

# **UNFPA CAMBODIA**

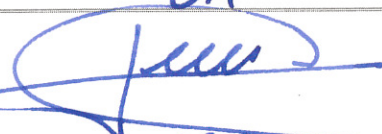
## **Country Programme Evaluation:**

**Fourth Programme Cycle, 2011 - 2015**

### **Evaluation Report**

**April 2015**

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OK  
  
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## MAP 1: CAMBODIA COUNTRY MAP



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### Disclaimer:

Please mind that the contents of the present report concern the viewpoint of the evaluators and do not necessarily reflect the opinion of UNFPA and its country office, nor those of RGC, development partners and other stakeholders concerned.

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## ABBREVIATIONS AND ACRONYMS

APRO	Asia Pacific Regional Office (UNFPA)
AWP	Annual Work Plan
BBC	British Broadcasting Corporation
CCWC	Commune Council for Women and Children
CDHS	Cambodia Demographic and Health Survey
CIPS	Cambodia Inter Census Population Survey
CMDG	Cambodia Millennium Development Goal
CNCW	Cambodia National Council for Women
CO	Country Office
COAR	Country Office Annual Report
CP4	Country Programme Cycle 4
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSES	Cambodia Socio-Economy Survey
CV	Curriculum Vitae
CWCC	Cambodia Women and Children Crisis Centre
CWPD	Cambodia Women for Peace and Development
DFAT	Department of Foreign Affairs and Trade
DOH	Department of Health
DOLA	Department of Local Administration
DOSAVY	Department of Social Affairs, Veterans and Youth Rehabilitation
DV	Domestic Violence
D&D	Decentralization and Deconcentration
D/M	District / Municipality
EmONC	Emergency Obstetric and Neonatal Care
EQA	Evaluation Quality Assurance
ERG	Evaluation Reference Group
ET	Evaluation Team
EW	Entertainment Worker
FTIRM	Fast Track Initiative Road Map for Reducing Maternal and New-born Mortality
FP	Family Planning
GBV	Gender Based Violence
GMAG	Gender Mainstreaming Action Group
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HR	Human Resources
HSSP II	Health Sector Support Programme (second phase)
ICPD (PoA)	International Conference on Population Development (Plan of Action)

IP3	Implementation Plan of the National Programme
JPIG	Joint Partner Implementation Group
JUTH	Joint UN Team on HIV/AIDS
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MIC	Middle Income Country
MIS	Management Information System
MLMUC	Ministry of Land Management, Urban Planning and Construction
MNH	Maternal and Neonatal Health
MOEYS	Ministry of Education, Youth and Sports
MOH	Ministry of Health
MOP	Ministry of Planning
MOSAVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MoWA	Ministry of Women's Affairs
MTR	Mid-Term Review
M&E	Monitoring and Evaluation
NCHADS	National Center for HIV/AIDS, Dermatology and STDs
NCPD	National Committee for Population and Development (Office Council of Ministers)
NHIS	National Health Information System
NIS	National Institution of Statistics
NP-SNDD	National Programme for Sub-National Democratic Development
NR	Neary Rattanak
NSDP	National Strategic Development Plan
PD	Population and Development
PYD	Paz y Desarrollo
RACHA	Reproductive and Child Health Alliance
RHAC	Reproductive Health Association of Cambodia
RGC	Royal Government of Cambodia
RMNH	Reproductive Maternal and New-born Health
RMH	Reproductive Maternal Health
SNA	Sub-National Administration
SRH	Sexual and Reproductive Health
STD / STI	Sexually Transmitted Diseases / Sexually Transmitted Infections
TA	Technical Assistance
TOR	Terms of Reference
TWG	Technical Working Group
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group

UNFPA ..... United Nations Population Fund  
UNICEF..... United Nations Children’s Fund  
UN DESA..... United Nations Department of Economic and Social Affairs  
USD ..... United States Dollar  
VAW ..... Violence Against Women  
WCCC ..... Women and Children Consultative Committee  
WHO ..... World Health Organization

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Table 1: Key Facts of Cambodia

Key Aspects	Data	Source
<b>Land</b>		
Geographical location	Southeastern part of Asia	
Land area	181,035 km <sup>2</sup>	
Capital	Phnom Penh	
Climate	Tropical with two distinct monsoon seasons	
<b>People</b>		
Population	14.7 million (2013)	CIPS
Population under 18 years of age	5.6 million (2012)	UNICEF
Adolescents 10-19 years of age	3.1 million (2012)	UNICEF
Urban population	20.1 per cent (2011)	UN Population Division
Population Annual Growth Rate	2.3 (1990-2012) 1.4 (2012-2030)	UNICEF
Life expectancy	69.35 years (2014)	NSDP 2014-2018
Total Fertility rate	2.7 (2014)	CDHS
Proportion of population over 60 years of age	7.7 (2012)	WHO
<b>Government</b>		
Government	Multi-Party democracy under a constitutional Monarchy established in September 1993	UN DESA
Administration	20 provinces and 4 municipalities	UN DESA
<b>Economic indicators</b>		
GNI per capita	880 USD (2012)	World Bank
GDP per capita average annual growth rate (1990-2012)	6 per cent	World Bank
Average annual rate of inflation (1990-2012)	3.9 per cent	World Bank
<b>Social indicators</b>		
Life expectancy at birth (years)	69.35 years (2014)	NSDP 2014-2018
Life expectancy, female (years)	71.2 years (2014)	NSDP 2014-2018
Life expectancy, male (years)	67.3 years (2014)	NSDP 2014-2018
Adolescents currently married/in union (females)	10.2 (2002-2012)	UNICEF
Adolescents currently married/in union (males)	1.6 (2002-2012)	UNICEF
Teenage (15-19 years of age) fertility rate	12 per cent (2014)	CDHS
Under-5 mortality (per 1000 live births)	35 (2014)	CDHS
Health expenditure (per cent of GDP)	5.4 per cent (2012)	WHO
Births attended by skilled health personnel, percentage	89 per cent (2014)	CDHS
Institutional Delivery	83 per cent (2014)	CDHS
Contraceptive prevalence (married or in union)	39 percent (2014)	CDHS
Contraceptive prevalence rate among girls 15-19 years (any modern method)	20.2 (2014)	CDHS
Unmet need for family planning (married or in union)	13 (2014)	CDHS
Underweight prevalence in children under 5 years of age (moderate and severe)	24 per cent (2014)	CDHS
Adult HIV in Entertainment Workers (EWs)	2.6 (2011)	SSS, NCHADS
Youth literacy rate male (15 -24 years of age)	88.4 (2008-2012)	UNICEF

Key Aspects	Data	Source
Youth literacy rate female (15 -24 years of age)	85.9 (2008-2012)	UNICEF
<b>Millennium Development Indicators</b>		
<b>1 - Eradicate Extreme Poverty and Hunger</b>		
Reduce the proportion of people living in poverty	19.8 per cent (2011)	CSES
Reduce the proportion of people living in hunger	2.7 per cent (2011)	CSES
Reduce prevalence of working children ( $\leq 17$ years) of the total children in this age-group.	13.8 per cent (2011)	CSES
<b>2 - Achieve Universal 11 year compulsory education</b>		
Literacy in the population aged 15-24 years	92.5 per cent (2013)	MoEYS
Net enrolment rate at primary school level	97 per cent (2013)	MoEYS
Gross enrolment rate at lower-secondary school level	53.6 per cent (2013)	MoEYS
Primary completion rate	87.4 per cent (2013)	MoEYS
Gender parity in education at the primary level	1 (2013)	MoEYS
Gender parity in education at the lower secondary level	1.02 (2013)	MoEYS
<b>3 - Promote Gender Equality and Empower Women</b>		
Gender disparities in upper secondary	87.3 per cent (2013)	MoEYS
Gender disparities in wage employment in all sectors	45.7 per cent (2011)	CSES
Gender disparities in public institutions	35 per cent (2012)	MoWA
All forms of violence against women and children	23.9 per cent (2009)	MoWA
<b>4 - Reduce Child Mortality</b>		
Infant mortality rate (IMR) to 50 by 2015	28 per cent (2014)	CDHS
Under 5-year child mortality rate (U5MR)	35 per cent (2014)	CDHS
Percentage of children vaccinated	94 per cent (2014)	NHIS, MOH
Infants $\leq 6$ months exclusively breast-fed	65 per cent (2014)	CDHS
<b>5 - Improve Maternal Health</b>		
Maternal mortality ratio (mortality per 100,000 live births)	170 (2014)	CDHS
Proportion of births attended by skilled health personnel	89 per cent (2014)	CDHS
Total fertility rate	2.7 (2014)	CDHS
Proportion of pregnant women with $\geq 2$ ANC with skilled health personnel	95 (2014)	CDHS
Proportion of deliveries by C-Section (per cent)	5.37 (2014)	NHIS, MOH
<b>6 - Combat HIV/AIDS, Malaria and other Diseases</b>		
HIV prevalence (per cent Adults 15-49 of age)	0.7 per cent (2012)	NHIS, MoH
Malaria mortality (Per 100,000 population)	0.29 per cent (2012)	MoH
Prevalence of all forms of Tuberculosis	715 (2013)	National Center for Tuberculosis & Leprosy MoH
<b>7 - Ensure Environmental Sustainability</b>		
Loss of environmental resources	58.39 per cent (2011)	NSDP/MTR 2009-2013
Dependence on firewood for cooking	79.5 per cent (2010)	CDHS
Proportion of people with secure land tenure	28 per cent (2011)	MLMUC
<b>9- Demining, Removing Explosive Remnants of War (ERW) and Victim Assistance</b>		
Number of casualties caused by landmines and ERW (killed and injured)	186 (2011)	Cambodian Mine Action Authority
Landmine and ERW contaminated land cleared/released	8,293	Cambodian Mine Action Authority

## Executive Summary

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The United Nations Population Fund (UNFPA) has been providing support to Cambodia since 1994 and is currently implementing the last year of its fourth country programme cycle (CP4) to assist the Royal Government of Cambodia (RGC) in achieving its International Conference on Population and Development (ICPD) goals. The fourth programme cycle runs from 2011-2015, in line with the United Nations Development Assistance Framework (UNDAF). With the fourth programme cycle coming to an end in 2015, a Country Programme Evaluation (CPE) was conducted.

Cambodia has made significant progress in terms of economic as well as social development in particular during the last two decades. Economic growth ranged from 6 to 11 per cent per annum in much of this period. Presently about 19.8 percent of the total population lives below the national poverty line. This means a huge improvement compared 2007 when poverty levels were at 47.7 percent. The sustainability of the gains concerning poverty are, however, precarious with many households living on incomes just above the poverty line. Cambodia aspires to become a Lower Middle Income Country (MIC) by 2015 and a Higher MIC by 2030.

Cambodia has been changing rapidly from a predominantly a rural society with 80.5 percent of the population living in rural areas (2010) towards a more urbanized society with intensive commercial farming in rural areas combined with urban based manufacturing and services. Many of the large population of young people are migrating out of rural areas contributing to rapid urbanization. There is an increasingly vocal demand of citizens and civil society organizations for more inclusive growth and political participation.<sup>1</sup>

Decentralisation and De-concentration (D&D) reform started in 2001 with in 2008 introduction of elected councils at the District, Municipality and Khan levels. The process evolved since the adoption of the National Plan in 2010 into the reform for Sub-National Democratic Development (SNDD).

The **purpose of the present CPE** combined accountability and learning objectives. The evaluation aimed to demonstrate accountability of performance of the country programme during the period 2011-2015 to stakeholders, to generate lessons learned, contribute to the knowledge base of the organization and broaden the evidence-base of achievements. The evaluation will inform the design of the next programme cycle of UNFPA in Cambodia through actionable recommendations.

Main audience for the results of the evaluation concerned the UNFPA country office and RGC partners. Secondary audiences concerned UNFPA regional office and headquarters, as well as other development partners including UN agencies, donor agencies and civil society organizations.

The evaluation included all of UNFPA's assistance and covered both those initiatives and activities funded through its own resources, as well as other resources. The evaluation included both national level activities as well as interventions supported at the sub-national level. In geographical terms the evaluation covered the whole of the country, defined by the territorial scope of the programme components at both the national and the sub-national levels.

Evaluation questions focused on a set of strategic aspects, including added value of UNFPA and coordination within the United Nations Country Team (UNCT), while programmatic issues included questions on relevance, effectiveness, efficiency and sustainability of the country programme and its results. Moreover, issues of monitoring and reporting were dealt with.

