



DFID
human development
resource centre

Health Sector Support Project: Component for Reduction in Maternal Mortality (RMMP), Cambodia

Output-to-Purpose Review Final Report

Fiona Duby

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Sincere thanks to all those who took considerable trouble to make my trip to Cambodia interesting, productive and enjoyable.

Fiona Duby

Acronyms and Abbreviations

| | |
|--------|--|
| AD | Anonymous Donor |
| ADB | Asian Development Bank |
| AusAID | Australian Agency for International Development |
| BAC | Basic Abortion Care |
| CAC | Comprehensive Abortion Care |
| CMDGs | Cambodia Millennium Development Goals |
| CDHS | Cambodia Demographic and Health Survey |
| CPR | Contraceptive Prevalence Rate |
| DFID | Department for International Development |
| RGC | Royal Government of Cambodia |
| HC | Health Centre |
| IEC | Information Education Communication |
| IUD | Intra Uterine Device |
| JICA | Japan International Cooperation Agency |
| LTFP | Long Term family Planning |
| LTPM | Long Term and Permanent Method |
| MA | Medical Abortion |
| MCH | Maternal and Child Health |
| MDG | Millennium Development Goal |
| MMR | Maternal Mortality Reduction |
| M&E | Monitoring and Evaluation |
| MoH | Ministry of Health |
| MoU | Memorandum of Understanding |
| MOV | Means of Verification |
| MSIC | Marie Stopes International Cambodia |
| MVA | Manual Vacuum Aspiration |
| NGO | Non Government Organisation |
| NMCHC | National Maternal and Child Health Centre |
| NRHP | National Reproductive Health Programme |
| NRRMMP | National Roadmap for Reduction in Maternal Mortality Project |
| OD | Operational District |
| OVI | Objectively Verifiable Indicators |
| PAC | Post Abortion Care |

| | |
|--------|--|
| PATH | Program for Appropriate Technology in Health |
| PEER | Participatory Ethnographic Evaluation and Research |
| PHD | Provincial Health Director |
| PM | Project Memorandum |
| PPMRH | Phnom Penh Municipal Referral Hospital |
| PSC | Project Steering Committee |
| PSI | Population Services International |
| PSI-SQ | Population Services International Sun Quality |
| QA | Quality Assurance |
| RACHA | Reproductive and Child Health Association |
| RHAC | Reproductive Health Association of Cambodia |
| RMMP | Reduction in Maternal Mortality Project |
| SAC | Safe Abortion Care |
| TL | Tubal Ligation |
| ToR | Terms of Reference |
| UNICEF | United Nations Children's Emergency Fund |
| UNFPA | United Nations Population Fund |
| USAID | United States Agency for International Development |
| VSC | Voluntary Surgical Contraception |
| WHO | World Health Organisation |

Summary

The Department for International Development (DFID) funded Reduction in Maternal Mortality Project (RMMP) is a three and a half year intervention, initiated in November 2006 with an initial budget of £2.2 million, increased by £1.1 million in February 2009. With the combined funding of DFID and the Anonymous Donor (AD) RMMP is now working in 19 of the 24 provinces in Cambodia. Over three years it has trained 345 health providers who have carried out over 23,057 Safe Abortions thereby averting numerous deaths.

This second annual review of RMMP was conducted by an external consultant between 15th-19th February 2010 and comes at a critical time for the project with many uncertainties regarding future funding. DFID support for RMMP1 ends in April with the possibility of a three month no-cost extension; funding from the 'anonymous donor' ends in December 2010 with no certainty as to whether this will continue; AusAID is considering support for three years from 2011, but this will not be known until May 2010.

The programme Goal is to reduce maternal mortality and improve reproductive health in Cambodia; the Purpose is to increase utilisation of sustainable quality and affordable reproductive and maternal health services by poor women.

Overview of programme progress

(Details of performance against logframe indicators are provided in the logframe review format at Annex 1).

General

Overall the project has made significant achievements in tackling the provision of safe abortion services in the public sector in a very challenging and complex Cambodian environment. RMMP is highly valued in the Ministry of Health (MOH) at the different levels. Development partners are equally solicitous in their praise of DFID for supporting safe abortion and of RMMP, but based on regulatory restrictions and/or a strategy of sector-wide support, donors are reluctant and/or unable to provide financial support. Funding from the 'Anonymous Donor' (AD) has therefore been tremendously beneficial, not only increasing funding to enable expansion in staff but increasing programme coverage from 12 to 19 provinces, and increasing access to safe abortion through private sector involvement. The success of this project has come from a combination of a strong institutional base in Cambodia with skilled and experienced management and technical expertise and a continuum of quality technical support from the UK-based Options team. The project documentation, training and research materials are excellent. The prospect of the DFID-funded project closing at this early stage is viewed with justified concern on the part of collaborating stakeholders, with the risk that many gains made in Safe Abortion Care (SAC) will not be sustained.

The logframe presented some difficulties in measuring progress. The purpose is very broad, while the RMMP focuses specifically on safe abortion and family planning. The logframe neither captures the key elements of the project nor do the indicators and means of verification allow for a comprehensive assessment of progress. Every effort has been made in this report to provide a fair review and to recognise the wider achievements of the project. It is suggested RMMP make some revisions to the logframe, even at this late stage. The project has four outputs. The following summarise findings against these outputs:

Output 1 (Supply-side) Capacity of Health Care facilities to provide quality interventions associated with maternal mortality reduction increased with safe abortion as a priority

The project has made significant achievements in Output 1, not only meeting, but in some cases exceeding targets: To date a total of 268 health providers in 102 health facilities in the 12 RMMP I provinces are providing safe surgical abortion services using the Manual Vacuum Aspiration (MVA) technique. Of these, 13 hospitals are registered as Comprehensive Abortion Care (CAC) sites. This exceeds the target of 240 for April 2010 by 12% (367 providers have been trained under both projects). All sites meet the minimum operating standards; CAC and sterilisation and referral training curricula have been integrated into MPA and CPA training modules. Government trainers now accompany RMMP Quality Assurance (QA) teams on training follow-up and QA visits.

The overall increase in number of women using SA services with support from both project donors during the last reporting period was 69% since the start of project. RMMP has undoubtedly helped to diminish harmful abortion practices in both public and private sector.

The Medical Abortion (MA) drug Medabon® has been registered and RMMP has now received MOH approval to include medical abortion as part of the comprehensive abortion care training package to public sector hospitals. (PSI provides MA through its non-formal outlets [pharmacies] and Marie Stopes Cambodia through its clinics).

Output 2 (Demand-side) Equity and Access to quality reproductive and maternal health services by poor women increased

The RMMP has generated substantial and high quality information to identify the many barriers to safe abortion care.(Figure 3). It has also been active in advocacy at national and provincial levels, with policy makers and health workers ensuring that safe abortion is reflected in strategy and plans. RMMP has developed and participated in numerous communication and research initiatives.

In partnership with 6 provincially based NGOs, work started in October 2009 on community awareness in five provinces where safe abortion services are well established in the public sector.

RMMP is also successfully working in partnership with other non-government agencies working in family planning and safe abortion (such as Population Services International (PSI) and Marie Stopes International Cambodia (MSIC)), promoting an integrated approach in provision of education and information for communities and providers, and expanding the reach of information.

Communication on safe abortion needs to be done in the context of reproductive health and ideally the MOH should be providing leadership on this. Capacity of the National Reproductive Health Programme (NFHP) is weak and coordination lacking with no overarching BCC strategy. RMMP has taken initiative to streamline communications materials with NGO partners. A subsequent phase might consider how to support MOH assume leadership and coordination in this area.

Output 3 MOH technical capacity for the development and implementation of a national CAC plan increased

RMMP's presence within the NMCHC has facilitated trusting relationships and respect for RMMP. Participation on Technical Working Groups at national and provincial level has been important for RMMP advocacy of safe abortion and has helped to ensure that SA is incorporated into policy and strategy. Safe abortion nevertheless remains an issue of contention and is not widely endorsed within the ministry. MOH capacity remains a concern for all partners. Without significantly increased budgets and salaries for the sector, it is unlikely that training, supervision and supply of commodities for safe abortion services will be sustained without external support.

Output 4 Cross-cutting activities

Ipas and RMMP/Options are working on a follow up to the initial study 'Ready or Not' with preliminary results expected in April. This will provide an assessment of the changes between 2005 and 2009 in safe abortion and abortion related morbidities in Cambodia, with analysis of geographical differences and changes related to level of RMMP intervention. An advocacy and dissemination strategy is being developed to inform policy and practice.

The project has generated outputs in a range of areas that are 'cross-cutting' that include among others, health management systems, communication and advocacy. The project has generated high quality reports and publications, the latter such as the Health Messenger are widely disseminated in the health sector. Better use could be made of project data for communication purposes. It is important at this stage in the project that the information generated is well packaged for national and provincial dissemination before end of RMMP1. Policy briefs for both the Government of Cambodia as well as for DFID would help to capture key lessons learned in a user-friendly format.

Project management

Annex 3 provides a chronology of RMMP since project start-up. Current arrangements with technical expertise based in the NRHP and well established office and systems to provide administrative and logistic backing to project implementation is appropriate and works well. Programme staff are respected, have developed strong relationships with key interlocutors, understand the complexities of the Cambodian environment and are able to respond quickly and flexibly to demands as they arise. There is scope for greater delegation to the country team.

It was envisaged that the Consortium partners¹ will meet up to twice a year to provide oversight of the project. While the original project Consortium members have not all been included in the implementation phase, a project oversight mechanism that is (ideally chaired by MOH) has not met regularly. It is especially important at this time when RMMP1 is winding down and prospects for the future need to be explored with Government.

¹ Options, Ipas Project Management, MSC, CHEMS, BBC World Services Trust, and PATH

Sustainability and future direction

RMMP is a vertical project focused on safe abortion with family planning. This arrangement was possibly the only way that access to safe abortion could be introduced but it remains problematic for RMMP to attract funding from other donors because of residual sensitivity to safe abortion. Prospects for project funding and sustainability at a time when DFID funding will end, are likely to be significantly increased if the project is reconfigured to be integrated within reproductive health/safe motherhood where it rightly belongs, and to be consistent with global approaches.² Emphasis on meeting the unmet demand for family planning and in particular on improving access to long-term and permanent family planning methods is critical to reduce the number of unplanned and unwanted pregnancies.

There is a balance of over £1 million. A three month no-cost extension for RMMP1 by DFID will provide additional time to consolidate current work, prepare communications materials, develop an appropriate exit strategy and support the MOH in their Fast Track Initiative (FTI) to integrate SAC into safe motherhood. Building on the institutional memory and lessons learned will ensure that a new phase can be rolled out quickly. By May, Australian AID will indicate whether or not it will be in a position to fund the project for a further three years. If the outcome is positive, RMMP can develop more detailed plans for a seamless transition in January. Continuation of funding from the anonymous donor is also unknown.

Likelihood of achieving project purpose

The project purpose is *'to increase use of sustainable, quality reproductive and maternal health services for poor women'*. It is beyond the scope of this project to improve maternal health services, and sustainability of safe abortion services in the public sector is likely to be problematic when RMMP ends. The project has contributed to reproductive health services to some extent – safe abortion certainly, and to a lesser extent to family planning. The work will most certainly contribute to a reduction in maternal morbidity and mortality. Some of the work will have wider benefits, (such as infection control, quality assurance). Health Equity Funds and Voucher Schemes do not include safe abortion and access to family planning methods in referral (CAC) sites is problematic. While the project has done well to achieve the purpose level targets, they do not reflect the breadth of the purpose statement. The project has been given a 2 score – as being likely to achieve the purpose by the end of the period (April or July 2010) with every likelihood that a '1' score will be possible at completion. A revision to the purpose statement is recommended.

The project implementation and management support teams are congratulated on work well done that has gone a long way to meet a large unmet need for safe abortion and family planning in Cambodia.

