia remittances play an important role in supporting and smoothing household consumption. COVID-19 has exerted a profoundly negative impact on remittances, with a recent World Bank report predicting that in East Asia and the Pacific countries, including Cambodia, remittances will decline by more than 10 percent.

The total ODA for the period 2018-2019 is given below in Figure 2 and in the same figure, top ten donors of gross ODA and bilateral ODA by sector are also shown. In 2018, net ODA dropped by about a 100 million and

⁵⁵ National Aging Policy (2017-2030)

⁵⁶ Health Strategic Plan 2008-2015, Ministry of Health, 2008

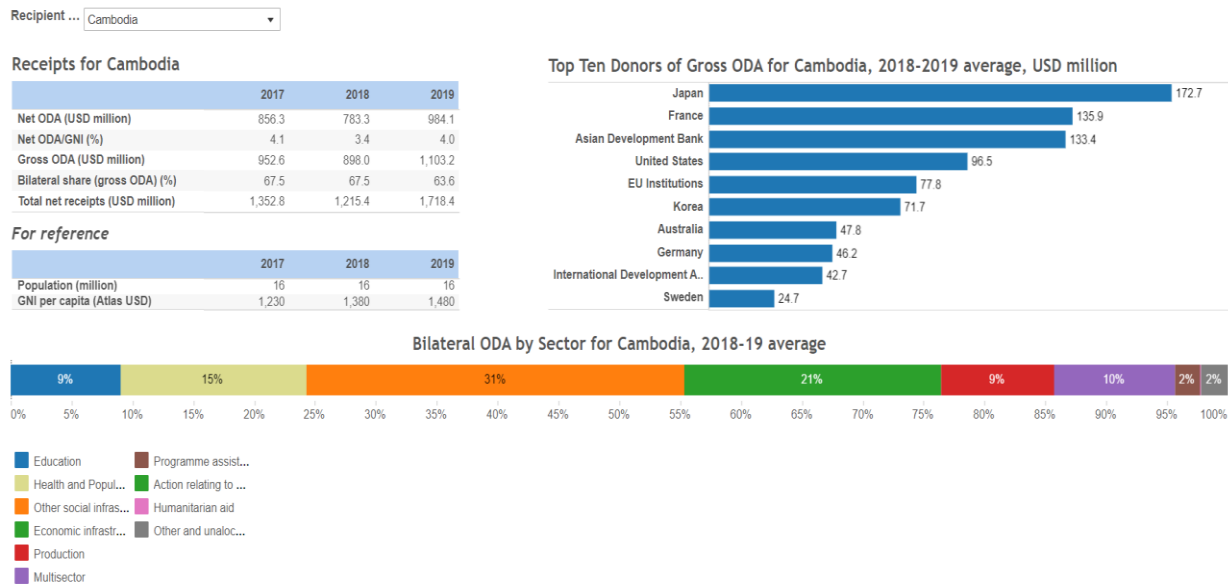
⁵⁷ Health Strategic Plan 2016-2020, Ministry of Health, 2016

⁵⁸ Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality (2016-2020), Ministry of Health, 2016

⁵⁹ EQHA Site Assessment on Gender Based Violence Service Response at Referral Hospitals: Summary Report, FHI360, 2021

increased to 984 million, about 200 million more than in 2018. Cambodia’s top ODA donors are Japan, France and ADB followed by United States, EU Institutions, Korea, Australia, Germany, IDA, and Sweden, in the order of the size of the amount. ODA support to development planning and implementation in Cambodia is in coordination with the development partners and a larger portion of bilateral ODA (31%) goes towards the social infrastructure and economic infrastructure (21%), as indicated below.

FIGURE 3: ODA FOR CAMBODIA USD MILLION (2018-2019 AVERAGE)



Source: OECD - DAC: <http://www.oecd.org/dac/financing-sustainable-development/development-finance-data/aid-at-a-glance.htm>

Source: <https://www.oecd.org/dac/financing-sustainable-development/development-finance-data/aid-at-a-glance.htm>

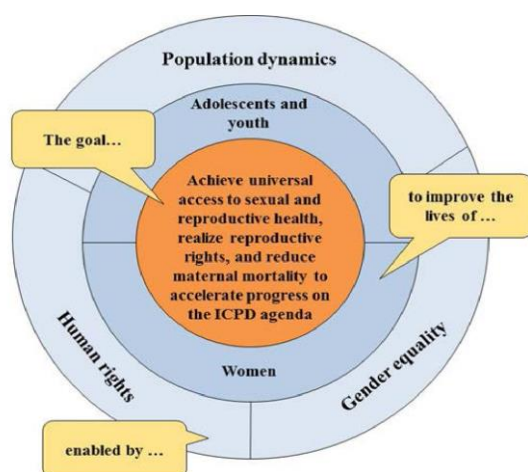
Chapter 3: UNFPA Response and Programme Strategies

3.1 UNFPA Strategic Response

Guided by the global corporate strategy set out in the UNFPA strategic plan, the 2018–2021 Strategic Plan (SP) and SP 2022-2025 cover the first and the second of the three UNFPA strategic plans leading to 2030. It describes the transformative results that will contribute to the achievement of the SDGs. The 2030 Agenda for Sustainable Development provides an opportunity to promote these transformative results and to implement the Programme of Action of the International Conference on Population and Development (ICPD POA). By aligning the strategic plan to the SDGs, most directly to Goal 3 (Ensure healthy lives and promote well-being for all at all ages); SDG4, (Quality Education), Goal 5 (Achieve gender equality and empower all women and girls); Goal 10 (Reduce income inequality within and among countries); Goal 16 (Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels); and Goal 17 (Strengthen the means of implementation and revitalize the global partnership for sustainable development), UNFPA plays a unique role addressing developmental issues with an emphasis on sexual and reproductive health (SRH), reproductive rights (RR), and gender equality (GE) within the context of ICPD POA and SDGs, particularly SDGs 3 and 5.

SP 2018-2021 as well as SP 2022-2025 reaffirmed the strategic direction represented by the “bull’s eye.” UNFPA, globally, works around three transformative and people-centred results in the period leading up to 2030: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c) an end to gender-based violence and all harmful practices. This is planned to be implemented through: UNFPA “bull’s eye” as shown below, for the strategic plan cycles leading up to 2030. The implementation process will be enabled by evidence and population expertise, with a special focus on empowerment of women and young people, especially adolescent girls, both in humanitarian and development settings.

FIGURE 4: STRATEGIC DIRECTION OF UNFPA, THE "BULL'S EYE"



The bull’s eye, the overarching goal to achieve universal access to sexual and reproductive health and reproductive rights (SRHR), has brought clarity and focus to the work of UNFPA. SRH and rights (SRHR) are essential for advancing the SDGs in all UNFPA contexts of operation. UNFPA has taken steps to integrate it into the theory of change, the modes of engagement and the integrated results and resources framework (RRF)⁶⁰.

UNFPA uses its strategic plan to mobilize and align its institutional strategies to the 2030 Agenda, and, throughout the period of its three strategic plans, the organization will monitor the 17 UNFPA-prioritized SDG indicators. To achieve the three transformative results, the strategic plan

emphasizes the need for strengthened partnerships and innovation.

While SP 2014-2017 covered the transition from MDGs to SDGs, SP 2018-2021 is the first cycle of the three SPs leading to 2030 where the achievement of the “three zeros⁶¹” (transformative results) are planned.

While SP 2018– 2021 set the course towards the achievement of the three transformative results, the new SP

⁶⁰ UNFPA Strategy Plan (SP) 2018-2021

⁶¹ Three zeros are to: (a) end the unmet need for family planning; (b) end preventable maternal deaths; and (c) end gender-based violence and harmful practices, including child marriage by 2030.

2022-2025 continues that mission, with what is being unchanged, to meet with the goals of the ICPD Programme of Action. However, the new SP demands a change in how business is done to achieve the objectives set. To achieve that, the new SP has identified six interconnected outputs to invest in (1. Policy and accountability; 2. Quality of care and services; 3. Gender and social norms; 4. Population change and data; 5. Humanitarian action; 6. Adolescents and youth Strategic Plan); and six accelerators to help achieve the outputs: 1. Human rights-based and gender-transformative approaches, 2. Innovation and digitalization, 3. Partnerships, South-South and triangular cooperation, and financing, 4. Data and evidence, 5. Leaving no one behind and reaching the furthest behind first, 6. Resilience and adaptation, and complementarity among development, humanitarian and peace-responsive efforts⁶². In line with UNFPA SP2022-2025, the new UNFPA regional programme in Asia and the Pacific will build on its leadership in SRHR including midwifery and family planning, strengthening approaches to prevention and response to gender based violence, enhancing efforts for domestic financing for the ICPD agenda, guiding implementation of a life cycle approach to population ageing, building national capacity in population data generation, analysis and use, while applying innovative technologies⁶³.

UNFPA's Global Gender Strategy 2018-2021 (Gender Equality Strategy 2018-2021) adopted a two-pronged approach to operationalize gender and rights aspects of its results framework. The first is to mainstream gender, and the second is to have dedicated outcomes for gender equality and reproductive rights (UNFPA, 2019). Priority areas for actions to promote gender equality include strengthening legal, policy and accountability frameworks to gender equality and reproductive rights, strengthening civil society and community action against discriminatory practices and norms against women and girls (including working with men and boys), strengthening multi sectoral approaches to prevent and address GBV, strengthening response to eliminate harmful practices affecting women and girls, and strengthen capacities to develop gender responsive data, statistics, and use it for SDG monitoring (as relevant to UNFPA mandate), advocacy and dialogues.

"My Body, My Life, My World!", UNFPA's global strategy on adolescents and youth, supports the implementation of Youth 2030. It puts young people at the centre of and embraces all adolescents (aged 10 to 19) and youth (aged 15 to 24). It is integral to UNFPA's efforts to achieve three transformative results by 2030 through leadership and innovation of young people for young people, in development, in humanitarian action and in sustaining peace. The strategy prioritizes every young person to have the knowledge and power to make informed choices about their bodies and lives, using sound evidence in designing comprehensive strategies to deliver rights and choices and shared leadership and shared responsibility through government and non- government agencies including youth led and youth serving organisations. The strategy recognizes heterogeneity of youth needs and reaffirms sexuality as a positive dimension of personality.

UNFPA Country Office does not have to change much in its programme components but need to focus more on the accelerators to get to the results faster.

UNFPA has paid special attention to the humanitarian programming, therefore, the UNFPA Global Response Plan is fully aligned to and part of the UN Secretary General's three-step plan to respond to the devastating socio-economic impacts of COVID-19. UNFPA's plan complements the WHO COVID-19 Strategic Preparedness and Response Plan. At the global and regional levels, UNFPA is part of the coordinated UN response under the Inter- Agency Standing Committee (IASC) COVID- 19 Global Humanitarian Response Plan.

The section below discusses the programme specific to UNFPA Cambodia.

⁶² UNFPA Global Strategy Plan 2022-2025

⁶³ UNFPA strategic plan, 2022-2025 (DP/FPA/2021/8) Annex 4 Global and regional programmes : Asia and the Pacific regional programme (2022-2025)

3.2 UNFPA Response through the Country Programme

3.2.1 Brief Description of Previous Cycle Strategy, Goals and Achievements

The fifth Country Programme, 2016–2018, grounded in human rights and gender equality principles, reflects the comparative advantage of UNFPA; it is aligned with national priorities, as reflected in the Cambodian NSDP 2014–2018, the UNFPA strategic plan, 2014–2017, and UNDAF priorities. The proposed three-year duration of the Country Programme is to allow alignment with the UNDAF 2016–2018 and the five-year NSDP 2014–2018. CP5 reflected the principles of the ICPD Programme of Action as it emphasized the value of investing in women and girls including the most marginalized both as an end in itself and as a key to improving the quality of life for everyone.

While the fifth programme cycle was a short one with only three years, the regular resources of the country programme were severely cut at two times, during which period those other resources were also diminishing. However, CP5 had responded aptly together with partners through phasing-out of a selected number of initiatives, leaving core aspects of the programme untouched. This guaranteed the continuation of those parts of the programme that were considered key to the support of UNFPA in-country⁶⁴.

The programme review (CP5) showed remarkable results in the past programme, especially against the backdrop of a substantial drop in resources. Lessons learned and recommendations included the need to: (a) continue high partner involvement in programme design in all areas of UNFPA comparative advantage (SRHR; population dynamics; CSE; and response to violence against women and girls through the health sector); (b) refine prioritization amongst provinces through identification of the most vulnerable communities and groups; (c) increase support to population data gathering and analysis in the monitoring of the SDGs and strengthen capacities in population-related data; and (d) strengthen a systems approach that incorporates short, medium and long-term efforts to build capacity.

3.2.2 Current UNFPA Country Programme

Given the middle-income country status of Cambodia, UNFPA supports the consolidation of earlier achievements as well as ‘upstream’ policy development, advocacy and Knowledge Management in line with the strategic focus of UNFPA’s interventions.

This Country Programme reflects the principles of the ICPD Programme of Action as it emphasizes the value of investing in women and girls including the most marginalized both as an end in itself and as a key to improving the quality of life for everyone. This Country Programme has three outcomes and each outcome has an output. Gender-based violence has been integrated into outcome one as UNFPA has focused more on health sector response to GBV.

TABLE 4: CP6 OUTCOMES AND OUTPUTS

Outcome	Outputs
Sexual and reproductive health (Strategic Plan Outcome 1) <i>Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services</i>	(SP Outcomes 1 and 3 have one output – Output1) 1: CPAP Output 1: Strengthened national and sub-national capacities to provide high quality integrated sexual and reproductive health and rights information and services particularly for the marginalized and vulnerable including in emergencies. (Atlas Project:)

⁶⁴ CPD UNFPA Cambodia and CP5 Review Report

<p><i>and exercised reproductive rights, free of coercion, discrimination and violence.</i></p> <p>Strategic Plan (2018-2021) Outcomes 3:</p> <p><i>Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings.</i></p>	<p>(There is no dedicated output under SP Outcome 3. CP6 has been designed to focus on health response to GBV is included under SRHR) GE is treated as a cross-cutting theme and GE is mainstreamed in all programmatic areas.</p>
<p>Adolescents and youth (Strategic Plan (2018-2021) Outcome 2)</p> <p><i>UNFPA Strategic Plan outcome 2: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts.</i></p>	<p>2: CPAP output 2: Young people, including the marginalized and those in vulnerable situations are empowered with knowledge and skills to make informed choices for sexual and reproductive health and reproductive rights and their well-being in an enabling environment.</p>
<p>Population dynamics (Strategic Plan (2018-2021) Outcome 4)</p> <p><i>UNFPA Strategic Plan outcome 4: Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development</i></p>	<p>3: CPAP output: Strengthened institutional capacities to produce and use data to map out inequalities and emerging population dynamics to inform policies and programmes and improve emergency preparedness.</p>

Source: UNFPA Country Office

CP6, under the three integrated outcomes, implemented mainly upstream interventions focusing on policy dialogue, advocacy, capacity development, partnerships, coordination and evidence generation in partnership with government institutions (MoH, MoEYS, MoP and MoWA), UN agencies and non-government partners. Strategies to address gender inequality were integrated across the programme. The programme continues to support RGC to achieve key SDGs and realize the transformational results of zero preventable maternal deaths, zero unmet need for family planning and an end to gender-based violence by 2030.

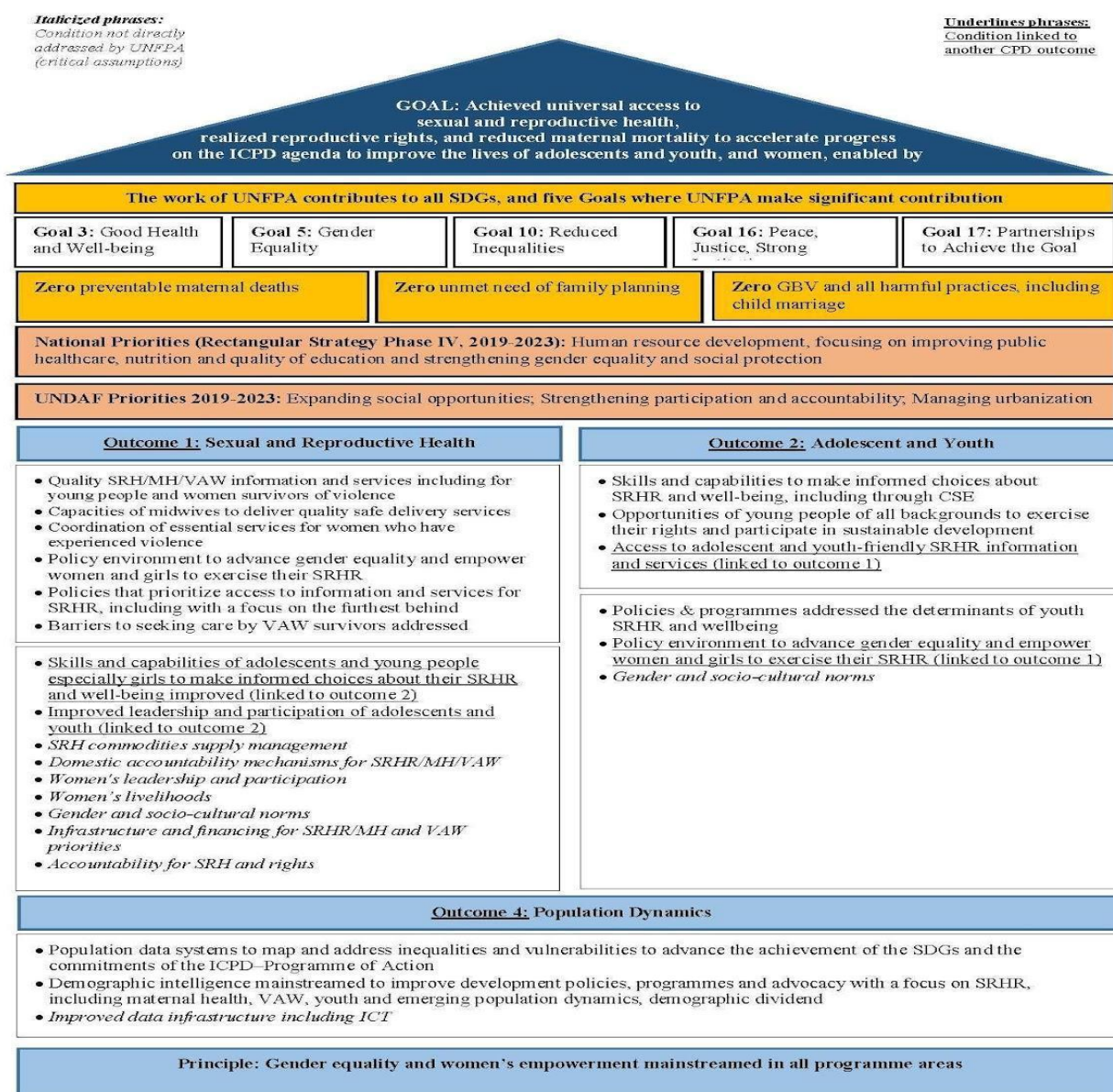
Sexual Reproductive Health and Rights - Output 1: Strengthened national and sub national capacities to provide high quality integrated sexual and reproductive health and rights information and services particularly for the marginalized and vulnerable including in emergencies. The main strategies are to provide policy support and strengthening capacities of health sector to deal with SRH needs of the vulnerable population including GBV survivors. In addition, it is also in line with SP Outcome 3 as the strategies also aim to achieve the results through provision of technical advice and capacity building support for the development of primary prevention of violence programs which could be implemented at sub/national levels and scaled up as part of MoWA national programme and priorities set out in national policy frameworks –National Action Plan on Violence Against Women (NAPVAW) Phase III This strategy will also involve advocacy, raising the awareness among rights holders of their rights and of the universality of rights.

Adolescent and Youth: Output 2: Young people, including the marginalized and those in vulnerable situations, are empowered with knowledge and skills to make informed choices for sexual and reproductive health and reproductive rights and their well-being in an enabling environment, the main strategies to achieve the results through provision of technical advice for the revision of the health education curriculum and syllabus frameworks and training strategies for teachers in line with international guidance and UN frameworks for CSE. This will provide opportunities for young people to develop their health knowledge and health seeking behaviours, reducing the risk of unwanted pregnancies, disease including HIV and promoting positive relationships, respect and gender equality. UNFPA focuses on strengthening the health system for adolescents and youth friendly services and comprehensive sexuality education.

Population Dynamics: Output 3: Strengthened institutional capacities to produce and use data to map out inequalities and emerging population dynamics to inform policies and programmes and improve emergency preparedness. The main strategies to achieve the results include the provision of technical support to design and conduct the population census in 2019 adhering to international standards and guidelines. The strategy also involves building the technical capacity of the NIS and different line ministries and subnational planning bodies to analyse and disseminate disaggregated data including the CDHS 2021/2022.

UNFPA Cambodia CO also takes part in activities of the UNCT, with the objective to ensure inter agency coordination and the efficient and effective delivery of tangible results in support of the national development agenda and the SDGs. Beyond the UNCT, the UNFPA Cambodia CO participates in the Humanitarian Country Team (HCT) to ensure that inter-agency humanitarian action is well coordinated, timely, principled and effective, to alleviate human suffering and protect the lives, livelihoods and dignity of people affected by humanitarian crisis.