The **evaluation methodology** made use of a participatory approach, involving a wide range and variety of stakeholders in the process and made use of an appreciative inquiry approach. Use was made of a variety of qualitative and quantitative methods and tools, including desk review, semi-structured interviews, focus

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<sup>1</sup> Cambodia Common Country Assessment – CCA, UNDAF 2016-2018, May 2014.

group discussions and observations, which allowed for triangulation of data. A four week in-country data gathering process was part of the evaluation. Data were gathered at the national and sub-national level, making use of a preliminary stakeholder analysis conducted as part of the inception phase. Three provinces, i.e. Banteay Meanchey, Ratanakiri and Kampong Chhnang, were selected out of the seven that received support from all components of the programme. Selection was based on poverty incidence, support received by UNFPA and geographical location. The ethical code of conduct of UNEG/UNFPA was adhered to in all stages of the evaluation process. Limitations to the methodology concerned the more limited representation through the selection of three provinces of the Sexual and Reproductive Health (SRH) component of the programme which was implemented country wide and changes made in the CPAP planning and tracking tool which limited the use of monitoring data.

In terms of the **relevance** of the programme it was found that the fourth programme cycle of UNFPA in Cambodia was aligned with the National Strategic Development Plan update 2009-2013 as well as with the UNDAF 2011 – 2015 and the UNFPA strategic plan 2011-2013. The programme was adjusted to align with the UNFPA strategic plan 2014-2017. The programme responded to the SRH needs of women, adolescents and youth in Cambodia, including marginalized groups and was responsive to changes in the context. The sub-national geographical focus proved relevant but will need to be further sharpened in the next programme cycle to focus in particular on those areas and groups with less access to quality social SRH and FP services and most in need of support.

In terms of **effectiveness** important results have been achieved in each of the three programme components. In the **PD component** support resulted in the functioning of sub-national Women and Children Consultative Committees (WCCC) at provincial level and Cambodia Councils for Women and Children (CCWC) at district and commune level in the targeted provinces, providing platforms to discuss and address women, adolescent and youth issues in a multi-disciplinary way and enhancing the attention to social development in sub-national planning processes. Less successful has been the leveraging of local investment budget with financial procedures of local resources a mayor constraint. Future support to WCCCs and CCWCs will need to build on developed capacities and focus on the active participation in decision-making processes and enhancing accountability for social services provided.

Moreover, capacities in data collection and analysis have been developed and a substantial number of population studies prepared, which enhanced the knowledge base used to inform national strategies and planning. The support to analysis and use of disaggregated population data in planning processes has so far proved much more successful at the national than at the sub-national level, where planning remains depending much more on needs assessments than on population data that could enhance a target on vulnerable groups or enhance equity of access to quality social services.

UNFPA support to **SRH and Family Planning (FP)** has contributed to increased access and use of quality reproductive, maternal, new-born health services as evidenced by increased incidence of delivery by skilled midwives, enhanced access to quality emergency obstetric and neo-natal care (EmONC), increased use of modern family planning methods and improved quality of public health services. Special focus has been on access for adolescents and youth. These results are all likely to have contributed to reduction of the fertility rate to 2.7 and a decrease of the Maternal Mortality Rate (MMR) to 170 in 2014 (CDHS 2014). Especially UNFPA's focus on EmONC, including the availability of trained midwives and a competency framework to inform training appears to have paid off. A next step will be to align midwife training with International standards and guidelines as well as ensuring availability of quality SRH services in remote locations.

As part of the focus on adolescents and youth UNFPA, together with others, successfully advocated for the inclusion of comprehensive sexuality education in the curriculum of primary and lower secondary schools. Support to the Love9 multi-media initiative of BBC Media Action, has enhanced access to SRH information for adolescents and youth. Through support to the SMART girl programme UNFPA has supported HIV/AIDS

prevention for Entertainment workers (EW) in selected province, while at the same time enhancing their access to SRH and FP services.

In the **gender component** of the programme UNFPA has successfully supported the new National Action Plan for Violence Against Women (NAPVAW II), in close cooperation with other stakeholders, which plan can be the basis of a programme based approach to address VAW. Through the meetings of the CCWCs and WCCCs a mechanism has been established to discuss and address issues of VAW and girls at the local level. UNFPA support to the development of the National Guidelines for Managing VAW and Clinical Handbook for services to survivors of VAW have been an important steps to improve quality of services.

The establishment of Gender Mainstreaming Action Groups (GMAG) has been successful in MOH and Ministry of Planning (MOP) with UNFPA support. Limitation of national budget allocated to implement the GMAG plans has proved an important constraint. Support to enhance women's participation has reached training targets but did not substantially affect the proportion of elected women at national and sub-national levels, the outcome level change concerned.

Regarding the **efficiency** of the programme, UNFPA's engagement with SRH and FP has been channeled primarily through the health sector support programme (HSSP II) which has proven efficient. UNFPA has played an important role in the management of HSSP II, in this way influencing the health development agenda in Cambodia and leveraging additional resources for SRH and FP.

Given the comprehensive nature of the country programme in the implementation of the fourth cycle the staffing of the country office proved relatively limited with only a small team of programme specialist to support the implementation of a wide range of activities in each of the programme components. This has limited the interaction of staff with RGC, civil society partners and other development partners. Notwithstanding limitations in the amount of human resources most of the deliverables were achieved on time, apart from delays beyond the control of the UNFPA team.

Regarding aspects of **sustainability**, the partnership approach applied in all the components of the programme has enhanced the ownership of results and enhanced partner capacities in the process, both enabling factors for sustainable results. The inclusion of a budget line for contraceptives in the national budget, informed by advocacy of UNFPA and Department of Foreign Affairs and Trade (DFAT), resulted in enhanced sustainability in access to FP commodities. Other results in each of the three components are not yet necessarily at sustainable levels. Explicit attention to sustainability strategies for initiatives concerned could contribute to ensure that their results will be sustained.

In terms of **monitoring and evaluation (M&E)**, the results framework of the Country Programme Action Plan (CPAP), which is meant to guide monitoring and evaluation, had several limitations, including weak indicators, outputs which were not within the management control of the country office and outcomes which were unlikely to be achieved only through the outputs concerned. This made the framework less useful as a tool for results based management of the programme. Nevertheless, multiple monitoring, reporting and evaluation activities have informed programme implementation. These could be enhanced by an improved results framework as well as by an annual Monitoring and Evaluation plan.

Concerning **United Nations country team (UNCT) coordination**, UNFPA is regarded as a valuable partner by RGC agencies of all three components and by other UN agencies and development partners. In terms of **added value**, UNFPA has been well regarded for its technical expertise in population policy, population data gathering and knowledge management, SRH, FP, prevention of HIV/AIDS for high risk groups and reduction of VAW. UNFPA has been leading UN and development partner support in Cambodia on SRH, FP, population policy and data and youth issues.

**The evaluation team recommends** (See detailed recommendations in the main report):

**At the level of the Country Programme:**

1. Reorient the programme to the new UNFPA strategic directions and adapt the focus of the PD and gender components of the programme to relate directly with SRH issues, bringing them in line with the comparative advantage of UNFPA in Cambodia. Remain engaged at the national as well as the sub-national level in support of the social development aspects of the process of administrative decentralization of RGC.
2. Review the human resource capacity for the next programme cycle and align the number of programmatic staffing positions with the requirements of the program. Increase staffing positions in line with the complexity of the programme and the needs for the combination of engagement at the national and sub-national levels
3. Enhance results based management of the country programme and its components in the next programme cycle, reviewing the monitoring system and processes concerned and adapting the results framework and its indicators. Enhancing the systemic aspects of M&E through annual planning of an integrated set of M&E activities aimed at informing results based management of each of the programme components as well as the whole of the programme.

**At the level of UNFPA Strategic Directions:**

**Increased availability and use of Sexual and Reproductive Health Services:** Continue to focus on key intervention that have proven successful including FP, skilled birth attendance and midwifery training and EmONC services, in particular in remote areas and where lack of access is persistent, with a focus on access to poor, vulnerable and marginalized groups; provide technical and financial support to MOH for the development of a human resource improvement plan informed by a capacity assessment; including men in the approach to family planning

**Priority of Adolescents and Youth:** Play a leadership role in addressing teenage and unwanted pregnancies, making use of the quantitative data of the CDHS and advocating for adequate national and sub-national responses; Increase attention to access to quality SRH/FP information and services of youth, including youth friendly clinical services, in particular vulnerable and marginalized groups; Continue support to the Youth Advisory Panel and chairing of the UN Youth Task Force by UNFPA; Work with civil society organizations on youth and adolescents' voice, their access to information and their role in accountability regarding access to and quality of SRH and VAW services; and support the development of a simple monitoring mechanism for the youth development policy.

**Advanced gender equality and women's and girls' empowerment:** Prioritize UNFPA support to VAW with a focus on SRH by utilizing the national guideline for managing VAW in the health system and the clinical guideline for health officials. Support the effective involvement of men and boys in the prevention of VAW; Focus UNFPA's intervention to gender mainstreaming in the MOP and MOH as a core area and direct support to those two GMAGs, with technical support from Ministry of Women Affairs (MOWA); Continue contributing to the programme based approach (PBA) in gender in order to enhance aid-effectiveness and to ensure coordination of UNFPA support with the inputs of other development partners

**Strengthened policies through evidence-based analysis of population dynamics:** Continue support to survey and census data gathering, in particular the preparations for the census of 2018 as well as support to other population related surveys; support the development of knowledge and information based on the results of CDHS 2014 to inform policy development and implementation; continue support to the review of the Cambodia Population Policy and to support the development of policies on key population issues as these emerge, including ageing, migration and urbanization; Continue support to Provincial and District councils in their strengthening of the WCCC and CCWC, orienting support towards citizen's role in the democratization process and local government accountability for social services provided.

## 1. Introduction

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The United Nations Population Fund is the lead UN agency for delivering a world where every pregnancy is wanted, every birth is safe, and every young person's potential is fulfilled. UNFPA aims to expand the possibilities for women and young people to lead healthy and productive lives. UNFPA focuses on PD issues, with an emphasis on SRH and gender equality. This in the context of the Programme of Action of the International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs), in particular MDG 5: to reduce by three quarters, between 1990 and 2015, the Maternal Mortality Ratio (MMR) and to achieve, by 2015, universal access to SRH.

UNFPA has been providing support to Cambodia since 1994. UNFPA is currently implementing the last year of its fourth country programme cycle to assist the Government of Cambodia in achieving its ICPD goals. The fourth programme cycle runs from 2011-2015, in line with the UNDAF. With the fourth programme cycle coming to an end in 2015 a CPE was conducted.

### 1) *Purpose and Objectives of the Country Programme Evaluation*

The purpose of the present CPE combined accountability and learning objectives. The evaluation was a means to demonstrate accountability of performance of the country programme during the period 2011-2015 to stakeholders. It aimed to broaden the evidence-base of achievements and to inform the design of the next programme cycle of UNFPA in Cambodia, in line with national needs, including the National Strategic Development Plan 2014-2018 (NSDP) and UNFPA's corporate strategies. The evaluation aimed to generate lessons learned in the process of implementation of the fourth country programme and in this way contribute to the knowledge base of the organization. It took stock of performance and actual achievements and provided actionable recommendations to adjust programming in the present cycle and more in particular to inform the formulation of the next country programme cycle (2016-2018). Thus the CPE was expected to provide ways to enhance the relevance and the performance of the present country programme and inform the development of the fifth country programme cycle, in particular through enhancing the evidence base of programme design.

The evaluation needs, moreover, to be seen in the light of UNFPA's new Strategic Plan 2014 – 2017. This strategic plan provided a point of reference for the ways in which CP4 results/challenges would be viewed in the new context of UNFPA's corporate strategy and informed the forward looking aspects of the evaluation.

Main audience for the results of the evaluation concerned the UNFPA country office and RGC partners. Secondary audiences concerned UNFPA regional office and headquarters, as well as other development partners including UN agencies, donor agencies and civil society organizations. Lessons learned and good practices captured in the evaluation would, moreover, be of use to a wider audience of development stakeholders.