² International Conference on Population and Development (ICPD)

Key recommendations

| Summary Recommendations | |
|-------------------------|--|
| 1 | Recommendation submitted to DFID by RMMP for no-cost extension is endorsed by OPR. Early decision requested |
| 2 | Minor revisions to logframe to make it fit for purpose (purpose, indicators, MOV) to be approved by DFID |
| 3 | Organise visioning retreat to agree on exit strategy and newly configured post December RMMP programme subject to positive response from AUSAUD |
| 4 | AusAID maintains robust advocacy on behalf of DFID on health financing for safe abortion services and full integration of SAC into reproductive health. |
| 5 | Subject to AUSAID (and AD) funding, draft concept note for third phase taking into account institutional needs in NRHP |
| | Ensure that AusAID Health Adviser is provided with regular updates of information that can inform his active participation and advocacy in donor and government policy meetings |
| 6 | If not already done, RMMP might consider working with other partners on an institutional needs assessment of the NRHP to identify areas where technical assistance is needed and agree on respective partners to provide this. This would be an important part of the exit strategy. |
| 7 | Close collaboration with MoH's QA unit in developing the QA tools will help to ensure that they are owned and used |
| 8 | Collaborate with URC and others to review research agenda and define priority research needs around health financing and abortion. Agree plan for collaborative research |
| 9 | Lessons learned from this approach need to be well documented and disseminated so that competency based training can be adopted as the norm and master trainers trained accordingly. |
| 10 | It is important that the studies undertaken by RMMP are adapted in Khmer in a simple format so that they can be read and used by a wider audience. |
| 11 | Participate in health equity fund meeting (Date TBD) and agree on working group to investigate how SA can be integrated into safe motherhood package |
| 12 | Options and RMMP to agree on adjustment on roles and responsibilities towards a more decentralised office in Cambodia |
| 13 | Develop communication package for end of project dissemination (CDs, policy briefs etc.) with NRHP involvement. |
| 14 | Agree on national and provincial dissemination and subject to DFID extension, plan for PCR |
| 15 | Consider whether it would be useful to organise a study tour for advocacy with key decision makers (e.g. to Bangladesh) |

Background

Cambodia's history of isolation and conflict ended in 1991 with the signing of the Paris Peace Agreements and the new 1993 constitution. Thirty years of war had devastated much of the country's physical, social and human capital. Rebuilding infrastructure, institutions and an educated population would be an immense task. The legacy of war and genocide included a weak civil service; patronage-based governance and institutions and serious inequality. Around 35–40 percent of the population is below the poverty line, with 15-20 percent in extreme poverty. Achieving the Cambodia Millennium Development Goals (CMDGs) will be difficult. Nevertheless, there have been improvements in some areas in the past 10 years (roads and telecommunications; safe water and sanitation; access to electricity; education; gender equity; HIV prevalence; infant and child mortality). Maternal mortality however is one area that has remained unchanged.

Governmental and non-government development agencies proliferate in Cambodia, creating a dependency culture; driving the development agenda in divergent directions and undermining harmonisation and national stewardship. One example is the plethora of health-financing systems which aim to increase access by the poor to services but create overlaps, opportunity costs for the administration and often achieve little impact. None of the current schemes enables poor women to access free safe abortion services.

Cambodia is a difficult development environment. However, an evaluation of the DFID country programme reported that "The most significant impact [of the DFID country programme] has been in the health sector, with institutional improvements, increased access to services, improved health facilities and growing and predictable budget allocations. There has been a positive impact on government capacity and responsiveness." (DFID 2009)

Methodology

The review was conducted by an external consultant working with different members of the RMMP team. The consultant was provided with key project documents by Options and the RMMP team. Meetings were held with Government and development partners (DPs), in-house with the RMMP team and visits made to Phnom Penh Provincial hospital and to Prey Anchang Health Centre in Kandal. (Annex 7).

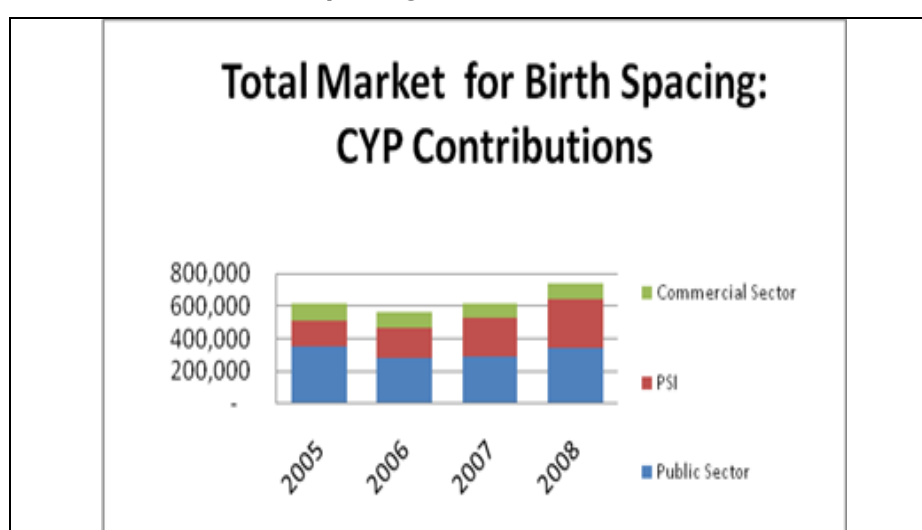
The RMMP team provided a briefing and update at the start of the assignment and the consultant made a presentation of key findings to the RMMP team and the DFID representative at the end.

The six monthly Options/RMMP reports provide details of achievements against logframe outputs. This report will endeavour to avoid unnecessary repetition and instead provide comments on reports, and highlight issues arising from the OPR visit. The RMMP team are to be thanked for providing all the updates on the logframe assessment.

Reproductive health and safe abortion in Cambodia

Maternal mortality in Cambodia is amongst the worst in Asia estimated by the 2008 census at 461 per 100,000 live births. Unsafe abortions are thought to account for about 30% of maternal deaths. There has been a significant and progressive decline in fertility (Figure 1), but relatively low contraceptive prevalence, so it is likely that the total fertility rate is affected by abortion. While there is a 25% unmet need for Family Planning (FP) among married women, a pronatalist attitude prevails at different levels and widespread antipathy towards long term and permanent methods. The use of modern contraceptives in the country has gone from 7 % among married/cohabiting couples in 1995, to 18.5% in 2000, and 27% in 2005. CPR still falls short of the >55% target of ICPD, and induced abortion continues to be commonly used as a family planning method.

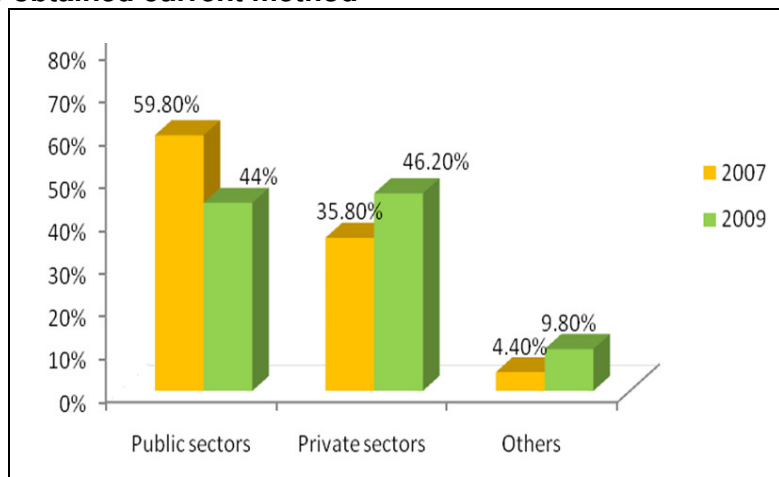
Figure 1: Total Market for Birth Spacing: CYP contributions



PSI TRaC Population Based Survey, 2nd round, 2009

Cambodia has one of Asia's most progressive abortion laws, defined in the 1997 Abortion Act however, as of September 2009, less than 200 private providers in Cambodia were legally certified to provide abortion. In a recent PSI survey 80% of respondents believed that having an abortion was against the law. (PSI 2009).

According to the 2005 Cambodia Demographic and Health Survey (DHS), approximately one in 12 women in Cambodia have had at least one induced abortion; a rate which other studies estimate as almost certainly under-reported. Of the women who have had abortions, more than two in five have had more than one abortion, and one in five has had more than two abortions. The DHS also found that only 11% of women who reported having had an abortion in the 5 years prior to the service had accessed abortion services at a government facility with the remainder using the private sector, aborting alone or at a private house. This is important contextual information when considering impact against this indicator. The PEER study shows that people know about family planning services and tended to use government facilities for FP whereas they were more likely to go to the private sector for abortion services because they are perceived as being more confidential and friendly.

Figure 2: Place obtained current method

PSI TRaC Population Based Survey, 2nd round, 2009

The report 'Ready or Not?' – a national needs assessment of Abortion services in Cambodia commissioned by RMMP provides a detailed and disturbing assessment of abortion services, attitudes and practices. 47% of hospitals and 10% of health centres reported providing SAC and 67% of facilities were forced to refer women wanting to terminate an unwanted pregnancy. Most refused services to adolescents and provider attitudes were a great barrier as providers were not aware of the legalisation of abortion. Quality of care was found to be lacking and most patients were not given analgaesics.

There appears to be little dispute among many Ministry of Health officials and development partners of the urgent need for safe surgical and medical abortion and SAC is reflected in the National Reproductive Health Plan and Fast Track Initiative (FTI) for maternal health. But DFID has been the only donor in Cambodia willing to support a Safe Abortion Project in the public sector. Following a change in AusAID policy, there are now no restrictions on support for Safe abortion through the pooled fund of the Health Sector Support Programme (HSSP). USAID's policy position however means that national NGOs receiving USAID funds are unable to provide safe abortion unless it is clear that their funding is separate. Only Marie Stopes and PSI are taking this on.

The most commonly used FP methods are oral contraceptives and injectables (11% and 8%, respectively). Most users now access their supplies from the private sector as shown in Figure 2. Barriers to FP services and information mean that more than one in four births is unplanned. This has contributed to high abortion rates.

HSSP: Component for Reduction in Maternal Mortality (RMM)

The DFID funded Reduction in Maternal Mortality Project (RMMP) is a three and a half year intervention, initiated in November 2006 with an initial budget of £2.2 million, increased by £1.1 million in February 2009 to work in 12 provinces. With the combined funding of DFID and since February 2009 with additional support from the Anonymous Donor (AD), RMMP has now expanded into seven new provinces. RMMP (I & II) provinces now represent an estimated population of 11,557,034.

Figure 3: Barriers to safe abortion services**BARRIERS TO PROVIDING SAFE ABORTION SERVICES**

- Lack of technical guidance and training in safe abortion for providers
- Lack of equipment to conduct safe abortions
- Unregulated, erratic and high fees
- Ministry of Health restrictions regarding who can conduct abortions
- Lucrative business opportunities have created thriving market in unsafe abortion services
- Inappropriate and risky techniques widespread in formal and informal sectors
- Failure to link abortion services with birth-spacing services
- Unwillingness of providers to conduct abortions in government facilities
- Unwillingness of clients to use government facilities for abortion services
- Negative provider attitude towards treating the poor and adolescents
- Greater availability and lower cost of PAC services may influence women to try to induce an abortion prior to seeking formal care
- Widespread availability of abortifacient pills, but currently unregulated
- Lack of awareness about legality of abortion among women and providers
- Lack of reliable information regarding preventing unwanted pregnancies and accessing reproductive health services
- Desire for anonymity

RMMP Cambodia Baseline Report

This project is unique in tackling the provision of SA services in the public sector as well as more recently in the private sector with AD support. It has made significant gains in a very difficult environment.