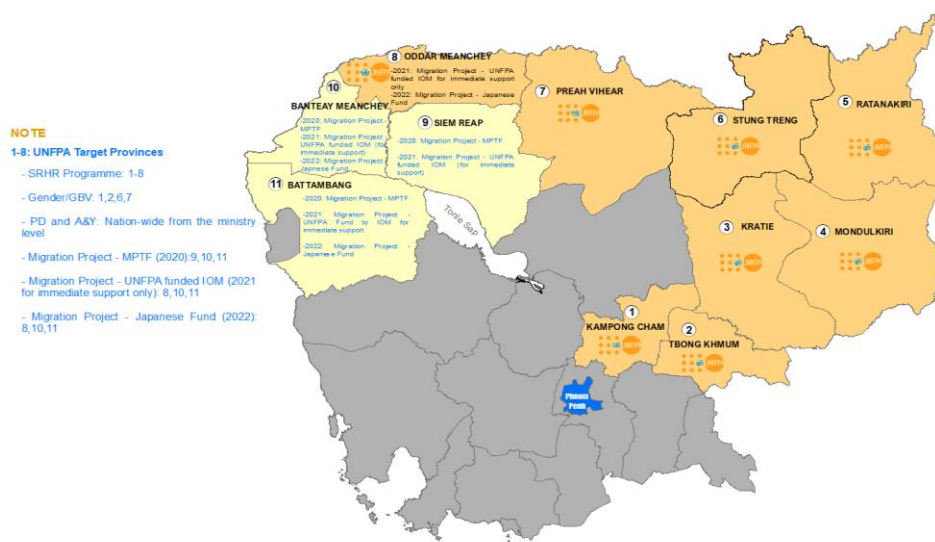
FIGURE 5: CP6 PROGRAMME LOGIC



According to the discussions held with the country office, the original plan was kept on schedule, with some interventions such as training being completed using online methods moving to more virtual mode of interaction. As such there has been no programme change due to COVID-19, except some changes in the delivery mode to suit the prevailing pandemic context at that time. Responding to COVID-19 pandemic, with Japanese funds, in addition to the CP6 planned programmes, UNFPA supported RGC to build a resilient and responsive health system to ensure that vulnerable populations in the target areas have continuous access to quality SRMNAH services and information. Project plan expected to cover the same provinces as was in the original CPAP⁶⁵. Another addition was the UN joint project on migration in 3 provinces as response to Covid-19 context. Three provinces were added to the existing eight provinces as the map below (Fig 6) illustrates.

Geographical coverage of CP6 Interventions

FIGURE 6: MAP ILLUSTRATING THE CP6 PROGRAMME INTERVENTION SITES



The process of geographic prioritization at subnational level involved an in-depth evaluation and analysis of several key indicators across the country with updated data sources. They are the locations that are performing poorly in comparison to the national averages, in line with CPE (CP5 evaluation) recommendations, where existing partnerships and resources can be leveraged, and where thematic convergence is possible. The result of this analysis and following in depth discussions with government partners during CPAP planning workshops was the basis for the selection of a total of 9 provinces that include Phnom Penh, for joint interventions across the three outcome areas. Figure 5 shows the schematic view of the 6th country programme logic.

UNFPA supported interventions are spread across the country for policy and strategy related work, through the relevant ministries, related to all thematic areas (SRHE, AY, PD with GE cross-cutting), and with a focus on development interventions in priority provinces with high need, covering 8 provinces (Kampong Cham, Kratie, Mondul Kiri, Oddar Meanchey, Preah Vihear, Ratanakiri, Stung Treng, Tboung Khmum and upstream work in Phnom Penh) with a varying degree of maturity, concentration and focus. As shown in the map, provinces 1-8 are the UNFPA target provinces, all of them having the SRHR interventions. 8-11 indicate the provinces with the migration project in response to COVID 19. Provinces 9, 10, 11 are added later as response to COVID-19 related to migration resulting in a Joint UN project by IOM, UNFPA, UNICEF and WHO. Oddar Meanchey (and two other, 10 and 11) received only immediate support on migration (Phase 1 in 2021 and phase 2 started in June 2022). Four provinces out of the eight, Kampong Cham, Tbong Khmum, Preah Vihear, and Stung Treng (1,

⁶⁵ Phnom Penh, Kampong Cham, Tbong Khmum, Ratanak Kiri, Mondul Kiri, Stung Treng, Kratie, Oddor Meanchey, and Preah Vihear

2, 6, and 7 in the map) cover Gender and GBV interventions.

For each of the outputs, CO provided an operational plan along with types of intervention that was developed at the beginning of the CP-6 implementation. The operational plan served as the basis to assess the current programme and through discussions with CO staff and document review provided background for updating/reconstructing the existing logic model, considering the emerging priorities due to changing context with the introduction of new policies and programmes as response to COVID19.

3.2.3 The Country Programme Financial Structure

Given the middle-income country status of Cambodia, UNFPA supports the consolidation of earlier achievements as well as ‘upstream’ policy development, advocacy, and Knowledge Management in line with the strategic focus of UNFPA’s interventions (CPD, 2019-2023).

TABLE 5: OVERVIEW OF THE BUDGET (ALLOCATION INDICATIVE) FOR THE PROGRAMMATIC AREAS OF CP6: 2019-2023 (USD) INDICATIVE FIGURES

Strategic plan outcome area	Regular Resources	Other Resources	Total
SP Outcome 1: Sexual & Rep. Health	5.70	2.35	8.05
SP Outcome 2: Adolescent and Youth	0.80	1.00	1.80
SP Outcome 4: Population Dynamics	1.30	1.35	2.65
Programme coordination & assistance (PCA)	0.50	0	0.50
Total	8.30	4.70	13.00

Source: UNFPA Cambodia Country Office.

As of mid-year, 2022 when the evaluation was done, a little over 3.7 million was mobilized (out of the planned 4.7m) and close to 1 million (\$966,360) needs to be mobilised by the end of 2023" Out of 4.7m of OR that is needed for the whole programme cycle, \$3,703,640 has been mobilised. Thus, \$996,360 more needs to be mobilised to meet the needs in the remaining one hand half years (from mid-year 2022 to Dec 2023).

A table showing the overview of CP6 resource allocation and expenditure for the programmatic areas from 2019 up to June 2022 (CPE scope) can be found in the Additional Information Part2 Annex.

Chapter 4: Findings - Answers to the Evaluation Questions

This chapter provides the answers to the main evaluation questions. Key assumptions considered (refer to Evaluation Matrix-Annex) at the evaluation design stage are assessed using findings from triangulated data sources.

4.1 Answer to Evaluation Questions on Relevance

Relevance: Evaluation question 1(EQ1):

1. To what extent did the programme (i) adapt to the needs of the population (in particular, the needs of vulnerable groups), (ii) align with government priorities (iii) align with the priorities and strategies of UNFPA (leaving no one behind and reaching the furthest behind), and (iv) align with the UNDAF 2019-2023?
2. To what extent was the country office able to respond to changes in the national development context and priorities?

CP6 has three (3) outputs under four SP outcomes. Due to the commonalities across all 3 outputs, the Relevance criterion is discussed together for all three outputs.

Summary of findings

UNFPA CP 6 is aligned with national programme priorities and strategies related to thematic programmes SRHR, AY, PD, as well as cross cutting areas such as gender equality and inclusiveness. At the national level, supporting the government priorities, CP6 took into consideration the national policies, strategic development plans (NSDP, CSDG, etc.), ICPD POA, other international treaties that Cambodia is part of and maintained alignment with UNDAF, when planning the interventions. The nature of the programme design is such that an integrated approach to programme interventions like SRHR, AY, and PD programmes together contributes to the transformative results.

CP6 leveraged digital technologies, audio-visual and edutainment measures to ensure continuity of engagement with young people, countering stigma and discrimination and addressing youth mental health concerns (through helpline) during COVID-19. Covering the humanitarian context that includes flooding and COVID-19, as per its global mandate, UNFPA's response during humanitarian crisis focused on the provision and continuation of services for pregnant women, women of reproductive years and adolescents to reduce mortality and morbidity among them. Supplies of dignity kits to women and girls are a significant contribution. During COVID-19 the focus was on the continuation of SRH services including for adolescents and youth (details provided under the effectiveness section). UNFPA joint MPTF enabled thousands of returning migrant workers particularly pregnant women, to access the essential SRHR information and services, including COVID-19 prevention.

Finding #1: CP6 design stayed relevant to the national strategies and priorities, aligned with UNDAF, UNFPA mandate, and the needs of the intended populations.

The UNDAF 2019 – 2023 outlines the partnership between the UN and RGC in support of the national development priorities as articulated in the Rectangular Strategy-Phase IV (RS-IV) and the 2030 Agenda. UNFPA support to the RGC is aligned with UNDAF, UNFPA Strategic Plan 2018-2021, and SP 2022-2025 principles (leaving no one behind and reaching the furthest behind), transformative results, and the business model. Program design and implementation reflect the needs of marginalized and vulnerable adolescents including adolescent girls, youth and women and migrants population (evidence: baseline, need assessments, situation analysis, thematic assessments on gender and key informant interviews).

UNDAF covers the five-year period of 2019-2023 and aligns with the National Strategic Development Plan 2019-2023. Five results groups, one for each of the five UNDAF outcomes, are established to lead and guide the UNDAF formulation and implementation, using Joint Annual Work Plans. UNFPA contributes to RG1 being the co-chair for that group. In support of national development priorities, as part of an integrated approach to sustainable development, UNDAF the UN system wide planning framework provides strategic orientation and an overview of the key results that the UN system aims to deliver.

UNFPA maintained programme relevance, keeping in line with government priorities, and the beneficiary needs in all key thematic areas, by updating the programme upon feedback gathered during monitoring missions as well the suggestions received from key stakeholders at annual reviews, thus maintaining the CP6 relevance under the outcome areas (SRHR, Youth & Gender, and PD) to the national priorities, the National strategies Provincial needs, and the needs of the beneficiaries. Operational strategies designed are results-based, gender-mainstreamed and have taken a human rights based approach. The design process as well as the implementation review process of the CP show evidence of national ownership, stakeholder engagement in decision making and progress monitoring of results.

Evident from baseline data, situation analyses, pilot studies, compilation of lists of vulnerable groups, the selection of priority provinces, and evaluations conducted prior to program intervention, CP6 design took into consideration addressing the needs of the vulnerable groups, however, reaching out to those who are furthest left behind in the implementation there was a gap due to the nature of the engagement UNFPA had, i.e. more engagement in policy and advocacy and the implementation rested more on IPs on the ground. Effective engagement of CSOs to translate the policy to action was limited. With SRHR across the propriety provinces, implementation addressed the needs of women, pregnant women, vulnerable and marginalized adolescents and youth and provided platforms for youth to directly advocate for their needs and concerns as related to SRHR.

While a dedicated output on gender equality and gender mainstreaming is not included in the CP6, as was in CP5, GE is integrated across other thematic areas with indicators to measure, and the related work is carried out with a budget allocation to carry out the integrated, cross-cutting interventions on gender equality. Furthermore, the CSE curriculum design is gender transformative. Health response to GBV is integrated in SRH and most of Gender related interventions are embedded in the SRH thematic area. Gender equality is cross-cutting and integrated into all areas. CSDG5 has included an indicator to measure intimate partner violence to capture aspects of VAW and GBV.

UN joint programme (UNDP, UNFPA, and UN Women) on “Programme to Promote Disability Inclusion and Quality Services for Gender-Based Violence (GBV) Victims”, has contributed to fulfilling Cambodia’s commitment towards the implementation of the National Disability Strategic Plan 2019-2023 (NDSP2) and the Third National Action Plan to Prevent Violence Against Women 2019-2023 (3rd NAPVAW). The programme contributed to the achievements in policy and legal framework development, institutional system strengthening and capacity development, and sustainable establishment of the networking between development partners (DPOs) and local authorities.⁶⁶

Humanitarian response plans were included at the design stage to address emerging issues specifically in the humanitarian context. Annual review meeting feedback⁶⁷ and the modifications made to the results framework and the programme components, and the programme shift to accommodate changes in the development context reveal the country office’s agility to respond to emerging needs.

⁶⁶ Final programme1 narrative report on “Programme to Promote Disability Inclusion and Quality Services for Gender-Based Violence (GBV) Victims” reporting period: 01 September 2019 – 30 November 2021 and CO interview feedback

⁶⁷ Minutes of annual review meetings (2020 and 2021), RRF Country Office

CO documentation and feedback from the field interviews reflected that investments in midwifery and support through the Joint UN responses for COVID-19 preparedness and mitigation activities enhanced CO's ability to respond to changing needs and priorities in the humanitarian context.

Finding #2: The needs of vulnerable groups were incorporated in the design and the implementation of CP6 and adjusting to the change of local context, especially under the COVID-19 pandemic (information referring to COVID-19 appears in several sections as most of the work in CP6 is during the pandemic)

UNFPA's response during humanitarian crisis (floods and COVID-19) focused on the provision of MISP for pregnant women, women of reproductive years and adolescents to reduce mortality and morbidity among them. Supplies of dignity kits to women and girls have been a useful and timely contribution. During COVID-19, the focus on the continuation of SRH services including for adolescents is detailed under the section on evaluation criteria Effectiveness. Gender equality is largely integrated into the design of humanitarian and COVID-19 response, with its commitment to the implementation of MISP for RH.

To ensure the needs of vulnerable groups are addressed in CP6 implementation, UNFPA carried four main activities:

(1) Annual review workshop was conducted with IPs and partners to share lessons learned, challenges and identified/ensure the needs will be incorporated in AWP of each fiscal year,

(2) Each programme lead carried out quarterly meetings with their own IPs to review the progress and adjust the interventions to ensure those needs were maintain through-out the programme cycle,

(3) carried out research/assessment to identify the need and re-orient the intervention to respond to the needs of vulnerable groups. E.g. the study impact of COVID-19 on returning migrants (UNFPA with three UN agencies), results are used in developing IEC to educate returning migrants of SRHR; the rapid assessment of impact of COVID-19 to essential SRHR service. Another specific intervention to build a resilient and responsive health system to ensure that vulnerable populations in the target areas have continuous access to quality SRMNAH services and information was added as response to the pandemic⁶⁸, and

(4) Strategic Information System (SIS): UNFPA produced quarterly reports, annual reports through SIS, which outputs and progress were used to support the planning of the next AWP to ensure or maintain the needs of those vulnerable groups continue to be in the on-going intervention of CP6. The needs of vulnerable groups were incorporated in the design and the implementation of CP6 and adjusting to the change of local context, especially under the COVID-19 pandemic (more in the section on response to COVID-19).

While the UN joint programme stated above addressed disability in GBV, there is more room to focus on people with disabilities as was observed in the programme documents as well as field visits. CO feedback revealed the reason was partly due to the fact that disability inclusion became part of the work plan later in its design and the effort so far is too early to assess the results. While the investments are made in provinces focusing on geographical areas with vulnerable populations (girls and women focus including in humanitarian crises) disaggregated information is found to be available, however for the PWDs, the data was limited⁶⁹.

Finding 3: CP6 stayed relevant, adapting to changes in the national development context and priorities.

During CP6, major changes in the national development context and its priorities were mainly related to the humanitarian crises, mainly COVID-19 and there were no other changes in the country context, except that RGC was moving towards digital economy. The priority of RGC during the pandemic was to mitigate its impact and minimize the spread of the pandemic.

Based on interview feedback and CO input, UNFPA has successfully delivered its programming even in the COVID-19 period, opening youth helplines, and investing in relevant and yet emerging programmatic priorities

⁶⁸ Country Office SIS and CO interviews

⁶⁹ CO file monitoring reports, ET field visits and CO interviews

such as counseling on GBV and MHM. More input on this is in the findings under the Effectiveness criteria section.

Other area of priority was RGC focusing on digitalization of the economy. Digital platforms were used, as explained in the Effectiveness section, to try and ensure continuity of capacity development and SRHR service provision during lockdown period and young people were actively involved in COVID-19 related awareness generation and supported local government in addressing the hesitancy to be vaccinated. Digital platforms also challenged gender norms during COVID-19, like breaking the silence on GBV and sharing of domestic/care work. The social media on SRHR topics were shaped and published which accessed million viewers during the pandemic.

4.2 Answer to Evaluation Questions on Coherence

Coherence EQ3. To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT?

Coherence EQ4

To what extent have issues pertaining to sexual and reproductive health and rights (SRHR) and GBV, been adequately integrated and addressed in joint COVID-19 response and recovery programming with UNFPA's leadership?

The following discussion relates to both EQ 3 and EQ4, as some responses are common and overlap.

Summary Findings:

Overall, the coordination role played by UNFPA within UNCT is well recognized, respected and appreciated by the UN agencies that provided responses.

The UNFPA Cambodia CO takes part in activities of the UNCT, with the objective to ensure inter agency coordination and the efficient and effective delivery of tangible results in support of the national development agenda and the SDGs. Beyond the UNCT, the UNFPA Cambodia CO participates in the Humanitarian Country Team (HCT) to ensure that inter-agency humanitarian action is well coordinated, timely, principled and effective, to alleviate human suffering and protect the lives, livelihoods and dignity of people affected by humanitarian crisis.

UNFPA's leadership in technical assistance is well recognized in joint UN initiatives and partnership with development agencies. With UNFPA's comparative advantage in rights-based approach to development, partnering at national and sub-national level with MOH, MOP, MOWA and MOEYS and other national institutes, on SRHR, AY, PD and GBV, UNFPA added value in incorporation of rights-based approaches in the provision of services and monitoring.

UNFPA addressed SRHR and GBV and integrated these in responding to COVID-19 as well as continuing to include them in the recovery programmes, in joint programmes with the UN agencies as well as government partners. More discussion is under the Effectiveness criteria. An initiative on building a resilient and responsive health system ensuring the vulnerable populations have continuous access to quality SRMNAH and GBV services and information is still in its early stages to assess its results.

Finding #4: UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT:

Under the leadership of the Resident Coordinator, the UNCT provides overall leadership to the work of agencies in the country. It serves as a platform for UN agencies to formulate common positions on strategic issues, ensure coherence in action and advocacy, and to plan and deliver work together.

UNDAF/CF is the most important instrument for the planning and implementation of UN development activities in each country. All UNCT members actively engage in all stages of the UN Cooperation Framework process, including through UN results groups and joint work plans.

UNDAF in Cambodia has four key Accelerators⁷⁰ which are expected to strategize and prioritize programming to speed up the achievement outcomes of selected SDGs and UNDAF outcomes. Out of the four accelerators, UNFPA leads two: youth and data. Youth (Empowering youth to realize their full potential, and Cambodia to reap its demographic dividend and accelerator four is to ensure greater availability and use of high-quality disaggregated data for sustainable development. UNFPA CO also takes part in activities of the UNCT, with the objective to ensure inter-agency coordination and the efficient and effective delivery of tangible results in support of the national development agenda and the SDGs.

UNFPA's active participation in UN Joint Programming and in working groups as chair, co-chair, and lead in RGs, TWGs, etc. and UNFPA's convening power are seen as positive contributions to UNCT.

UNFPA has been very responsive and has played a strong coordination role in the Humanitarian Context. Based on interview feedback and documented evidence, UNFPA had been relevant and adaptable to the situation working jointly with other UN agencies. A key informant commented, "UNFPA had been resilient, responsive and strategic in responding to the emergency needs, specifically during COVID-19 pandemic period, addressing those of the vulnerable, disadvantaged and marginalized groups in a timely manner (e.g. Joint response in the migration project including four provinces)." UNFPA's participation was not only seen as valuable, but seen as a partner who is a joy to work with and a key respondent mentioned, "I would be ready to work in partnership with UNFPA anytime."

Finding #5: UNFPA adds value to the results of other development actors' interventions:

Main comparative strengths and how UNFPA adds benefits to the results of other development actors' interventions have been the strong voice UNFPA brings to the table on human rights issues. Strong advocacy role, especially the sensitive areas (e.g., human rights, SRHR, ASRH with CSE, GBV) that UNFPA focuses and works on have been commended highly by key stakeholders. There is no other agency that lobby for ASRH, in the minds of many.

Partners look up to UNFPA for its long-term partnership working with key government agencies (MoH, MoEYS, MoP, and MoWA). Data and support in national surveys and research (Census, EMOC studies, input to CSE curriculum, youth related studies), and the global technical expertise and experience UNFPA brings into the country are valued by development partners. UNFPA-focused areas aligned well with the government priorities for long-term cooperation. Joint programming experience – good coordination and leadership role that UNFPA has and bringing the development partners together are seen as key areas that UNFPA adds value to the development of the country and the to the partners UNFPA works with.

UNFPA Cambodia's comparative advantage is evident particularly in the areas of SRHR through building capacity of midwife workforce for service quality improvement, in Population Dynamics, where it has a unique support position in line with its mandate for generation of quality data for evidence based policy making, CSE in terms of Adolescents and Youth programming and multi-sector approach to VAWG and GBV through the health sector and local government. In terms of policy and advocacy support UNFPA has added value in all four programme components-

Examples of UNFPA long-term work in SRHR, Data, health response to and rights-based approaches to FP, GBV are all explained under different sections, especially under Effectiveness 4.3. Perceptions of comparative advantage of UNFPA in general is the global pool of quality technical assistance that UNFPA is able to mobilize and

⁷⁰ different from the UNFPA SP 2022-2025 six Accelerators

draw from for the CP as well as at national level needs as appropriate. UNFPA also holds a longstanding leadership role in the areas of SRHR and PD. In the resource shrinking environment, and more development partners entering into similar fields, the niche UNFPA had in these two key areas may not stay the same unless adequate technical resources are allocated and rights- based approaches to maternal health, FP programme and joint programmes are promoted on the ground. UNFPA’s technical leadership and strategic partnerships in establishing collaboration between the government as well as non-governmental development partners are clearly added values⁷¹.