In order to reach the purpose of the evaluation, focus was on three evaluation objectives as identified in the Terms of Reference (TOR) of the evaluation:

1. To provide an independent assessment of the progress of the programme towards the expected outputs and outcomes set forth in the results framework of the country programme, making use of the evaluation criteria of relevance, efficiency, effectiveness and sustainability;
2. To provide an assessment of the country office strategic positioning within the developing community and national partners, in view of its ability to respond to national needs while adding value to the country development results;
3. To draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next country programme cycle in Cambodia, in line with national and corporate strategies and plans and the agenda of the ICPD beyond 2014 and the post-MDG development agenda where foreseeable.

## **2) Scope of the Evaluation**

The evaluation included all of UNFPA's assistance and covered both those initiatives and activities funded through its own resources, as well as those funded through other resources. The evaluation included both national level activities as well as interventions supported at the sub-national level. In geographical terms the evaluation covered the whole of the country, defined by the territorial scope of the programme components at both the national and the sub-national levels. For field visits a sample of field locations was selected. The evaluation took into consideration the national and corporate strategies and sectoral planning documents which guided the programme and its implementation.

The evaluation focused on outputs achieved through the implementation of activities in the three components of the country programme, covering the period from 2011 to 2015. Output level results are those changes which are meant to be under the management control of UNFPA and for which UNFPA and its implementing partners can be held accountable. Moreover, the evaluation assessed the extent to which output level results contributed, or could be considered likely to contribute to outcome level changes. As the outcome level results concern those changes beyond the management responsibility of UNFPA, their realization usually depends on many factors and inputs and therefore focus was on UNFPA's contribution to outcome level results.

In addition to planned results, the evaluation included those programme activities that were added during the life cycle of the programme as well as unexpected and unforeseen results of the activities and initiatives of the programme. The explicit inclusion of unexpected results was meant to broaden the perspective of the evaluation beyond those results identified in the CPAP results framework and to probe what unanticipated results had occurred. These could be unforeseen gains and positives, as well as undesirable effects. The evaluation assessed how the results identified were achieved and the extent to which the country programme provided the best possible modalities for reaching the programme's results.

The evaluation reviewed the monitoring and evaluation functions of the country office, the ways in which these functions were organized and the extent to which they enhanced accountability. Moreover, aspects of results based management were included, with a focus on the extent to which monitoring and evaluation results informed programme management.

With the UNFPA programme paying substantial attention to youth and adolescents and with UNFPA leading the UN Technical Working Group (TWG) on Youth, the evaluation paid special attention to these groups. This was, moreover in line with the more prominent position of these age groups in the UNFPA strategic plan 2014-2017.

In line with the set-up of the UNFPA Programme as outlined in the Country Programme Action Plan (CPAP) the evaluation included:

- The Population and Development Component
- The Sexual and Reproductive Health Component
- The Gender Component
- The Partnership Strategy
- Programme Management
- The whole of the Country Programme and the coherence of its parts
- UNFPA's strategic positioning in Cambodia

In terms of the forward looking aspects of the evaluation, recommendations focused on the strategic directions and programmatic modalities for the fifth UNFPA programme cycle in Cambodia as well as on the remaining period of the present programme cycle implementation in 2015.



### 3) Evaluation Methodology and Process

#### a. Evaluation Criteria and Evaluation Questions

The evaluation focused on the one hand on **the programmatic aspects** of the country programme and made use for its assessment of four evaluation criteria:

- i. relevance;
- ii. effectiveness
- iii. efficiency
- iv. sustainability

On the other hand the evaluation focused on **UNFPA's strategic positioning**, for which assessment two evaluation criteria were used:

- v. coordination with the UNCT
- vi. the added value / comparative advantage of UNFPA

For each of the evaluation criteria a set of evaluation questions were developed, which are presented below (based on the TOR which is presented in Annex 1, with adaptations to TOR in *italics*).

#### **Relevance**

To what extent is the country programme in line with the intermediary UNFPA Strategic Plan 2011-2013 and the current UNFPA Strategic Plan 2014-2017, the NSDP update 2009-2013, the UNDAF 2011-2015 and other key sectoral planning documents?

Issues essential to address:

- Is the formulation of UNFPA's interventions in the different areas relevant to: a) national needs and priorities of Cambodia, b) the needs of target populations; and c) are the focuses of the CP outputs in line with the organizational and regional strategies manifested in the ICPD-PoA, relevant UNFPA Strategic Plans (2011-2013 and 2014-2017), the Cambodia MDGs and the UNDAF in the country?
- Has the current CP been aligned with the priorities as set out in the UNFPA Strategic Plan 2014-2017 and its Business Model?
- To what extent was the country office able to respond to changes in the national development context?
- Has UNFPA applied the appropriate strategy with regard to the political, economic and social context in Cambodia?

Issues desirable to address:

- How well did the CP's design respond to and reflect the current trends, future challenges in the Cambodian context including those of the regional Association of South East Asian Nations (ASEAN)?<sup>2</sup>
- Has the CP taken into account the country's evolution towards the Middle Income Countries (MIC) status as well as the changing donor context?
- Were gender, equity, and human rights dimensions effectively incorporated into the CP's design?

#### **Effectiveness**

The CP evaluation will examine the degree of achievement of the country programme outputs, and progress made towards achieving the programme outcomes given the changes in the global and national policy environment, and identify reasons for this progress and/or discrepancies between plans and achievements.

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<sup>2</sup> As the Country Office was not in a position to support ASEAN related issues, this question was not pursued.

Issues essential to address:

- To what extent have the expected results of the programme been achieved or are likely to be achieved? If so, to what degree? What were the factors that influenced the achievement and/or the non-achievement of the results?
- What was the intervention coverage - were the planned geographic areas and target groups especially those of the marginalized ones appropriately and equitably reached?

Issues desirable to address:

- How complementary and well-coordinated were the SRH, PD and Gender components of the CP?
- What were the constraining and facilitating factors and the Influence of context on the achievement of results?

### **Efficiency**

To what extent has the UNFPA CO made good use of its human, financial and technical resources in pursuing the achievement of the results defined in the country programme?

Issues essential to address:

- What was the timeliness of inputs; timeliness of outputs?
- How could more efficient use of resources be made given the country context?

Issues desirable to address:

- What was the quality of outputs achieved in relation to the expenditures incurred and resources used?
- How adequate and effective were the monitoring and evaluation tools of the programme, including baseline and end line survey instruments?
- To what extent has the country office succeeded in mobilizing other resources and what are enabling and constraining factors concerned?
- In what way have activities and outputs been coordinated across the UNFPA programme components and with the outputs of other UN agencies, in order to contribute in an efficient way to outcome level changes?

### **Sustainability:**

To what extent are the results of the UNFPA CO supported activities likely to last after the termination of the development assistance?

Issues essential to address:

- Has the programme incorporated appropriate exit strategies and developed the capacities of partners to ensure the sustainability of outputs?
- Have conditions and mechanisms been developed and enhanced to ensure that national partners will take ownership of them upon completion of UNFPA intervention?

### **Assessment of UNFPA's strategic positioning**

#### **UNCT Coordination:**

To what extent has the UNFPA CO contributed to the good functioning of coordination mechanisms and to an adequate division of tasks within the UN system in Cambodia?

- To what extent does the UNDAF fully reflect the interests, priorities and mandate of UNFPA in the country?

#### **Added value / Comparative Advantage:**

- What are the main UNFPA comparative strengths in the country- particularly in comparison to other UN agencies?
- What is the main UNFPA added value in the country context as perceived by national stakeholders?

For each of these evaluation questions a set of assumptions was identified as well as types of evidence to be used for their verification, in order to guide the in-country data gathering of the evaluation team. Moreover, for each of the assumptions sources of information and method and tools to be used in data collection were specified. Details are presented in the Evaluation Matrix in Annex 2.

### **b. Methodological Approach**

The evaluation methodology was set out to cover a variety of qualitative and quantitative methods and tools. The use of multiple methods allowed for the use of triangulation of data across these methods. The variety of methods allowed for foci on both in-depth as well as broader based data gathering as part of the evaluation process. A four week in-country data gathering process was part of the evaluation. Data were gathered at the national and sub-national level, making use of a preliminary stakeholder analysis conducted as part of the inception phase (see details below).

The evaluation made use of a participatory approach, and included as much as possible a wide range and variety of stakeholders in the various stages of the evaluation process. This included the introduction of the evaluation, the process of data gathering, the provision of recommendations, the validation of evaluation findings and conclusions, and commenting on the evaluation report. This in order to enable the inclusion of a range of perspectives on the development and implementation of the UNFPA country programme during the period under review. The inclusion of multiple stakeholders, moreover, allowed for triangulation of data across the various respondents and in this way enhanced validation of findings. Through the use of a participatory approach the level of ownership of the evaluation process and the results were enhanced which in turn was expected to enhance the likeliness of the use of the evaluation recommendations.

The evaluation made use of appreciative inquiry rather than a problem oriented approach. In appreciative inquiry the focus is turned away from finding solutions to problems towards a more positive approach, focusing on what works and how this can be reinforced within an organization. Through its focus on appreciative questioning, appreciative inquiry provides a powerful way to engage participants in evaluative discussions. Rather than addressing problems as negatives, appreciative inquiry addresses what does not work by assessing what participants would wish to be different in their organisation, and the way in which projects are implemented, in order to enhance results.

Methods for data collection included a desk review in which the evaluation team consulted the existing secondary documentation regarding the programme and the context of the programme components in Cambodia. Documentation reviewed included country programme documentation; RGC, UNFPA and UN strategies and policies; details on partners and partnership arrangements; UN TWGs; and monitoring details. Data gathering made use of semi-structured interviews with selected stakeholders at the national, provincial, district, commune and village level. Focus group discussions were conducted with village health support groups and mother support groups. Use was made of systematic observations in provincial and Operational District (OD) hospitals and in health centers. In order to address information gaps use was made of e-mail communications to gather additional details.

In preparation of the CPE the CO had conducted thematic evaluations on parts of programme components in order to inform the evaluation process. These thematic evaluations included D&D, FP, Midwifery, Comprehensive Sexuality Education (CSE) and GBV. The evaluation team made use of the results of these evaluations which provided an important source for triangulation of findings.

Data analysis focused on the Evaluation Criteria of relevance, effectiveness, efficiency, sustainability, UN coordination and UNFPA added value. Use was, moreover, made of stakeholder analysis, SWOT analysis, and analysis of the results framework. Further details on methodology are presented in annex 3.

### c. Selection of Stakeholders for data gathering

UNFPA worked with a range of stakeholders in order to achieve the aims of the Fourth Country Programme. Partners included RGC Line Ministries and agencies, other UN agencies, (I)NGOs, civil society partners, Development Partners, Provincial and District authorities and community leaders.

UNFPA collaborated closely with UN agencies through the mechanism of the UNCT and other sector-specific channels in support of the UNDAF and the NSDP. Where civil society organizations have a comparative advantage, particularly in work focusing on new or sensitive issues at community level, UNFPA entered in partnerships with relevant NGOs under CP4 including Cambodia Women for Peace and Development (CWPD), Reproductive Health Association of Cambodia (RHAC), Reproductive and Child Health Alliance (RACHA), BBC Media Action. Partnerships were expected to evolve and change during the implementation of the Fourth Country Programme, in response to evolving priorities and realities. In Annex 4 a stakeholder mapping is provided. Based on the stakeholder mapping, parties to include in the field visits were identified at the national, provincial, district, commune and village levels.

At the national level a total of 64 persons were interviewed, including senior management and technical resource persons of key government and civil society partners, UN agencies, relevant donor agencies and senior management and staff of UNFPA. For details on persons interviewed at national level see annex 5.

At the sub-national level the evaluation team met with relevant government departments, women and child committees, hospitals, health centers, and schools related to the UNFPA programme. At the commune level the team met with CCWC members, health center staff, teachers and students of primary schools and village health support groups, mother support groups and selected households or household members on GBV and SRH issues. A total of 75 persons were met at the sub-national level. An overview of the meetings is provided in table 2 below.

### d. Selection of locations for sub-national data gathering

For field work at the sub-national level three provinces were selected, based on the following criteria:

1. Provinces with a combination of SRH, PD and Gender component initiatives
2. Provinces with high or very high poverty indices (making use of the details provided in RGC, MOP/WFP, *Identification of Poor Households Cambodia*, 2012).
3. The combination of provinces allowed for assessment of all the initiatives supported by UNFPA at the sub-national level
4. Provinces were located in different ecological zones with differences in socio-economic opportunities
5. At least one of the three provinces included a significant proportion of ethnic minority people

Concerning the first criterion, the SRH component was implemented in all provinces of the country. Most of the activities of PD and Gender components were geographically limited to 7 provinces, i.e. Siem Reap, Kampong Cham, Banteay Meanchey, Preah Vihar, Ratanakiri, Kampong Chhnang, and Stung Treng, while dissemination of population policy took place in the entire country with data gathered covering all provinces.