With funds from the Anonymous Donor, safe abortion is also being provided by Marie Stopes Cambodia (MSIC). Now that the abortifacient pill Medabon® is registered, medical abortion will roll out through PSI's social marketing and social franchising outlets, MSIC and from public sector hospitals. Meanwhile, unregistered and often harmful abortifacient pills are widely available and frequently misused to the detriment of many poor women.

Although RMMP is working with the MOH, the nature of SA has made it necessary to manage these activities through a vertical project which means there is a high risk that the services could reduce or even end in the public sector when funding finishes in December 2010. The MOH with Development Partners (DPs) launched a fast track initiative (FTI) to reduce maternal mortality; which offers an opportunity for Options to mainstream SA into a comprehensive approach to safe motherhood (SM) in Cambodia. It is with this in mind that recommendations are made in this report for a third phase of RMMP beyond December 2010. This would be dependent upon continued funding by the anonymous donor and/or provision of new funding by AusAID neither of which are yet known.

Findings and progress towards achievement of outputs and purpose

While addressing the requirements of the Terms of Reference (Annex 9) the report also addresses issues raised by Marilyn McDonagh (Options Health Systems Senior Adviser) during her visit immediately prior to the OPR.

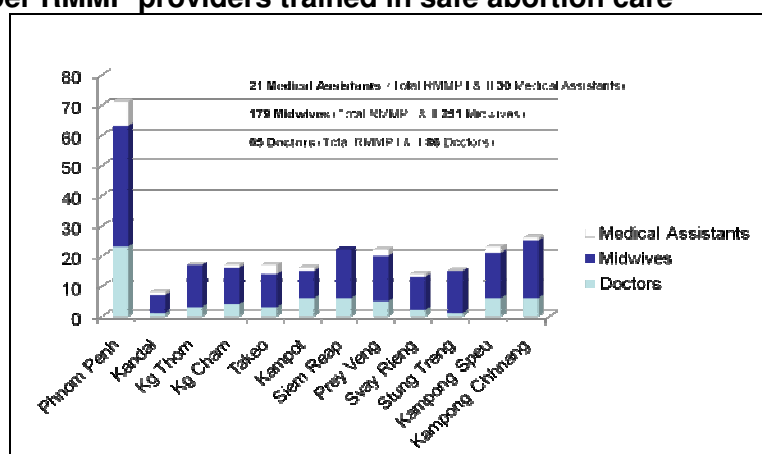
Output 1: (Supply-side) Capacity of health care facilities to provide quality interventions associated with maternal mortality reduction increased, with safe abortion as a priority

1. Perceived improvement in staff attitude, behaviour and responsiveness at health facilities for reproductive health services (as a proxy for abortion care) over time.
2. Numbers of RMMP providers trained in safe abortion care
3. The number of basic and comprehensive safe abortion care sites included.
4. Proportion of RMMP included facilities that reach a minimum operational standard as per RMMP quality guidelines.
5. CAC and sterilisation and referral training curricula integrated into MPA and CPA training modules.
6. Medical equipment and supplies for safe abortion care, VSC and IUD integrated into national procurement systems.
7. RMMP monitoring systems for CAC/IUD and VSC implemented.
8. % of women reporting that a non health care worker helped with an abortion
9. % of trained RMMP providers who attend a refresher training course 12 months after original training (specify % aimed for)
10. % of trained RMMP facilities that receive on-site supervision and technical QA advice in line with QA protocols in one year
11. Development and piloting of the private provider protocol

The project has made significant achievements in Output 1, not only meeting, but in some cases exceeding targets: Since the programme began, in over three years, a total of 268 health providers in 102 health facilities in the 12 RMMP I provinces have provided safe surgical abortion services to 23,057 women using the Manual Vacuum Aspiration (MVA) technique. Of the 102 facilities, 13 are hospitals registered as Comprehensive Abortion Care (CAC) sites. This exceeds the target of 240 for April 2010 by 12%. (A total of 367 providers have been trained under RMMP 1 and 11 projects). All sites meet the minimum operating standards; CAC and sterilisation and referral training curricula have been integrated into MPA and CPA training modules. Without regular supportive supervision it will be difficult to know whether or not the quality of service will be sustained and whether there will be sustained change in behaviour towards the clients. During the remainder of the project it will be useful to monitor a sample of clinics from ghost client visits and exit interviews.

The process for advocacy and sensitisation, facility and trainee selection and facility renovation and procurement is complicated but appears to have been well managed and undertaken with MOH collaboration throughout. Training has also required adaptation and development of appropriate training modules and tools and clinical protocols that are consistent with global standards. RMMP provides technical expertise of high calibre which is appreciated by the Ministry of Health.

Safe abortion training is currently provided at two training sites in Phnom Penh: the National Maternal and Child Health Centre (NMCHC), and the Phnom Penh Municipal Referral Hospital (PPMRH). To increase the training capacity during the last reporting period RMMP established a third training site in Kampot, working closely with the Provincial Health Director (PHD) and hospital staff. Of the 367 trainees, all midwives were female, an equal number of male and female paramedics were trained and there were 33 female doctors to 53 males.

Figure 4: Number RMMP providers trained in safe abortion care

RMMP will continue to work on improving the availability and quality of safe abortion services in the remaining period of the project taking a lead role in distributing Medabon® to public sector facilities after providers have received training and also leading a partnership with PSI and MSC which seems to work very well. Each organisation works to their respective strengths and regular partner meetings led by RMMP ensure that there is harmonisation and coordination of activities.

Table 1: Trainees by gender

| | Female | Male |
|--------------------|--------|------|
| Doctors | 33 | 53 |
| Medical assistants | 15 | 15 |
| Midwives | 251 | |
| Total | 299 | 68 |

RMMP is making some useful technical contributions that have wider implications than SAC. Improving infection control practices is one such example and RMMP has provided TA to review Cambodian national infection control standards and guidelines and develop supplemental training materials to help quality assurance monitors and other staff better coach and support these practices.

As reported by RMMP, various factors can undermine the impact of RMMP interventions:

- lack of consistent and appropriately placed supplies of FP commodities; lack of training infrastructure for safe abortion training; lack of clarity regarding salary supplements, incentives and other payment schemes.
- IUDs and other contraceptives are not available at referral hospitals which means that clients have to be referred to another site (or room if the health centre is on the property) if they request a post abortion contraceptive method. Is a deterrent to uptake likely to impact on programme achievements.
- All training and follow-up monitoring is currently funded and supported by RMMP. It is not embedded in an established training centre or ongoing programme and therefore is at significant risk of ending if external support ends. Sustainable inputs such as protocols, training skills, materials and renovated training facilities will require institutional ownership and management by the government in order to continue.

- Trainers, data collectors and other government counterparts currently rely on incentives or salary supplements provided by RMMP. (RMMP Biannual report July – December 2009)

A Quality Assurance system has been developed through consultation with RMMP staff, providers and other partners (MSIC, PSI, the MoH Quality Improvement Working Group), and is an evolving document that recognises the dynamic and progressive stages of the programme and includes lessons learned during the development process. The QA process (and forms) are being piloted by RMMP to assess their effectiveness and appropriateness for the national programme. Recommendations for integrating or adapting these for the national programme will be proposed for the next phase. Data entry and analysis is currently kept to a minimum in order to support eventual integration with the HMIS. Very few fields in the current QA forms are entered into the data base, as most of the information is used to inform programme implementation and support for providers and facilities. RMMP will model effective use of data to inform programme planning and monitoring during the dissemination of results at the national and provincial levels with participation from the OD and commune levels.

The QA forms and protocols support a broad process of quality assurance. As such, they are quite complex. Given that MoH is unlikely to be able to fund any supervision after support from RMMP ends, it will be important to agree with the Quality Assurance Unit in the MoH and other technical partners (WHO, UNFPA) on the simplest version that will help ensure that health providers and managers and data entry personnel use these properly

Output 2: (Demand-side) Equity and access to quality reproductive and maternal health services by poor women increased

1. Abortion, with a focus on equity of access by the poor included in the national health sector plan 2008-2015
2. Knowledge of long term contraceptive methods among married women
3. Knowledge and understanding about long term contraceptive methods among unmarried women
4. Perceived quality of care for RH services is higher in RMMP included facilities compared with non-RMMP included
5. Knowledge and awareness of RH service availability and legality among providers, the poor and wider public
6. Mainstreaming of government ownership of evidence based policy options to address demand side barriers

There is demand both for abortion and for family planning, but misconceptions regarding legality of abortion and safety of long term and permanent FP methods have to be overcome.

Two PEER studies completed in Phnom Penh and rural areas of Kampong Thom found that women have good knowledge of modern contraception and safe abortion, while identifying cost as a primary barrier to using safe services. Most families wanted to limit themselves to two to three children, with birth intervals of two to four years. The concept of using a modern contraceptive was widely accepted, with friends and neighbours seen as a primary source of reliable information.

It is suggested that unsafe abortions may contribute to about 30% of maternal mortality and that there is a 25% unmet need for family planning. It is important to overcome the widely held view that abortion is illegal and that long term and permanent methods of family planning are harmful. With health workers being highly subsidised for deliveries and private

sector abortions being profitable, there are many disincentives to the promotion of family planning and public sector safe abortion services.

RMMP began work to increase demand for services once safe services were established so it was always anticipated that progress in output 2 would be slower. In fact it has been much slower than expected due to the resistance of MOH to allow demand creation activities. There is considerable political sensitivity regarding abortion and permanent methods of family planning and to date no permissions have been obtained to create signage or brochures to identify where safe services are available. Government partners have been hesitant to introduce a comprehensive programme of services including Medical Abortion. Introduction of MA services was delayed after a client died from a ruptured ectopic pregnancy (but unrelated to the MA drugs). The RMMP played a critical leadership role during sensitive negotiations following this maternal death. MA services could only resume at the hospital level in the public sector, although private sector distribution through pharmacies can continue with support from PSI.

RMMP is now working with 6 NGOs in 5 Provinces to reach communities with messages about family planning and abortion. Mid-project evaluation indicates that over 10,000 people were reached with information.

It appears that RMMP has been sensitive to the need to balance demand and supply of services and through the Team Leader, is advocating effectively for safe abortion at all levels. However, understanding from the various studies where the cultural barriers lie, messages and BCC need to be specifically targeted which is a specialised task. Collaboration with other NGOs (e.g. PSI, MSC) is necessary and messages must be endorsed by MOH. While RMMP has worked with various NGOs to streamline information, leadership is needed by MOH with the development of a national BCC strategy focused on reproductive health, to include safe abortion. The information generated by RMMP (baseline, PEER studies etc.) provides a valuable evidence base for communication materials.

The original RMMP had planned to involve more partners with specific communication expertise (e.g. BBC World Service Trust) and had an ambitious plan in this area. Currently, there are no communication experts on the staff and little capacity in government so RMMP is not well positioned to develop capacity in this area and might be considered for a subsequent phase.

Promoting abortion care financing: Health Care Financing is an incredibly complex area, with Health Equity Funds, Voucher and Health Insurance Schemes overlapping and inconsistent, creating a situation where there is little equity and plenty of duplication. (Some examples of these are provided in Annex 6). Since its inception, RMMP has advocated for CAC services to be included in health equity funds and community based insurance schemes. Post Abortion Care (PAC) is included.

Cambodian NGOs such as RHAC and RACHA receive USAID funds and because of this, they are not engaged in abortion related services. The concern expressed by USAID is that they would need to prove that no USAID funds are used for abortion. Restrictions such as this further limit access. RMMP plans to explore mechanisms to study this situation and to document recommendations for increased access and support from equity funds for women seeking safe abortion services. RMMP might consider collaboration with community –based programmes managed by such NGOs.

Output 3: MoH technical capacity for the development and implementation of a national CAC plan increased

1. National Roadmap for Reduction in Maternal Mortality (NRRMM) developed
2. Organisational and coordination arrangements for reproductive health including safe abortion in place
3. Reproductive health policy and laws acknowledged, including those related to safe abortion and family planning, amongst political leaders, policy makers and the wider public by 2009.