Finding #6: Within the division of labour, UNFPA CO has actively contributed to UNCT working groups, results groups, and joint initiatives, ensuring synergy and maximizing and optimizing results, both in development and humanitarian contexts

During the response to COVID-19 pandemic UNFPA contributed in the implementation of the joint UN response at national and provincial level in health sector response to GBV (for details see section 4.3). The joint collaboration responding to COVID-19, in the western provinces had been satisfactory and the experience could be replicated in similar settings elsewhere, with necessary modification to the context. An initiative on building a resilient and responsive health system ensuring that the vulnerable populations have continuous access to quality SRMNAH services and information seems very positive; however the initiative is still in its early stages to assess its results⁷².

UNFPA has been contributing to Results Groups: UNFPA co-chairs in RG1 (“expanding social opportunities” - PEOPLE pillar) working closely with UNICEF. Each results group is co-chaired by two Heads of Agencies, to take appropriate decisions and lead the results groups in the implementation of the Joint Work Plans. The results groups’ chairs are collectively responsible for the overall performance of the results groups and accountable for the coordinated achievement of results in the Joint Work Plans⁷³.

Beyond the UNCT, CO participates in the Humanitarian Country Team (HCT) to ensure that inter-agency humanitarian action is well coordinated, timely, principled, and effective, to alleviate human suffering and protect the lives, livelihoods, and dignity of people affected by humanitarian crises.

Taking a leading role in gender, UNFPA is a key partner in different forums such as UN Theme Group on Gender (Co-Chair), Technical Working Group on Gender –GBV (TWGG-GBV), Provincial and District Working Group on GBV (Technical and Financial Support), and Humanitarian Response Forum and Protection Cluster (Lead GBV in Emergency (GBViE). UNFPA was able to localize the recommendation from two studies (Gender Dimension and VAW Big-data) to mobilize resource from potential donors. This also had helped gender dimensions to be mainstreamed and to remain engaged with the working partners to focus on the GE programme priorities.⁷⁴

Finding # 7: Additional work and innovative initiatives are being done to contribute to the improvement of health service response to GBV in emergency settings such as COVID 19 pandemic

In response to COVID-19, UNFPA and MoWA have embarked on innovations, which are very helpful in responding to the pandemic and also built into the multi-sectoral GBV response mechanism: Some initiatives by UNFPA are listed below:

- Moved quickly from in-person meeting/training/workshop to work *via zoom and virtual arrangements*.
- *Big data on VAW*: with UNFPA support, the Big data on VAW was conducted in mid-2021 to see VAW incident and its trend during the pandemic to capture how women/survivors use the internet to seek help.

⁷¹ documents review and interview feedback

⁷² Country office Monitoring and Trip Reports, KII feedback

⁷³ UNCT meeting minutes, KII feedback, CO monitoring reports

⁷⁴ TWG reports, CO interview feedback and related documents

- *Increased use of social media* to promote access to essential GBV services to ensure continued access to services despite the pandemic.
- *Increased online dialogues* to promote the awareness of VAW and access to services
- *Initiate GBV digital platform* for awareness raising, services information, and access to services need (Chatbot and SAFE APP)

During COVID-19 outbreak 2020-2021, UNFPA still supported MoWA to use virtual approach to conduct regular quarterly meetings and trainings on GBV. The supports also assisted MoWA to develop IEC materials including e-message, spots, and radio program for awareness raising on GBV prevention and services available to ensure people with disability could understand and receive information (MoWA, 2022)⁷⁵. According to UNFPA annual report (2021)⁷⁶, in 2021, 71,460 adolescents and youth (51,051 females) were reported utilizing AYFH services at the health facilities in the eight targeted provinces.

(More information is available under SRHR Effectiveness section below)

4.3 Answer to Evaluation Questions on Effectiveness

Evaluation Question 5. To what extent have the expected outputs and outcomes of the programme been achieved or likely to be achieved? What were unintended results of the programme?

Evaluation question 6: To what extent were gender equality, equity and human rights and disability dimensions effectively incorporated into the CP design, implementation and monitoring *iii) what were the factors (external and internal) that facilitated or hindered the achievement of intended results?*

***Findings on Effectiveness criteria are reported separately under each thematic area. Both questions (EQ5 and 6) are addressed together. Unintended results of the programme are reported under 4.8.1.**

SRHR Effectiveness: Answers to EQ 5 and 6

Summary Findings:

UNFPA has contributed to the country's improvement in SRHR in improving SRHR policies/strategies, incorporating health service response to GBV, improving the EmONC services, strengthening FP services, providing support to the MoH through the in-service and pre-service midwifery education and by supporting the public training institutes including TSMC/UHS, 4 RTCs, and Health Science Institute of Royal Cambodian Armed Force, to renew pre-service midwifery curriculum to align with the ICM and international standard,. Through these, UNFPA is addressing the principle of leaving no one behind (LNOB), but there is more room to target these populations and to engage more CSOs at sub-national, especially at community level. Quality of care also needs more time for improvement. For in-service training, UNFPA supported the NMCHC in providing clinical skills for the midwife workforce to enhance the life-saving skills in the target provinces. Lastly, UNFPA successfully contributed to the AYFS services and health response to GBV in UNFPA priority provinces where GBV was included. Disability dimension was included in the curriculum (midwife as well as AY) Performance of SRHR in CP6 is indicated in the table below and the targets are achieved according to planned schedules. The interventions are planned to contribute to the outcomes by laying the necessary foundation and the output performance indicate that SRHR is likely to achieve its outcomes, but would take a longer time, beyond CP6. Quality improvement of SRHR services also has been raised as an issue.

Support of UNFPA through the capacity building of the COVID-19 and SRHR service was acknowledged. Challenges faced in rural HCs include the coverage of the internet for rural HCs, limited skills of senior staff

⁷⁵ Mid Term Review and Annual Workplan 2022

⁷⁶ Annual Report 2021 – Cambodia, UNFPA 2022

on ICT and the use of mobile phone which didn't support the modern technology of e-learning platform.

Table 6: SRHR Progress to Date (as per M&E performance data on output indicators)

The Progress: Indicator (Baseline vs Target)			
CP6	Baseline (2019)	Target (2023)	Results (Jun 2022)
Compact of Commitment: safe deliveries will be performed at health facilities equipped with skilled health personnel, especially midwives, who provide high quality life-saving interventions based on national standards, across high maternal health needs provinces targeted by UNFPA in Cambodia.	55,000	275,000	173,581
Indicator 1: Percentage/number of midwifery schools that implement the national pre-service curriculum based on the ICM standards	0	6	3
Indicator 2: Number of health facilities per 500,000 providing emergency obstetric and newborn care according to international standard	18	30	25
Indicator 3: National Gender Policy and Strategy includes specific strategies to address barriers to accessing sexual and reproductive health and VAW information and services.	No	Yes	Yes
Indicator 4: Percentage of public health facilities that provide essential health services to women survivors of VAW in 5 UNFPA focus provinces.	28%	50%	44%
Indicator 5: Percentage of public health facilities that provide quality-assured, adolescent-friendly integrated sexual and reproductive health services in 8 UNFPA focus provinces.	28%	50%	44%

Source: UNFPA CO

Finding #8: UNFPA successfully contributed to the improvement of policies/guidelines (review, renew, develop and implement policies) on SRHR and Gender Equality according to international standards keeping in line with the principle of “leaving no one behind”, there is more room to engage more CSOs at sub-national, especially at community level, to see these policies get translated to action on the ground..

UNFPA has made great progress to contribute to the improvement of SRHR policies in the country. Under CP6, UNFPA has contributed to the review, renewing and updating policies and guidelines, and developing new policy/guidelines. Support extended to MoWA has been positive in ensuring that the policies are in place: completing the Draft National Gender Policy and Strategy (including specific strategies to address barriers to accessing sexual and reproductive health and VAW information and services), updating Cambodian Gender Assessment, developing and implementing the new National Action Plan on VAW (Policy dialogues on VAW conducted (influence DV law review), national budget and address barriers faced by women), assisting the Five-year Gender Strategy (Neary Ratanak V) to be endorsed and disseminated, and conducting the GBV campaign. UNFPA support in advocacy and engagement of more local level CSOs and other partners seem to be limited to ensure the implementation of the policies and strategies at ground level where it is most needed. However, it is too early to see the outcome as most these have not been translated to action.

Nationally, according to 2021-22 CDHS shows significant progress in SRMH services. However, MMR declined minimally. The unmet need dropped minimally from 13% in 2014 to 12% in 2021. Access to SRHR information and services (including the modern contraceptive and ANC), particularly among the indigenous population

remained an issue⁷⁷. This proves there is a need to further improve the quality of SRHR service and access to SRHR information among certain vulnerable groups, if the 3 zeros are to meet by 2030.

The key SRHRH policies successfully supported by UNFPA within the CP6 programme cycle are included in CPE Annex part2.

Keeping in line with the principle of “leaving no one behind”, UNFPA has also successfully integrated gender (GBV) and disability into policy advocacy. For example, UNFPA has incorporated gender (GBV) and disability in pre-service education of midwifery. According to the meetings with CO staff, and documented evidence, UNFPA has successfully advocated having GBV and disability integrated into the Core Competency Framework for Midwives 2022 under the environment and society theme which inform the new ADM curriculum development. The voice of disability is also incorporated in the governance body of the provincial GBV WG.

“UNFPA includes the concept of disability in the current work. E.g. we include the disability NGO to represent and bring the voice in the provincial GBV WG” (CO staff)

However, there seems to be weak evidence of disability mainstreaming in other programme implementations by IPs. As expressed by an IP *“We didn’t separate or notice the disability, but we respect the right- based approach” (key informant)*

While health service response to GBV is UNFPA’s priority areas, there seems to be limited understanding of roles and responsibilities among the sub-national stakeholders in these provinces. As said by IP:

“For Gender, we focus on it but not much, it belongs to MOWA. While, I am not so sure if disability is included neither” (PHD_province 1)

Finding #9: Quality of the Emergency Obstetric and Newborn Care (EmONC), partnering with the MoH is improved, there is more room for improvement of the quality of service

The evaluation team did not include the quality dimension as the core objective of this evaluation as there is an ongoing study of clients’ feedback on Sexual Reproductive and Maternal Health services in Cambodia⁷⁸. However, ET captured the quality on the implications of the improvement of confidence of health workers (midwives) in providing SRHR and related services to their clients. The midwife workforce in Cambodia consisted of primary, secondary and bachelor degree of midwife. Their level of clinical practice is guided by the Scope of Practice for Midwife.

According to the interviews with national and sub-national stakeholders, the quality of SRHR services provided by midwives is perceived to be improved. The stakeholders at the national and sub-national levels, including policymakers at MoH, believed that the improvement of the capacity and confidence of midwives for SRHR service was proved through the improvement of the national SRMCH key indicators. They claimed that this mainly contributed from the improvement of capacity and confidence of the midwifery workforce. The evaluation team though had originally planned to carry out an online survey to assess the capacity and confidence of midwives after the training. However, this was not done due to the sensitivity of the issue at hand. As such the evaluators had to rely on documented reviews and in-person interviews with relevant stakeholders, which showed positive feedback related to the capacity and confidence improvement).

“It is more successful...the midwife capacity is also increased. E.g., before midwife didn’t dare to inject magnesium, or work on abortion...but now they can do that. For the referral, they are skillful in filling the referral form.” (PHD1)

⁷⁷ Clients’ Feedback on Sexual Reproductive and Maternal Health Services in Cambodia: A qualitative study (draft) (Sep 2022)

⁷⁸ *ibid*

“MMR and IMR are reduced, so this can prove that our midwife has the capacity to work on those services” (MCH_2)

An ongoing assessment of clients' satisfaction under the UNFPA targeted provinces shows that, overall, clients can access the essential Sexual Reproductive and Maternal Health (SRMH) when they needed. The satisfaction among clients from the indigenous population was better than the common population. However, other aspects of perceived quality such as long waiting time, presence of advanced medical supplies, the unfriendly attitude among some health staff and discrimination among clients with IDPoor cards remained the issues⁵¹.

Finding #10: Improving pre-service for midwife workforce in Cambodia

Pre-service Education

UNFPA has a strategic vision in the long term to support the midwife workforce through updating the curriculum of pre-service midwifery education. UNFPA, through the Burnet Institute's technical assistance, have supported the IPs to revise and align their curriculum with international standards (ICM). UNFPA provided capacity development for midwifery faculties in the TWG of the ADM Curriculum alongside the Associate Degree of Midwife (ADM) curriculum renewal process. The current ADM curriculum includes all emerging and urgent needs of the population such as EmONC, GBV, MISP, adolescent health, family planning, perinatal mental health and disability. The curriculum draft has been finalized and is under the Ministry of Health's endorsement process. When it is approved, the Bachelor of Science in Midwifery (BSM)-curriculum will be designed.

UNFPA contributes to the improvement of pre-service training in various ways. Firstly, the technical and financial support has been offered to renew the Competency-based Education (CBE) curriculum (ADM) and BSM curriculum. Secondly, clinical training for hospitals midwifery preceptors and educators were carried out. Thirdly, the faculty development such as contemporary teaching and learning and course syllabus formation for midwifery educators and the TWG for ADM were given to implement the renewed ADM curriculum. The support of UNFPA in midwifery education has been acknowledged by the Ministry of Health and both public and private training institutions (IPs). UNFPA brought in the Burnett Institute as an implementing partner to work closely with training institutes to update the curriculum align with ICM standard.

“Without UNFPA, we are not sure if we are coming to this stage of curriculum revision. We also have limited knowledge; we also have little materials as reference for the curriculum revision” (a representative, Training Institute)

UNFPA successfully facilitated the TWG on curriculum revision. Even under COVID-19, UNFPA still managed to adjust the intervention by converting all face-to-face meetings into online meetings among the members of TWG to ensure revision of the curriculum is ongoing. As a result, the ADM has been successfully finalized and being endorsed.

Though the rollout of the new curriculum was a bit slow among the target training institutes to align with the curriculum revision process of other health care professionals (2018: Baseline: 0; Target 2023: 6, 2022:3), UNFPA stayed focused more on quality, and sustainability with some adjustments under COVID-19.

“We want the best quality and more sustainability for the training and quality of midwifery training, we go with national counterpart. Going alone may be faster, but we want quality and sustainability of the support” (key informant, CO)

“Sometimes it looks so slow of UNFPA, but it may be the right way to work with the government. It takes time to bring MOH and stakeholders along. It is slow but it is a right way for sustainability” (Burnet Institute)

Finding #11: Improving in-service training and family planning service reducing unwanted pregnancy, partnering with the MoH

In-service training

UNFPA supported the MOH in providing in-service training on FP methods and Emergency Obstetric and New borne Care (EmONC). The capacity improvement has been done through the in-service training under the NMCHC for midwifery workforce for the purpose of having adequate life-saving skills in the short term. The in-service training, especially the training on contraceptive implant for midwives, has raised more confidence in the midwifery workforce in the UNFPA target provinces. According to the interviews with midwives in the rural health center (Ratanakiri), the training of contraceptive implant made them more confident in providing contraceptive service to the female clients, including indigenous population who started using that method.

“we received training, we are more confident [in providing service]. If anything happened, we can handle it well” “We always referred patients to other place as we can’t provide the implant service. But now we provide this service at our center. We can explain the side effects to the client before they can make decision for the choice” (HWS_HC1_province 1)

Finding #12: UNFPA partners well with MoH, MoWA, and CSO to support health sector response to Violence Against Women/Gender Based Violence. (development setting). There is more room to improve outreach services by HCs.

UNFPA focus on GBV has mainly been on the health response and has been working closely with MoWA, MoH and CSO to mainstream gender, especially on the Gender-Based Violence in the health sector response through providing clinical training of GBV to health managers. At the national level, UNFPA provides support for the gender mainstreaming policy and GBV related policies/guidelines⁷⁹ in health sector (a list indicating the work, at upstream level, supported by UNFPA in CP6 is included in the Part 2 Annex on Additional Information under SRHR).

In addition to the work at policy level at national level, at the sub-national level, UNFPA provided support to respond to the GBV health service response through setting up GBV Working Groups at sub-national level (ToRs updated and endorsed by four Provincial Governors and 9 District Governors), updating the GBV service directory in all four targeted provinces, capacity building to providers on Essential Services package (basic counseling, referral guideline, legal aspects, and health response) (on-going and expected to complete by mid-2023) and establishing two multi-services rooms piloted in Kampong Cham and Stung Treng (and initiated in Preah Vihear recently). MOWA and MOH drafting the SOP for this multi-service room.

While the outcome of these efforts is too early to assess, UNFPA support to MoH to roll out the national guidelines and manual for health sector response to GBV and through capacity development and service availability, a few hundred⁸⁰ women victims of violence had been reported to have received health care services at health facilities in the four provinces of Kampong Cham, Tbong Khmum, Preah Vihear, and Stung Treng. If programme implementation is continued as planned positive results could be expected. Within the four provinces, the Provincial and District Working Group on GBV assisted over hundred cases of related to GBV and rape incidents. The interventions are not yet mature enough to see outcome results; however, the planned interventions seem to be in the right direction towards achieving the planned outcomes, with more room for including outreach services to reach remote areas and those without access to HC.

Through the above activities, UNFPA provides support for GBV in health sector response especially through the training of health providers, staff of PDOWA and initiates the setup of the GBV working group (WG) at national, provincial and contribute to the establishment of district GBV WG.

⁷⁹ Programme M&E update_ppt September 2022

⁸⁰ As per WHO guidelines on reporting VAW and GBV data, exact numbers will not be stated in this report (Improving the collection and use of administrative data on violence against women: global technical guidance. New York: United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) and World Health Organization (WHO); 2022)



ET MEETING PDoWA GBV-WG

The training was provided for the GBV WG at the provincial level. Then the WG at provincial (led by PDoWA) level continues to provide provincial cascade training and set up the district GBV WG.

Overall, the current CPE confirmed that UNFPA effectively implements the gender mainstreaming activities in the health sector response. UNFPA makes a great contribution to the GBV health sector response through: incorporating GBV into the policies of MOH and MOWA; supporting the coordination of GBV through setting up the GBV WG at the national and sub-national level; capacity building of health workers on GBV

health service response; set up multi-service room at PRH and counseling service at Health Center (HC) level. However, there seem to be some gaps when it comes to adherence to service at the facility level.

GBV interventions at the HC level are still limited. I.e. GBV basic treatment and counseling take place at HC, but information of the GBV services available at the public facility is less incorporated in outreach services. According to the discussion with HCs staff/service providers, the outreach service is delivered by HC to rural villages within their catchment areas; however, GBV awareness raising efforts seem to be less compared to standard outreach on other services.

“[we] do not focus much on GBV in our outreach service! We generally work more on children and pregnant women in community”. (HWs_province 1)

Finding #13: Quality reproductive health services available to address related needs in humanitarian settings

Under COVID-19 response, UNFPA has worked on both supply and demand side of the health system to ensure the functionality of essential SRHR service as well as the service reach to the vulnerable groups. On supply side, UNFPA has supported developing guidelines and policy to address the COVID-19 and SRHR; training capacity building for HWs on COVID-19 response to SRHR, particularly through the e-learning platform. On demand side, UNFPA has contributed to the joint project of UN agencies to directly respond to the needs of migrants who returned mainly from Thailand by ensuring the SRHR/GBV service and information flow to the migrant workers; providing culturally relevant about 10,000 dignity kits to migrants including women and girls; using social platform for SRHR and GBV related information. In addition, UNFPA also provided support to the IPs to carry out rapid assessments to document the needs and barriers of the accessibility of SRHR among various group under COVID-19, which results have been translated urgently into the innovation of intervention under pandemic⁸¹.

The interview feedback from the sub-national level informants revealed that the support of UNFPA through the capacity building of the COVID-19 and SRHR services was appreciated and acknowledged. UNFPA supported national guidelines for maternal and child health service during the pandemic 2020 was used as the basis for training. In 2021, UNFPA continued to provide technical and financial support to the Ministry of Health to further enhance the capacity of the health system to provide services to women and girls who experienced violence, particularly during the context of COVID-19 pandemic. Follow up monitoring and supervision visits had been made to health facilities to follow up on GBV/VAW services offered by the health care providers to women and to monitor improvement on the case recording and referral systems at health facilities.⁸² See Part 2 Annex (Additional Information for details). Training on the Essential Service Package for VAW survivors covering all five topics; namely basic counselling, referral guidelines, health response, and key legal issues have

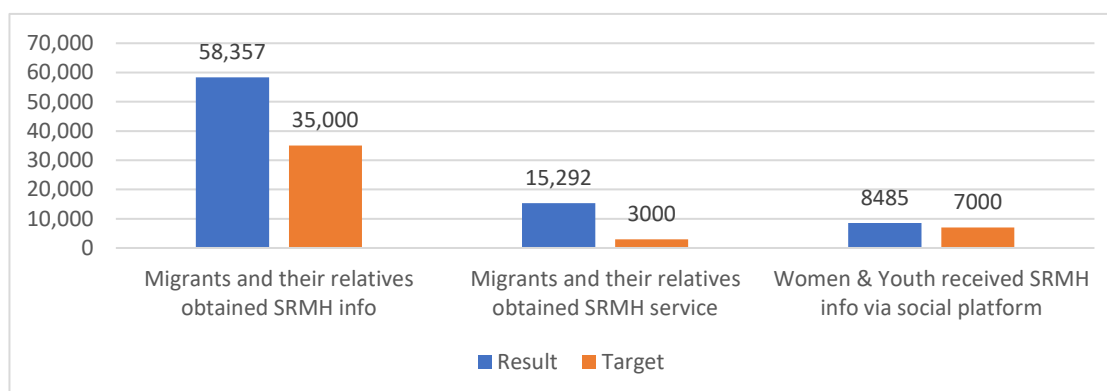
⁸¹ 2020 Annual Report-Cambodia

⁸² Final programme1 narrative report on “Programme to Promote Disability Inclusion and Quality Services for Gender-Based Violence (GBV) Victims” reporting period: 01 September 2019 – 30 November 2021

been provided with support to MoWA in 2022. Number of frontline service providers, particularly in the quarantine centres, had been trained on psychological counselling for GBV.