Based on the criteria concerned the following provinces were selected for sub-national data gathering:

- Ratanakiri
- Banteay Meanchey
- Kampong Chhnang

In each of the provinces two districts were selected and in each of the districts one commune was visited. The selection of districts was based on a relatively high poverty incidence combined with the presence of an Operational District health facility.

**Table 2: Overview of Meetings at Sub-National level** (with 'x' indicating number of meetings)

Agencies visited	Provinces		
	Banteay Meanchey	Ratanakiri	Kampong Chhnang*
Provincial level			
WCCC	x	x	x
Planning and Investment Division	x	x	x
Planning Department	x	x	x
Education, Youth and Sport Department	x		x
Health Department	x	x	x
Department Women's Affairs		x	x
Provincial Hospital	x	x	
CWCC shelter	x		
District / Municipality level			
WCCC		xx	x
Education Office	xx		x
Planning Bureau	xx	x	
Operational District Hospital	xx	xx	x
Lower Secondary School	xx		
Disaster Management Committee	xx	xx	
Smart Girls project / Entertainment workers	x		x
Commune level			
CWCC	xx	xx	x
Primary School	xx		
Secondary School			x
Health Center	xx	xx	x
Village Health Volunteers	xx	xx	
Mother Support Group	xx	xx	
Selected households GBV/HIV/SRH	xx	xx	

\* While in Banteay Meanchey and Ratanakiri the team was able to visit two districts and two communes, due to time constraints in Kampong Chhnang only one district and one commune could be visited.

#### e. Ethical Considerations

The evaluation team followed and abided by the ethical code of conduct for UNEG/UNFPA evaluations (attached as annex 6) as well as the UNEG Standards and Norms for Evaluation in the UN System. This

included the independence of the evaluators, the anonymity and confidentiality of individual participants to the evaluation, sensitivity to social and cultural context and acting with integrity and honesty in relations with all of the stakeholders.<sup>3</sup>

#### **f. Evaluability Assessment**

The CPAP contained a planning and tracking tool. This tool was based on the results framework of the CPAP and contained the indicators at output and outcome levels. The country office used this tool to assess results achieved and details were available for all three components of the programme on an annual basis from 2011 to 2014. The annual results were used as an input to the evaluation of the programme, with data gathering at national and sub-national level verifying and further detailing the information provided. A limitation to the use of the planning and tracking tool concerned the changes that were made to some of the outputs and indicators over time, which limited some of the sequential comparability.

The in-country data gathering process focused at the sub-national level on three provinces. In terms of the PD and Gender programme this meant a fair representation of the seven provinces in which the components were implemented. For the SRH component, however, this was less representative as this component was implemented country wide, in all provinces. However, it was important for the evaluation to focus on a limited set of provinces to enable sufficient depth of data gathering and to enable assessment of the cross linkages amongst the programme components.

#### **g. Evaluation Process**

The evaluation process consisted of five phases: (i) preparatory phase, (ii) design phase, (iii) field phase, (iv) reporting phase, and (v) management response, dissemination and follow-up phase. Details on the design and field phases of the evaluation as well as an overview of the CPE workplan is presented in Annex 3.

In order to guide and support the evaluation process an Evaluation Reference Group (ERG) was established consisting of senior management staff of UNFPA, key Government partners, Civil Society partners and other UN agencies. The ERG reviewed the TOR, design report and draft evaluation report and provided comments and suggestions to each of these evaluation outputs.

#### **h. Evaluation Team**

The evaluation team consisted of three members: Frank Noij, Team Leader, Specialist in Complex Evaluation and Population and Development, Nakagawa Kasumi, Gender Specialist and Dr. Em Sovannarith, Specialist in Sexual and Reproductive Health.

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<sup>3</sup> UNEG, Standards for Evaluation in the UN System, April 2005; UNEG, Norms for Evaluation in the UN System, April 2005; UNEG, UNEG Code of Conduct for Evaluation in the UN System, March 2008.

## 2. Country Context

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### 1) *Development Challenges and National Strategies*

Cambodia is located in south-east Asia and bordered by three countries: Lao PDR, Thailand and Vietnam. It is geographically and culturally diverse. Cambodia has experienced relative political and institutional stability since the first national election in 1993, with a democratically elected government. Backed up with the political stability, Cambodia's economy has remained strong with robust growth in services and expanding export industries driving economic growth at an estimated 7.2 per cent in 2013.

The Human Development Index (HDI) has been improved and Cambodia now ranks at 138th out of 187 countries, enabling Cambodia to be within the medium human development category at 0.543 in 2013. According to the Gender Inequality Index, which measures the level of gender disparity in three realms: SRH, empowerment and labour market participation, Cambodia is ranked 96th out of 148 countries (2012).

Cambodia has made significant progress in terms of economic as well as social development in particular during the last two decades. Economic growth ranged from 6 to 11 per cent per annum in much of this period. About 19.8 percent of the total population lives below the national poverty line (which was redefined in 2011 which meant raising the bar on poverty). This means a huge improvement with poverty levels at 47.7 percent in 2007. The sustainability of the gains concerning poverty are, however, precarious as many households live on incomes just above the poverty line. Cambodia aspires to become a Lower Middle Income Country (MIC) by 2015 and a Higher MIC by 2030.

After 2007 economic development slowed down mainly due to the fall out of the global economic downturn, with a substantial decline in the building sector and the textile industry, two pillars of Cambodia's economic development. The agricultural sector is the only sector of the economy that has continued to grow at an average rate above 5 per cent per annum. With over 80 per cent of the population living in rural areas, Cambodia is looking at the agricultural sector as a source for economic growth and sustainable livelihoods. The sector contributed 34.4 per cent to the GDP in 2008, which was an increase of 13 per cent compared to 2007. Dependent primarily on a single annual rain fed crop the sector as well as the country is vulnerable to the effects of climate change.

With regards to the achievement of (MDGs), in 2003, the Royal Government of Cambodia (RGC) officially embraced the eight universally agreed-upon MDGs, with some modifications and localization to better suit its realities. The RGC added de-mining, explosive remnants of war (ERW) and victim assistance as Cambodia's ninth MDG, as more than two decades of devastating war has left large areas of the country contaminated by mines and ERW. These nine goals are known as the Cambodia Millennium Development Goals (CMDGs). CMDG targets have been adapted to the country context. Quantitative targets for many of the indicators have been modified in order to match with the targets of the country's five-year strategic development plan, based on earlier established benchmarks.

Cambodia is changing rapidly from a predominantly a rural society with 80.5 percent of the population living in rural areas (2010) towards a more urbanized society with intensive commercial farming in rural areas combined with urban based manufacturing and services. Many of the large population of young people are migrating out of rural areas contributing to rapid urbanization and constraining workforce availability in rural areas, which remain dependant on labour intensive agricultural production. There is an increasingly vocal demand of citizens and civil society organizations for more inclusive growth and political participation.<sup>4</sup>

The difference between Phnom Penh on the one hand and other urban and rural areas on the other hand remain considerable with poverty rates in rural areas about twice as high compared to the capital. Provinces

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<sup>4</sup> Cambodia Common Country Assessment – CCA, UNDAF 2016-2018, May 2014.

in the south and southeast, are more densely populated and have a long tradition of practicing sedentary farming. These provinces have a lower poverty rate compared to those in the north, northeast and northwest. The north-eastern provinces, with a high amount of people of ethnic minorities are of particular concern. These provinces are predominantly rural and less integrated in the national mainstream. People survive predominantly by subsistence agriculture, hunting and gathering.<sup>5</sup>

It is observed that the number of literate population aged 7 years and more has risen from 62.8 per cent in 1998 to 78.35 percent in 2008. Though the adult literacy rate has shown a fairly good increase during 1998-2008, Cambodia is the lowest in the Southeast Asia region after Laos. The number of children aged 6 years and more attending school or educational institution have increased during 1998-2008, though the proportion of females attending school continues to be less than the corresponding proportion for males both in the urban and rural areas.

The Global Gender Gap Index 2013 ranks Cambodia at 14 with women's participation in the labour force 82 per cent as compared to 88 per cent for men. The female to male ratio is 0.93. The Economist Intelligence Unit's Women's Economic Opportunity Index 2012 rates Cambodia as the 3rd most improved country in the world in terms of gender-responsive labour policy and promoting equity in labour and women's opportunity and rights to economic development. (The overall value of 44.6 per cent though remains on the lower side with Cambodia ranked 96 out of 128 countries).

The Phase III of the Cambodian Rectangular Strategy for the period 2014-2018 focuses on inclusive growth as an overarching development priority, with such growth considered to include equal access of all to human development, comprising of social protection and access to meaningful employment. Moreover, good governance has remained at the core of the strategy in the third phase, with attention to reforms of social services, legal and judicial system, public finance and administration and decentralization and deconcentration of functions.<sup>6</sup>

D&D reform started with the Law on the Administration and Management of commune/sangkat of 2001 and the establishment of the commune/sangkat fund. The Organic Law of 2008 introduced the creation of elected councils at the District, Municipality and Khan levels. The process evolved since the adoption of the National Plan in 2010 into the reform for Sub-National Democratic Development (SNDD) and the adoption of the National Programme on Sub-National Democratic Development (NP-SNDD). This programme outlines the reform of the organization of the public sector at sub-national level over a 10 year period with the aim:

“to develop management systems at provincial/municipal, district/khan and commune/sangkat levels based on the principles of ‘democratic participation’. These systems will operate with transparency and accountability in order to promote local development and delivery of public services to meet the needs of citizens and contribute to poverty reduction within the respective territories”.

The National Plan identified three platforms in the process which cover three consecutive time periods:

**Platform 1** (2010-2012) Establish and institutionalise governing systems and structures at the subnational and national level that ensure implementation of policies and the effective and efficient delivery of public services by Sub-National Administrations (SNAs)

**Platform 2** (2013-2015) Strengthen and broaden the established system and structures, ensuring that the SNAs can adopt and execute local policies that result in improved public services and increased access to public services for women and the disenfranchised

**Platform 3** (2016-2019) Adjust programs and deepen impact by replicating lessons learned and ensuring that the SNDD programs correspond to and reflect new policies and strategies of the RGC

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<sup>5</sup> RGC, MOP, Annual Progress Report, achieving Cambodia's Millennium Development Goals, April 2014.

<sup>6</sup> Cambodia Common Country Assessment – CCA, UNDAF 2016-2018, May 2014.



The National Plan is guided by separately prepared Implementation Plans (referred to as IP3). In the IP3 of 2010-2013 (extended to 2014) the focus was on policies, legal framework and guidelines for decentralization as well as putting functional SNA structures at Districts, Municipality and Khan level and at commune and sangkat level in place as well as planning system design, resources and capacity of Associations of councils.<sup>7</sup>

The MTR of IP3 mentions the substantial progress that has been made over the past 15 years and during the first part of IP3, including the establishment and staffing of 185 District/Municipal (D/M) structures, the law on SNA financial management and the establishment of the D/M Fund, which allows the SNAs to pay for their own staff. However, there have been delays, notably with regard to the definition of functions for the newly established D/M-SNAs, as well as with regard to developing the D/M-SNA funding mechanisms. Moreover, the MTR considered insufficient attention paid to strengthening the councils and the councillors, as being the new focal points for sub-national democratic development.<sup>8</sup>

The new IP3-II (2015-2017) is designed to move some of the functions of government from the national to the local level along with the associated human and financial resources, bringing service delivery closer to the people who in turn are expected to contribute in terms of improved accountability and performance. The plan includes five outcome areas including: reform management, democratic accountability, human resource management and development, SNA service delivery and functions, and fiscal decentralization. The reform process envisions a transfer of the bulk of national service delivery responsibilities to the level of district/municipality, while strengthening provincial capacities for strategic planning, coordination, support and oversight of lower tiers. In the second IP3 some of the challenges of the first have been addressed, including better management of the complex nature of the reform process, application of a demand driven approach to capacity development, greater participation of civil society, and a renewed focus on service delivery. 69% of DM development component will be financed by RGC with Development partners expected to fund 31%. RGC will, moreover, finance 99% of the funds accessed by SNAs through fiscal transfers.<sup>9</sup>

After the first Commune/Sangkat (CS) council elections in 2002, the RGC issued a sub-decree in which the C/S Council was directed to appoint a woman councillor to be in charge of women's and children affairs. In August 2008, more detailed guidelines for the functioning of CCWC was issued by the National Committee for the Management of Decentralization and Deconcentration Reform.