The National Roadmap was approved In September 2008. The RMMP Country Director has attended Provincial TWG meetings in 18 of the 19 RMMP provinces and TWGs using these occasions to advocate for inclusion of SAC programming activities in the AOPs, as they may then qualify for pooled donor funding. His advocacy at this level is very important and is likely to have led to some change in attitudes towards SA. This will be examined in a study in 2010 with key stakeholders.

The MoH Hospital Services Division (HSD) requested RMMP to facilitate a conference on safe abortion in the government and private sectors, stating its wish for closer contact with RMMP in the future, pointing out that all abortion cases should be reported to them by law. RMMP has indicated that it will arrange to send reports to Dr. Rathavy for onward forwarding. It is suggested that RMMP arranges for the facilities to send reports since this function must carry on after the project closes.

WHO requested support in the preparation of a fast track maternal mortality reduction strategy (Fast Track Initiative [FTI]). RMMP responded by preparing a paper for scaling up safe abortion programming nationwide that might be used to provide a coordinated comprehensive strategic response to Safe Motherhood in Cambodia. It is vitally important that the NRHP has capacity to lead partners (whether or not they are part of the pooled funding arrangement) in the development of a national costed AOP for RH that reflects all partner contributions. Thus a clear set of indicators of technical capacity would be useful to agree. The areas under Technical capacity should include:

- Annual planning and budgeting
- Monitoring and evaluation, supportive supervision
- Health management information systems
- Co-ordination (via TWGs) of all key thematic areas under RH/SM (including Community health, Adolescent Reproductive Health among others e.g. Safe Motherhood, Family planning etc.)
- Behaviour change communication
- Procurement
- Training (national data base of health workers, and master trainers and training plan)

If not already done, RMMP might consider working with other partners on an institutional needs assessment of the NRHP to identify areas where technical assistance is needed and agree on respective partners to provide this. This would be an important part of the exit strategy.

The lack of political support for safe abortion has been mentioned in spite of a very liberal abortion law already twelve years old. Some health workers also claim not to know about the law which affects their willingness to provide SAC. RMMP has prepared a package of orientation materials designed to inform government and community leaders and health care professionals about the abortion law, RMMP programme activities and strategy to increase

access to safe services. These materials were not seen, but a Ministry of Health directive is essential if not already issues and would have the relevant authority.

Output 4: Cross cutting activities

1. Impact of introduction of SA services in Cambodia” to be completed in April 2010 in partnership with Govt and local academic institutions

This output has only one indicator. Ipas and RMMP/Options are currently working on a follow up to the initial study called ‘Ready or Not’. It is important that there is reference to work undertaken by PSI and MSI on abortion.

A number of cross-cutting areas underpin the core project areas that might have been included under this output include among others: Health Management Information Systems (HMIS) - developing and using a tool for collecting SAC related data; advocacy at national and provincial levels; knowledge generation and dissemination (contributing to publications such as the Health Messenger - Cambodia’s professional medical journal with an issue dedicated to safe abortion; reviews of research - such as compilation of all abortion-related research in Cambodia during the last 10 years; networking and collaboration with key partners (such as MSIC and PSI and also meets regularly with RH and FP NGOs such as Racha, RHAC, and URC; subcontracting PATH and the Cambodian Midwives Association as well as 6 local NGOs to conduct referral and community awareness-building activities).

The project has introduced competency based training, requiring providers to demonstrate competency on patients prior to being certified. This is in contrast to the theoretical/didactic models of training that are inadequate for testing competence. Lessons learned from this approach need to be well documented and disseminated so that competency based training can be adopted as the norm and masters trainers trained accordingly.

The outputs of RMMP’s work go beyond the scope of safe abortion and family planning such as the development of national protocols in infection prevention that will be of benefit in all areas of clinical care. Contributing in this way will also help to dispel the stigma attached to safe abortion.

A number of studies are currently in progress, with reports expected during the next quarter. Others are planned by the end of the project in April 2010, including:

- Quality improvement studies; Household survey; Assessing the impact of community work; Increasing access to contraception

It is important that the studies undertaken by RMMP are adapted in Khmer in a simple format so that they can be read and used by a wider audience.

RMMP has been active in networking and advocacy with partner organisations and potential donors to advocate for inclusion of safe abortion in all reproductive and maternal health programmes. It is important to continue and possibly scale up these activities for the remainder of the programme.

RMMP has made some very useful contributions to publications such as the Health Messenger, of which 30,000 copies were distributed. It would be worthwhile evaluating their

effectiveness in getting the information out to health professionals and to learn whether it influences practice in any way.

There remains little time to develop film projects as anticipated. If these go ahead then it is important to ensure that there is local ownership in MOH otherwise there is a risk that the films will not be used.

Lessons learned from RMMP experience will be of wider interest and have the potential to help reduce stigma and encourage mainstreaming of safe abortion into other reproductive health and safe motherhood programmes. MOH should be actively involved in the dissemination process.

Likelihood of achieving project purpose

Purpose: To increase utilisation of sustainable quality and affordable reproductive and maternal health services by poor women.

- Evaluation report will present client profile of RMMP users to ascertain proportion of users who are of the low socio-economic position.
- Number of women utilising safe abortion services delivered by providers trained under RMMP.
- Number of permanent contraceptive methods conducted by providers trained under RMMP
- % of Safe Abortion (SA) clients at RMMP included centres who accept post-SA FP
- % of Safe Abortion (SA) clients at RMMP included centres who accept post-SA FP

The project purpose statement is broad and unrealistic in the context of the RMMP. The OPR has focused on RMMP's ability to increase access to quality safe abortion (and to a lesser extent family planning). The project has:

- Leveraged additional funding and now works in 19 of the 24 provinces
- Trained 268 providers
- Upgraded 166 facilities
- Generated demand for training which now exceeds planned provision
- Seen Medical Abortion registered
- Established NGO and private practical training sites and training providers
- Succeeded in getting safe abortion included in key documents, meetings and strategies

RMMP is not a maternal health project though it is clear that providing access to safe abortion will contribute to a reduction in maternal mortality. The project has certainly increased access to quality services, likely to be sustainable in private sector and to a lesser extent in the public sector, unless they become more affordable for the poor and if there are adequate incentives to the health providers. It is suggested that the purpose is revised to focus on safe abortion to be relevant to the project focus. A 2 score is given.

Other issues

Project management

Annex 3 provides a chronology of the project management since December 2006, from project start-up to the present day. The turnover of international staff during the inception phase created delays in the establishment of the project and an institutional base. Hence there was need for significant support from the UK office. The current office was established in May 2009 when the original project office was deemed unsuitable for a range of reasons. Managing such a project without a strong institutional base in country especially one as complex as Cambodia is bound to be challenging. Institutional requirements for such a project, originally even more complex, should have been rigorously assessed at the outset of the project.

Current arrangements however appear efficient and effective, providing an appropriate level of administrative and logistic backing to project implementation across 19 provinces. Government staff that are working in the office on the QA team are gaining invaluable experience and expertise and this also creates strong relationships. Likewise, the MOH location for the Team Leader and advocacy person have proved highly beneficial and enabled RMMP to have the ear and trust of the MOH.

The country office is well established with systems in place. The personnel have strong relationships with key stakeholders and an excellent understanding of the operating environment. Options is now in a position to delegate more of the management and technical responsibilities but continue to provide appropriate backstopping as the project considers the different options that present themselves.

Project oversight

Originally, a Core Consortium Management Group comprised the designated Project Managers from Options and Ipas, the Team Leader and Technical Director to be responsible for overseeing the progress and to meet twice a year either in Cambodia (with local Consortium Partners [CHEMS, PATH, MSC]) or in the UK. Meetings with Ipas and MSIC have been very regular basis and a tripartite 6 monthly project review with UNFPA, DFID & Dr Rathavy and the Country Director have been held until recently. This Consortium Management group preferably with the involvement of the key government partner (e.g. Dr Rathavy) now needs to help provide strategic guidance to help define the future direction and configuration of the project.

Financial Situation

The DFID budget is £3,397,817 million. Up to end December 2010, a total of £2,117,282 had been spent, £720,707 of it over the previous 6 months leaving an unspent balance of £1,280,535. With the project running smoothly, a three month extension from DFID would enable RMMP to spend if not all, at least a significant portion of the balance of budget.

Sustainability

Sustainability of RMMP initiated activities in the public sector is challenged by several key issues:

Vertical project status of interventions: Vertical projects can be strategic in the early stages, particularly in sensitive areas, and to ensure focused funding and technical oversight necessary to advocate for changes to policies and practices. But If activities remain outside the mainstream systems and programmes for too long this can become detrimental to any sustainable impact. The challenge for RMMP is to identify opportunities and strategies for integration. There is scope to make a more significant contribution including among others, integration of SAC with Reproductive Health (RH) and health financing systems, ensuring SAC is properly reflected in national and provincial Annual Operating Plans (AOPs) and strengthening private sector contribution to quality SAC within RH. RMMP's support to the Fast Track Initiative, and advocacy to policy makers are both important.

Political sensitivity regarding abortion and permanent methods of family planning: The 1997 Abortion law is very liberal. It is therefore surprising that this has not been reflected in support from donors. Profit motive may explain reluctance to include this in the health equity fund package.

Threats to commodity security: There is no funding for family planning commodities from KfW beyond 2012 and RGC is unwilling to contribute to this. So far no donors have offered to pay for commodities. Agreements need to be made soon to avoid stock outs in 2012. The likelihood is that the HSSP will find emergency funds if this happens but there is little appetite to do this.

Reform of health policy, plans and systems takes time: Extended funding for the project will help address issues that are barriers to access. Ideally safe abortion should be integrated into safe motherhood programming and this will be essential for a third phase of the project.

On a more positive note:

If there is no funding beyond December 2010, the project will nevertheless leave a strong legacy that is likely to be sustainable in different ways:

Over three hundred health providers have been trained in Safe Abortion Care. They are likely to continue to provide services both from the public and private sectors. The quality standards currently expected of providers may diminish over time without adequate supervision, but are nevertheless likely to spill over into other areas of care. In the market place, consumers of services will vote with their feet and if they have a choice, quality of care, including positive provider attitudes will influence their choice of provider.

There is a strong legislative framework to underpin and justify safe abortion policy, strategy and programming.

Logframe

The logframe has evolved over time which is appropriate as it is a responsive instrument. However, as currently written the RMMP logframe presented some difficulties for this evaluation and on one hand is not specific enough (such as referring to maternal health services) and on the other does not adequately capture the breadth of the project and its diverse activities.

- Problems with the purpose statement have already been stated in 3.1 and a recommendation made to re-draft the purpose statement, which will require DFID approval;
- Contraceptive prevalence is an outcome and not an impact indicator but can be left

- Output 4: 'cross cutting activities' is not an output
- Indicators (Output 1) too many – some better as activities
- Some indicators not good measures of output
- For future reference, always insert date of document (all documents)
- Means of verification should allow for measurement to be made at the appropriate time, therefore output indicators and MOV should be measured periodically. This is not possible when using the Demographic Health Survey (DHS) as the MOV since the 2010 DHS will not be available until 2011 after the implementation of the project. Only measure what can be measured.

It is suggested that at this point in the project, modifications to the logframe should be kept to a minimum.