Within the 6 months period under the humanitarian setting, UNFPA has managed to over reach the targets of supporting the access and utilization of SRMH information and service among returning migrants. For example, the number of returning migrants and their relatives obtained the SRMH information and service were over 58,000 and 15,000, which were higher than the target of 35,000 and 3,000, respectively. Among those migrants who used the SRMH service, women are accounted for 97%.

FIGURE 7: NUMBER OF MIGRANTS AND THEIR RELATIVES WHO RECEIVED SRMH INFORMATION AND SERVICE UNDER COVID-19 JOINT PROGRAMME



The sub-national stakeholder illustrated the improved knowledge of HWs on both the COVID-19 procedure to respond for SRHR service adherence and the innovative approach of e-learning platform as mode of capacity building.

HWs have improved the knowledge, especially on the COVID-19 guideline. The e-learning is new things and after COVID-19, many staff get used to with e-learning. (PHD_province 1)

Though the e-learning was seen as the innovative approach and rapidly respond to the capacity building of HWs under the pandemic, the sub-national stakeholders identified a few challenges under this mode of operations such as *“in coverage of internet for HC...some health staff are old and didn’t know how to use technology...some use old fashion mobile” (PHD_province 1)*

Finding #14: Adolescent and youth-friendly health services are set up and scaled up. While there are some challenges with quality of services, the initiative is too young to assess the quality standards.

UNFPA provides support for the setting-up of Adolescent Youth Friendly Service (AYFS) at the HC level. The approach of UNFPA is working through the initiation of having a policy; supporting the training for HWs on AYFS service and having community workshop/meetings organized. By mid-2022, 22 HCs out of 50 HCs among 8 targeted provinces of UNFPA were equipped with the AYFS; 18 training sessions of AYFS were organized for HWs and 18 community workshops/meetings took place.

From the field interviews with sub-national stakeholders and observation; the AYFS service is setup at the health centers. However, a supporting environment for the demand generation for the AYFS seems to be less apparent and the setting of the current HC, the AYFS room may not be possible to ensure the confidentiality of information for the client. From the field observation of the AYFS service room, the filing system, privacy and room setting may not ensure the confidentiality and privacy of the clients/adolescents and youth who come there seeking for services. The quality of the AYFS at the health center and the referral (demand generation) from community still remaining the major challenges for AYFS. There were certain constraints

beyond the UNFPA support on AYSF at the HC level. As ET understands from the in-depth interviews and field observations, the AYFS is not yet fully functional within the HC. While AYSF is available for services, there is more to be done to provide quality services standards.

PHD_province 1 illustrated that the money for providing training is available, but no budget for producing IEC and it was a challenge to set up the service room at the HC.

There was evidence of collaboration between HC and school nearby to create the demand generation of the AYFS for AY within the school setting. There were a few evidence of having health center staff visiting school to provide SRHR information, and there was collaboration from school to send students to the health center nearby for health information and checkup often. Overall, the evidence shows that there are some collaboration between school and nearby HC to promote awareness and utilization of service of SRHR among school children. This could imply that those services reach in school students, but it cannot reach the out-of-school students.⁸³

*“This is a new service and it is more challenge. That’s why we work with high school only”
(PHD_province1)*

Discussions with students confirmed that there is less connection between in-school students and the nearby local HC about the AYFS resulting in limited availability of SRHR information. According to the discussion with students, SRHR information they received was only from the school teachers and social media.

Interviews with CO staff revealed that AYSF service are to be carried out by health workers (HWs) as the outreach service for community to create more demand from out- of- school youth. However, the interview at sub-national level shows that the AYSF is less incorporated in the outreach service of the HC. According to the HCs, *“the AYSF and GBV were mainly mainstreaming through the HCMC meeting, CCWC, rather than HC’s monthly outreach activity.”* (HC key informant, province1)

AYFS at HC level incorporate the treatment and does provide counseling on STIs, however some HWs expressed that they have some challenges in skills and knowledge for the STD treatment and commented on the lack of medicine for the treatment.

*“we don’t have skills and knowledge in treating STD. We test some medicine for youth, and then if they could not be recovered, we will change to another medicine and then keep changing again and again!”
(HC informants_province1)*

Considering the overall progress and the results achieved in CP6, ET reports that SRHR planned outputs have been achieved and in the right direction to contribute to the final outcomes. UNFPA has supported SRHR programmer over several CPs and the effects of the long-term input are already seen as described in the above findings, especially with regard to the reduction in MMR, IMR, and increasing CPR. Although UNFPA is not the only contributor, UNFPA is a main actor assisting the government in these areas and the achieved outcomes can be contributed to UNFPA supported interventions. Quality improvement of the services may take longer and CO has already included plans on SRHR quality improvement in CP6.

Facilitating factors (SRHR)

There are a few facilitating factors that contribute to the progress and achievement of UNFPA interventions under the current CP. These are (1) using existing government system(structure) for the implementation (2) taking the driver seat in SRHR (including FP, midwifery education, EmONC, GBV health service response and AYFS) among other key stakeholders (including UN agencies) (3) institutional capacity building for IPs and (4)

⁸³ in-depth interviews (school, HC and PHD) and CO monitoring reports.

building trust among IPs, CSOs, and UN agencies. UNFPA's past contributions to SRH and good standing the commitment to ICPD programme of action is a major facilitating factor.

UNFPA typically uses the existing government's system to support the intervention. The implementation of all interventions is seen to go through the existing government system, by providing financial, technical and administration/management support to the IPs. However, UNFPA contracted a consultant to be situated at the NMCHC to provide day to day support to administration and management for the IPs to strengthen the services. The roles of UNFPA plays in the country are well acknowledged by various stakeholders to be the leading in the focused areas. *"UNFPA plays important roles as the broker in information, support the MoH HRDD and Midwifery schools RTCs. They support and bringing those people together"* (Burnet Institute).

UNFPA also enhanced the government's system through the capacity building of IPs to roll out its intervention. This has been seen as the sustainable approach by not creating more systems or ad hoc system for intervention in the country. For instance, UNFPA has supported the training institutes through building capacity of midwife trainers at the training institute and hospital preceptors through-out the process of curriculum revision.

During COVID-19 outbreak 2020-2021, UNFPA still supported MoWA to use virtual approach to conduct regular quarterly meetings and trainings on GBV.

Hindering factors (SRHR)

UNFPA has been seen as the key SRHR policy advocacy to ensure the essential SRHR service available for the marginalized groups. However, there are a few hindering factors, as described below, when it comes to the implementation of UNFPA intervention at the sub-national level.

a. Midwife workforce turn over/rotation/retired:

UNFPA provided the support for the in-service training to midwifery. However, as the health system constraint, there were some midwives turn over/rotation and retired and more new midwives are placed in the HC under targeted provinces. This implies that UNFPA needs to continue providing the in-service training for new midwives. As claimed by national and sub-national stakeholders that: *"Training for HWs is important! But more HWs are retired! That's very difficult for us, we train and train..."* (National Stakeholder).

b. AYFS and GBV, the AYFS is provided only at the HC. Though services are available, there is limited effort in demand generation from the health facility level for the services. Service is there but information about the existence of service is not well informed to the target groups (e.g. youth-in and out of school; GBV survivor).

UNFPA provides support to the national and sub-national IPs to set up the GBV health service response and AYFS. However, the GBV health service response is available only at a few provincial hospitals and some GBV counseling service is available at HC. Similarly, the AYFS is provided only at the HC. Though services are available, there is limited effort in demand generation from the health facility level for the services.



GROUP DISCUSSION WITH STUDENTS

For example, high school students nearby the health center were aware of SRH information from school teachers and social media, rather than from HC. Sub-national stakeholders also confirmed that AYFS is a somewhat new service, compared to the standard service (the Minimum Package of Activity) at the health facility. This also implies limited progress and challenges to ensure that the services reach out widely to AY.

Although some CSOs are supporting through HCs to provide awareness raising programmes on SRH to the youth (example in

Ratanakiri, province), there is limited connection between the health center (in UNFPA target provinces) service points and the adolescents and youth in the community.

c. CP6 achieved objectives to ensure policies/strategies of SRHR by LNOB as its intended objective.

UNFPA has made a great achievement on supporting the MoH with the SRHR and related policy under the CPs as its intended outputs, moving down to provinces to implement key policies and strategies. However, overall, UNFPA prioritized the upstream intervention rather than supporting the downstream implementation. In addition, with the approach of giving more ownership to the national IPs to take the driver seat in rolling out the intervention at sub-national level, UNFPA has not been able to effectively ensure the connection between the communities with the service delivery. This could also imply that the LNOB is still a challenging agenda.

Adolescents and Youth: (Effectiveness) Answers to EQ 5 and 6 for Output 2

CP Output 2: Young people, including the marginalized and those in vulnerable situations, are empowered with knowledge and skills to make informed choices for sexual and reproductive health and reproductive rights and their well-being in an enabling environment.

Summary of findings

UNFPA works well with the Cambodian government, UN Agencies and implementing partners to complete its activities, producing outputs and outcomes as planned in CP6. Despite the COVID-19 pandemic, AY programme efficiently completed its planned activities during that period, as evident in the performance indicators below. Working with the existing government mechanisms on AY-SRHR for student population in-school, UNFPA supports implementation of CSE and GBV related programmes, introducing it gradually to all schools country wide. This curriculum promotes SRH, CSE and gender equality. It also addresses barriers in the prevention and response to GBV and EAWG in education system. The national budget for 2023 had been confirmed at USD 100,000 for printing the Health Education/CSE curriculum training manual for teachers in grades 4, 7 and 10. UNFPA will continue to advance advocacy and technical efforts to ensure the full-scale implementation of the health education and CSE curriculum nationwide. However, as CSE is new to schools, there is a need for the strong commitment from the government, especially MoEYS, MoH, and other IPs to support CSE interventions, specifically on access to information and services, at national, sub-national and community levels. Furthermore, UNFPA's strategy is not yet sufficiently clear to guide the coordination leadership with relevant CSOs networks on CSE with in-school-students and out of school youth. While UNFPA coordinated well with RGC, UN Agencies, funding agencies and international NGOS on youth participation, there is limited coordination and collaboration with CSOs network at sub-national and local level, such as Health Action Coordinating Committee (HACC), a network NGOs on health, NGO Education Partnership (NEP) a network NGOs on education and CSO network on youth, health and education such as Youth Council of Cambodia (YCC), to name a few.

Adolescents and Youth (AY) programme is designed to contribute to the CP6 Outcomes as (1) skills and capacities to make informed choices about sexual and reproductive health and rights (SRHR) and well-being, through comprehensive sexuality education (CSE), (2) Opportunities for young people of all backgrounds to exercise their rights and participate in sustainable development, and (3) Policies and programmes address the determinants of youth SRHR and well-being (CPAP, 2019)⁸⁴. AY programme invested in SRHR and CSE and Gender at the national and sub-national level for the adolescents and youth in school and out of school. The programme is implemented at the national level Phnom Penh capital city, and 8 provinces; Mondul Kiri, Ratana Kiri, Preah Vihear, Steung Treng, Kratie, Kampong Cham, Odor Meanchey, and Tboung Khmom (UNFPA Annual

⁸⁴ Country Program Action Plan 2019-2023 (CPAP), UNFPA 2019

Report, 2019-2021)⁸⁵. The following table shows the output results, by mid-year 2022, contributing to achieving the AY outcomes.

Table 7: Adolescence and Youth Programme Progress to Date

The Progress: Indicator (Baseline vs Target)			
CP6	Baseline (2019)	Targets (2023)	Results (June 2022)
Indicator 1: Percentage of public schools in eight UNFPA focus provinces that provide comprehensive sexuality education according to international standards.	0%	Target: 12% (M&E)	10.26%
Indicator 2: National strategy in place to deliver innovative out-of-school sexuality education that targets marginalized and vulnerable young people.	Baseline: No	Target: Yes	Yes
Indicator 3: Strategic advocacy plan in place to inform efforts for increasing domestic investments on youth in line with Cambodia Youth Development Index domains.	Baseline: No	Target: Yes	Yes*

(Source: UNFPA CO) * Although target is achieved, it is pending until CDHS is finalized.

Finding #15: 8 public schools provided the knowledge, skills and practice on sexuality education, reproductive health and reproductive rights to Adolescents and Youth (AY) throughout CSE piloting roll-out (in-school)

Working in partnership with other UN Agencies and implementing partners, UNFPA is supporting MoEYS to train adolescents and youth in public schools on the comprehensive sexuality education, reproductive health and reproductive right⁸⁶s. Under the UNFPA technical support,



GROUP INTERVIEW WITH STUDENTS

MoEYS finalized CSE textbooks and training manuals inclusive of gender equality and VAWG components for schoolchildren and students from grades 5 to 12.⁸⁷ Moreover, MoEYS planned to roll out CSE to all schools and all grades⁸⁸ in Cambodia by school year 2024-25. During the COVID-19 pandemic (2020-2021), UNFPA supported MoEYS and National Youth Development Council (NYDC) with 48 computer laptops, 7 LCD projectors, and packages of a sound systems for online training, online meetings and communication operations.

As a result of UNFPA support, MoEYS provided the CSE training to in-service teachers at the school level. In 2020, twelve national core teachers were trained on CSE for grades 7 and 10 in Kampong Cham Regional Teacher Training Center (RTTC) (MoEYS Field Mission, 2022)⁸⁹. In 2021, MoEYS provided virtual training on CSE to a total of 760 in-service teachers and school directors (396 female) from 169 schools (10.26% vs 12% target in 2023) in UNFPA’s target provinces (UNFPA M&E Matrix, 2019-2023)⁹⁰. However, all teachers did not teach CSE as a subject in their schools as they needed an official letter

⁸⁵ UNFPA Annual Report 2019-2021-Cambodia

⁸⁶ Based on feedback from KIIs, field observations and CO documents

⁸⁷ CSE textbooks and teachers guidebook from grade 5 to 12 published by MoEYS

⁸⁸ Concept Note on Roll out of Health Education Curriculum In Cambodia

⁸⁹ Field mission for AY Program and MoEYS 2022

⁹⁰ Sixth Country Programme Planning Matrix for M&E, UNFPA Cambodia, 2022

from MoEYS. Currently, this is the piloting process. In June 2022, MoEYS officially requested UNFPA for support material to pilot school health room programme in 8 schools.⁹¹ The plans are underway to provide more equipment (55 laptops to youth focal points at national and subnational level to implement the school health room program and 8 laptops, 8 LCD projectors and basic equipment/materials) to 8 schools in the eight provinces to implement school health room model. The intervention is also to enhance the monitoring and reporting of the implementation of the National Youth Policy and National Action Plan on Youth Development.

CSE contents included not only SRHR but also Gender Based Violence (GBV); however, CSE was not the main subject for school curriculum. As such, they recommended that the CSE to be the main subject from primary to secondary levels with at least one hour of lesson per week because: *“it is very challenging while teaching CSE which is not included in a compulsory curriculum in school. Our school has the room for the consultation on SRHR and GBV, but the material and teacher’s skills on SRHR are our challenges to operate it”* (key informants, provincial level).

Finding #16: UNFPA contributed to developing the national strategy in place for both in-school and out-of-school comprehensive sexuality education. However, out-of-school is not implemented in many needy areas.

Although in-school work is going on, out-of-school programme is not yet off the ground. UNFPA has greatly contributed to developing the national strategy to be in place for both in-school and out-of-school CSE, providing technical support to National Youth Development Council (NYDC) to develop the Out-of-School CSE Strategic Plan 2022-2026.⁹² Being updated after the approval of the National Action Plan on Cambodian Youth Development (NAP-YD), the strategic plan is now in the final draft version.⁹³ The out-of-school adolescent and youth still have limited awareness on CSE (SRHR and GBV) particularly the ones living in rural communities and from ethnic minority groups. The marginalized AY dropped out of school to seek employment, get married and/or migrate to other areas. UNFPA supported MoEYS at the national and sub-national levels to create consultation rooms and SRHR services and School Health Rooms in 8 provinces.⁹⁴ As mentioned under the finding above, materials and equipment (medical devices, pharmaceuticals, electricity devices, and office furniture and equipment) are being procured to support the school health rooms. But, the support was not for HC which caters to out-of-school-youth. The statement from Health Center Chief in Ratanakiri province was: *“Our HC had a private room for out-of-school youth to consult their issues related to SRHR. However, the room had only prioritized on the activities related to COVID-19 prevention and vaccination. Due to lack of funds and human resources only a few awareness raising activities on SRHR were carried out at the community level”*. UNFPA support on CSE technical working groups at national level is limited and without much support to CSO networks it may be difficult to enhance community level work on outreach work.

Findings 17: CP6 provided opportunities for young people of all backgrounds to exercise their rights and participate in sustainable development process.

⁹¹ Concept note: UNFPA’s Support to MoEYS for 8 provinces CSE roll-out 2022

⁹² UNFPA annual report 2021

⁹³ Draft of National Action Plan on Cambodian Youth Development (NAP-YD)

⁹⁴ Concept Note SH Room & NYDC dashboard_MoEYS 2022

United Nations Youth Advisory Panel (UNYAP) was established in 2007 as an interactive platform for dialogue



UNYAP MEMBER BEING INTERVIEWED

with young people led by young people, to understand their development priorities and perspectives and ensure the voices of Cambodian young people are heard within the UN system. Currently, in CP6, UNFPA coordinates the UNYAP which is composed of 24 members who are CSO representatives working on adolescents and youth, and people with disabilities, SOGI (LGBTQI) community, and youth groups/networks.⁹⁵ UN Youth Advisory Panel (UNYAP) is the empowerment and engagement platform for the marginalized and vulnerable, who are empowered with knowledge and skills to make informed choices for SRHR through

debate, training, meeting, and awareness raising. At the same time, UNFPA supported youth to debate and UNYAP mobilized youth from groups including LGBTQ, various ethnic minority groups, people with disabilities, youth from the private sector, and CSO representatives. In the interview with Youth Panel (UNYAP), they claimed that this platform could improve inclusion and leave no one behind as the members were from different backgrounds. The platform can link the youth to practice their rights, improve capacity and bring their voice to the public, government and CSOs.

UNFPA also focuses on the AY's increased access to SRHR, GBV and CSE via digital media since 2021. UNYAP social media campaign on COVID-19 Response through social media and radio programme reached 222,259 young people.⁹⁶ UNFPA planned to develop the Mobile App on sexuality education and innovative communication initiatives emphasizing the need for access to Sexual and Reproductive Health Rights information and service (SRHR), Comprehensive Sexuality Education (CSE), Gender and Mental Health and Psychosocial Support (MHPSS) to make young people.⁹⁷ This is expected to be available on Google Play Store in late November or early December 2022 and Apple Store in early 2023. It will allow key young population for testing and



UNYAP GROUP ACTIVITY

revising. UNFPA has contributed its CORE FUND (USD 120,000) to expand AY project to other provinces (MoEYS, 2022)⁹⁸. It is expected that 20,000 young people aged 15-30 in Cambodia will access to Mobile App on SRHR, CSE, GBV, Gender and Mental Health and Psychosocial Support (MHPSS). The statement from a UNYAP member revealed *"UNYAP provided the opportunity for me to join with other youth and raise my voice on the problems and challenges of disabilities faced by students to the government and public through meeting and social media"*.

AY programme has achieved the planned outputs and laid the necessary foundation in terms of national level advocacy and policy development for achieving the outcomes. CSE is still being introduced in schools and the input on behaviour change of the service providers (mainly teachers and health service) is limited. To achieve the final outcomes under this programme it may take beyond one CP cycle. However the progress made is in the direction of achieving the final outcomes. While equality issues are given due consideration, dealing with different groups of youth and adolescents, especially vulnerable groups, marginalized groups, attention given to equity issues seem limited. Achieving the final outcomes would need both equality and equity issues addressed. Programme outputs are achieved to a great extent and it is likely that outcomes can be achieved;

⁹⁵ Mid-term review of UNFPA Cambodia 6th Country Program 2021

⁹⁶ *ibid*

⁹⁷ Invitation for proposals IFP #2022-KHM-IFP-001

⁹⁸ Concept Note: UNFPA's support for the implementation of CSE in 8 provinces

however, behaviour change that is needed will take a long time. The programme interventions planned are in the right direction. It will be easier to track the progress if immediate and intermediate outcome indicator measures are established in addition to the output indicators.

Facilitating Factors:

UNFPA works well with other UN Agency and implementing partners and the AY programme has good coordination between UN Agencies, MoEYS, MoH and Implementing Partners at the national level, although inter-ministry coordination particularly between MoEYS and MoH is somehow limited in the development of AY CSE programme for in-school and out-of-school. UNFPA's strong support of policy development at the national level with MoEYS and MoH, enthusiastic young people engaged in youth working groups and an active UNYAP at the national level also are facilitating factors.