The major roles and responsibilities of the CCWC include:

- To prepare an annual work plan and budget for the Committee;
- Raise awareness on laws and policies related to women and children's rights to people in the commune;
- Advocate for women to participate in decision making;
- Increase and strengthen communication, collaboration and coordination among CCWC, service providers and villagers to support women and children in the CCWC;
- Assist CCWC to collect and analyze data related to issues and needs of women and children and integrate this information into the CDP and the CIP;

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<sup>7</sup> Royal Government of Cambodia, National Committee for Sub-National Democratic Development – Secretariat, Mid-Term Review of the Implementation Plan 2011-2013 (IP-3) being Phase-I of the National Programme for Sub-National Democratic Development (NP-SNDD/IP-3), Draft Report, Phnom Penh, October 2012.

<sup>8</sup> Ibid.

<sup>9</sup> Royal Government of Cambodia, National Committee for Sub-National Democratic Development, 3 Year Implementation Plan Phase II (2015-2017) of the National Program for Sub-National Democratic Development (IP3-II), December 2014.

- Participate in the implementation and monitoring of CCWC work plan and report regular;

The CCWC is chaired by the C/S Chief with the Vice Chief of the C/S as Deputy Chairperson and the Women and Children Focal Point as permanent member. Other members include C/S Secretaries and representatives from the Commune/Sangkat police, schools, health centres and chiefs of all the villages.

WCCCs were established by a decree of the Ministry of Interior in December 2009 at the level of the capital, provincial, municipality, district and khan. WCCCs are a sub-national mechanism to promote gender equality and the empowerment of women and children under the jurisdiction of the province and district and should provide advice and recommendations to the councils, boards of governors, governors, and other committees on issues related to gender equality, women, youth, and children. Each WCCC is chaired by a female councillor with a female Deputy Governor, a member of the provincial and district councils, a representative from the Department of Social Affairs and a representative of the Provincial Department of Women's Affairs as vice chairs and other relevant sectoral offices' staff as members.

## 2) Population and Development

The total population of Cambodia amounts to about 14.7 million (2013)<sup>10</sup> with 5.6 million or 38.1 per cent under 18 years of age. Life expectancy amounted to 69.35 years in 2014, with the life expectancy of females at 107.8 percent of that of males. This is a substantial increase from 57.1 in 2004. Cambodia is currently going through a demographic transition with over a third of its population aged 10 – 24 years. The total fertility rate has declined since 1990 and stands at 2.7 in 2014<sup>11</sup> down from 4.0 in 2000<sup>12</sup>. The population is increasing at an annual growth rate of 1.4 percent (2012-2013), down from 2.3 per cent before (1990-2012).<sup>13</sup> There is a substantial differential in fertility by region, ranging from a low of 2.0 births per woman in Phnom Penh to a high of 4.5 births per woman in Mondulakiri/Ratanakiri provinces. Both education and wealth were found to affect fertility. Women with secondary or higher education had 1.3 fewer children than women with no education. The poorest women had more than twice as many children as the wealthiest.<sup>14</sup> Average household size has declined, from 5.1 persons in 2004 to 4.7 in 2010. The teenage fertility rate is relatively high with 12.0 per cent of women aged 15-19 who began childbearing before the age of 20<sup>15</sup>. The percentage increases with age and is higher for rural compared to urban areas. Level of education is strongly related to teenage pregnancy with more than one third of teenagers who have no education and fewer than 10 percent of those with a secondary education starting childbearing before the age of 20.<sup>16</sup>

Cambodia has a relatively high population between the ages of 15 and 29 years of age with 32.8 percent of the population being in this age group (with an average of 27.3 percent across Southeast Asian countries).<sup>17</sup> The Cambodia Demographic and Health Survey 2014 reported that only 32 to 50 % of young people (15 – 24 years of age) have sufficient knowledge about HIV/AIDS.<sup>18</sup> The national Youth Literacy Rate for youth

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<sup>10</sup> CIPS, 2013.

<sup>11</sup> CDHS 2014.

<sup>12</sup> CDHS 2000.

<sup>13</sup> Data from UNICEF at [http://www.unicef.org/infobycountry/cambodia\\_statistics.html](http://www.unicef.org/infobycountry/cambodia_statistics.html).

<sup>14</sup> CDHS 2010.

<sup>15</sup> CDHS 2014.

<sup>16</sup> Ministry of Planning, National Institute of Statistics, Directorate General for Health, and ICF International – The DHS Program, *Cambodia Demographic and Health Survey 2014, Key Indicators Report*. Phnom Penh, Cambodia and Rockville, Maryland, USA, February 2015.

<sup>17</sup> Royal government of Cambodia, Ministry of Planning/UNFPA, Cambodia Rural Urban Migration Project Report. 2012.

<sup>18</sup> Royal Government of Cambodia, Ministry of Planning, National Institute of Statistics, *Cambodia Demographic and Health Survey 2014*.

aged between 15 and 24 has increased from 76.3 percent in 1998 to 84.7 percent in 2007 and an estimated 90 percent in 2013. This reflects increased access to primary education nationwide in the last ten years and the introduction of early child education.<sup>19</sup> An unprecedented numbers of youth have been migrating to urban areas.

Cambodia launched its first National Population Policy in 2003, which was revised in 2010 in order to respond to new trends and emerging issues, following the Census of 2008. The National Institute of Statistics (NIS), is part of the Ministry of Planning (MOP), and the focal point on statistical issues. The NIS compiles and consolidates statistics provided by decentralized offices and also collects primary data through household and establishment surveys as well as population, agricultural and economic censuses. Cambodia has a decentralized statistical structure with statistical bureaus and sections within planning and statistics departments of the various Ministries and in the planning and statistical units in the provinces and districts.<sup>20</sup>

Capacities for the collection, analysis and dissemination of population data have been substantially enhanced over the last decades, since the first General Population Census of 1998, a process supported by UNFPA. A second General Population Census was implemented in 2008 by the NIS with two inter-Censal population surveys conducted in 2004 and 2013. The Cambodia Demographic and Health Surveys (CDHS) were conducted in 2000, 2005, 2010 and most recently in 2014 with preliminary results available early 2015. The CDHS of 2014 contains data on fertility; family planning; childhood mortality; maternal and child health indicators; nutrition; HIV/AIDS, and maternal mortality.<sup>21</sup> UNFPA has supported these censuses and surveys as well as analysis of quantitative data to develop a knowledge base that can influence policy making at the national and sub-national levels.

Cambodia has been producing eight MDG reports and has merged the MDG indicator framework and the NSDP monitoring framework into a single measurement tool which was used from 2011 onwards to assess the implementation of the National Strategy and MDG achievements simultaneously. Moreover, Cambodia produced the MDG scorecard report<sup>22</sup> with province specific data for many of the MDG indicators presented in spider web diagrams for easy comparison. Cam Info has been consolidated as the principal national system for data management to inform development planning.

By the end of 2012, The RGC set up a National Working Group on Monitoring and Evaluation (M&E) in order to streamline Monitoring and Evaluation activities for the planning cycle 2014-2018 and beyond. In its initial meetings the working group addressed data related issues including data sources, compatibility between different sources, definitions of variables, and coverage of surveys. Moreover, the working group proposed to initiate a debate on linking M&E with the overall planning framework of the NSDP in the context of results based management.<sup>23</sup>

### 3) *Sexual and Reproductive Health*

Cambodian Reproductive, Maternal and Child health has improved over the past decade with support from development partners and civil society under the stewardship of the MOH. The public health system has made great strides in ensuring that every health facility in the country has at least one secondary midwife whereas

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<sup>19</sup> UNCT CCA 2014.

<sup>20</sup> Source: <http://www.nis.gov.kh/index.php/en/2013-11-10-19-27-49/general-information.html>

<sup>21</sup> Ministry of Planning, National Institute of Statistics, Directorate General for Health, and ICF International – The DHS Program, *Cambodia Demographic and Health Survey 2014, Key Indicators Report*. Phnom Penh, Cambodia and Rockville, Maryland, USA, February 2015.

<sup>22</sup> RGC, Scorecard of the implementation of Cambodia Millennium Development Goals at sub-national level by Capital, Provinces, Municipalities, Districts, Khans in Year 2012. July 2012.

<sup>23</sup> RGC / MOP, Monitoring and Evaluation: An approach to Strengthen Planning in Cambodia. Phnom Penh, May 2014.

the goal is to have at least two secondary midwives per health facility. The number of both primary and secondary midwives is increasing rapidly— primary midwives from 1,997 to 2,327 and secondary midwives from 1,994 in 2011 to 2,963 in 2014. Midwives are trained and managed by the Department of human resources of the MOH.

One of the major causes for maternal and neonatal deaths was the lack of quality EmONC services. EmONC is integral to the Government's intensive strategic intervention in saving lives of women in Cambodia, called the Fast Track Initiative Road Map for Reducing Maternal and New-born Mortality. An assessment conducted in 2009 was technically and financially supported by the UNFPA for the National Reproductive Health Programme. The assessment found that the country was lacking both basic and comprehensive EmONC facilities, with 1.6 basic facilities for 500,000 populations versus a recommended level of five. EmONC Improvement Plan<sup>24</sup> 2010-2015 was introduced with a number of health facilities upgraded to be able to respond to the complications of deliveries.

In spite of the rapid growth in health personnel, Cambodia continues to have a lower number of specialized medical staff, including doctors, medical assistants, anaesthetists and nurses and midwives per capita than neighbouring countries: in Cambodia there is one per every 1,000 people. There is also a recognized need for an effective referral system for more serious issues: emergency obstetric care for complications, antibiotics for premature rupture of membranes, neonatal resuscitation, and management of new-borns with complications. An improvement plan for EmONC services was prepared for the period 2010-2015.<sup>25</sup>

With regard to achieving the CMDG targets for reproductive and maternal health, Cambodia was on track for maternal mortality, while improvement needs to be made for both skilled birth attendance deployment and quality emergency obstetric and neo-natal care (EmONC) services. In terms of MMR, the country has already met the CMDG target of 250 in 2015. In 2014, the MMR was at 170/100,000 live births decreasing from 472 in 2005 and 206 in 2010. There was an increase in the percentage of deliveries at health facilities from 71 per cent in 2010 to 89 per cent in 2014<sup>26</sup>. It is in particular the quality of ante-natal care services, EmONC, maternal health, youth friendly services and family planning that need continued attention. One of the major effects of the increased number of ante-natal visits have been to inform women of the benefits of institutional delivery and to encourage them to go to a health facility when it is time to give birth. As a result, there been a dramatic rise in the percentage of institutional deliveries. The RGC has introduced the 60,000 Riel incentive per facility birth to midwives in order to increase their motivation.<sup>27</sup>

Neonatal mortality has decreased in the past four years from 27 per 1,000 live births to 18 in 2014. Infant mortality has seen a decrease from 95 in 2000 to 28 per 1,000 in 2014 while the under-five mortality rate decreased from 124 to 35 per 1,000 in the same period. This decline is in particular related to the national immunization programme, promotion of exclusive breastfeeding, improved access to basic health services, improved coverage of EmONC and an overall reduction in poverty levels and greater access to education and health care, supported by an expanded and improved road system.

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<sup>24</sup> Royal Government of Cambodia, Ministry of Health, Cambodia EmONC Improvement Plan, for Implementation January 2010 – December 2015, A Plan to Support and Increase the availability and utilization of quality functional EmONC throughout Cambodia, Phnom Penh, December 2009.

<sup>25</sup> Royal Government of Cambodia, Ministry of Planning, *Cambodia Country Report, International Conference on Population and Development Beyond 2014*, Phnom Penh, August 2013 and Royal Government of Cambodia, Ministry of Health, *Cambodia EmONC Improvement Plan, for Implementation January 2010 – December 2015, A Plan to Support and Increase the availability and utilization of quality functional EmONC throughout Cambodia*, Phnom Penh, December 2009..

<sup>26</sup> MoH, HIS, 2013.

<sup>27</sup> HSSP2 Policy on Midwife Incentives.