Programme risks

DFID funding is planned to end in April, with the possibility of a three month no-cost extension through to July. This report has been clear that such an extension is appropriate as well as desirable. Funding from the anonymous donor until December 2010 provides an additional cushion. With safe abortion still sensitive and lacking funding support, yet critical in reducing maternal mortality, there is a risk that without this project and continued support, RGC will not be able to maintain safe abortion in the public sector. The project logframe provided a comprehensive list of assumptions that are largely relevant and the table below assesses the likelihood of these not holding true. There are few signs of either government funding for safe abortion or donor support (other than AusAID) to sustain programme activities.

| Assumptions | Likelihood of not holding true | Impact | Current Status |
|---|--------------------------------|--------|--|
| Conflict free environment prevails. | Low | Medium | Cambodia is peaceful |
| National disasters (e.g. environmental and or infectious disease) do not occur. | Low | Medium | Unlikely. For swine flu 9 cases confirmed to date in Cambodia, 7 fatal. (WHO 2009) |
| Macro-economic development, socio-political changes continue in line with development of sustainable health and social systems. | Low | Medium | Improvements visible in economic growth, poverty reduction, roads, telecommunications, safe water and sanitation, electricity, education y, HIV prevalence, IMR, CMR, infant and child mortality |
| Sustained commitment and leadership in maternal health interventions from RGC. | Medium | Medium | Commitment not matched with RGC funding. Health sector donor dependent. Likely donor support continues. |
| Funds for a Maternal Death Audit leveraged and Audit implemented in good time to allow baseline. | Low | Low | Some lack of appetite for MDA but likely to happen. |
| National political commitment and leadership in maternal health and pro-poor policy making is sustained. | Medium | Medium | See above |
| Trained providers are willing to collect the relevant information accurately. | Medium | Low | Data collection shown to be inaccurate and will need constant monitoring & QA |
| Trained providers deliver services in public health facilities | Medium | Medium | If incentive system discontinued as recently happened, providers will limit provision to private sector. |
| MMR will decrease with an increase in the utilization of prioritised maternal health services. | Low | Low | Steady decrease in TFR and slow increase in uptake of FP and use of SAC. MMR likely to decrease. |
| Other partners contribute to and expand the use of family planning methods. | High | High | Stock outs likely 2012 when KfW funding ends. RGC not offering funds. No alternative donor commitments |
| Provider & consumer behaviour changes in response to reforms | Low | High | Gradual changes observed – likely to continue |
| Integration and consistency of MMR component with wider reform initiatives that work to improve Maternal and RH | Low | Low | RMMP is consistent with national plans, law and strategy. |

| Assumptions | Likelihood of not holding true | Impact | Current Status |
|--|--------------------------------|--------|--|
| RMMP operational districts agreed by TWG | Low | Medium | The MOH is keen for RMMP to expand to all provinces |
| Wider health sector institutional reforms progress (provider incentives, equipment / drugs provision, budget execution etc). | Medium | Medium | Possibility that incentives will not be resolved or sustained and that health financing may not include SAC. However services will continue to be available from private sector though access to poor may not improve. |
| Training of providers will improve quality of service delivery. | Low | Medium | Service providers have improved quality of services. Challenge is for this to be sustained beyond project. |
| Provincial Health Directors and facility managers support training and refresher training and quality SAC at public health facilities. | Low | Medium | There has been enthusiasm for this programme at national and PHD level. It is unlikely that PHDs would object to training of providers as it reflects well on them. |

Future direction

Both MOH and partners are concerned that DFID is withdrawing support from the project. It is fortunate that the anonymous donor has been able to complement funding and ensure that activities can continue until the year end, if not beyond.

The case for a no-cost extension

RMMP received a large increase in the budget in February 2009 and there is a budget balance of over £1 million. Constraints outside the control of the project have affected the speed of expenditure, particularly the scale up of medical abortions. A three month no-cost extension for RMMP1 by DFID will provide additional time to consolidate current work, seek approval to work in two additional areas and to develop an appropriate exit strategy in December and/or an appropriate future strategy that might be differently configured to become a more integrated RH programme with strong emphasis on SAC. In this context, RMMP is already supporting the MOH's Fast Track Initiative (FTI) to reduce maternal mortality. RMMP's contribution to this process of integration is important. A well argued case for a no-cost extension has been submitted to DFID.

The position of continued funding beyond December by the anonymous donor is not yet known, but it is important that there is continued dialogue between the AD, DFID, AusAID to agree on a way forward that will not undermine continued access by poor women in Cambodia to safe abortion services.

Exit strategy and new directions

Integration of DFID funded activities and personnel into the longer term programme funded by the anonymous donor will help to ensure a smooth transition with no disruption of

activities. Building on the institutional memory and lessons learnt from a solid institutional base will ensure that any new phase can be rolled out quickly. By May, Australian AID will indicate whether or not it will be in a position to fund the project for a further three years. If the outcome is positive, RMMP can develop more detailed plans for a seamless transition in January. Continuation of funding from the AD is also unknown. This is summarised as follows:

| Status and options | Actions |
|---|--|
| DFID funding ends April 2010 | Potential for no-cost extension to July 2010 <u>but not beyond</u> |
| LAD funding ends Dec 2010 | Future funding unknown |
| AUSAID: interest in 3 year funding from Jan 2011 | Status unknown Should the donor(s) support a project doing 'business as usual' or a programme that is different (e.g. integrated with MNH/RH, differently configured etc.) |
| Option 1: | No funding beyond December |
| Action: | <ul style="list-style-type: none"> a) Develop detailed two phase exit strategy: b) Complete all DFID-funded work that must be paid and accounted for using remaining funds c) Undertake PCR d) National and provincial dissemination and communication for DFID supported work e) Integrate remaining work into LAD and phase out all work in December – hand over equipment etc. as agreed with donors |
| Option 2: | Funding beyond December |
| Action: | <ul style="list-style-type: none"> a) Develop detailed exit strategy (for DFID funding) and integrate existing activities into newly configured (3 year?) project plan b) Complete planned DFID activities by April (or July if extension agreed) c) Dissemination and communication of project achievements and lessons learned |

RMMP has indicated that it will develop a strategy for sustainability (exit strategy) including, but not limited to: (1) handing over resources, materials and data to other organisations working in this field to ensure their programmes continue to benefit from RMMP learning and capacity; and (2) providing all government partners with copies of materials, resources and data, to the extent that these can be incorporated into current infrastructure. This is appropriate and needs to be initiated without delay.

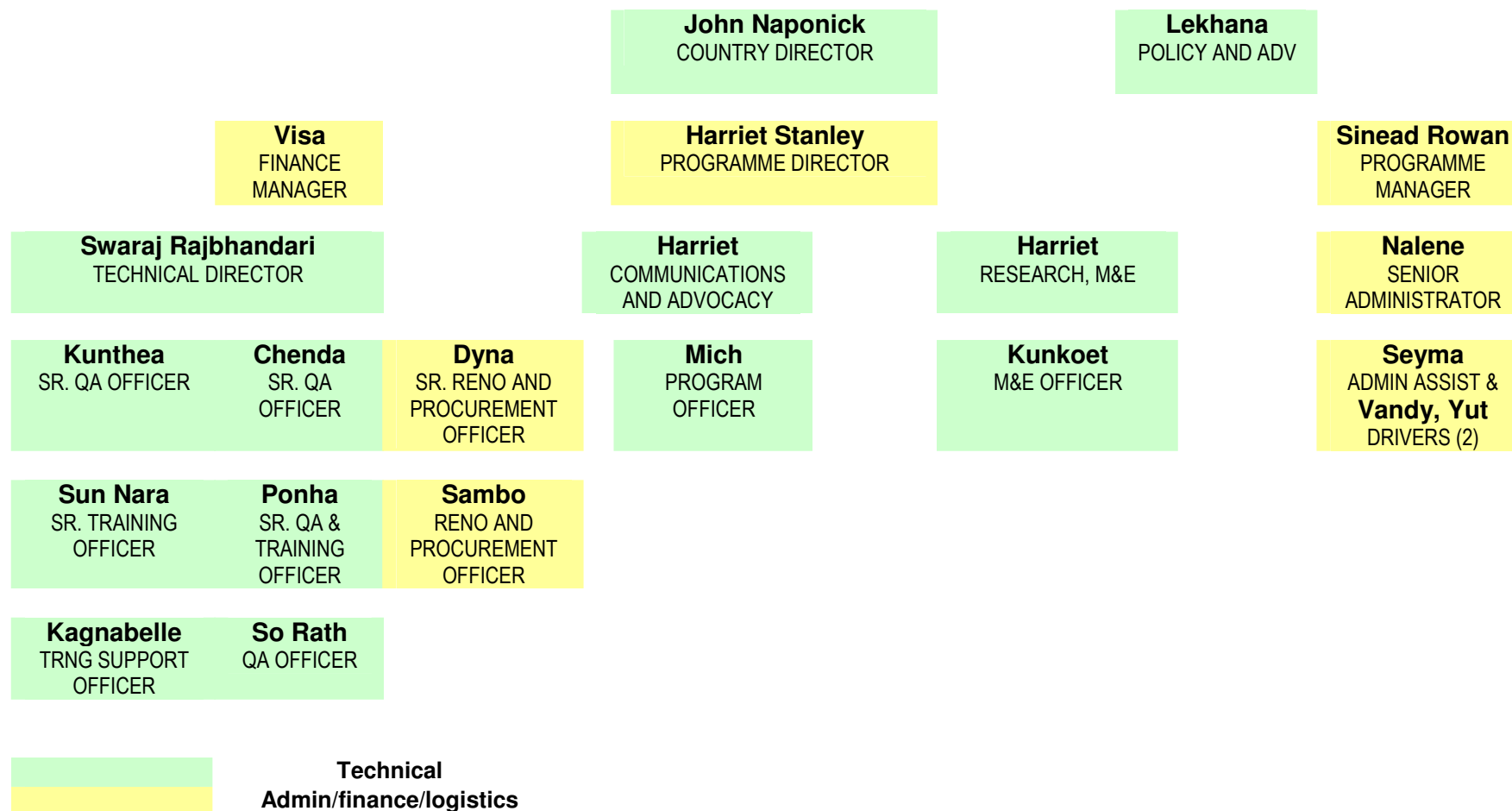
A retreat with key partners is recommended to agree on reconfiguration of the current project so that it will be consistent with the FTI and an integrated approach for SAC within safe motherhood. Staffing, and management requirements will need to be part of this reconfigured project.

Lessons learned

- RMMP project has networked with key partners such as MSIC and PSI and also meets regularly with RH and FP NGOs such as Racha, RHAC, and URC. The programme also subcontracts PATH and the Cambodian Midwives Association as well as 6 local NGOs to conduct community awareness-building activities. Many of these partners are funded primarily by USAID and because of the restrictions on abortion programming for USAID funded organizations, this has limited our partnering opportunities. Local NGOs receiving USAID funding are very cautious and unwilling to explore ways to work with RMMP, largely as a result of many years of very restrictive regulations. Also, given the major role that USAID plays in funding non-abortion programming in RH and maternal health, these restrictions have also contributed to the lack of mainstreaming of RMMP activities
- RMMP has successfully introduced competency based training requiring providers to demonstrate competency on patients prior to being certified. This has resulted in successfully linking the government training with NGO and private service sites in order to meet the need for practical training. As a result, private sector providers and sites are now included in the programme
- Having two key technical staff work within the NRHP has helped develop strong relationships and keep track of local issues. This is most important for influencing and building trusting partnerships. However, it is equally important to have a strong institutional base to backstop the project in country and this was only established late in the project. Setting up a base with robust systems in Cambodia at the outset may have led to less reliance on the UK base and may have brought about earlier results.