Hindering Factors:

- While support for policy development at the national level with MoEYS and MoH is strong, Implementation at sub-national, particularly at local level schools and health centers are still to be strengthened. There is a gap especially in capacity building, knowledge transfer, and support with materials.
- The coordination between MoH and MoEYS at the sub-national and community level is limited with AY intervention, especially the connection between school and HC for in-school-students and out-of-school youth on SRHR and CSE. Comparatively, there is less interventions on AY in rural areas and for the ethnic minority groups.
- AY has supported MoEYS to provide capacity building of in-service teachers and school principals, but their role has not been functional yet mainly due to the teachers' limited pedagogical skills to address sensitive content of the curriculum, even if some of teachers are familiar and trained on CSE. Another challenging point is that the schools have limited materials needed for the in-school consultative room.

Population and Dynamics: (Effectiveness) Answers to EQ 5 and 6 for Output 3

Output 3: Strengthened institutional capacities to produce and use data to map out inequalities and emerging population dynamics to inform policies and programmes and improve emergency preparedness

Summary of findings

In CP6, in collaboration and partnership with the government and other development partners, UNFPA supported strengthening and building capacities of the government staff especially on data management, data collection, data analyses and data reporting. Cambodia has achieved the SDG indicator 17.19 (target: 17.19.2: The proportion of countries that (a) have conducted at least one population and housing census in the last 10 years). The capacities of the government counterpart have been improved in data collection and analyses but they are still in need of further technical support. There are still many more challenges to be addressed. UNFPA helped to advocate with the government counterparts to take into consideration of the issues of sexual and reproductive health and rights, violence against women, youth and emerging population dynamics. The government plans and policies have included these issues into their plan development both at national and sub-national level. However, there are still various challenges especially in terms of implementation and both technical and financial supports are needed to effectively implement the plans and policies. In terms of emergency preparedness, UNFPA also provided both technical and financial support to NIS to be prepared for emergency situations by supporting NIS with updates of its current data-sharing platforms. As for the overall programme progress, CP6 achieved more than what was planned and these results indicate the likelihood of achieving the outcomes as indicated.

PD programme aims to strengthen institutional capacities of the government especially National Institute of Statistics (NIS) of the Ministry of Planning to produce and use data to map out inequalities and emerging population dynamics to inform policies and programmes and improve emergency preparedness. Throughout the last five years, many activities were carried out to strengthen and build capacities of the government staff especially on data management, data collection, data analyses and data reporting. UNFPA worked in collaboration with many other development partners, UN agencies, academia, civil societies, NGOs/INGOs and private research institutions/companies to achieve this output. It is worthwhile to note that Cambodia has achieved the SDG indicator 17.19 (target: 17.19.2: The proportion of countries that (a) have conducted at least one population and housing census in the last 10 years).

Out of the two key indicators for PD in CP6, the first focuses on producing reports (target to complete 13 reports) based on in-depth thematic analyses of data using 2019 census and 2021-2022 demographic health survey CDHS data. With technical support and coordination by UNFPA and close collaboration with MoP 15 reports were successfully produced so far⁹⁹. Out of these completed thematic reports, five reports were produced by NIS and three were jointly produced between NIS and Census Technical Advisor. However NIS also actively engages in providing comments and ensuring quality of other reports as well. This provides evidence that the capacities of the government staff on data analyses have been strengthened. Moreover, the data collected by NIS have been used nation-wide by all relevant stakeholders. Overall, this indicator has been achieved more than planned. The list of completed 15 reports is included in the additional notes Annex Part 2. List all in the Part 2 Annex.

Table 8: Population Dynamics Programme Progress to Date

The Progress: Indicator (Baseline vs Target)			
Indicators	Baseline (2019)	Target (2023)	End-line data (By June 2022)
Indicator 1: Number of in-depth analysis reports which include mapping of inequalities produced using data from 2019 census and 2020 DHS in line with ICPD priority SDG indicators with focus on UNFPA prioritized provinces	0	13	19 (15 ¹⁰⁰ of 2019 GPCC in-depth analysis reports)
Indicator 2: National and sectoral policies and plans which explicitly integrate identified inequities in areas of sexual and reproductive health and rights, violence against women, youth and emerging population	0	5	11 ¹⁰¹

Source: UNFPA CO

The second indicator focuses on national and sectoral policies and plans integrating the issues of sexual and reproductive health and rights, violence against women, youth and emerging population dynamics. Although the target was set for five plans and policies, with the available data and UNFPA’s technical support and coordination, working closely with MoP, plans and evidence base for policy development were achieved more than planned, according to the UNFPA annual report.

Finding #18: UNFPA contributed to strengthening institutional capacities to produce and use data to map out inequalities and emerging population dynamics to inform policies and programmes and improve emergency preparedness. Feedback from KIIs and document review show that the institutional capacities of NIS have been strengthened as a result of the support from UNFPA. While NIS capacity strengthening was at the national level, provincial level capacity of MOP was enhanced in relation to data collection and analyses. Although NIS capacities have been strengthened, there are still some challenges to be addressed. NIS still

⁹⁹ Planning matrix for monitoring and evaluation, UNFPA Cambodia, by June 2022

¹⁰⁰ Full list is available in Part 2 Annex Additional Information attached to this report

¹⁰¹ ibid

needs more support from UNFPA for the transition into the country's digital economy. The report on *"statistics 2030: towards a draft reform agenda,"* also discussed about the issues faced by NIS especially on administrative governance of NIS, an institution currently sitting under the MOP¹⁰². *"NIS is a sub division of MOP (not as powerful as MoEF and Mol) .Clearly the way that NIS is working needs to improve "(KII feedback).*

However, the discussion with senior high-ranking officials of MOP reveals that the government officials are confident to report that their capacities have been increased due to the long-time support from UNFPA. Out of all the completed in-depth thematic reports mentioned above, eight reports were completed by NIS itself following international standards in their analyses and reporting.¹⁰³ (See Annex part 2 for the detailed list of reports).

"UNFPA has provided a lot of support to the NIS since 1996. UNFPA supported NIS to complete data collection for the 2019 census and 2021-22 CDHS. UNFPA provided us with short term, long term and on the job training courses. Seven of our staff got master degrees in population science from India. We are very satisfied with the capacity building and strengthening support from UNFPA. Now we have the capacity to conduct national census and many other surveys by ourselves. We are even able to produce several reports using the 2019 census and 2021-22 CDHS data by ourselves." (Group discussion with MOP).

Although MOP is satisfied with the capacity built within NIS, they requested for further collaboration with UNFPA on capacity building. UNFPA's comparative advantage in Population Dynamics, where it has a unique upstream policy and advisory support position in line with its mandate, was acknowledged by several stakeholders. Although UNFPA and other development partners have invested in capacity strengthening of MOP, specifically NIS, MOP expressed the need for UNFPA's continued technical assistance in the area of advanced statistical data analyses and reporting. More than the financial support, what is expected of UNFPA is the technical advice and support.

"UNFPA is the data accelerator but UNFPA does not even have a specialist in this field yet, especially to undertake advance statistical data analyses. There is a lot of work for PD. UNFPA needs to work on ICPD25, CSDG, NSDP, CDHS, responses to requests for data from relevant stakeholders; multisectoral data need requests, inter-census data, stakeholder coordination, and more. GBV and youth data need to be collected and analyzed nationwide. UNFPA needs to speed up with data accelerator role commitment in UNDAF."(Interview with a key informant).

In terms of emergency preparedness, UNFPA also provided both technical and financial support to NIS to be prepared for emergency situations by supporting NIS with updates of its current data sharing platforms such as CAMSTAT and REDATAM. UNFPA also supported NIS to conduct training and workshops online during the COVID 19 emergency. Due to continuous support from UNFPA, the government capacities have been strengthened to respond and prepare for the emergency situation. Almost all NIS staff now able to use digital communication technologies for meetings and even in the face of emergency situation NIS staff are able to manage and operate their workload as usual. The mid-term review of UNFPA CPE6 also mentioned that under PD effectiveness, almost all the target indicators and milestones were achieved even in the face of COVID 19 emergency situation.

"COVID 19 broke out during the time that we were supposed to work on data collection. Therefore, our trainings for field data collection were conducted via online zoom meetings. We worked hand in hand with government staff to move forwards successfully even if we had COVID 19 problem." (Interview with UNFPA CO).

¹⁰² Statistics 2030: towards a draft reform agenda (2020)

¹⁰³ Planning matrix for monitoring and evaluation, UNFPA Cambodia, by June 2022

Finding #19: UNFPA contributed to the integration of population dynamics, reproductive health, and gender equality into development planning at national, sectoral and local levels.

The findings from field interviews and existing literature prove that population dynamics, reproductive health, and gender equality were integrated into the development planning at national, sectoral, and local levels¹⁰⁴. At the national level, Cambodian national policies, and strategic development plans (NSDP, CSDG, etc.) all took into consideration the issues of population dynamics, reproductive health, and gender equality into its planning development. For example, within the NSDP, gender equality is clearly set as a priority focus under the human resource development strategy of the rectangular strategy of the government¹⁰⁵. The MTR of NSDP also discusses about the remaining gender equality issues and proposed the next strategies focusing mostly on economic empowerment for women through skill development¹⁰⁶. The demographic and gender dividend report also focused on the population dynamic and gender equality issues that the country can reap the benefits from its population growth and inclusion of female’s workforces in its economic development policy¹⁰⁷. A clear commitment had been made by the government to respond to Nairobi summit with a focus on three transformative results supported by data and evidence and to follow this up, a sub-decree on establishment of special committee for Nairobi commitment was signed and DSDP of MoP taking the coordinating roles for this committee¹⁰⁸. Having said that, the programme lacks measurement indicators of the level of gender equality integrated in the implementation as well as behavioral change at the individual or institutional level as a result of this sensitization.

To implement and achieve the CSDGs, the RGC through the MOP, has integrated the goals, targets, and indicators of the CSDGs into the national planning system, especially to NSDP, Sectoral Strategic Development Plans (SSDP) and sub-national plans. After implementation in 2019, the RGC has registered with the United Nations to evaluate the results of the CSDGs through the development of the Voluntary National Review 2019 (VNR 2019) and supplemented by the development of the Progress Report 2019 on the implementation of the CSDGs. Both reports are published and disseminated both at national and sub-national levels. It is worthwhile to note that SDG custodian agencies, both government and non-government, are responsible for their own respective SDG indicators and targets as agreed with the UN at global level. The CSDG framework clearly set out the goal and indicator for the gender equality issues for Cambodia.



MEETING WITH PROVINCIAL PLANNERS

At the provincial and local levels, the interview with the provincial planning departments revealed that the disaggregated data for population dynamics, reproductive health, gender equality and disabilities are all available at the provincial level. Each provincial planning department is able to collect all types of data from all sectors from the village level up to the provincial level. The 3-year rolling investment plan collected from Kampong Cham provincial planning department also shows that all disaggregated gender data, education data, population data; reproductive health data as well as disability data are all included in the plan for situational analyses of the province¹⁰⁹. For example, in Kampong Cham, the evidence shows that these data are included for provincial planning¹¹⁰.

¹⁰⁴ Interview feedback, provincial level development plans and other project documents and plans

¹⁰⁵ National Strategic Development Plan, 2019-2023

¹⁰⁶ Mid-term review 2021 on the national strategic development plan 2019-2023

¹⁰⁷ The profile of demographic and gender dividend of Cambodia (2021).

¹⁰⁸ Sub-decree on establishment of special committee for ICPD25

¹⁰⁹ 3-year rolling investment plan of Kampong Cham province (2022-2024)

¹¹⁰ Field observations, planning documents and discussions with provincial planning staff and PDOWA.

“We have both capacities and tools to collect and analyze data for our provinces. We are even able to produce the provincial situational analysis report by including data from all sectors in our provinces. It is our tasks that we need to frequently collect data and produce provincial statistical book for our provinces so that the provincial governors can use our data to design investment plans for development of our provinces.” (feedback from group discussions with Provincial Planning Departments).

Finding 20: Data sharing platforms were not updated (still uses old data) because of limited funding support and there was no in-house expertise available to consistently feed in the data for sharing to others. The poor quality of data and inconsistency of statistical data and figures still exist, partly due to the use of paper-based household survey data collection specifically for provincial planning departments. Even efforts were made to switch from paper-based data collection to using tablets for data collection; the problems still existed especially with the software compatibility issues from the beginning of the data collection. Moreover, a lot of new questions from different sectors were also added into the provincial planning data collection survey every year. Both the respondents and the enumerators had to spend so much time to complete the survey. Because of this, the quality of the collected data was also affected.

“The quality of data collected from village level is very poor. We asked village chiefs to help us with our data collection but we do not have incentive money to pay them for their services. We do not even have money to properly provide trainings to them on data collection. However, because of their roles as village chiefs, they were still able to provide us with the requested data. Moreover, the questionnaires used in the past had only about 50 questions. Now the questionnaires had at least 500 item questions (including all sectors) to ask. Therefore, we are not sure if the village chiefs would still have time and commitment to provide us with the accurate data or not.” Group discussion with provincial planning departments.

Considering the overall progress and the results achieved in CP6, PD programme’s planned outputs have been achieved and they are in the right direction contributing to the final outcomes. UNFPA has been supporting RGC in population dynamics, especially in data generation and supporting the evidence-based policy and planning. The results achieved are contributing directly to the final outcomes expected as described in the above findings. Achieving the final outcome under PD is a long-term effort and would need another CP cycle at least to see the full realization of the efforts.

Facilitating factors (PD)

UNFPA is a long-time trusted development partner with the government. Right now, UNFPA was appointed by the government as a co-chair, with the government, of the data for development (D4D) sub technical working group. With its role as a co-chair of the working group, UNFPA can play significant roles to lead, to coordinate and to convene relevant stakeholders to take actions towards the successes of the working group as a whole.

Hindering factors (PD)

UNFPA has made significant progress, yet PD programme still faces a lot of challenges for UNFPA to continue to be successful in this field of expertise. Although NIS designated a key official and selected staff to jointly implement the current CPD, the demand of many competing priorities at least during the implementation period had limited the capacity of the concerned official and staff in coordinating and carrying out the necessary activities.

In-depth thematic data analyses were done by requesting for both technical and financial support from other UN agencies or development partners. It is a challenge to find experts in advanced statistical data analysis, especially with large data sets. While NIS is able to do basic analyses, the same cannot be said about advanced analyses such as estimation methods. Almost all ministries at the national level and even at the sub-national level did not have staff with the capacity for advanced statistical data analyses. An external consultant was hired to write this analysis. Currently, UNFPA successfully achieved the planned PD programme under CP6, however to leverage UNFPA to become a Data leading agency and respond to the high demanding of real-time Data (Gender, VAW, SRH, Youth) in the context of digitalization, IT-Statistics expert is a priority.

The UNFPA core fund for the PD section was limited and small. It is hard for PD to thrive in its mandated role in terms of statistics and data accelerator. Funds from DPs and UN agencies are all decreasing because Cambodia is transitioning from LDC to a Middle-Income Country (Orange county status). Support at the sub-national level on data collection, data analyses and data sharing did not even exist. With limited budgets available at the national level, the sub-national level faced even more challenges with the budget. All the 25 provincial planning departments were able to produce statistical books for their respective province but adequate budget was not there to print these statistical books or to even put them all online.

“We have all the statistical books and data for our province. But we do not even have the budget to print these books to share with all development stakeholders. Before, we used to have funding support from UNICEF, but now we do not have it anymore. There are no other donors and development partners to help us anymore” (Group discussion with Provincial Planning Departments).

4.4 Answers to Evaluation Questions on Efficiency

Efficiency criteria (Common to all thematic areas)

Evaluation question 7: To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the outcomes defined in the UNFPA country programme in a timely manner? Including during COVID 19 pandemic.

Evaluation question 8 To what extent did UNFPA systems, processes and procedures (particularly in terms of finance, partnerships, logistics, procurement and human resources) foster or, on the contrary, impede the adaptation and efficiency of the country programme to changes triggered by the COVID-19 pandemic?

Summary Findings

Based on the interview feedback and the documented evidence, CO has been able to manage the programme well and has achieved most of the planned results despite limited financial resources and various challenges faced during CP6. Establishment of strategic partnerships and resources invested by UNFPA has had a leveraging effect (triggered provision of resources from other development partners as well as achieve planned results with IP support) and joint programming enabled expanding interventions with the same available HR. The planned resources were received to the expected level to carry out the AWP and the resources were available in a timely manner. No delays in the process of fund transfers and IPs received resources that were planned, to the levels foreseen in a timely manner. Even during the COVID-19 pandemic period, there were adequate funds generated to complete the planned work as well as the additional work demanded by the pandemic. UNFPA has made good use of a joint UN programme on migration in response to COVID 19 pandemic as discussed earlier, under Coordination criteria. CO has been able to effectively lobby and convince to attract development partners on innovative interventions (CO’s established credibility, recognition and respect) e.g. Covid-19 response, Joint project on Migration as well as the MPTF joint project on disability inclusion optimizing the available human resources.

IP selection was effectively speeded up by using the established partnerships that met with IP selection criteria which also included PSEA assessment in the recruitment process.

Programmes were delivered via virtual mode of operation (Covid-19 context), in some cases, outreach even exceeded the originally planned number.

Despite a mix of challenges faced by the country office (leadership changes, staff realignment, and COVID 19 pandemic), CO managed to complete the planned work programme on time with high implementation rates¹¹¹. The following graphs show the expenditure versus budget allocation under the regular/core as well as other/non-core resources. The expenditure pattern of OR depended on when the funds were approved and made available for its use, thus unlike the regular resources, other resources are not set as annual allocations, only the expenditure can be reported against the total¹¹².

FIGURE 8: REGULAR RESOURCE EXPENDITURE VS ALLOCATION (2019 TO JUNE 2022)

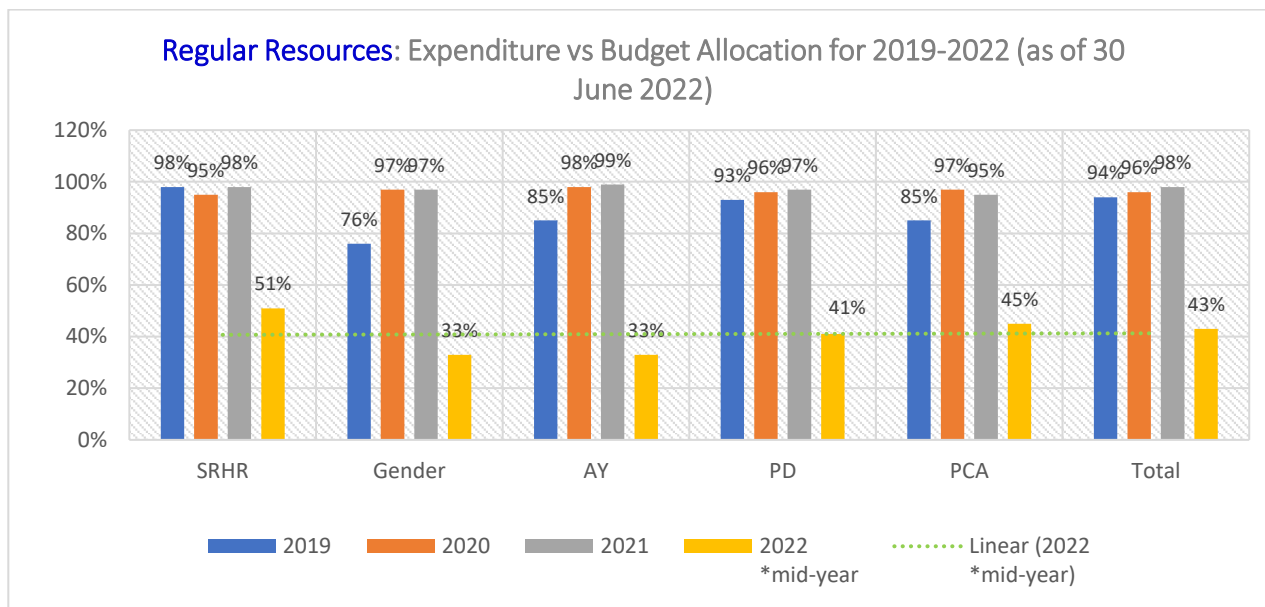
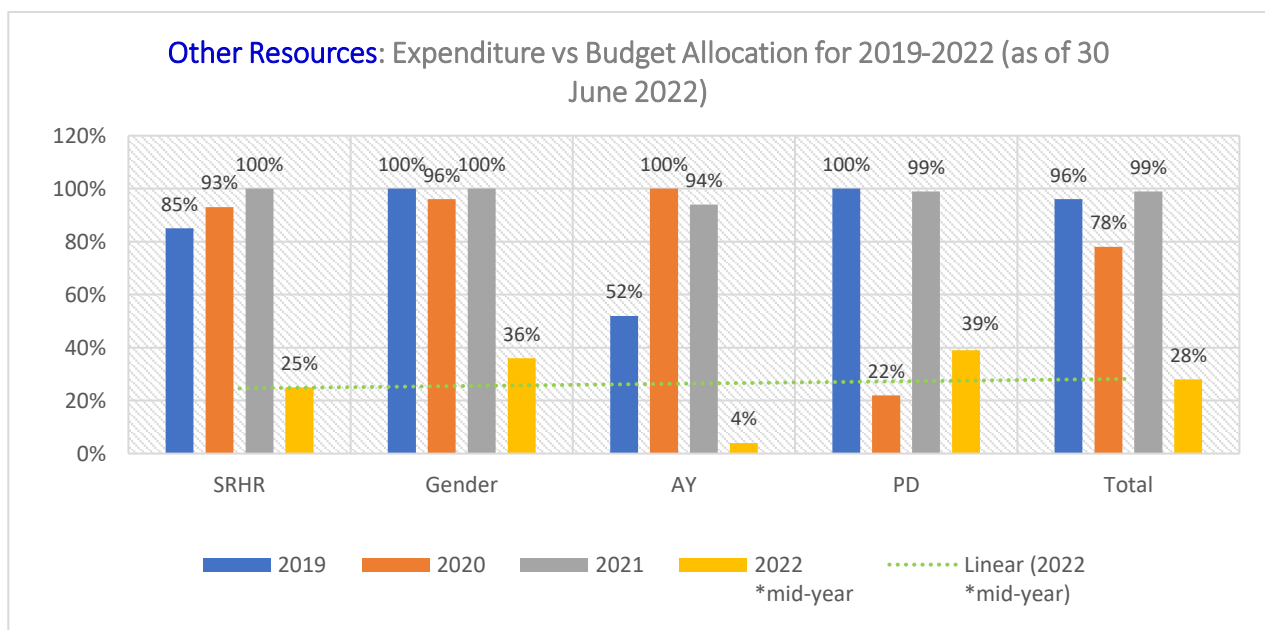


FIGURE 9: OTHER RESOURCE EXPENDITURE VS ALLOCATION (2019 TO JUNE 2022)



Findings # 21: Beneficiaries of UNFPA support received the resources that were planned, to the level foreseen and in a timely and sustainable manner: The partnership with Government, UN and developmental partners were observed to be good. The findings under the expected mode of engagement related to all thematic areas

¹¹¹ CO staff feedback and finance documents, Annual Reports

¹¹² CO staff feedback and finance documents

were found to be on target and the planned work programme had been achieved according to the targets. The eight focus provinces as well as the newly identified three provinces to address the SRMH issues of return migrants and their host families under the pandemic were also completed successfully with funds allocated with the help of UNRCO and UNCT. CO was able to mobilize additional resources to carry out the planned interventions without any interruptions, despite additional responsibilities as response to the pandemic¹¹³.