Pertaining to family planning programme, Cambodia has made progress in reducing the total fertility rate (TFR) from 4.0 in 2000 to 3.0 in 2010 and 2.7 in 2014 and has already achieved the CMDG target for 2015. The use of family planning methods in Cambodia is increasing, and this is one of the main reasons for the fertility decline, together with enhanced access to health services and availability of contraceptives.<sup>28</sup> Practically, all Cambodian women are familiar with at least some methods of contraception. All health centers and health posts now are able to provide at least three contraceptive methods, while pills and condoms are additionally provided through community-based distribution in over 50 per cent of the overall primary health care facilities. The Contraception Prevalence Rate (CPR) in 2014 is at 39 per cent which remains far below the ambitious CMDG target for 2015 of 60 per cent.

Adolescents and youth have been key target beneficiaries of the UNFPA programme. In its support the country programme prioritised the most vulnerable and marginalised, particularly adolescent girls, ethnic minorities, migrant workers, entertainment workers, primary and secondary school students, persons living with HIV and persons with disabilities. The focus goes beyond merely improving their health to include their ability to participate in the decision-making process on health related issues that affect their lives.

#### **4) Gender**

Gender equality and gender mainstreaming are prioritized by the RGC, and are integrated into key strategies and policies, including the Rectangular Strategy, the National Population Policy and the NSDP and related sectoral strategies. The Cambodian constitution (1993) recognizes gender equality in its Art. 31 and it prohibits discrimination against women (Art.46).

After the national reconciliation in 1991, and the first democratic election in 1993, the participation of women in decision-making positions has steadily improved in many fields. The number of women in the National Assembly has continuously increased over the past four legislatures, from 5 per cent in 1993 to 20.3 percent in 2013. The proportion of female members in the Senate, however, remained stable at 14.7 per cent between 1999 and 2012.

There has been an increase in the proportion of women in senior government positions since 1998. In 2013, although there are no female Senior Ministers among a total of 15, one out of nine Deputy Prime Ministers is female. The percentage of female Ministers has increased from 7.14 per cent (two female ministers out of a total of 28) in 2008, to 11 percent (three female ministers out of 27) in 2013.

At sub-national level, strong progress in female representation was made at provincial level with women comprising 16.78 percent of Deputy Governors at Provincial/Capital level (24 on a total 143) and almost 25 percent of Deputy Governors of Municipalities, District & Khans (196 of 828 total). The proportion of women elected as members of commune/Sangkat councils more than doubled from 8 per cent in 2002 to 18 per cent in 2012.

##### **Gender mainstreaming policies**

The Secretariat of State for Women's Affairs was elevated to the status of Ministry of Women's Affairs (in 1996). Other institutional mechanisms for gender equality and the empowerment of women include the Cambodian National Council for Women (CNCW), GMAGs in all line ministries and the TWG on Gender. At the sub-national level, provincial and district WCCCs have regular meetings with the Board of Governors on women, youth and children's issues. For better delivery of services to rural men and women CCWCs have been established and Sub decree 22 requires that among three village leaders, one must be female.

Gender is also mainstreamed in national policies including the Socio-Economic Development Plan I (1996-2000) and II (2001-2005), the National Poverty Reduction Strategy, later referred to as National Strategic

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<sup>28</sup> UNFPA Cambodia, Annual report 2014.

Development Plan (NSDP), the Rectangular strategy 1, 2 and 3. The CMDGs also considers gender equality as a priority.

MoWA developed a national policy for women in 1996 to guide the country for promoting gender equality and women's empowerment. The national policy was operated through the five year strategic plan called Neary Rattanak (NR), and it passed through three generations, NR1 (1999), NR 2 (2005-2009), and NR 3 (2009-2013) and the 4th generation (2014-2018) was adopted in December 2014 in alignment with the key national documents of the fifth RGC's mandate (2013-2018), namely, the Rectangular Strategy III and NSDP 2014-2018.

### **Gender- based violence**

In Cambodia, violence against women has been identified as a serious human rights violation that affect daily lives of women and girls. In the CDHS of 2005, 12.8% of women reported experiencing physical violence from their intimate partners within the last 12 months. GBV occurs both in urban and rural areas and across social status, education level, and employment status. Women and girls are daily impacted by violence, including sexual, physical and emotional abuse, underpinned by traditional gender norms. In order to protect women from such rights violation the Law on prevention of domestic violence and the protection of victims was adopted in 2005. The implementation of this law has been at the center of the interventions to prevent and stop GBV, and a variety of initiatives have been carried out at both national and sub-national level.

Since 1993 Cambodia has experienced rapid economic growth particularly in urban areas that have provided some women with greater economic opportunities. However as women and girls migrate for employment opportunities in urban areas they become exposed to increased risks of GBV through labour or human trafficking, and to increased risk of rape and sexual harassment and assault in industry settings or other occupations.

In recent years significant data has been collected which add to the understanding of VAW/G in Cambodia and efforts have been made to generate more knowledge in order to make effective intervention to addressing GBV. The CDHS in 2000, 2005 and 2014 included a domestic violence module and generated information on the knowledge of, and attitudes towards, violence against women.<sup>29</sup> In 2005 and 2009 MoWA conducted baseline and follow-up surveys that measured perceptions about VAW/G. In 2012, Australian Agency for International Development (AusAID, now DFAT) supported a collaborative research project to better understand violence against women with disabilities (Triple Jeopardy) and Partners for Prevention completed a representative prevalence study on men's perceptions and perpetration of violence against women. WHO is conducting a prevalence survey on VAW which is expected to be completed in the near future.

For the prevention of GBV, the national action plan to prevent violence against women (NAPVAW) has been developed, the first NAPVAW covering 2009-2012 and the second covering the period 2013-2017. Both action plans include five main pillars as priorities; primary prevention, legal protection and service provision, law/policy formulation and implementation, capacity building and monitoring and evaluation.

## **5) The Role of External Assistance**

ODA has been highlighted by the Government as an important source of financial and technical input to attain the NSDP objectives and the CMDGs.<sup>30</sup> Disbursement of external assistance amounted to USD 1.46 billion in 2013. This was the first year of decline after a continuous increase of ODA in the period 2004-2012. The relative importance of concessional loans has increased over the last decade with 2013 the first year in which these loans were greater than ODA grants, a trend that is expected to continue with Cambodia's graduation to lower MIC status with the major sources of development finance transition from grants to concessional

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<sup>29</sup> Results of the VAW module of the CDHA 2014 were not yet available at the time of reporting.

<sup>30</sup> Source: <http://www.cdc-crdb.gov.kh/cdc/aid-management-cambodia.html>.

loans. While technical cooperation projects disbursement over the past decade remained about the same at USD 250-300 million annually, the investment portfolio has tripled from 300 million in 2003/4 to 1 billion in 2012 and 2013. Over the longer term the ratio of ODA per GDP has remained around 10% which indicates that GDP and ODA have grown at similar rates over the period 2004-2013. By 2013 this resulted in a contribution of about USD 100 per capita annually.

Sector wise there has been a significant change in external support. While social sector support used to represent the largest share of development cooperation, peaking at 40% in 2007, it declined afterwards, reaching around 31% in 2013. The infrastructure sector on the other hand has grown and has become the largest recipient sector since 2012. In particular the transportation sub-sector has been debit to this increase, with external support to transportation increasing from 7% of total aid in 2006 to 25% in 2013. Main partners in this sub-sector are China, Japan, ADB and Korea. In addition to infrastructure, support to the agriculture sector has increased. The largest decrease can be observed in the health sector, which declined from 20% of aid in 2010 to 13% in 2013, together with governance, which received 14% in 2004 and ended up with 4% in 2013.

In terms of alignment with the NSDP, ODA funding over the period 2009-2013 appeared slightly higher than the needs identified in the plan. Amounts available for the social and cross-cutting sectors proved about equal with NSDP requirements, while infrastructure received an excess at the expense of shortfall in the economic sectors. In terms of bilateral support it is China that has become the single largest development partner to Cambodia. The EU, Japan, US, Australia and Korea remain large bilateral donors.

NGO funding has been stable over the past few years and primarily focused on social aspects including health, education and community welfare.

The relative share of UN funding has decreased over time and ranged from 10 - 15% in the period 2006 – 2010 and dropped to 6.1 to 6.7% in the period 2011 - 2013 (including core and other resources). In absolute terms it varied from 89.5 million USD in 2011 to 148.9 in 2009 and stood at 98.2 in 2013. The proportion of UNFPA core funding in the total of UN agencies' core funding changed from 3.9% in 2006 to 9.3% in 2013, with the highest proportion reached in 2011 at 9.7%.<sup>31</sup>

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<sup>31</sup> Royal Government of Cambodia, Council for the Development of Cambodian, Cambodian Rehabilitation and Development Board, *Development Cooperation Trends in Cambodia. Using Evidence to promote Partnerships and Development Effectiveness*, Phnom Penh, July 2014. Calculations based on data provided in the document. Figures for 2013 concern estimates.

### 3. UNFPA Strategic Response and Programme

#### 1) UN Response through the UNDAF

The UNDAF of 2011-2015 responded to the development context in Cambodia, which has experienced high levels of growth, but also has encountered several external shocks. With the Rectangular Strategy Phase II and the NSDP in place, RGC has taken clear ownership of the national development agenda, with coordination mechanisms for external assistance put into place.

The national strategy pursues four priority areas: 1) enhancement of the agricultural sector, 2) further rehabilitation and construction of physical infrastructure, 3) private sector development and employment generation, 4) capacity building and human resource development, with good governance and gender mainstreaming at the centre of the strategy as a prerequisite to sustainable development. The UNDAF priorities are aligned with these development strategies and combine economic growth with social development and protection, governance and gender equity (see Box 1 below).

#### Box 1: UNDAF Strategic Priorities in Cambodia (2011 – 2015)

- i. **Economic Growth and Sustainable Development:** By 2015, more people living in Cambodia benefit from, and participate in, increasingly equitable, green, diversified economic growth
- ii. **Health and Education:** By 2015, more men, women, children and young people enjoy equitable access to health and education
- iii. **Gender Equality:** By 2015, all women, men, girls and boys are experiencing a reduction in gender disparities and progressively enjoying and exercising equal rights
- iv. **Governance:** By 2015, national and sub-national institutions are more accountable and responsive to the needs and rights of all people living in Cambodia and increase participation in democratic decision-making
- v. **Social Protection:** By 2015, more people, especially the poor and vulnerable, benefit from improved social safety net (SSN) and social security programmes, as an integral part of a sustainable national social protection system

#### 2) UNFPA Strategic Response

At the goal level the UNFPA strategic framework of 2008-2011, which was extended to 2013, focused on PD, SRH, and gender equality, each component with its own set of outcome level changes. In the Mid Term Review of the strategy, the three goals were brought together in one goal. This overarching goal reads as follows:

*To achieve universal access to sexual and reproductive health (including family planning), promote reproductive rights, reduce maternal mortality, and accelerate progress on the ICPD agenda and MDG 5 (A & B).*

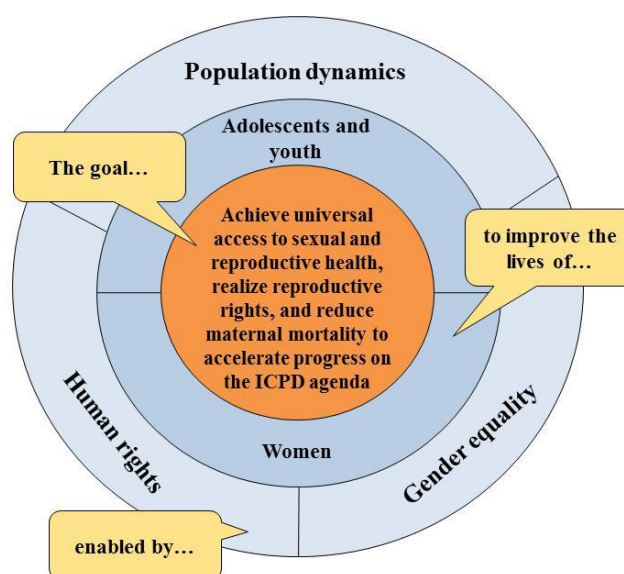
These strategic dimensions are meant to be operationalized in line with national priorities related to ICPD goals, with application of the principle of national ownership and leadership. Central to the approach is the development of national capacities, supporting systems and institutional development for governmental as well as civil society organizations. Special attention is meant to be placed on advocacy and policy dialogue, enhancing policy analysis and development. Effective dialogue is to translate in increased allocations of national and international financial resources for population and SRH programmes, positioned to reduce



poverty and achieve the MDGs. This is to be done in multi-sectoral partnerships with other UN partners, international and national institutions and civil society. The strategy asks for more attention to results based management and knowledge sharing across the organization and with partners.