Annex 1: Logframe: project scoring assessment

See separate excel report

Annex 2: RMMP Organisational chart

Annex 3: Chronology RMMP, Cambodia

- Start date November 2006 – End date April 2010
- £2.2 million over 3.5 years (additional £1.1 during last year of implementation, total £3.3m)
- Associate Partner Ipas (Technical backstopping of Technical Director)
- Subcontract Partner MSIC (LTFP expert TA)
- In-country leadership –Long Term International Team Leader and Technical Director, (followed with Programme Director and Programme Manager under LAD)
- Technical and Project Management support from Options STTA team

YEAR 1 Nov 06-Oct 07

| | |
|----------|---|
| NOV 2006 | Contract signed with DFID |
| DEC 2006 | In-country international team arrive. Interim Team Leader, Technical Director , and Project start up consultant |
| JAN 2007 | Technical Director departed.. Team Leader takes on both international roles. |
| FEB 2007 | Local team recruitment |
| MAR 2007 | Inception phase report submitted (Programme Manager visit from HQ to support report production) |
| MAR 2007 | Transition proposal submitted regarding new replacement Team Leader and Technical Director |
| APR 2007 | Approved TL and TD arrive (6 months following project start date) |
| MAY 2007 | Previous Team Leaders departs |
| JUL 2007 | Inception phase report finalised |
| JUL 2007 | First biannual progress report submitted |
| AUG 2007 | DFID Health Adviser Lizzie Smith leaves, Dr. Jean-Marion Aitken arrives |

YEAR 2 Nov 07 - Oct 08

| | |
|----------|---|
| DEC 2007 | CAC training begins |
| JAN 2008 | Biannual progress report submitted |
| JUL 2008 | MSI Cambodia clinics closure |
| AUG 2008 | Biannual progress report submitted |
| AUG 2008 | LAD funding discussions begin |
| OCT 2008 | MSI Abortion conference in London, RMMP presents on project progress and sponsors GoC delegation to attend conference |
| OCT 2008 | First DFID Output to Purpose Review |

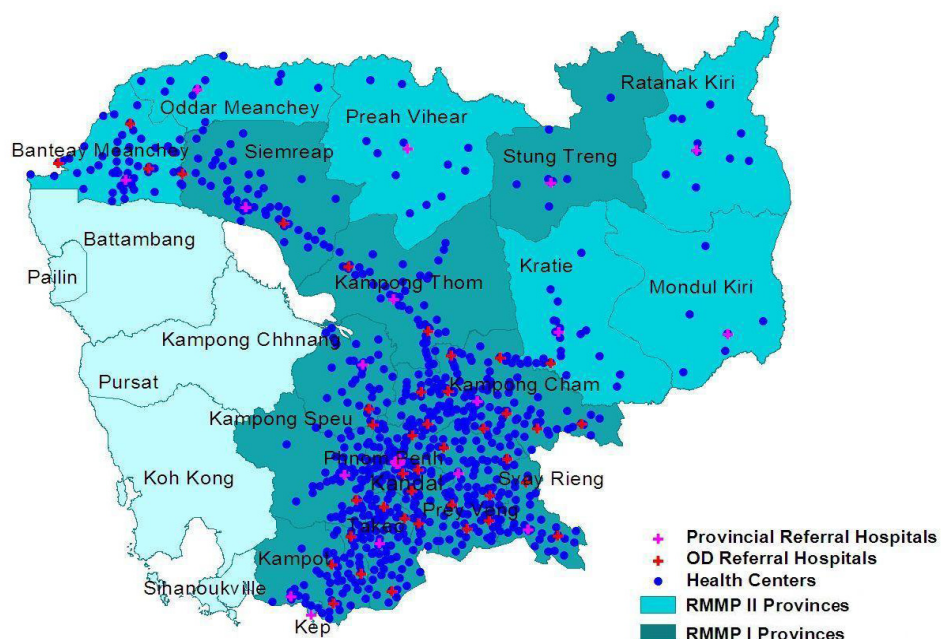
YEAR 3 Nov 08 - Oct 09

| | |
|----------|---|
| DEC 2008 | LAD proposal submitted from Option For International Health (US Office) |
| JAN 2009 | Biannual progress report submitted |

| YEAR 3 Nov 08 - Oct 09 | |
|------------------------|--|
| FEB 2009 | LAD Scale Up of SA and LTFP Intervention contract signed, project begins (1 year and 11 months \$6.4m) |
| FEB 2009 | Programme Director and Options Programme Manager arrive |
| FEB 2009 | Options Cambodia INGO registration completed |
| FEB 2009 | DFID extension funds proposal submitted |
| FEB 2009 | New team recruitment |
| MAR 2009 | DFID extension funding received (£1.1m - total contract £3.3m) |
| APR 2009 | New office renovation and construction |
| APR 2009 | Scale up in new provinces begins (LAD funded) |
| MAY 2009 | Office move |
| JUL 2009 | DFID office closure confirmed |
| AUG 2009 | Biannual progress reports submitted to DFID, LAD, MOFA |

| YEAR 4 Nov 09 - Apr 10 | |
|------------------------|--|
| DEC 2009 | GoC cancel salary supplements |
| JAN 2010 | Biannual progress reports submitted to DFID, LAD, MOFA |
| FEB 2010 | Adverse Event (maternal death related to MA client at MSI) |
| FEB 2010 | No-cost extension request |
| FEB 2010 | Second Output to Purpose Review |
| APR 2010 | End of contract |

Annex 4a: Map of government sites in RMMP Provinces

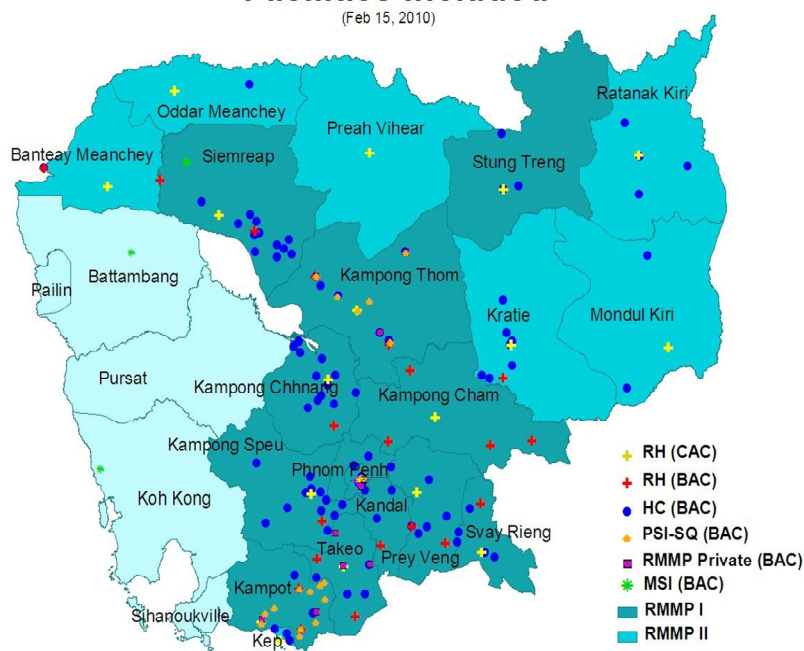


Annex 4b: Sites in all sectors receiving RMMP training and support



Facilities Included

(Feb 15, 2010)



Annex 5: Country statistics**General Population Census of Cambodia 2008****Final Census Results****Figures at a Glance**

| | | |
|----|---|---------|
| 1. | Number of Municipality | 1 |
| 2. | Number of Provinces | 23 |
| 3. | Number of Districts | 159 |
| 4. | Number of Khans | 8 |
| 5. | Number of Cities | 26 |
| 6. | Number of Communes | 1,417 |
| 7. | Number of Sangkats | 204 |
| 8. | Number of Villages | 14,073* |
| 9. | Population by Urban-Rural residence and sex | |

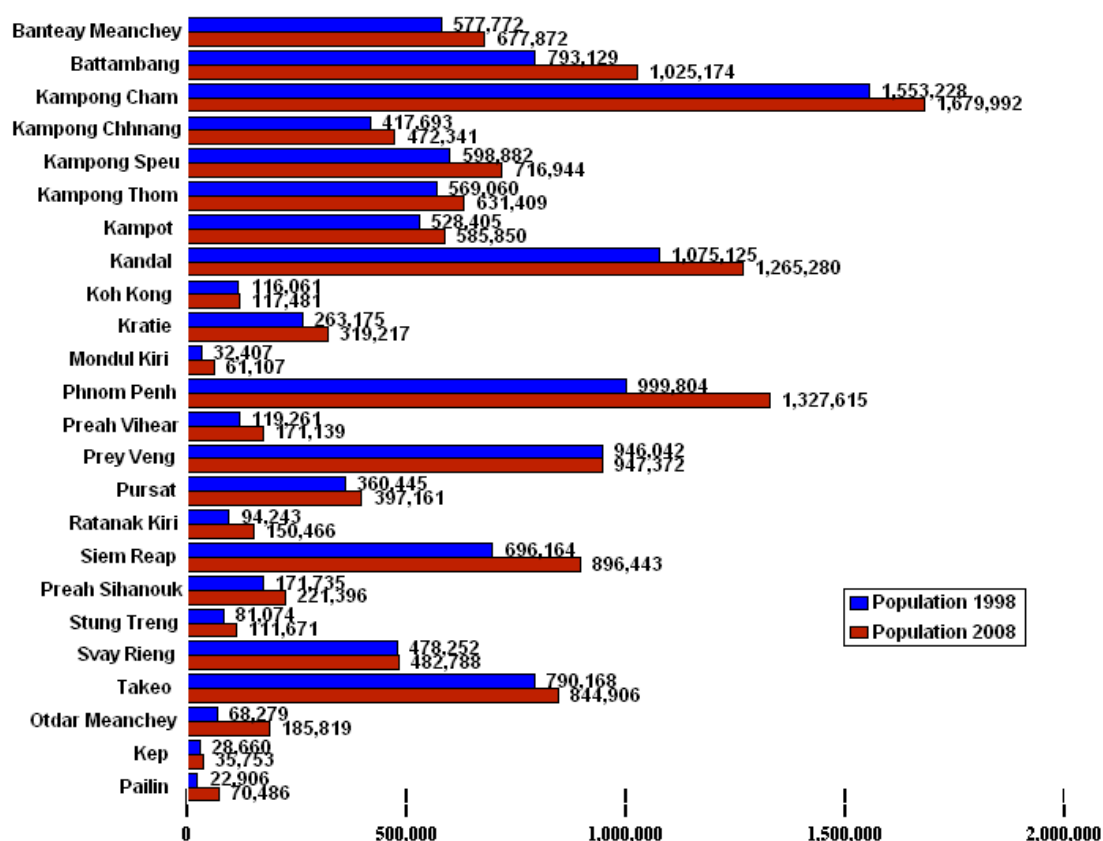
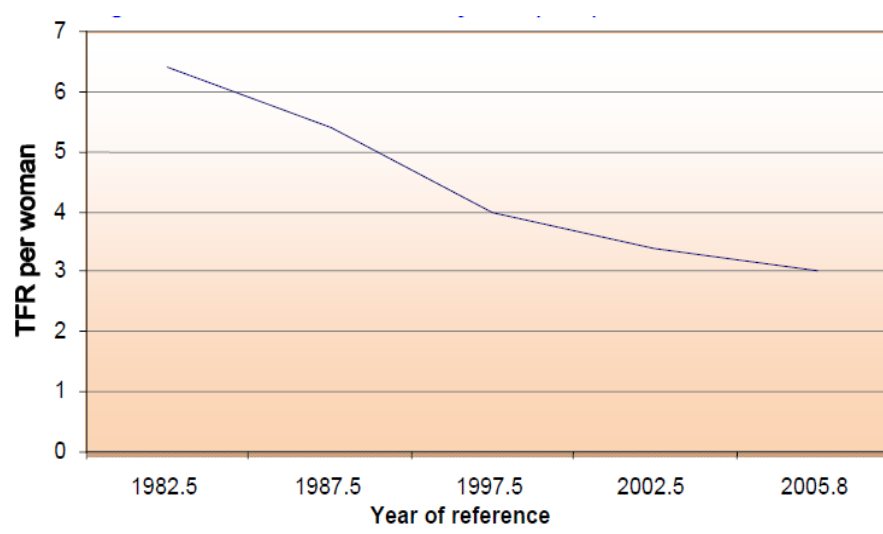
| Total/ Urban/ Rural | Both sexes | Males | Females |
|---------------------|------------|-----------|-----------|
| Total | 13,395,682 | 6,516,054 | 6,879,628 |
| Urban | 2,614,027 | 1,255,570 | 1,358,457 |
| Rural | 10,781,655 | 5,260,484 | 5,521,171 |