In partnership with MoWA, and UN Women, on a joint project led by UNDP with MPTF funds, UNFPA supported training on the Minimum Standards of Basic Counseling to 271 GBV service providers of which 122 were females¹¹⁴.

Finding # 22: Country Office, with the available human resources, was able to find additional funding resources, partner with other agencies, development partners to deliver uninterrupted services and adapted to the changes triggered by the COVID-19 pandemic to serve the needy populations:

With the dedication of the CO staff, country office was able to adapt quickly, with the existing staff to provide the needy services and maintain uninterrupted services to the needy populations in the targeted provinces and beyond. Examples of the efforts made by the country office in response to COVID-19 situation are well described under the criteria Effectiveness, Coherence, sections above as well as under Coverage and Connectedness criteria below and as such it will not be repeated here.

To enhance efficiency, CO conducted online training for in-service teachers on CSE during Covid-19 outbreak. The online training reduces the cost of the AY programme and kept the momentum of the programme implementation. The planned budget versus the spent one was on track, especially in 2020-2021 during Covid-19 outbreak. Although the budget was very small to complete the activities, indicator targets were still achieved. At the same time, AY programme still got financial support, increased its budget year by year, from 2019 to early 2022, funded by WFP, UNICEF, UNRCO, UNAIDS and Japan government amounting up to a total of USD 292,800 (UNFPA Financial Report, 2022)¹¹⁵. The trust and financial support from various donors indicated that UNFPA has strong financial management, accountability, transparency, and efficiency. Even when the donors could directly provide the funds to IPs, donors preferred to manage their funds through UNFPA due to these qualities mentioned above¹¹⁶.

Finding # 23: The resources provided by UNFPA have had a leveraging effect

CO has been able to manage the programme well and has achieved most of the planned results despite limited financial resources. Resources invested by UNFPA have had a leveraging effect (triggered provision of resources from other development partners) and joint programming enabled expanding interventions with the same available HR. For example, great achievement by PD is about the advocacy to the government counterpart to take actions and invest in producing data on sexual and reproductive health and rights, violence against women, youth and other emerging issues. The results showed that the government has allocated 2.1 million dollars from its national budget to collect data for Cambodian health demographic survey (CDHS) in 2020 and another 9.1 million dollars to collect data for its country wide census in 2019¹¹⁷.

UNFPA put a lot of efforts to mobilize resources from other development partners to help strengthen capacities of NIS staff to analyze the data and produce in-depth thematic reports. Without the support from the development partners, there would be no further in-depth analyses to map out the issues of inequalities in line with the government's commitment at the International Conference on Population Dynamics (ICPD), data response to the indicators set for NSDP, and the Cambodian Sustainable Development Goal (SDG) indicators

¹¹³ CO staff interview feedback, finance documents, progress reports, UN Joint Project Report on Return Migrants

¹¹⁴ MPTF Office Final Programme Narrative Report and CO interview feedback

¹¹⁵ Financial Report, UNFPA 2022

¹¹⁶ Stakeholder (donor interview feedback)

¹¹⁷ UNFPA annual report 2019, 2020, 2021

especially in the target provinces of UNFPA. This also indicates the need for realistic long-term exit strategies for continuity of services and sustainability.

“When data becomes available, we have to seek support from other development partners to help NIS and MOP. Without the technical and financial support from development partners, the data and information are just sitting there at the NIS, MOP.” (Interview with a key informant).

The results showed that UNFPA was able to mobilize funding support for more than one million dollars in addition to its core fund of about 1.3 million dollars. Out of the one million dollars, 90% of the fund came from GIZ, 6% came from UNDP, 3% came from UNICEF and 1% came from UNRSCO. Other donor agencies did not channel their funds to UNFPA directly but they helped by recruiting their own consultants to use the data from NIS and to produce the in-depth thematic reports by themselves. These other donor agencies included WFP, EU, WB, ADB, SIDA, and DFAT. Altogether, UNFPA was able to mobilize 93% more in addition of its allocated core fund (core fund was 1,350,000 and actual non-core fund was 1,053,733)¹¹⁸. All of these funds were mainly used to build and strengthen the national capacities of government staff, especially NIS staff, on data collection, data management, data analyses, and reporting and data sharing using the existing systems of NIS such as the CAMSTAT and REDATAM platforms for the data sharing including the NIS website¹¹⁹.

This established mechanisms with the government and other partners continued to operate during COVID 19 pandemic period as well and UNFPA was able to carry out the work effectively and efficiently facing the changes triggered by emergency context. Thus, despite some on-going challenges from COVID-19, work plans were successfully implemented, achieving the intended milestones, and targets. This was made possible to the CO’s concerted efforts in being flexible and agile to the situation. Under the Effectiveness, achieved results of the CP6 in all programmatic areas are discussed and will not be repeated here.

4.5 Answers to Evaluation Questions on Sustainability

(Sustainability criteria: Common to all thematic areas)

Evaluation Question 9: To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects across the development-humanitarian continuum, including during the COVID-19 pandemic?

Evaluation Question 10: To what extent has UNFPA been successful in mitigating the threats to the sustainability of results caused by the COVID-19 crisis?

Summary of findings:

UNFPA uses existing government systems (no parallel systems created) while filling the gaps to align with national/international standards through capacity building of IPs by training and coaching. Capacity building is directed at institutional capacity building with less of one-off events. For example, addressing health service response to GBV, UNFPA has mainstreamed gender in the pre-service curriculum of HWs.

Sustainability is linked to promoting a rights-based approach. UNFPA has made an effort to build the capacity of rights holders to make claims on government, but greater attention is required on empowering the communities and strengthening them to know their rights to make informed choices. Efforts at strengthening capacity of duty bearers on gender sensitivity have been good, but fragmented. With regard to empowering and capacity building, there was no evidence of timelines or exit strategies to indicate when UNFPA support will be gradually reduced for the government system to be on its own.

¹¹⁸ UNFPA annual report 2019, 2020, 2021

¹¹⁹ documents, interview feedback

The technical assistance provided by UNFPA and its consistent coordination on the development of various legal frameworks and policies of the government and working closely with the demands and the participatory approach that UNFPA practices also contribute to sustainability of the supported interventions.

With regards to mitigating threats to sustainability of results during the pandemic, there was no nationwide lockdown, UNFPA continued with the planned CP6 programme during the pandemic period, with programme staff following COVID19 preventive measures. Some interventions were implemented by changing the delivery mode. Face to face delivery was changed to virtual mode and although some remote populations may have been left out, the reach was greater due to the virtual mode.

Emergency interventions aimed at recovery and resilience could not ensure sustainability due to the nature of the short-term funding.

Finding # 24: UNFPA support to gender equality and empowerment of women could have been more focused for it to be sustainable

All thematic areas in CP6 are planned to integrate gender equality and women's empowerment at the design stage, based on the programme logic of CP6. It is apparent, from the documented evidence and interview feedback that CO has made an effort to make the interventions gender-sensitive and responsive. SRHR programme has a specific focus on health response to GBV in the planned operational strategies and most of the CP6 efforts seem to have been on GBV, but less on overall GE and women's empowerment. However, at the policy level these have been included, but at the implementation level, it has less focus which needs attention.¹²⁰

Although in the CO programme documents gender initiatives call for gender norm changes, studies on understanding root causes are limited and how to measure if any gender norm changes take place are not very clear.

Finding # 25: Policies, strategies and laws that are gender sensitive and responsive are institutionalized which contributes to sustainability.

Feedback from key informants and documented evidence point to the sustainability of UNFPA supported interventions as they are implemented however the agreements or the project documents lack any exit strategies or a measure when these interventions could be gradually withdrawn indicating a possible timeline when the national mechanism can work on its own without UNFPA support.

According to the interview with the SRHR relevant stakeholders at national, sub-national and CO for SRHR, UNFPA's approach used under the CP6 has been seen as a sustainable approach, although it is not evident the duration UNFPA support will be needed and exit strategies were not indicated in any project document. There are a few major reasons contributing to the sustainability of the intervention of the CP6. First, UNFPA aligns with the government system, policies and strategies by embedding the intervention within the current structure. Second, UNFPA provides ownership to the IPs (national and sub-national IPs) along with the capacity building. For example, UNFPA complements the gaps of MoH to align with national/international standards through capacity building of IPs by training and coaching of midwife workforce. Finally, UNFPA takes the driver seat in coordination among development partners and other key CSOs key players to support the policy of SRHR in the country.

"Instead of doing the in-service training on clinical handout book to health providers, UNFPA has incorporated the skills in pre-service curriculum. This is for the purpose of the sustainability in long run. (UN agency)

¹²⁰ CPAP, CP6 implementation progress reports, field observations and interview data

Overall, this has been seen as the sustainability approach; however, it may take time to see the concrete impact especially when investing on midwife workforce development.

“Strengthening midwifery competency at least need 10-20 years project. Sometimes it looks so slow of UNFPA, but it may be the right way to work with government. It takes time to bring MoH and stakeholders along” (Burnet Institute)

For AY, linking to ICPD+25, UNFPA invested with AY to uphold their rights, and created the opportunities through comprehensive sexuality education and youth-friendly services that ensure their health and empowerment, as a necessary precondition for sustainability.¹²¹ Under UNFPA support and collaboration, MoEYS developed and published CSE (grads 5-12).¹²² The government committed to sustain it as the compulsory subject in school curriculum nationwide. MoEYS has piloted CSE in some schools, and had a strategic plan which are planned to roll it out to all schools in the whole country in 2024. To ensure sustainability, MoEYS allocated budget to implement its CSE strategic plan for in-school and out-of-school youth.¹²³ However, CSE is just in the early stage with piloting process. To make sure sustainability of CSE for school curriculum, MoEYS still needs more collaboration and further support from UN Agencies and Implementing Partners to implement CSE for the whole country.¹²⁴ Furthermore, MoEYS needs time to advocate MoEF for allocation of more budget on textbook publication for teachers, and support institutional capacity building on training mechanism, supervision support, and usage of materials for CSE consultative rooms for both sub-national and school level. At the same time, MoEYS also needs more assistance from UNFPA which plays a key role on arrangement of coordination mechanism with UN Agencies, Implementing Partners and other key stakeholders to work together on CSE in schools.¹²⁵ As acknowledged, the in-school CSE teaching will greatly contribute for students who will then share and pass on the acquired knowledge to their communities especially out-of-school AY – friends and family members. In 2014, the Minister of MoEYS agreed to have the basic SRH into the core curriculum as part of the new Education Strategic Plan (ESP) 2014-2018¹²⁶. The implementation of the new national curriculum was scheduled to start in 2022.

Gender equality, disability and social inclusion of AY participation in UNYAP will continue their role as the change makers and role model. UNYAP brought the opportunities for the youth to practice their rights. The youth who came from different organizations and various background has joined as the youth panel (UNYAP) and general participants through UNFPA facilitation and support – meetings, workshop, training, youth debate. It was evident that through these capacity building interventions, as rights holders, they were able to engage in policy discussions and advocate for accountability. They have become the potential youth who continue to share their perspective, skills and knowledge on health, leadership, gender, inclusion to general AY in school, at workplace and social media platform. Some youth panel members currently have become leaders of CSOs and active members of CSOs (e.g. Green Lady, RHAC). With the experience gained, after joining UNYAP, some members have developed proposals for new interventions related to gender and social inclusion¹²⁷ which are aimed at contributed to Cambodia SDG – leave no one behind.

As for GBV, with support from UNFPA, a number of laws, policies and strategies have been introduced and GBV response services have been established. However, not all GBV survivors are able to access the services they need, only 24 percent of women who have experienced physical or sexual intimate partner violence seek help from formal service providers¹²⁸.

¹²¹ Country Program Action Plan 2019-2023 (CPAP)

¹²² CSE textbooks and teacher guidebook from grade 5 to 12 published by MoEYS

¹²³ CSE strategic plan draft by MoEYS

¹²⁴ KII with MoEYS official

¹²⁵ KII with IP and MoEYS official

¹²⁶ KII with officials of Ministry of Education, Youth and Sports, Cambodia

¹²⁷ KII with UNYAP members

¹²⁸ CDHS 2014

Unless multi-sectoral units are well established and the commune system is well aligned with the established health system/health centers the sustainability of the GBV services to all those who need it is questionable. Referral system is not functioning well in the provinces, although the GBV working groups are there.

As for PD, all PD interventions are more likely to sustain in the long run. The focus of PD is to build and strengthen capacities of government staff on population data collection and analyses. As discussed in the effectiveness section above, the NIS staff capacities have gradually been improved. With the strengthened capacities gained from UNFPA PD interventions, NIS staff will be able to continue to work in the far future especially on data collection, data analysis, report writing and sharing of the data results to stakeholders. The group discussion with the MOP clearly shows that the MOP was very satisfied with all the technical and financial assistance given by UNFPA. They also requested for continuous technical and financial support and collaboration from UNFPA as a long-term development partner.¹²⁹

The technical assistance provided by UNFPA and its consistent coordination on the development of various legal frameworks and policies of the government on population data and statistical development are going to sustain in the far future. The law on statistics was developed and promulgated for enforcement by the government. NIS is clearly the leading agency to coordinate with all stakeholders from national level to the local level on the survey and census work. There are rules and regulations in place for NIS to lead the data collection and analyses to provide data for indicators set in the NSDP, ICPD25, as well as SDG framework for the government to present its progress, especially at the UN headquarter.

All UNFPA PD interventions are adopted by the government. As discussed, the government spent a lot of money from its national budget line to conduct its nation-wide general population census and a lot more large-scale surveys such as CDHS, census of agriculture, economic census, socio-economic survey, labor force survey, and many more. The data and reports of these studies are all available on the website of the NIS. Due to the technical assistance from UNFPA, government staff is able to learn and replicate what they have learnt to apply to other areas as shown above.

Interventions under emergency situation cannot ensure sustainability due to the nature of the short-term funding. In 2022, the Cambodia-Thai border reopened, and the supported beneficiaries continue migrating to work in Thailand to seek employment. The statement from IOM concerns that “we cannot ensure the sustainability of our program intervention as its short-time support of less than one year. Even if we support their health and family income generation, they will migrate again after border reopening”. Capacity developed within the communities and the government structures are expected to be sustained, however, it is too soon to see their sustainability. A follow up review will be able to assess the sustainability of the capacity built.

4.6 Answers to Evaluation Questions on Coverage

Evaluation Question) 11: To what extent have UNFPA humanitarian interventions systematically reached the affected populations, especially the most vulnerable and marginalized groups (including young people and women with disabilities; those of racial, ethnic, religious, and national minorities; LGBTQI populations)

Summary Findings:

Cambodia scores high on the global vulnerability index with regard to the risk of flooding in certain areas, this rarely results in displacement or disruption in access to services. Although, in 2020, during CP6, there was some disruption due to flooding. COVID 19 pandemic was a new experience that affected major part of CP6

¹²⁹ CO M&E reports, KII feedback (MOP and CO staff)

period UNFPA included emergency preparedness throughout its programme to ensure stronger linkages between the humanitarian and development pillars as well as promote resilience within communities.

During emergency situations (floods and COVID- 19, in Cambodian context), CO was quick to come up with plans to serve the needy populations and to avoid interruptions to services, especially SRHR, within UNFPA mandate, jointly with UNCT as well as the government agencies.

To enhance efficiency and effectiveness UNFPA joined with other UN agencies to launch two joint programmes to reach the affected populations by these emergency situations.

Note: Discrepancy in the numbers reported observed and given the emergency situation, different data sources have caused this issue. However, the differences are marginal.

Finding # 26: Targeted population groups were reached and disaggregated data were available by geographic locations at healthcare service points. However, specific data on socially disadvantaged groups are limited.

During CP6 period UNFPA had to support RGC to respond to two major humanitarian crises: COVID-19 pandemic and flash floods in October 2020.

Since June 2020, CO provided over around 10,000 dignity kits to assist RGC to support vulnerable women and girls, pregnant women, affected by floods as well as the returning migrant workers affected by the COVID-19. UNFPA made these available to the relevant national authorities (NCCT, MoWA, NMCHC, NCDM, RHAC and Department of Prisons) for distribution¹³⁰ to needy women and girls; however, the number of total eligible persons to receive the kits was not available for the evaluation. Thus, the coverage as a percentage of total eligible persons is difficult to mention. These contained essential basic hygiene items as well as information on COVID-19 prevention that women and girls would need (for details, see Annex Part2 Additional Information). UNFPA also provided communication and information materials containing advice for pregnant and lactating women and young girls to help protect them against COVID-19, tips for coping with stress at home, and necessary information on GBV/VAW response services during the pandemic¹³¹.

While three provinces (Banteay Meanchey, Battambang and Siem Reap) had specific programme to serve the returning migrants, other UNFPA focus provinces continued to serve the populations as routine services were carried on uninterrupted. The same three provinces were affected by the October 2020 floods making it difficult to reach remote locations.¹³²

Overall, as for the data are concerned, documented evidence and interview feedback pointed to the availability of disaggregated data of population by age and sex and to some extent on ethnicity that can be used by the service planners . Census included the variable on disability, but ET was not able to find disability data that could be used for enhancing access to services. The provincial level feedback revealed (planning department) the availability of disaggregated data for vulnerable and marginalized populations, down to the commune level¹³³. However, based on ET observations and interview feedback from service providers, there seems to be a gap in data accessibility and availability, as most service points had limited data on people with disabilities. Data on LGBTQI and other socially disadvantaged groups such as

¹³⁰ CO monitoring reports and CO staff feedback

¹³¹ ibid

¹³² interview feedback from different sources and documents

¹³³ Meeting with Provincial Planning Department and evidence of data bases (observation)

entertainment workers were also limited. According to several key informants, during the response to COVID -19, without any discrimination or restrictions, services were provided to all those seeking for services. These include health services, quarantine support, mental health awareness and support, social protection and economic assistance to vulnerable groups. UNFPA's contribution was mainly in SRHR, health response to GBV including psychosocial support (TPO) and mass awareness on related issues (interview feedback from UN agencies participated) as part of the UN collaborative team. Number of frontline service providers, particularly in the quarantine centres, had received training d on psychological counselling for GBV.¹³⁴

UNFPA also supported the information material to the general population including youth, and migrating people. Based on UNFPA Annual Report, 2020, UNFPA mobilized USD 200,000 from the UN - Multi Partner Trust Fund (UN-MPTF) (and in 2021, UNFPA in partnership with IOM supported sexual, reproductive, and mental health (SRMH) and GBV to 10,574 (3,686 female) migrants as response to and recovery from COVID-19.¹³⁵

Based on CO Monitoring report data and feedback information over 50,000 had participated and received information about COVID-19 and SRHR topics including SGBV through 6,147 outreach education sessions conducted by CCWC and RHAC staff/volunteers in 520 villages in the target provinces w CCWC and RHAC staff/volunteers. A total of 2,684 returning migrants had attended the education sessions. 7,319 were provided with maternal care and GBV information plus psychological support and 91 survivors of violence were assisted in the three target provinces. The data were collected at different points in time and there is a slight discrepancy in the numbers reported, depending on when it was collected. However, on an average, overall, UNFPA had been able to cover and respond to a large number as they envisaged possible given the nature of the situation.

17 migrants were identified as experiencing SGBV, and were referred to receive appropriate supports by CCWC and RHAC staff. 2,150 dignity kits were distributed through government and NGO partners to returning female migrants and venerable women and girls of reproductive age and vulnerable in the host communities in the three provinces. The figures below show the coverage limited only in the three provinces where a large number of migrants entered the country, mainly from Thailand. It was reported that during the programme implementation about 215,000 migrants had returned to the country. Below numbers show the coverage, however as an exact percentage of those who may have needed the services is difficult to report. According to the interview feedback the understanding is that the neediest persons and those who sought for services were provided with the services.