Based on the recommendations of the MTR, the most recent strategic plan for the period 2014-2017 puts universal access to SRH, realization of reproductive rights, and reduction of maternal mortality to accelerate progress on the ICPD agenda as the agency’s goal. This in particular for women and adolescents and youth which are the key beneficiaries of UNFPA support and enabled by information and analysis on population dynamics and a human rights and gender equality based approach. The focus is presented as "the bull's eye" (see figure 1 below).<sup>32</sup>

**Figure 1: The “bull’s eye” of UNFPA’s strategic plan 2014-2017**



The focus on realization of sexual and reproductive health does not only address Millennium Development Goal 5 on improving maternal health, but also indirectly affects the other six goals as shown in table 3 below.<sup>33</sup>

**Table 3: Ways in which improving maternal health is linked to broader development impact**

MDG	Linkage of improvement of maternal health to broader development impact
<b>MDG 1:</b> Eradicate Extreme Poverty & Hunger	Reducing the complications of pregnancy – with the associated costs – and the significant economic benefits of family planning both contribute to poverty reduction
<b>MDG 2:</b> Achieve Universal Primary Education	Reducing orphan hood by ensuring that fewer women die in childbirth and supporting greater control over family size both facilitate primary education, particularly for girls
<b>MDG 3:</b> Promote Gender Equality and empower women	In addition to the benefits of girls’ education, achieving universal access to SRH and realizing reproductive rights are fundamental to the attainment of full gender equality;

<sup>32</sup> United Nations Population Fund, *The UNFPA Strategic Plan, 2014-2017*. Report of the Executive Director. New York, September 2013.

<sup>33</sup> Ibid.

MDG	Linkage of improvement of maternal health to broader development impact
<b>MDG 4:</b> Reduce Child Mortality	The health of infants is directly linked to the health of their mothers, so reducing maternal mortality and the complications of childbirth will have important benefits for child mortality
<b>MDG 5:</b> Improve Maternal Health	MDG 5 targets maternal health directly
<b>MDG 6:</b> Combat HIV/AIDS and other diseases	Attention to HIV and its effects has been mainstreamed across all aspects of the Fund's work
<b>MDG 7:</b> Ensure Environmental Sustainability	Ensuring universal access to family planning is an important component of a path toward sustainable development

### 3) UNFPA Response through the Country Programme

UNFPA's third country programme cycle in Cambodia, which was implemented from 2006 – 2010 focused on three components, PD, SRH and Gender, in line with the then strategic framework of the organization. The PD component focused on national and sub-national level capacities to gather, analyse and utilize disaggregated population data for decentralized planning and policy making. The SRH component of the programme addressed the enabling policy environment to promote reproductive rights, to increase access to and use of high quality SRH services and enhanced awareness of women and youth and their empowerment regarding their reproductive rights. The gender component aimed to advance gender equity through building capacities of priority ministries and selected commune councils and the media on empowerment of women and youth and increase the awareness of women and youth in priority areas on their rights to gender equity.

An evaluation of UNFPA's third country programme was conducted in 2011, and completed in 2012, after the programme had ended. The evaluation results showed that the relevance of the programme had been high and promoted national ownership. Results in terms of effectiveness were found to be mixed, with the means to assess programme performance insufficient, and many of the indicators not sufficiently 'SMART'.<sup>34</sup> Impact directly attributable to UNFPA was considered limited which was partly related to the limited resources of the programme in comparison with other stakeholders.

The evaluation recommended for UNFPA to limit its support in Cambodia to fewer issues, focusing on those in which the organization could show comparative advantage over other development partners. With much of its resources spent on capacity development the evaluation recommended the development of a demand driven strategy for capacity development initiatives, based on a comprehensive assessment of gaps and needs, specifying measurable objectives and means for rigorous monitoring and evaluation (M&E). UNFPA was advised to regularly evaluate the results of the initiatives it supports and ensure that interventions are justified through a solid evidence base. With several other donors active in the UNFPA thematic areas, joint evaluations could be usefully considered. It was further recommended to ensure that the activities of partners contribute to the desired results with sufficiently specific and measurable indicators to ascertain results.

<sup>34</sup> SMART indicators are indicators that are specific, measurable, achievable, realistic and timely. UNFPA, Independent Evaluation Office, *Handbook, How to design and conduct a country programme evaluation at UNFPA*, New York, 2013.

The fourth UNFPA Country Programme cycle (2011-2015) followed up on the achievements made during the third cycle and focused on the same three components: SRH, PD and gender equity, with several changes to the contents of these components.

The fourth Country Programme of Assistance to Cambodia was approved by the Executive Board in July 2010, with three programmatic components and a fourth component of programme coordination and assistance. It was harmonized with the UNFPA Strategic Plan 2008-2011 (later extended till 2013) and aligned with the Strategic Framework of Cooperation of the United Nations in Cambodia 2011-2015. The CP was meant to contribute to four UNDAF outcome areas, i.e. health and education, gender, governance and social protection. Though the outputs of the CPD are UNFPA specific, many of the outcome level changes concern joint results shared with a number of other UN organizations. The results framework of the fourth country programme, including output and outcome level changes, is presented in table 4 below. Additional details on the country programme are presented in annex 7.

### **The Capacity Development Strategy of UNFPA in Cambodia**

Capacity development is a key strategy across the programme components of the country programme of UNFPA. As recommended in the evaluation of CP3 a capacity development strategy was developed. With the document prepared in July 2014, it is meant to inform the remainder of the fourth as well as the fifth programme cycle.<sup>35</sup>

The strategy refers to the definition of capacity development as:

“the process through which individuals, organizations, and societies obtain, strengthen, and maintain the capabilities to set and achieve their own development objectives over time”

This definition includes a focus on communities and vulnerable groups and their formal and informal means of organization and related capacities.

UNFPA defines capacity development more specifically as:

“the process by which skills, systems, resources and knowledge are strengthened, created, adapted and maintained over time in order to achieve development results”

The strategy of UNFPA in Cambodia acknowledges the three levels on which capacities can be developed, i.e. the individual, organizational and societal levels and identifies key approaches for support to capacity development, including:

- Technical Assistance
- Training, including international as well as national courses, pre- or in-service training of varying duration and at times in combination with procurement of equipment
- Development of capacities at organizational level including provision of equipment, temporary funding and provision of incentives (for short time periods)
- South-South cooperation primarily within the Asia Pacific region

Target groups for capacity development support include selected Government agencies at national and sub-national level, social service providers like hospitals and schools, communities and their formal and informal organizations, civil society organizations and staff of UNFPA itself in order to strengthen internal country office capabilities and related staff competencies. Support is provided both by country office staff as well as by staff of the Asia Pacific Regional Office (APRO) and by national and international consultants.

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<sup>35</sup> UNFPA Country Office Cambodia, *Capacity Development Strategy*, Phnom Penh, July 2014.

In order for the results of capacity development initiatives to sustain, the strategy stresses the importance to adhere to the aid effectiveness principles, including national ownership, alignment with national policies, strategies and plans, harmonization across development partners, results orientation and mutual and transparent accountability. It is realized that some of these characteristics of capacity development cannot be achieved from the start but can require considerable timeframes. Sustainability of results is considered as the prime requirement for capacity development initiatives and those of which the results cannot be sustained should not be initiated or discontinued in the next country programme cycle.

### **Population and Development Programme Component**

The PD component of the country programme contributes to the UNDAF priority area of good governance: By 2015, national and sub-national institutions are more accountable and responsive to the needs and rights of all people living in Cambodia and increased participation in democratic decision making.

Work under this component makes use of the entry point of the on-going process D&D, which focuses on sub-national democratic development, ensuring that women and youth can participate in emergent local decision-making structures and processes. This is done in close collaboration with other development partners active in the area of sub-national democratic development, including UNICEF, UNDP, World Bank, GIZ and the EU.

Moreover, support is provided to the collection, dissemination and utilization of disaggregated data and building capacities for evidence-based planning and budgeting at national and sub-national levels, in order to ensure that local planning is responsive to needs and includes a focus on underserved issues and groups. This was done in close cooperation with the General Department of Planning of MOP, NCPD, the National Institute of Statistics (NIS) and other UN agencies and development partners.

### **Sexual and Reproductive Health Programme Component**

The SRH component is contributing to the UNDAF priorities in the areas of Health and Education: by 2015, more men, women, children and young people enjoy equitable access to health and education.

Reproductive, maternal, newborn and child health are recognized by the RGC as a major priority and as such identified in the Health Strategic Plan for 2008-2015. UNFPA has contributed to the development of the National Strategy for Reproductive and Sexual Health 2011-2015, which provides the policy framework for SRH in Cambodia and which enshrines the principles of reproductive choice and rights and serves as a road map for an effective coordinated response to SRH. It aims to attain a better quality of life for all Cambodians, by improving the SRH status and rights of women, men and young people. UNFPA's current country programme has initiated the improvement and roll-out EmONC plan, and continued to support improvement and expansion of family planning services and choices, and improvement of access to quality reproductive and maternal health services through strengthening regulatory framework for midwives and on-going capacity development in order to reduce maternal and newborn mortality.

During the period of 2011-2015, UNFPA has channeled its support to SRH through HSSP II, a sector strengthening approach in which RGC and seven development partners collaborate, including UK Aid, AFD, BTC, DFAT, WB, and UNICEF. HSSP II followed on HSSP I which started in 2003 till 2009. HSSP allows for a harmonized programmatic approach amongst all parties in alignment with RGC strategies, in which maternal and reproductive health are a main priority, enhancing aid effectiveness. The programme makes use of both pooled and discrete funding modalities. Since the start of HSSP, its secretariat office was established under the management of MoH and based at MoH. In 2013 and 2014, three development partners decided to stop their support for the HSSP, including DFID, AFD and BTC.

**Table 4: Results Framework of the Fourth UNFPA Country Programme in Cambodia 2011-2015**

CPD / CPAP Outcome	CPD / CPAP Outputs
<b>Population and Development Component</b>	
1. Effective mechanism for dialogue, representation and participation in democratic decision-making established and strengthened	1. Avenues and structures developed & strengthened to empower youth and women to participate in decision-making and planning at national and sub-national level
2. Enhanced capacities for collection, access and utilization of disaggregated information (gender, age, target populations, region) at national and sub-national levels to develop and monitor policies and plans that are responsive to the needs of the people and incorporate priority population, poverty and development linkages.	2. Improved availability and utilization of disaggregated (gender, population, region) data and information. 3. National and sub-national capacity to develop plans and budgets that are evidence based, gender and child sensitive and incorporate priority population, poverty and development linkages strengthened.
<b>Sexual Reproductive Health Programme Component</b>	
3. Increased national and sub-national equitable coverage of quality reproductive, maternal, newborn, child health and nutrition services.	4. Increased national and sub-national capacity to increase availability, accessibility, acceptability, affordability, and utilization of quality reproductive, maternal, newborn, child and nutrition health services. 5. Increased competency and availability of health human resources, particularly midwives and other Professionals where skill gaps exist
4. Enhanced national and sub-national Institutional capacity to expand young people's access to quality life skills including on HIV and technical and vocational education and training (TVET)	6. Enhanced access to and utilization of life skills training [and TVET] especially by disadvantaged young people and out of school children.
5. Strengthened multi-sectoral response to HIV	7. Enhanced national and sub-national capacity to target key populations at risk with effective HIV prevention interventions
6. Increase in national and sub-national capacity to provide affordable and effective national social protection through improved development, implementation, monitoring and evaluation of a social protection system	8. Increased national and sub-national capacity for emergency preparedness and response to reduce and mitigate vulnerabilities to disasters, both environmental and health, of the poorest and most marginalized, especially women, children, youth and people living with HIV.
<b>Gender Component</b>	
7. A harmonized aid environment that promotes gender equality and the empowerment of women.	9. Increased UN leadership and facilitation of a programme based approach to promote gender equality and the empowerment of women
8. Strengthened and enhanced gender mainstreaming mechanisms at national and sub-national levels	10. Enhanced capacity of Gender Mainstreaming Action Groups (GMAGS) in all line ministries/institutions (24+3) at national and sub-national level.
9. Enhanced participation of women in the public sphere, at national and sub-national levels	11. <i>Enhanced opportunities and mechanisms to strengthen women's capacity to participate in the public sphere at national, sub-national and community levels.</i> <i>(This output was dropped in close consultation with MOWA)</i>
10. Improved societal attitudes and preventive and holistic responses to gender based violence.	12. Increased institutional capacity to provide multi-sectoral mechanisms for GBV and community awareness on prevention intervention

CPD / CPAP Outcome	CPD / CPAP Outputs
	<p><i>(This output was adapted in 2013 Annual Review Meeting with MOWA from the following)</i></p> <p><i>Increased community awareness and involvement in the promotion and protection of women's rights, gender equality and prevention of GBV</i></p>

New DPs have joined the initiative in its second phase, including German Government and KOICA. Though UNFPA funding started off making use of the pooled funding mechanism, due to organizational financial management constraints the country office changed to a discreet funding modality, retaining its participation in the sector strengthening approach.