| | | |
|-----|--|-----------|
| 10. | Percentage of urban population | 19.5 |
| 11. | Annual population growth rate (percent) | 1.54 |
| 12. | Total number of households | 2,841,897 |
| 13. | Number of normal or regular households | 2,817,637 |
| 14. | Average household size (based on normal or regular households) | |
| | Total | 4.7 |
| | Urban | 4.9 |
| | Rural | 4.6 |
| 15. | Percentage of female headed households | 25.6 |
| 16. | Density of population per Km ² | 75 |
| 17. | Percentage of population by age group | |
| | Children (0-14) | 33.7 |
| | Economically productive age group (15-64) | 62.0 |
| | The elderly population (65+) | 4.3 |
| 18. | Dependency ratio | |
| | Total | 61.2 |
| | Urban | 40.8 |
| | Rural | 67.1 |
| 19. | Sex ratio (No. of males per 100 females) | |
| | Total | 94.7 |
| | Urban | 92.4 |
| | Rural | 95.3 |
| 20. | Marital status of population aged 15 and over | |

| Sex | Marital Status (in percentage) | | | | |
|------------|--------------------------------|---------|---------|----------|-----------|
| | Never Married | Married | Widowed | Divorced | Separated |
| Both sexes | 32.7 | 60.2 | 5.0 | 2.0 | 0.1 |
| Males | 37.0 | 60.8 | 1.3 | 0.8 | 0.1 |
| Females | 28.9 | 59.6 | 8.3 | 3.1 | 0.2 |

* Number of villages according to Ministry of Interior is 13,852

Note on administrative names: In this report Municipality refers to the Capital, Phnom Penh. Cities refer to municipalities in Provinces

Figure 5: Population by province 1998 and 2008**Figure 6: Trend in total fertility rate (TFR) Cambodia 1982-2006**

Sources of the estimates: 1982.5 to 1997.5: CDHS 2000; 2002.5: CDHS 2005;
2005.8: the present estimate from 2008 census.

The total fertility rate in Cambodia is around 3.0, infant mortality is around 60 and per 1,000 live births and maternal mortality ratio is around 461 per 100,000 live births. Estimates of child and under-five mortality are too implausible to arrive at a conclusive figure. The declining trend in fertility and infant mortality is continuing, although the speed of decline appears to have slowed down a little. The maternal mortality ratio (MMR), obtained from information about maternal deaths in the past 12 months collected at the 2008 census is 461, 287 and 490 maternal deaths per 100,000 live births for the period September 2007-September 2008 for total, urban and rural areas respectively. In spite of under-reporting of births and deaths including maternal deaths in the past 12 months, reporting on maternal deaths and live births appear to provide plausible estimates of maternal mortality ratio.

Annex 6: Health Financing mechanisms in Cambodia

Table 1: Summary of the different MCH related PBF schemes applied in 10 ODs in Kampong Cham as per February 2009

| ODs | Partner(s) | Targeted MCH services | | | | | Scheme descriptions |
|--------------|--------------|-----------------------|----------|-----|-----|----|---|
| | | ANC | Delivery | PNC | EPI | BS | |
| Kampong Cham | Government | X | O | X | X | X | Government disburses US\$15 per HC delivery. |
| Chamkar Leu | BTC | O | O | X | O | O | Quantity of these services and other HC performances (e.g. staff friendliness) scored. BTC disburses 1,200,000 riels (US\$292)/HC/month X (actual score/maximum score). |
| | RHAC | O | O | O | X | X | RHAC disburses US\$7 plus transportation costs for delivery if mothers come from 4 ANCs, delivery at HC and 2 PNCs. |
| | Government | X | O | X | X | X | Government disburses US\$15 per HC delivery. |
| Kroch Chhmar | GAVI-HSS | O | X | X | O | X | GAVI-HSS disburses US\$1 for each ANC visit, EPI dose and maternal consultation visit. |
| | UNFPA/AusAID | X | X | O | X | O | UNFPA/AusAID disburse US\$1 for each PNC and BS visits. |
| | Government | X | O | X | X | X | Government disburses US\$15 per HC delivery. |
| Srey Sentor | RHAC | O | O | O | X | X | See Chamkar Leu. |
| | Government | X | O | X | X | X | Government disburses US\$15 per HC delivery. |
| Choeng Prey | BTC | O | O | X | O | O | See Chamkar Leu. |
| | Government | X | O | X | X | X | Government disburses US\$15 per HC delivery. |
| Prey Chhor | BTC | O | O | X | O | O | See Chamkar Leu. |
| | RHAC | O | O | O | X | X | See Chamkar Leu. |
| | Government | X | O | X | X | X | Government disburses US\$15 per HC delivery. |
| Memut | SCA | O | O | X | O | O | Quantity of these services and other HC performances components are scored. SCA disburses total disbursement amount /HC/month X (actual score/full score). |
| | Government | X | O | X | X | X | Government disburses US\$15 per HC delivery. |
| Ponhea Krek | SCA | O | O | X | O | O | See Memut. |
| | Government | X | O | X | X | X | Government disburses US\$15 per HC delivery. |
| Tbong Khmum* | RHAC | O | O | O | X | X | See Chamkar Leu. |
| | Government | X | O | X | X | X | Government disburses US\$15 per HC delivery. |
| Oreang Ov | RHAC | O | O | O | X | X | See Chamkar Leu. |
| | Government | X | O | X | X | X | Government disburses US\$15 per HC delivery. |

1 UNFPA provides Tbong Khmum OD with funds for MCH component of the AoP through HSSP, not in the form of the PBF.
 2. Government delivery incentive started from 4th quarter of 2007. 3. BTC scheme started Dec 2005 4. RHAC scheme started April 2009.
 5 GAVI-HSS scheme started 4th quarter of 2007, 6. UNFPA/AusAID scheme started July 2008. 7. SCA contracting started April 2004, ended March 2009.

2.1.1 HEALTH CONTACTS SUPPORTED BY URC IMPLEMENTED HEFS

At the end of 2008, URC was implementing 22 HEF schemes across 25 of the 76 ODs in Cambodia. Funding from USAID, through the Health Systems Strengthening in Cambodia project, supported the administration costs in 11 of these schemes which covered 15 of the 25 ODs. The direct benefits in these areas were supported by the HSSP under funding from the RGC and World Bank through a co-funding arrangement. An estimated total of 3,025,000 of Cambodia's population reside in the catchment areas of these 11 HEF schemes with an estimated 769,000 poor.

Under contract with HSSP with funding from the Asian Development Bank, URC is also implementing 10 HEF schemes in an additional 10 ODs. An estimated total of 1,463,000 Cambodia's population reside in the catchment areas of these 10 HEF schemes with an estimated 422,000 poor. Also under contract with HSSP with funding from the World Bank URC was implementing the HEF scheme in Preah Vihear which covers 1 OD. There is an estimated total population in Preah Vihear of 149,000 with an estimated 82,000 poor.

In total, URC is implementing HEFs in areas which have an estimated total population of 4,638,000 out of Cambodia's total population of 13,388,910 with an estimated poor population of 1,273,000. This represents about 9.8% of Cambodia's population as eligible for support by URC implemented HEFs.

Existing HEFs in Cambodia

| Implementer | Donor | Operator | Province |
|-------------|----------------|-------------------------|--|
| BTC | Gov of Belgium | CHHRA, CAAFW, CFDS, AFH | Siam Reap, Kampong Cham, Oddar Meanchey |
| URC | USAID | CFDS, USG, AFH | Banteay Meanchey, Pursat, Kratie, Battambang, Phnom Penh |
| HNI | EU, HNI, HSSP | CAAFW, AFH, BFH, CFDS | Banteay Meanchey, Prey Vieng, Takeo, Mondul Kiri, Ratanak Kiri |
| UNICEF | UNICEF | Local Committee | Svay Rieng |
| VSO | VSO | Hospital | Stung Treng |
| SRC | SRC | CFDS | Takeo (Prov. Hospital) |

Current Budget

| | |
|-----------------------|----------------|
| Government of Belgium | 450,000 US\$/y |
| HSSP (ADB, WB, DFID) | 350,000 US\$/y |
| USAID | 675,000 US\$/y |

EU, HNI, SRC, UNICEF, VSO

In the future

| | |
|------------------------------|----------------------------|
| ADB grant through HSSP | 1,800,000 US\$ for 3 years |
| Royal Government of Cambodia | 830,000 US\$ for 3 years |

CBHI Schemes in Cambodia

5 organizations implementing in 9 districts covering 36,025 individuals

| Scheme | Location | Coverage | |
|---------------------|------------------|-----------------|---------------|
| | | No. of Families | Individuals |
| GRET Urban SKY | Phnom Penh | 623 | 2417 |
| GRET Rural SKY | Kandal | 155 | 665 |
| | Takeo- Tram Kok | 1054 | 5774 |
| | Takeo-Kirivong | 258 | 1166 |
| | Kampong Thom | 105 | 565 |
| CAAFW | Banteay Meanchey | 4926 | 21783 |
| CHHRA | Oddar Meanchey | 238 | 1073 |
| RACHA | Pursat | 232 | 1247 |
| Buddhist for Health | Kirivong | 215 | 1335 |
| Total | | 7806 | 36,025 |

Annex 7: Recommendations from 2008 OPR

| Recommendation |
|--|
| <p>Although a revision of the logframe was approved in July 2008, it is recommended that the two indicators of the purpose of the project relating to male and female sterilization (OVIs 3 & 4) are combined. It would read "Number of women and men receiving voluntary surgical contraception (VSC) by providers trained under RMMP increases from 0 to 50 by Jan 2008, to 250 by Jan 2009 and by 400 by Jan 2010."; and that OVI 4 under Output 1 is changed to read "100% of RMMP included facilities reach and maintain minimum operating standards as per RMMP quality guidelines."</p> |
| <p>Changes to plans will be required as rules and regulations on salary supplementation become defined and implemented. It is recommended that RMMP works closely with each of the institutions, in particular, the MCH centre and the National Reproductive Health Programme, ODs and PHs it is working with, or plans to work with, to ensure that safe abortion activities, related staffing and salary supplementation (if relevant) are included in the AOPs being developed from the first quarter of 2009 for the 2010 management and budget cycle. Assuming no additional resources would be required RMMP may need to produce technical guidelines on what should be included in AOPs at each level, address capacity building, and monitoring of abortion services.</p> |
| <p>While it is hard to make recommendations to address the overall difficulties of access of poor women to health services, it is recommended that close collaboration with KfW is maintained and RMMP works with KfW to ensure that the voucher scheme remains appropriately designed.</p> |
| <p>It is recommended that the issue of continuing support to RMMP is considered in April 2009. How CAC services developed by the project will be maintained and scaled up to other provinces and healthcare facilities, must be addressed at the time, given that the project will be one year from completion. At this time, a proposal for continuing DFID funding could be developed. Whatever support is obtained from other potential donors for development of private sector services, support to the public sector needs to be maintained beyond the end of the RMMP project.</p> |
| <p>The project is demonstrating that staff attitudes are changing because of training, however, the perceptions of women of staff attitude and behaviour has not been assessed. It is recommended that the Key Informant Monitoring activity planned for late 2008 tries to address this.</p> |
| <p>It is recommended that RMMP continues to plan introducing a new copackaged mifepristone/misopristol product, as part of CAC as activities are implemented in its current ODs and as they are finalized and implemented in new ODs in 2009.</p> |
| <p>The lessons learnt should be written up for publication in a relevant health service delivery journal and findings from the PEER research and the subsequent KIM follow up should be written up for publication in a social science journal. Consideration should be given to disseminating all the findings through newsletters and websites of partner organizations, as well as information channels which might have broader coverage in health and women's issues, including eldis and other list-serves.</p> |
| <p>It is recommended that measures be considered already to minimise the impact of the possible closure of DFID's office in Phnom Penh. In the event of its closure, retention of a Health Advisor at the Embassy is essential for this and all health related activities. It is not possible for national or international NGOs to support and influence government and senior officials on safe abortion in a similar manner to the way in which a major governmental donor, like DFID can. Moreover, no other funding body is willing to make the financial and intellectual inputs necessary to support the public sector on this issue. Without these inputs, the risk that this critical effort to address a key component of MDG5 will not be maintained will increase significantly.</p> |
| <p>The lack of institutional capacity within the National Reproductive Health Programme (NRHP), with its limited number of staff and poor linkages within the Ministry of Health must be addressed if the project is to integrate its work into mainstream MoH functions and services. It is recommended that staff of NRHP, together with RMMP, review the most appropriate mechanisms by which this might be achieved. With the support and facilitation of DfID, this issue and means of its resolution should then be presented at the highest possible level within the MoH. RMMP is limited in its ability to provide effective and sustainable capacity building efforts to the NRHP in relations to the weak linkages within the Ministry of Health and would welcome the opportunity to work further with DFID on finding a workable solution to the address the issue.</p> |