Joint programme response to COVID 19 Pandemic included coverage ¹³⁶of:

- 520 villages in three provinces, providing over 6000 sexual, reproductive, and maternal health (SRMH) education sessions to the communities.
 - 58,357 migrants and their relatives received COVID 19 prevention messages and on SRMH services. Out of these 14,978 were between 15-24 and 31,928 between 25 – 49 (not disaggregated by sex) and 267 were living with HIV/AIDS
- Access to MHPSS, GBV and Maternal care support:
- 8,543 women, adolescents and youth were reached through social media campaign on maternal care services
 - Deployment of social workers: 575 (Female 257) professionals/social service workers and quarantine center staff trained on MHPSS (for mental health services) and on GBV risk mitigation
 - nearly a hundred of GBV survivors who were among the migrants had been assisted

¹³⁴ interview feedback from UN agencies participated and Project completion report

¹³⁵ ibid

¹³⁶ Final Report UN Joint Programme (UN-COVID 19 Recovery and Response Multi Partner Trust Fund) April 2021

- 947 eligible female) migrants received hygiene kits, when referred for quarantine and 4,938 women and girls had received hygiene kits in home communities¹³⁷

4.7 Answers to Evaluation Questions on Connectedness

Evaluation Question) 12: To what extent has UNFPA contributed to developing the capacity of local and national actors (government line ministries, youth and women’s organizations, health facilities, communities, etc.) to better prepare for, respond to and recover from humanitarian crises?

Summary findings:

UNFPA, with other UN agencies responded well to reduce the impact of COVID 19 pandemic by strengthening their capacity to deal with the challenges that arose in the recent crisis (COVID19 pandemic). Response plans for emergency situations were in place, and UNFPA keeping to its mandate enhanced the capacity on health sector response to GBV by including MISP) and essential service package to health service providers.

Cambodia was not spared when the COVID- 19 pandemic hit the world. With the objective to support and complement the RGC efforts in providing essential health and social services to the most vulnerable migrants and host communities, UN joint programme strengthened multisectoral coordination, at sub-national levels, from the provincial administrative level down to the commune, engaging health and non-health actors, as well as civil society, engaging the community to respond immediately to the needs of the populations that are most urgent during the emergency period. This multidisciplinary, multi-stakeholder structure was able to provide a continuous service to all affected, without discrimination or any gaps making a smooth transition from emergency to development context.

UNFPA implemented four key interventions in partnership with the Reproductive Health Association of Cambodia (RHAC); provincial departments of health, social affairs and education; provincial, districts, commune and village authorities: 1) improving access to maternal care for returning migrants via social media communication, 2) providing safe spaces and psychosocial support for GBV survivors among the returning migrants, 3) distributing culturally appropriate dignity kits to women and girls of reproductive age among the returning migrants and 4) leading an Assessment on the Social and Health Impact of COVID-19 among Returning Migrants.

Similarly, in another UN joint programme to promote disability inclusion and quality services for GBV survivors, UNFPA was able to support the government during COVID-19 pandemic period in the UNFPA priority provinces, with responding to GBV and strengthening capacity of front line worker with necessary training adapting to online hybrid platforms.

As stated earlier, UNFPA, in preparation to respond to humanitarian crisis supported the government on the Minimum Initial Services Package (MISP) that got adapted and endorsed by MoH. Nine provincial disaster management teams in provinces that are prone to flooding were also trained. UNFPA also strengthened the focus on SRH and VAW/VAW in the National Strategic Plan for Disaster Risk Management for Health 2020–2025 and Provincial Disaster Preparedness Plans in priority provinces which aligns with UNFPA’s Minimum Standards for Prevention and Response to GBV in Emergencies¹³⁸.

¹³⁷ Final Report UN Joint Programme (UN COVID-19 Recovery and Response Multi Partner Trust Fund) April 2021

¹³⁸ Relevant CP project progress reports and CO and MOH KI interview feedback

Finding # 27: Capacity of national institutions, CSOs, and NGOs are increased as a result of long-term preparation for similar or other crises in the future

UNFPA, together with other UN agencies responded well to reduce the COVID-19 pandemic. On a UN joint programme with UNICEF, IOM and WHO, “to protect the return migrants and host communities from the risk of large-scale transmission of COVID-19 and to provide them with essential socio-economic services”, UNFPA worked in three provinces to serve the returning migrants from the bordering countries, collaborating closely with public administration of RGC and relevant partners, NGOs and CSOs and making use of the commune structure to reach local communities. This joint programme applied a systems approach, using the existing structures and administrative systems from the provincial level to the commune level, strengthening the services and establishing communication linkages to provide prompt and needy service to all the migrant populations as well as the local communities. The system that was strengthened had been effective in delivering and monitoring the services that could be replicated as a model in similar emergency settings and for strengthening sub-national systems for transition from humanitarian to development nexus.¹³⁹

This UN Joint programme, as a response to COVID-19, produced a model for replication in similar humanitarian contexts. Working at a multi-level with multi-disciplinary stakeholders developed a system that can be used in responding to and building resilient populations by addressing recovery phases in emergency situations. With some modification, this model may be applied in the development setting as well – although, it may have challenges unlike working in an emergency situation where all stakeholders come together to assist each other focused on short-term plans and emergency funding.

With technical support from UNFPA through RHAC, a local NGO, 698 local authorities and stakeholders including provincial, district, commune, and village officials, provincial health departments, relevant operational health districts, provincial departments of education, youth, and sports, provincial departments of women’s affairs, and commune committees for women and children were sensitized and oriented on COVID-19 prevention and the reproductive, maternal health and GBV with a focus on migrants from Thailand in the three provinces. Dozens¹⁴⁰ of migrants identified as experiencing SGBV were referred to receive appropriate support services by CCWC and RHAC staff.

Similarly, in another UN joint programme to promote disability inclusion and quality serves for GBV survivors UNFPA was able to support the government with training front-line GBV service providers in the UNFPA priority provinces during COVID-19 pandemic period, adapting to online hybrid platforms. Capacity built and the relationships developed and maintained between UNFPA CO, RGC partners and donors are important achievements¹⁴¹.

UNFPA, in addition to the UN joint programme, supported the government to provide uninterrupted services to the other priority provinces by enhancing capacity, together with MoH. Services on health sector response to GBV were through the existing health cadre as they had received the training before. UNFPA has worked with the Government to update the Minimum Initial Service Package (MISP) guidelines and supported to incorporate them in the National Strategic Plan on Disaster Risk Management for Health (2020-2025) and mainstream the response plans.¹⁴² UNFPA has been supporting the health sector over several CP cycles and what exit strategies will be in place for a sustainable system is not evident.

More details on how UNFPA adapted to the situation and how the programme interventions were carried out during the pandemic have been already included in the discussions under effectiveness criteria and are not repeated here.

¹³⁹ KII with IOM, UNICEF, UNFPA, RCO and WHO; joint Programme Completion Report

¹⁴⁰ exact numbers are not reported for ethical and confidentiality purposes

¹⁴¹ CO and other stakeholder interview feedback and UN Joint report

¹⁴² Relevant CP project progress reports, Disaster Risk Plan and CO and MOH KI interview feedback

The systems approach followed in responding to the situation and the strengthening of the capacity of the communities to overcome the emergency situation and the recovery phase, including the income generation interventions by other joint partners have shown positive results. However the ET was not able to observe the ground situation as the visit to these provinces was not part of the evaluation plan, although several key stakeholders involved in this were interviewed. An impact study is underway to follow up and assess the capacity and readiness of the local organizations and services to face such emergencies in the future.

4.8 Other Concerns

Environmental concerns: Although CO did not include plans in the CPAP on any direct interventions to support the mitigation of climate or environmental issues, given the intensity of the effect of climate change; the CO has integrated activities that would directly or indirectly help reduce the impact of climate change. One example CO's contribution is the "Sanitary Hygiene Pad" under MHM¹⁴³.

UNFPA has included interventions to respond to climate change and emergency and natural disasters: to name a few: (a) MISP training to sub-national health staff, (b) Telemedicine and E-learning: new innovative solutions being established and functioned, (c) Climate change and environment were embedded into the new standards for midwifery education like waste management, MISP, (d) New midwifery curriculum incorporates perinatal mental health skill to support women causes by the climate change.¹⁴⁴

South-South and Triangular Cooperation: For SSTC, PD programme initiated a programme by supporting MoP in establishing a relationship with a university in Malaysia on data analysis and ageing in 2019. However, it has been postponed due to financial constraints and the COVID-19 pandemic. In the meantime, Gender programme has started exploring the possibility of SSTC, especially on OSCCs. The discussion has happened with APRO and MoWA on where the Royal Government of Cambodia could learn about OSCCs. However, due to financial constraints, these have not been initiated yet. As for the SRHR, currently, UNFPA is supporting the NMCHC in establishing fertility services by working with UNFPA Thailand. While this is still at an early stage, it is envisaged to progress within CP6. There are lessons that can be shared that may not cost much and save resources by not reinventing the wheel. APRO will be able to provide good practices from other countries in the region. For example, lessons from Bangladesh on Midwifery, SRH in Garment Factories, Health Leadership and Governance Programme (HLGP) (Philippines UNFPA), GBV guidelines and OSCCs, SWEDD (Africa demographic dividend) are some examples that UNFPA can benefit from. Other countries in the region may benefit from the Cambodian UN joint programme experience, responding to an emergency situation, and working with the provincial structure providing multisectoral services.

4.8.1 Unintended Effects

There are no negative unintended outcomes observed, however, there are positive unintended outcomes found during this time. Few examples are illustrated below:

Because of the COVID 19 pandemic, NIS was able to receive more funding support from development partners to conduct a survey on socio-economic impact of COVID 19 on the country. Although NIS did not plan for this, the financial support was available for NIS to undertake this survey¹⁴⁵.

"Some activities we have not planned, but we got the final support. After we conducted our regional launching workshop to present our efforts and achievements to development partners, we were able to receive other support for our work. WB provided us with 50,000\$ to conduct a survey on the socio-economic impact of COVID19 on the country. We do not have a plan for this but we got the support for it." (Group discussion with MOP).

¹⁴³ CPAP document, field observation (School in Ratanakiri), CO/AY Progress reports, KI and Students' interviews

¹⁴⁴ KI interview feedback and CO M&E reports and trip reports.

¹⁴⁵ KII feedback main source), CO PD documents,

In general, the investments in digital health interventions served as useful tools during service disruption due to COVID 19 pandemic. The expanded use of the e-learning platform created for capacity building of providers for the programme implementation was unintended and expanded the scope and reach of the platform. The use of e-learning platform was used in all programmatic areas as well as in the emergency context for training and communication purposes and as a result, all planned programmes were completed and in addition CO staff, relevant ministry and CSO staff were able to experience and enhance their skills in the use of e-learning and other online communication.¹⁴⁶

The inclusiveness of the entire evaluation process may have become a learning experience for the new and old staff equally. Most of the UNFPA staff got a good understanding of the entire programme as staff due to time pressure, focus only on their programme and may not have been fully aware of other areas of work. The CPE process provided enough time to look back at one's own work in the context of the overall programme.

UN Joint program responding to COVID19 – came together to respond to the emergency situation and the coordination took place on the ground as the need arises to address the issue at hand. With the collaboration of all government and non-governmental institutions, a functional system was established, to efficiently make use of all capacities, specifically at sub-national levels down to the commune level. This system's approach now will be able to replicate in a similar setting. The lessons learned during this joint intervention have given rise to new ideas which will be formulated into new interventions¹⁴⁷. Identification of challenges faced by migrant workers in this specific joint programme could be useful in working with migrant populations in general. Internal migrants – as a vulnerable group, issues faced by this population provides lessons for future planning.

4.8.2 Good Practices and Lessons Learned

- UN Joint programme, as a response to COVID-19, produced a model for replication in similar humanitarian contexts. Working at a multi-level with multi-disciplinary stakeholders developed a system that can be used in responding to and building resilient populations by addressing recovery phases in emergency situations. With some modification, this model may be applied in the development setting as well – although, it may have challenges unlike working in an emergency situation where all stakeholders come together to assist each other focused on short-term plans and emergency funding.
- Lessons learned in the Humanitarian and development nexus, as explained above on the systems approach applied in responding to and reducing the impact of covid-19, are commendable and worth sharing with other partners. Preparation and working in the pandemic environment also shows the necessity of agile programming.
- Until all programmes achieve gender transformative stage, it is useful to include a dedicated outcome and output for gender equality and women's empowerment. However, inclusion of GE element in all programmatic areas in CP6, with a key programme officer to oversee and to do reporting and progress monitoring the gender mainstreaming across all outputs, is a good example. As the next step it will be useful to include gender transformative approach to programme interventions with the aim to change those norms and practices that discriminate against men and by which men can feel overburdened. In CSE curriculum this has already been addressed to a certain extent.
- CPE Cambodia engaged a young emerging evaluator (YEE) as a member of the evaluation team. Fully immersed in the evaluation exercise, from the design to the final reporting phase, YEE received hands-on experience and built skills and technics in evaluating complex programmes. While this was helpful in building youth evaluation capacity in the country, it would have been useful to consider the extra time and effort required to mentor a trainee during an exercise such as CPE.

¹⁴⁶ CO Trip reports, KI interview feedback, CO M&E performance data

¹⁴⁷ KI interview feedback, UN Joint Programme on Return Migrants (COVID-19) Completion Report

Chapter 5: Conclusions

1. Overall, UNFPA maintained the programme's relevance keeping in line with the government priorities, UNFPA mandate, and the beneficiary needs. CP6 is aligned with the principles of the 2030 Agenda for Sustainable Development and UNFPA's three transformative results. UNFPA enhanced UN's collective contribution to national development (significant contribution to UNDAF (UNSDCF) via working groups, results groups (RGs), and bringing UN agencies together onboard on common themes such as Gender Equality, Disability, COVID19-GBV response etc. (Origin: Findings #1,2,3,4.Relevance, Coherence).
2. Given the well-established long-term relationship with the government and other development partners for over several country programmes, UNFPA offers unique contributions and builds on its comparative advantage in SRHR, gender equality, social inclusion, rights, and data to UNDAF and joint UN initiatives, and has demonstrated specific technical contribution to the country's development agenda (Origin: Findings #4,5,6, Coherence, Effectiveness).
3. Maintaining the alignment with UNDAF, UNFPA mandate, Strategic Plan principles and the needs of the intended populations in general, inclusion of the needs of the marginalized populations in the design was evident where the programme design and implementation reflected the needs of marginalized and vulnerable adolescents and youth (for example, baseline surveys, situational analysis etc., have been conducted prior to programme intervention). However, in the implementation, there seems to be some challenges in reaching out to the most vulnerable groups which may affect the leaving no one behind (LNOB) objective. Gender equality, and human rights and disability dimensions are effectively incorporated into the CP design, to a certain extent in implementation and monitoring (Origin:Findings #1,2,12, 13, 16, Relevance, Effectiveness)
4. Limited engagement with CSOs and NGOs at ground level: As stated above, the programme design reflect the needs of marginalized and vulnerable groups (e.g. the choice of Ratanakiri), however, based on the strategy plan 2018-2021 business model, CP6 was designed and implemented to focus more on the upstream policy advocacy (which was accomplished remarkably) and capacity development. Without a strong presence at the local level through local level IPs, the efforts to ensure that the upstream achievements are translated to downstream are limited. Given the structure and the resources, UNFPA and the government cannot accomplish it alone. CP6 covered a lot of ground, all aligned well with UNDAF, UNFPA mandate and the needs of the targeted populations, but had there been more collaboration and follow up with CSOs and NGOs on the ground, focusing on the identified targeted groups while engaging at policy level, CP6 could have achieved high-impact and more sustainable results. However, active engagement and presence of CSOs made UNFPA supported response to COVID-19 effective (Origin: Findings # 1, 8, 12 27, Relevance, Effectiveness, Efficiency, Sustainability, Connectedness).
5. While ET recognizes the limitations with the human resources at CO level, the strategic partnerships established at the national as well as provincial-level have been a factor in accomplishing development results. However, there is limited engagement with private partners. Similarly, linkages with local CSOs/ downstream development organizations (working towards similar objectives) who are present in the UNFPA priority provinces could have been stronger and the evidence of results achieved by CSO contribution is difficult to quantify or single out (Origin: Findings #1,2, 25 all under Effectiveness, Efficiency, Sustainability).
6. With regard to implementation, CP6 planned interventions under the outcome areas (SRHR, AY & PD with Gender Equality as a cross-cutting theme) are found to be highly relevant to the national priorities, UNDAF, UNFPA mandate, ICPD POA, 2030 Agenda (Origin: Findings#1,2, all findings under the Relevance, Effectiveness and Sustainability).

7. CP6 does not have a dedicated output for Gender equality and women's empowerment. Although GE is integrated into all thematic areas with most of the indicators measuring GE, CP6 mainly focuses on health response to GBV reported under SRH. The interventions, in general, are gender-sensitive and only a few interventions such as CSE planned curriculum shows evidence of being gender transformative. The measurement indicators of expected behavior change are not included in the performance plans. Dedicating a separate outcome and output on GEEW is to be reconsidered and addressed from several different angles (SDG 5 is stagnating). On GE, policy and advocacy support has been achieved as planned and disaggregated data by age and sex are reported to be available in most data bases, both at national and provincial levels enabling a base for gender analyses (Origin: Findings 1,12, 19,24, Relevance, Effectiveness).
8. Most outputs had mentioned social norm change and behavior change efforts as part of the interventions; however CP6 has not focused fully on addressing these root causes. There is more room to address these as well as the need to develop tools and indicators to measure the norm changes (Origin: Findings # 24, Effectiveness, and Sustainability).
9. CP6 focus on disability is apparent (OEE also has a dedicated output on disability) but needs more focus and data in the area of disability inclusion in programme interventions in a meaningful way. Nevertheless, given the limited time that disability inclusion was made as part of the country programme, there is a commendable effort to include disability in a strategic way more broadly (e.g., Census, CSDGs, national curriculum for midwives). Midwifery curriculum already adapted to the needs of the persons with disabilities (Origin: Findings 2,7,8,19, Relevance, Effectiveness).
10. UNFPA contributed positively towards coordination mechanisms, both internal as well as external partners and agencies, mainly at upstream level. As for the internal coordination, UNFPA actively contributed to the UNCT working groups, results groups, and joint initiatives in the development as well as in the humanitarian context. Externally, UNFPA coordinated well and implemented the CP with the full support of the participating ministries as well as the non-governmental IPs and other development partners in delivering the programme. The government as well as other development partners consider UNFPA as a leader, specifically in the areas SRHR, CSE, GBV and Data. Both, internal as well as external partners expressed their willingness to work closely with UNFPA in joint programmes. As mentioned earlier, UNFPA's collaboration with private partners as well as local level CSOs is limited with more room to include them as development partners (Origin: Findings# 3, 13, 27.Coherence, Effectiveness, Connectedness).
11. With regards to humanitarian response, especially under the SRHR, health response to GBV plans were included at the design stage taking emerging issues into consideration in the humanitarian context. Issues pertaining to SRHR and GBV have been adequately integrated and addressed in joint COVID-19 response and recovery programming with UNFPA's leadership. UNFPA's leadership as well as the partnership in UN joint programmes and, coverage on SRHR and GBV services during the floods and the pandemic period and the contribution on preventing/addressing GBV through media and strengthening services at one stop centres during COVID-19 period were commendable and received praise from the development partners. By maintaining uninterrupted implementation of planned interventions, programmes were delivered via virtual mode of operation (COVID-19 context), when appropriate to enhance efficiency and effectiveness (Origin: Findings# 1,2,13,26,27.Relevance, Effectiveness, Coverage, Connectedness).
12. Adapting to new programme delivery modes, planned CP6 work plans did not have to be changed, except for the mode of delivery, to achieve planned results. In response to COVID-19, addressing mainly the SRHR needs of return migrants and host families, UN Joint program (UNICEF, UNFPA, IOM and WHO) in three provinces worked in close collaboration between public administration of RGC and relevant partners, NGOs and CSOs making use of the commune structure to reach local communities; a systems approach had been established that can be used as a model where structure from provincial level to the commune level had been strengthened to ensure a continuous flow of services and

establishing communication linkages. In this process, CO linked prevention services, response to COVID-19 and recovery along with building the sub-national level capacity. Once tested well, this can be replicated as a model in similar contexts (Origin: ToC, Findings # 1,2, 3, 28 Effectiveness, Coherence, Efficiency, Coverage, Connectedness).

- 13.** UNFPA's contribution to promoting a focus on young people and rights issues is well recognized. UNFPA has demonstrated its added value to the national RMNCH+A programme by bringing to the foreground rights perspectives, particularly in the context of FP, maternal health service delivery and health response to GBV. Quality of service varies and is an issue to address. However, UNFPA's efforts to address this are apparent from the study delegated to understand the quality of health services in the priority/focus provinces (Origin: Findings #9, Effectiveness).
- 14.** Support extended to MoWA has been positive in ensuring that the policies are in place with policy level upstream work satisfactorily completed. Support in the implementation of these at sub-national level is needed. the Draft National Gender Policy and Strategy (including specific strategies to address barriers to accessing sexual and reproductive health and VAW information and services), updating Cambodian Gender Assessment, developing and implementing the new National Action Plan on VAW (Policy dialogues on VAW conducted (influence DV law review, national budget and address barriers faced by women), assisting the Five-year Gender Strategy (Neary Ratanak V) to be endorsed and disseminated, and conducting the GBV campaign. UNFPA support in advocacy and engagement of more local level CSOs and other partners seem to be limited to ensure the implementation of the policies and strategies at ground level where it is most needed (Origin: Finding # 25 Effectiveness).
- 15.** Resources provided by UNFPA have had a leveraging effect triggering provision of additional resources from other development partners. UNFPA was also able to bring leading NGOs to the development table enhancing their visibility and entry to working with the government and other development partners and in return UNFPA benefitted by receiving their services at no cost. As for the timeliness, IPs received resources that were planned, to the levels foreseen in a timely manner and there were no reported delays in the process of fund transfers. The selection of IPs has been efficient and effective. CO has been able to effectively lobby and convince to attract development partners on innovative interventions. CO's established credibility, recognition, and respect were evident in the willingness of partners to enter into joint programming with UNFPA (Origin: Finding# 8 (in general under effectiveness) and 22,23 Effectiveness, Efficiency).
- 16.** UNFPA's mode of operation by using existing government systems (without creating parallel systems/structures) ensures continuity and sustainability of the efforts/support to development interventions. UNFPA working with the Government to update the Minimum Initial Service Package (MISP) guidelines to incorporate them in the National Strategic Plan on Disaster Risk Management for Health (2020-2025) and to mainstream seems the right step toward ensuring timely response to emergency situations and the sustainability of this service. Filling the gaps to align with national/international standards through capacity building of IPs by training and coaching and avoiding one-off training events on individuals, capacity building targeted national institutions to ensure sustainability while enhancing efficiency and effectiveness (Origin: Findings# 1,2, Effectiveness)
- 17.** UNFPA's support to the MOH midwifery initiative and its collaboration with an international organization (Burnet Institute) has opened avenues for major national contribution to maternal health and reduction in maternal mortality. It also contributes to overcoming the shortages in human resources for SRH. However, the midwife workforce turnover has challenges in terms of the necessity to provide (repeat) training as newcomers join (Origin: Findings# 9,10, Effectiveness).
- 18.** UNFPA plays a critical role in supporting the SRHR knowledge management for the IPs, particularly the NMCHC. There is room for more in-depth understanding of the access to SRHR information and service and the utilization among different socio-economic groups within the target provinces for

UNFPA to effectively target the intervention by leaving no one behind. Although there is access to essential SRMH in UNFPA target provinces, the quality of services when it comes to waiting time, availability of advanced medical supplies, the attitude of health staff towards clients, discrimination, etc. remain issues to be addressed. The very attempt to delegating a study to assess quality indicates UNFPA's interest and sensitivity to focus on quality health service (Origin: Finding# 8,9,11 Effectiveness).

19. Working with youth, at the national and provincial level, specifically in-school has shown promising results as observed as well as by documented evidence. UNYAP is a good example where reaching marginalized youth leads to increased awareness, creating a cadre of peer educators, and the development of a range of knowledge products including topics on SRH, mental health, personal hygiene, etc. In addition, although in a nascent stage, initiatives on MHM with an attempt to contribute to keeping the environment clean and green are a useful intervention. However, currently this is more active in the urban setting with plans to extend through youth networks. It is difficult to assess their sustainability as most programmes are new, but the process appears to bring sustainable results with a good monitoring system in place (Origin: Findings# 14,15,17. Effectiveness).
20. While UNFPA support for policy development at the national level with MoEYS and MoH is strong, policy implementation at sub-national, particularly at local level schools and health centers are still to be strengthened. CSE technical working groups at national level need to be strengthened and support to CSO networks to enhance community level work on outreach work. There is a gap especially in capacity building, knowledge transfer, and support to materials for training (Origin: Findings# 16, Effectiveness and hindering factors under AY).
21. The PD programme has highlighted many of the related key advocacy areas in statistics such as an increasing appreciation for statistics, the importance of intra-and inter-institutional coordination, clear delineation of roles, and strong leadership, and the need for continuous capacity building. A more rational, well-coordinated, and results-based approach to financing statistics will ensure that priority indicators and statistics are produced to support better analysis and comprehensive monitoring of the NSDP and C/SDGs, including progress in the continued development of the national statistical system (Origin: Findings# 18,19. Effectiveness).
22. UNFPA contributed to strengthening institutional capacities at the national level and provincial level capacity of MOP was enhanced in relation to data collection and analyses. However, there is more room for improvement, particularly in data accuracy at subnational levels and strengthened data coordination between national and subnational levels. There is a need to strengthen institutional capacities on production of quality data through census and relevant national surveys, data analysis, and dissemination, especially on large dataset management and analyses using more robust and rigorous advanced statistical models. (Origin: Finding# 18,19,20 Effectiveness, Hindering Factors under PD)
23. Overall, UNFPA has performed well. At the national level (upstream work/ policy, advocacy) UNFPA has done an excellent job (in all thematic areas). A missing link between policies to their implementation is observed. Covering all thematic areas, SRHR including GBV, AY, PD and Gender, support to relevant national IPs in terms of policy guidelines, strategies, studies and surveys, UNFPA has been an ardent supporter at the national level. Given the nature of the work plan and the allocation of human as well as financial resources, follow-up on the implementation of these on the ground is limited. As mentioned above, there is room for engagement with IPs working closely with the targeted populations to expand the reach and to get the policies translated into action on the ground (Origin: Findings under Effectiveness, Efficiency and Sustainability).
24. Opportunities to learn from other country programme achievements, experience and SSTC initiatives seem lacking. Engagement of a young emerging evaluator on the CPE team is a good attempt to build youth evaluation capacity (Origin: under Other Concerns and Lessons Learned).

Chapter 6: Recommendations

Note: The report includes 10 recommendations of which one is design related (recommendation1) and to be implemented (if agreed) within CP6 cycle when CP7 plans are being developed. Four recommendations are identified as strategic and five as programmatic, indicating of the level of priority. Unless it is specified, all action plans are the responsibility of UNFPA CO (implementation in collaboration with RGC, other national and international development partners, CSOs and selected UN agencies as agreed by the country office and relevant to the UNFPA mandate).

At the time these recommendations are made, ET had no indication about the budget allocation for CP7. Human resource availability is assumed to be at the same level as when the evaluation was done. Hence more collaboration with other UN agencies and NGOs/CSOs are included in the recommendations.

Recommendation 1 is related to the Design of CP7 and is to be carried out during CP6 (Linked to conclusions in general and specific to 7, 8, 9)

Recommendation 1: (High Priority) Design related: Develop TOC focusing on the three transformative results and Conduct Ex-ante evaluation to ensure evaluability of the planned programme

Action Plan:

- For CP7, for new initiatives, conduct a thorough *evaluability assessment (ex-ante evaluations)* at the onset of the programme for each-planned CPAP Output, under the SP outcome, assessing the availability of data (specifically for vulnerable and marginalized populations, including data on disability) for measuring performance, with an in-built M&E system.
- Develop monitoring tools for assessing quality improvement; improve on programme design-related issues based on identified programme gaps/needs; develop clear and detailed intervention logic model with risk assumptions and mitigation plans included for periodic checking along the process of implementation
- Prioritize UNFPA input with explicit sustainability strategies (exit strategies) in the work plan. Enhance program evaluability (with SMART and gender-sensitive indicators) to ensure that comparable data are available to measure the progress (either qualitatively and/or quantitatively; using primary or secondary data). Formulate simple, practical, realistic and easy-to-measure indicators.
- Continue the focus on priority (target) provinces with key interventions, especially focusing on those that are directly contributing to three zeros, by contextualizing the interventions to suit/ as relevant to the ground level. To accelerate the achievement of the three transformative results, UNFPA is to continue to build on the successes in developing human capital and the achievements in improving the quality of life of women, girls and adolescents.
- To make it feasible and easier to monitor and evaluate results, link all planned interventions to the three zeros as key objectives/outcomes of CP7, establishing clear results pathways between outcomes and outputs. Focus equally on setting indicators at intermediate and/or immediate level to measure results. It may be useful to engage the Communication team to effectively communicate the programme results to stakeholders.
- Establish measurement indicators for social norm changes as several programmes entail changes in behavior and it is necessary to determine preferred or expected changes and the measurement of those (attitude change, behavior change, gender norm changes etc. need to be measured). Include structural barriers or root causes that can impede the achievement of results
- Long-term (not limited to one cycle, if possible) interventions to be planned in a more focused manner at the Provincial level (sub-national level) to have a high impact.

- Create more opportunities to learn from good practices from the provinces and replicate them where possible, with due consideration to socio-cultural and other contextual factors that are specific to the situation.

6.1 Strategic Recommendations

Recommendation 2: Linked to conclusion # 1,2,3,4,5,23

(High priority) UNFPA to maintain the leadership role, as in CP6, in Coordination, Advocacy, and Strategic Partnerships and expand the current partnerships:

With UNFPA currently operating through strategic partnerships as the key mode of engagement, extend the partnership to non-traditional Partners and Private Partners to go the extra mile. While maintaining visibility at the national level continuing to support with technical expertise on policy dialogue and contribution to national level needs, efforts to strengthen the coordination with IPs at the sub-national level would enhance the effectiveness and efficiency of UNFPA objective on LNOB.

Action Plan:

- Building on CP6 and other experience and maximizing UNFPA's comparative advantage explore joint programming with other UN agencies if it adds value mutually, and specifically to UNFPA planned programmes. This to be finalized upon availability of shared resources, mutual agreement, on the new UNSDCF and how UNFPA mandate/ 3TRs are positioned there, and on added value. Joint programmes to be focused on addressing the needs of the furthest left behind. With clear responsibilities – optimizing comparative advantage of each partner.
- Conduct a scoping exercise (informal) to see which other development implementing partners are operating in the same thematic area or contributing to the same objectives of the operational strategies and interventions that UNFPA intends to include in CP7 (to be more coherent and to avoid any overlap). This may help in planning financing proposals as well.
- Partnerships and Coordination: Engage private partners in development. Partnering with private sector may unlock financial resources and may promote new avenues to address and promote health and well-being of women and girls.
- Enhanced collaboration and coordination with CSOs to translate policy to action. Programme interventions to be contextualized as each province and its people have their own unique characteristics. Expanding and strengthening working relationships with civil society organizations working to end discrimination and promote equality. Specifically, partnership with CSOs will be useful (a) to provide services to the most vulnerable where CSOs can be present but government services are in shortage or access to information and services are difficult, and (2) to help changing social and gender norms and empowerment of communities, especially women and girls.
- Country office to learn from other UNFPA country experiences where relevant and culturally appropriate. APRO to be consulted as information is available on other countries' good practices, regionally and globally. E.g., SRH in Garment Factories, Health Leadership and Governance Programme (HLGP) (Philippines UNFPA), GBV guidelines and OSCCs (Malaysia, Sri Lanka), SWEDD (Africa demographic dividend), are a few examples that UNFPA Cambodia can benefit from.

Recommendation 3: Linked to conclusion 7,8,9,14,23

Gender Equality and Women's Empowerment to be considered as a stand-alone outcome. Maintain rights-based approach to gender equality, and engage with other ministries, going beyond current strategic partners (e.g. MEF, private partners). Response to GBV to be a more comprehensive and intersectional approach as it entails much more than the health sector response to GBV (however, not to lose sight of the MoH on health

response to GBV, SRHR to maintain the same focus as in CP6). Focus on mainstreaming gender, and applying gender-transformative design principles in programme development.

Action Plan:

- Next CP cycle gender mainstreaming in PD efforts may focus on strengthening national and provincial capacity to monitor SDG (5.1-5.3, 5.6.1, and 5.6.2) and analyse trends and patterns.
- Social Norm Change and Measurement (mentioned above as well): More focus on social norm change interventions (it is already there in CP6) embedded in the thematic areas.
- Include Gender Transformative programming to address root causes of gender inequality within society. Address social norms related to gender equality and GBV (service providers and service receivers).
- Development of tools to measure social norm change, attitude and behavior change of the individuals.
- Allocate a specific budget line for Gender transformative interventions and integrate an intersectional gender equality analysis in relevant interventions under CP7.
- Working in connection with UNICEF on VAC, to address gender inequalities when addressing VAW. Life cycle approach maybe appropriate in this situation as VAC and VAW can be closely related behavior patterns embedded in the family setting and some of the violent incidents occurring at a specific stage in a woman's life can reoccur or continue throughout her life.

Specifically for GBV:

- Coordinate among UN Agencies and line ministries to lobby to include GBV in their operational plans
- Support to improve the capacity and the system on GBV case management maintaining utmost confidentiality with data.
- Re-activate the plans to Initiate SSTC on OSCCs (GBV related) – although SSTC on OSCCS was planned in the CPAP due to financial constraints, it was not implemented.

Recommendation 4: Linked to conclusion 7, 8, 20

(High priority): UNFPA to consider providing support to updating the existing working group, or initiating new CSE Technical Working Group (CSE-TWG).¹⁴⁸

Action Plan:

- UNFPA to provide support to updating the existing working group for more functioning on CSE or support initiating new CSE Technical Working Group (CSE-TWG)¹⁴⁹. CSE-WG is the technical group of partnership and coordination of UN Agencies, government (MoEYS, MoH, Mol, and MoWA), IPs, and CSO networks 150 who are working on CSE, SRHR, and GBV with AY. CSE-TWG to work together with a clear ToR to support both AY in and out of school.
- At the national level, UNFPA to support MoEYS to finalize and publish CSE and selected policies related to SRHR, such as Cambodia Youth Development Index and Out of School Comprehensive Sexuality Education Strategic Plan.

¹⁴⁸ CP6 Mid-term evaluation report also recommended UNFPA to work with MoEYS and IP at national levels to roll-out the CSE, and the working group will push the roll-out activities from national to sub-national levels.

¹⁴⁹ UNFPA has supported MOWA on Technical Working Group-GBV, so, UNFPA can also use this model to support MoEYS on CSE Technical Working Group

¹⁵⁰ Cambodia has the network from CSOs that they worked also with government. Health Action Coordinating Committee (HACC), a network NGOs on health. NGO Education Partnership (NEP) a network NGOs on education at all levels -national and sub-national. Youth Council of Cambodia (YCC) is working with youth network in Cambodia at sub-national and local level.

- UNFPA to coordinate with and support to CSO networks working in the education and health sector. In partnership with CSO networks, work with CSOs at local and community levels to benefit AY in and out of school population.
- UNFPA to consider provision of material, financial and technical support to schools to develop SRHR consultative room for in-school adolescence and youth.
- While continuing to empower youth, identify the social norms and the behavior change that needs to be addressed to achieve desired outcomes. Apply gender-transformative design principles in curriculum development and in all youth interventions (CSE curriculum has adopted a gender transforming approach).
- While maintaining the UNFPA M&E framework as the prime reference for CP, UNFPA to work with MoH and MoEYS (on CSE) to conduct the Knowledge, Attitude and Practice (KAP) survey with AY. The survey will confirm the outcome and impact of UNFPA support on CSE, SRHR, GBV with in-school and out-of-school AY at the middle of CP7 – the survey will also provide the lesson learned and recommendations which serve as a leader to guide for program improvement.
- Given the limited measurement of behaviour change, social and gender norm changes, develop indicators to measure these changes to monitor progress. For an effective Measurement of change behavior, the interventions should be based on systematic barrier analysis embedded in context-specific social norms, cultural beliefs, and practices.
- UNFPA to provide support to the MoEYS monitoring & evaluation department on fieldwork monitoring, reporting and learning on CSE roll-out activities.

Recommendation 5: Linked to conclusion 10,11,12

(Medium priority): Joint programming and monitoring: UNFPA to partner in more joint programmes, and establish clear theory of change and realistic indicators on final planned outputs (strong design and clear roles and responsibilities agreed upfront). Scale up (roll out) the experience gained from the joint programme in the three provinces (on migration project) to other areas, addressing similar issues as relevant to the local context.

Action Plan:

- UN joint plans (as it fits CP7 objectives) to be considered and results indicators to be agreed upon upfront, as an integrated package and to work in harmony with one another, helping to look at the issues through a social, gender transformative, rights-based and environmental lens. A planning and monitoring system to be inbuilt to understand if each agency contribution is on track for achieving the final outcome. In turn, this reinforces the need for a limited number of indicators that are practical and easy to monitor and to communicate easily. As the saying of Albert Einstein goes, “Not everything that counts can be counted and not everything that can be counted counts,” thus the process that takes one from A to B is important to understand, monitor, and assess (which can mostly be qualitative) for realizing the ultimate results.
- In joint programmes and/or integrated programmes that are agreed on upfront based on the mandate and expertise of the Agency, include clearly defined roles and responsibilities mapping out the specific expertise that each Agency contributes to the results chain. UNFPA to develop, jointly with other UN partners, a clear and detailed theory of change (TOC) where a *contribution analysis* can be conducted.
- UNFPA to work on the TOC in *collaboration with relevant IPs* to have a clear understanding of the context, objectives, and expected results of interventions as well as to increase IPs’ ownership

6.2 Programmatic Recommendations:

Recommendation 6: Linked to conclusion 18

(High priority) *Ensure and enhance the quality and availability of essential SRHR services to reach out to the community: UNFPA to enhance the quality of the SRHR service and be more targeted at enhancing access to*

SRHR information, particularly among vulnerable groups. This could be done by providing technical assistance and playing coordination roles among DPs and key stakeholders to further support the NMCHC. Rights-based approaches to be strengthened.

Action Plan:

- Increase access to SRHR information (including the modern contraceptive and ANC), particularly among the indigenous population
- Working with MoH to address improving the quality of care: programmes to address service providers' negative attitudes towards clients, promptness in attending to delivery of service (shorten waiting time), and improvement of quality of medical supplies.

Recommendation 7: Linked to conclusion 3,4,5

(High priority) *More collaboration with CSOs at national and sub-national levels,*

Action Plan:

- UNFPA to consider enhancing more collaboration with CSOs both at national and sub-national level.
- At the national level, it will be beneficial for UNFPA to gather evidence and lessons learned from the CSO's downstream implementation to inform policies at their development stage to shape the policies that are contextually appropriate and relevant to the ground level.
- At the sub-national level, UNFPA could facilitate the work with CSO to create demand generation of the essential SRHR service, particularly the AYFS and GBV, so that the gaps between community and service points of delivery would be narrowed.

Recommendation 8: Linked to conclusion 21,22

(High priority) *Data accuracy at subnational levels to be improved and data coordination between national and subnational levels to be strengthened. Continue to strengthen institutional capacities on production of quality data through census and relevant national surveys, data analysis, and dissemination, especially on large dataset management and analyses using more robust and rigorous advanced statistical models.*

Action Plan

- Continue to strengthen the availability of quality data to guide policymaking, planning, and programming. This will also help evidence-based advocacy for the rights of those populations left behind and also advocate for gender equality.
- Continue to provide both technical and financial support to the government on accelerating the C/SDGs and ICPD25 agenda including the promotion of utilization of data and evidence for the development of policies, planning and programming. Inter-census data, NSDP, national strategies on statistical development, CDHS.
- Continue to provide support to the government in the Data for Development (D4D) as Co-chair of the sub-working group to keep engagement more effective between the demand side (data user) and supply side (data producer) for updating and sharing data to respond to multisectoral demand.
- Lead and promote more collaboration and coordination amongst UN agencies on data sharing and updating its current UN Cambodia Report Dashboards to provide up-to-date and consistent statistical numbers and figures.
- Strengthening the capacity of NIS for the generation of quality data through census and relevant household surveys, and
- Continuing to generate and carry out the development of knowledge management on the changing demography and its megatrends of the country for better forecasting of the impact and their future implications on the economy, and opportunities for harnessing double demographic and gender dividends.

- Strengthen UNFPA's in-house capabilities of PD on in-depth statistical data analyses, large dataset management, and advanced digital communication skills while extending support with technical assistance to build national capacity. This is given the fact that the big data and data sharing platforms are highly demanding. All data users, both government as well as and development actors, look for credible data in the context of digitalization. This also involves IT, as periodic technical backstopping or expertise in this area is required to meet the demands and to maintain the standard of UNFPA as lead agency in data.
- Lead coordination of different studies and findings needed within and outside the UNFPA office on different thematic areas such as GBV, SRH, AY, MCH, Migration, etc., and share consistent data figures with stakeholders.

Recommendation 9: Linked to conclusion 21,22

(High priority) *Adoption of a digital technology and digital platform for advancing programme intervention in CP7*

Action Plan:

- As lessons learned from the adaption of the mode of operations under COVID-19, particularly with the introduction of the e-learning platform for pre-service and in-service training for health workers and the use of social media for the service users and wider audience (especially AY GBV), UNFPA to continue to adjust and adapt the digital technology for advancing the programme interventions.(the he suggestion on using social media is based on the results of COVID-19 response to GBV)
- Adaption of a digital platform for the supply and demand side of the health system for capacity building of health workers, and also to share educational messages for awareness raising purposes to specific groups or wider general audiences. Overall, it is a digital era and learning from the approaches taken during covid-19, ET finds the digital platform can reach out to wider groups, including health staff and the service users.
- Coordinate with other government line ministries such as MoEF, MoH, MoI, MoLVT, MoEYS, MoWA and others to learn and share experience on digital data collection, data development, data management, data utilization and analyses using more advanced robust estimated models such as small area estimation or other prevalence estimation methods.

Recommendation 10: Linked to conclusion 17

(Medium priority) UNFPA to advocate the MH to consider having dedicated body/institute for in-service training provided before deploying midwives into their work stations.

Action Plan:

- UNFPA to continue supporting the in-service training, coping with the health system challenges on the midwife workforce turnover.
- Rather than providing the in-service training at specific target provinces, UNFPA may advocate for setting up a programme to ensure that all newly recruited midwives are equipped with in-service courses before being dispatched to their workplace.