Annex 8: OPR mission schedule and people met

| Day, Date | Time | Place and who met | Participants |
|--------------------------------|-----------------------------------|---|---|
| Monday 15February | 09:00–10.30 British Embassy | DFID team introductions and briefing, Ian Belshaw, Deputy Programme Manager | Fiona Duby |
| | 11.00 – 13.00 RMMP Office | RMMP team introductions Team role introductions, Review schedule for week and agree expectations. Presentations - brief history and context project and output to purpose progress <ul style="list-style-type: none"> • Introduction and context (Harriet) • Output 1 Supply Side(Swaraj) • Output 2 Demand-side (Harriet) • Output 3 & 4 MOH Technical capacity and Cross cutting activities (John) • Knowledge Sharing, Challenges and Recommendations (Harriet) | Fiona Duby RMMP core team (Harriet Stanley, John Naponick, Swaraj Rajbhandari, Sinead Rowan) |
| | 13:00-1400 | Lunch | |
| | 14.00-17.00 RMMP Office | RMMP team presentations continued | RMMP core team Fiona Duby |
| | | | |
| Tuesday 16 February | 09:00 -10.00 NMCHC office | Review team meeting time with Dr Rathavy, Director National Reproductive Health Programme, MOH | Fiona Duby John Naponick Harriet Stanley |
| | 10:30:12.00 RMMP Office | Office meetings | Fiona Duby, Harriet Stanley |
| | 12:00-13:00 | Lunch | |
| | 14:00–15:30 MSIC office | Che Katz, MSIC Programme Director | Fiona Duby, Harriet Stanley |
| | | | |

| | | | |
|----------------------------------|--|---|--|
| Wednesday 17 February | 09:00-13:00 (appointment at Municipal for 9.30am) | Site visit SITE Phnom Penh Municipal Referral hospital, training and provider interview or for the reviewer to have further discussions with RMMP team. s | Fiona Duby Swaraj Rajbhandari, RMMP clinical team |
| | | Lunch | |
| | 14.00-15.00 AusAID Australian Embassy | Dr Andrew Cornish, Health Adviser, AusAID (and representing DFID), Socheat Chi, Senior Programme Manager (Health) | Fiona Duby Harriet Stanley |
| | 15.00-16.00 UNICEF office | Dr Cheang Kannitha, Making Pregnancy Safer Officer WHO Dr Viorica Berdaga, Chief, Child Survival and Development, UNICEF | Fiona Duby, Harriet Stanley |
| Thursday 18 February | 9.00 – 13.00 (expected time of arrival in PP) | Field visit to RMMP site, Prey Anchang, Kandal (30 minutes from Phnom Penh) Including trained provider interviews. | Fiona Duby, Swaraj Rajbhandari, RMMP clinical team |
| | Lunch | | |
| | 15.00-16.00 US Embassy | USAID, Kate Crawford, Director, Office of Public Health and Education Adviser/Rep, Dr Joan Woods, RMCH Advisor | Fiona Duby, Harriet Stanley |
| Friday 19 February | 8.30 URC office | URC team: Dr Jerker Lilestrand (MNCH and Nutrition Team Leader), Dr Mary Mohan (MNCH and Nutrition Dpty Team Leader) | Fiona Duby, Harriet Stanley |
| | 10.0PS PSI office | Alysha Beyer, Senior Technical Advisor, PSI | Fiona Duby, Harriet Stanley |
| | 12.00-13.00 | Lunch | |

| | | | |
|--|-----------------------------|---------------------------------------|--|
| | 15.00-16.00 UNFPA Office | Alice Levisay, UNFPA | Fiona Duby, Harriet Stanley |
| | 16.00-17.00 RMMP Office | De-brief/ feedback from DFID reviewer | RMMP Core Team DFID team – Ian Belshaw and Fiona Duby |
| Saturday 20 February | All day | DFID review consultant report writing | Fiona Duby |
| | Lunch | With team, Dr Swaraj Rajbhandari, | |
| | 9.00 | Leave for airport | Fiona Duby |
| Sunday 21st February | 16.20 | Arrive Heathrow | Fiona Duby |

Annex 9: Key Documents Reviewed

- RMMP 2008 Annual Review
- RMMP Inception Phase Report
- Options RMMP Bi-Annual Report Jul – Dec 09
- Options RMMP Bi-Annual Report Jan – Jun 09
- Options RMMP Bi-Annual Report Jul – Dec 08
- Project Memorandum
- Budget Extension Justification Documents
- Logical Framework – Version 5,
- RMMP Roadmap and annexes
- Options technical proposal
- RMMP. Cambodia Baseline Report
- DFID. Cambodia: Country Strategy Paper 2000-2002
- Abortion and family planning use in Kampong Thom province, Cambodia – A second PEER study for the Reduction in Maternal Mortality Project. Dr Sarah Barnett and Sam Swartz
- Ipas Ready or Not
- National Institute of Public Health and National Institute of Statistics. ORC Macro. Cambodia Demographic and Health Survey 2005. December 2006
- National Institute of Statistics. Ministry of Planning, (2009) General Population Census of Cambodia 2008. August 2009.
- Evaluation of DFID's Country Programmes: Cambodia 2003 – 2008. Thornton et al, May 2009
- Modern Contraceptive Methods Among Women at Reproductive Age Second Round. PSI Research Division 2009
- USAID. Evaluation Report: Health Equity Funds implemented by URC and supported by USAID. September 2009
- JICA. Performance-based Financing of MCH Services: Financial and Behavioural Impacts at the Field Level in Kampong Cham Province. February 2009.
- Preserving Equity in Health in Cambodia: Health Equity Funds and Prospects for Replication
- Bitran et al, Bitran & Associates. Vincent Turbat, World Bank
- Bruno Meessen & Wim Van Damme
- Country context: Joint Analysis by the ADB, DFID, UN system, World Bank
- Ministry of Health. National Reproductive Health Programme National Strategy for Reproductive and Sexual Health in Cambodia 2006-2010. Royal Government of Cambodia .February 2006

Annex 10: Terms of Reference

DFID Cambodia Reduction in Maternal Mortality project

Annual Review

Background

Maternal mortality is a major problem in Cambodia. In 2000, the Cambodia Demographic and Health Survey (CDHS) estimated the Maternal Mortality Ratio to be 437 per 100,000 live births. The 2005 CDHS revised this figure to 472 per 100,000 live births. This is ten times the rate in neighbouring Thailand and four times the rate in Vietnam. The major causes of maternal death include haemorrhage, hypertensive disorders, obstructed labour, infection and unsafe abortion. Cambodia has one of the lowest contraceptive prevalence rates for modern methods in Asia, but high reported unmet need. Unmet need is especially high among rural women. Unsafe abortion has been estimated by WHO to contribute 30% of maternal mortality.

To help address these critical issues, DFID Cambodia devised the Reduction in Maternal Mortality Project (RMMP). The goal of RMMP is to reduce maternal mortality and improve reproductive health in Cambodia. The purpose is to increase utilisation of sustainable quality and affordable reproductive and maternal health services by poor women. The £3.3m, 3.5 year project commenced on 1 November 2006 and will run to end April 2010. It is managed by a competitively procured contractor, Options Consultancy Limited.

Overall Objectives of the Review

The overall objective of the review is:

1. To provide an analysis of the experiences and impacts of the RMM project to date and any recommendations for its implementation until the end of DFID funding in April 2010;

Key outputs of the review

1. To complete an assessment of project strategy and progress to date in the format of the DFID Annual Review (AR) format;
2. To assess the clinical training strategy: its technical quality, effectiveness in influencing practices in public and private practice and its likely sustainability after the project end.

Scope of work

The review will be based primarily on the annual implementation reports and qualitative information obtained through interviews with a broad range of actors including Options Consultancy Group, donor and partner country representatives and civil society.

Tasks

The Consultant should:

- Familiarise themselves with the project documentation, the history and scope of RMMP activities and DFID requirements for an Annual Review;
- In consultation with the DFID Programme team, prepare a programme for the review detailing meetings to be held with a range of groups and individuals (Options, government, donor and civil society), and the topics to be covered;
- Hold the meetings detailed in the programme. Discussions should be focused around the outputs from the original and revised log frames and the key questions posed in these ToRs;
- Liaise frequently with DFID Programme team throughout the review, and ensure that emerging conclusions and recommendations are shared with them.
- Prepare a report detailing
 1. progress towards the achievement of the different outputs;
 2. an overall assessment (with justification) of the likelihood of the project purpose being achieved by April 2010, based on achievements to date (above), assumptions in the original and revised log frame, and other external factors which have influenced the activities and progress of the project;
 3. realistic recommendations, given the limited time remaining, (with justification) for modifications to existing outputs and/or the addition of new outputs in order to increase the likelihood of achievement of the project purpose;
 4. recommendations (with justification) for modifications to existing assumptions and/or the addition of new assumptions to reflect the analysis of changes in state, donor and non-state environments, and an assessment of risks to the project's achievement of its purpose;
 5. an assessment (with justification) of the attribution of any progress to the project;
 6. an analysis of lessons learned;
 7. an analysis of likely future scenarios in Cambodia, and recommendations for how DFID and other donors could respond to these to strengthen the MMR impact;
 8. any gender issues arising with recommendations on how these could be addressed;

The consultant will be responsible for the overall delivery of the report and the incorporation of comments received.

Output required

The report should follow the DFID template (Annex A) and project scoring completed as required for DFID's monitoring systems.

Timeframe

The consultancy will involve 10 person days. One day will be allowed for report reading and preparation. The in-country review should commence on xxx Jan 2010 for 5 days. A further 4 days will be allocated for follow up interviews, report writing and subsequent revision in the light of comments from partners. The consultant will undertake the tasks and activities as outlined in these terms of reference. The draft report will be submitted to DFID Deputy Programme Manager in DFID Cambodia by no later than the XXX Jan/Feb 2010. Two weeks will be allowed for comments and the consultants will be expected to submit the final report and scoring by the XXX Jan/Feb 2010.

Reference Material

The consultants will be supplied with key background material by DFID.

Expertise RequiredEssential

- Experience in clinical training, particularly in safe abortion techniques and Obstetrics and Gynaecology,
- health systems development, particularly in weak regulatory environments with fragile public health systems;
- Experience of working in the health sector in Cambodia.

Desirable

- Experience in reproductive health;
- Experience of different health financing modalities;
- Experience in DFID log frames and AR reporting.

Reporting

The DFID Cambodia Deputy Programme Manager will oversee this work.

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