UNFPA chaired the Joint Partners Implementation Group, the governance mechanism of HSSP, for almost three years (35 months) in total. Moreover, the Country Office plays an active role in the Joint Annual Health Sector Review Process, Joint Quarterly Reviews, Joint Monitoring Review Missions, and Annual Operational Plan Reviews. This enables UNFPA to advance adolescent, reproductive and maternal health and family planning as key priorities of the national health sector plan and participate in the development of concerned national policies and strategies.

Key mechanisms for collaboration between government and development partners are the TWG which have been established on key development topics. UNFPA has been active in the TWG-Health for several years and has served to date as the TWG-Health Secretariat member. In this way UNFPA contributed to shaping the agenda of the TWG-Health meetings and various policy discussions. With the TWG-Health Secretariat being a decision making body for all matters related to the International Health Partnership (IHP+) this meant contributing to IHP+ positioning and implementation. Moreover, UNFPA actively participated in the monthly Health Partners Group meetings (co-chaired by WHO and Australian DFAT). UNFPA is an active member of the MCH Sub group of TWG-Health, of the Reproductive, Adolescent, Maternal, Newborn and Child Health and Nutrition Taskforce and of the Contraceptive Security Working Group of MoH.

Building on UNFPA's comparative advantage, achievements and lessons learned from the last Country Programme, UNFPA has supported four outcome areas and five outputs in line with the government's current priorities expressed in the Health Strategic Plan, the Fast Track Initiative Road Map for Reducing Maternal and Newborn Health, the Third National Strategic Plan for a Multi-Sectoral Response to HIV/AIDS, and the Reproductive and Sexual Health Strategy 2012-2014.

### Gender Programme Component

The gender component of the CPAP is directly contributing to the UNDAF priority in the area of gender: by 2015, all women, men, girls and boys are experiencing a reduction in gender disparities and progressively enjoying and exercising equal rights.

There are five outputs which aim to contribute to the national priorities which are specified in the Neary Rattanak 4 (2014-2019) and the 2nd NAPVAW. UNFPA supported MOWA in the building of capacities of female leaders at the sub-national level, raising awareness to communities on SRH and HIV and through its support to TWG-GBV at national level aimed to contribute to creating an effective mechanism to address GBV through policy implementation.

The development of a multi-sectoral response model for GBV was undertaken by a consortium of NGOs with comparative advantage in this area, in close collaboration with relevant departments at provincial and local level as well as engagement of MOWA at policy level. This approach is expected to incorporate robust lesson-learning to facilitate replication. UNFPA collaborates with other UN agencies to work with MOWA, which is seeking opportunities to explore holistic multi-sectoral responses to GBV which is aimed to enable other

line ministries to engage with GBV. An innovative approach to engage men and boys to prevent GBV has been taken up with the “Good Men Campaign” initiative of MOWA’s, supported by UNFPA.

### **Support from UNFPA’s Regional Office**

The country programme implementation has been supported by UNFPA’s APRO, which was established in July 2008 in Bangkok, Thailand. The APRO provides a key link between UNFPA’s organization-wide vision, strategies, policies and analyses and the needs of the region and the country office. The regional office is comprised of teams of technical, programme, communications, security and operations staff providing integrated support, and ultimately aiming to strengthen national and regional capacities. APRO provides leadership in positioning the agenda of the ICPD at the forefront of poverty reduction and development strategies, policies, and debates in the region. APRO has been instrumental in the formulation of the fourth cycle of the country program in Cambodia, and provided substantial technical assistance in the implementation process.

## 4. Evaluation Findings

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Evaluation Findings are presented for each of the Evaluation Criteria used in the evaluation process and outlined in the evaluation methodology. These include relevance, efficiency, effectiveness, sustainability and strategic positioning. Moreover, attention is paid to monitoring and reporting.

### 1) *Relevance*

**Evaluation Question:** To what extent is the country programme in line with the intermediary UNFPA Strategic Plan 2011-2013 and the current UNFPA Strategic Plan 2014-2017, the RGC NSDP update 2009-2013, the UNDAF 2011-2015 and other key RGC sectoral planning documents?

#### **Finding 1: The Formulation of UNFPA's interventions in the each of the programme components was in line with the RGC development strategies and plans.**

The UNFPA Objectives of the fourth programme cycle were in line with the NSDP at that time which covered the period 2009-2013 and which was based on the Rectangular Strategy for Growth, Employment, Equity and Efficiency, Phase II. The UNFPA support related in particular to the fourth part of Capacity Building and Human Resources Development, which included the implementation on the population policy, the enhancement of health services and the implementation of the gender policy. UNFPA support to PD focused on the capacities of NCPD and MOP/NIS to implement and update the population policy. Support to SRH related to the focus of the HSP II on reproductive, maternal, new born and child health, as well as communicable diseases including HIV/AIDS. The gender aspects of the fourth cycle of the country programme related in particular with the promotion of women in decision-making, gender mainstreaming in national policies and programmes and promotion of health of women and girls, all part of the implementation of the gender policy of the NCPD.<sup>36</sup>

The UNFPA support proved also in line with the new NSDP of 2014-2018 and the Rectangular Strategy Phase III, which builds on the previous National Development Strategy and includes further development of capacities and human resources, including a focus on population policy, SRH and communicable diseases and gender policy.<sup>37</sup> The country programme, moreover, aligned with the Health Sector Strategic Plan and the Fast Track Road Map Initiative as well as with the Cambodia Sexual and Reproductive Health Strategy 2013-2016.

The interventions proved responding to needs of the population in the provinces concerned, with a need for attention to social development issues in local planning processes, relatively high levels of domestic and gender-based violence and clear needs in terms of SRH at the local level and for specific target groups. The particular programme focus on women and girls, adolescents and youth, including primary and secondary school students, as well as the more specific focus on entertainment workers in HIV prevention, integrated with a family planning approach, reflected an emphasis on vulnerable groups.

While the SRH component had a country wide coverage through support to the HSSP II, selection of provinces for PD and Gender components, considered multiple factors, including poverty related indicators.

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<sup>36</sup> Royal Government of Cambodia, National Strategic Development plan, Update 2009-2013. For Growth, Employment, Equity and Efficiency, to reach Cambodia Millennium Development Goals. Phnom Penh, November 2009.

<sup>37</sup> Royal Government of Cambodia, National Strategic Development plan, 2014-2018. For Growth, Employment, Equity and Efficiency, to reach the Status of an Upper –Middle Income Country. Phnom Penh, July 2014.



The country office has been working on the selection of a set of indicators which could further enhance the focus on under-served areas and vulnerable and marginalized groups, which could enhance the equity aspects of UNFPA support in the next programme cycle. The gender component further enhances the focus on gender inequalities, a focus which is moreover included in the other two programme components.

**Finding 2: The formulation of UNFPA’s interventions in the different programme components was in line with the organization’s Strategic plan 2008-2011/13 and was sufficiently aligned with the new Strategic Plan 2014-2017 and its business plan. UNFPA Cambodia’s enhanced focus on adolescents and youth is in line with UNFPA’s corporate strategy concerned.**

The design of UNFPA support to RGC is based on three components, i.e. PD, SRH, and Gender Equality, which is in accordance with the UNFPA strategic plan 2008-2011, which centers on these three thematic areas and which plan was after the MTR conducted in 2011, extended till 2013.<sup>38</sup> The programme, moreover was guided by principles of the strategy, including national ownership, and national capacity development.<sup>39</sup>

While the programmatic objectives of SRH, PD and gender equity remain present in UNFPA’s new strategy for the period 2014-2017, its outcome areas (see details in box 2 below) reflect a more integrated approach to these aspects. Moreover, there is an increased focus on adolescents, in particular very young adolescent girls, including the most vulnerable ones. Though CP4 cannot be expected to be fully aligned with the newly developed UNFPA strategy, the components of CP4 are easily related to the outcome areas of the new UNFPA strategy. Moreover, the CO developed alignment tables of the CP outcomes with the intermediate outcomes of the strategic plan. The CP5 design can be used to further integrate the three components as required in the new strategic plan and to review the country programme’s focus on adolescents, in particular the most vulnerable ones.

**Box 2: Outcome Areas of UNFPA Strategy 2014-2017**

1. Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access
2. Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health
3. Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth
4. Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality

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<sup>38</sup> Executive Board of the United Nations Development Programme, the United Nations Population Fund and the United Nations Office for Project Services, United Nations Population Fund Midterm review of the UNFPA strategic plan, 2008-2013, Report of the Executive Director, July 2011.

<sup>39</sup> Executive Board of the United Nations Development Programme and of the United Nations Population Fund, United Nations Population Fund Strategic plan, 2008-2011: Accelerating progress and national ownership of the ICPD Programme of Action. Report of the Executive Director, July 2007.

In the new business model of UNFPA, which accompanies the new strategy, Cambodia has been identified as a country with relatively high needs and limited ability to finance social development initiatives. This results in the ability of the country office to make use of multiple modes of engagement in the country programme including: Advocacy and policy dialogue/advice, knowledge management, capacity development and service delivery. This means that UNFPA in Cambodia can make use of all these ways of programming. In practice, UNFPA has started to move away from some direct delivery in its programming.<sup>40</sup> Over time reducing of direct delivery aspects of the programme will enable the country office to focus on the other modes of engagement and to be prepared for a future change of the business model for Cambodia, once the country has reached middle income status.

During the implementation of the fourth programme cycle UNFPA Cambodia has enhanced its focus on adolescents and youth, which has been in line with the corporate strategy on UNFPA's engagement with youth.<sup>41</sup> The programme includes aspects of each of the five strategic prongs as shown in table 5 below.

**Table 5: Items of UNFPA Adolescents and Youth Strategy and Initiatives supported in Cambodia**

No	Strategic Item	UNFPA supported initiative(s) in Cambodia
1	Evidence-Based Advocacy for Development, Investment and Implementation	Support gathering, analysis and use of youth and adolescent related data and advocacy to address issues concerned, including: Teenage Fertility and its Socio-Demographic Characteristics and Risk Factors Aspects of rural – urban migration of youth
2	Promote Comprehensive Sexuality Education	Advocacy for and support to Comprehensive Sexuality Education in curriculum of primary and secondary schools
3	Build Capacity for Sexual and Reproductive Health Service Delivery, including HIV prevention, treatment and care	Support to HSSP II (including youth and adolescents as target group) Support to the Love9 programme (oriented towards youth and adolescents as well as their parents / caretakers)
4	Bold Initiatives to Reach the Most Vulnerable	Support to the SMART girl programme (focused on Entertainment workers and Casino workers)
5	Youth Leadership and Participation	Leading the UN Youth Task Force Providing support the UN Youth Advisory Panel

**Finding 3: The design of UNFPA's interventions in the different programme components was responsive to the national development context and to changes in this context over time.**

The programme contents in the three programme components can be considered to be an adequate response to the development context in Cambodia and to the needs identified in terms of SRH, PD and gender and this is confirmed by RGC and development partners. Moreover, the country programme has been responding to

<sup>40</sup> In this respect UNFPA Cambodia in practice already implements Modality #1 of the UNFA Strategy for MICs, which includes a 'full menu of UNFPA funding and services', but operational involvement is expected to be gradually replaced by more analytical and strategic activities. UNFPA, UNFPA Strategy toward Middle-Income Countries (MICs). In line with the UNFPA cooperate strategic plan 2014 – 2018 the CO continues to provide procurement services for the purchase of contraceptives paid for by RGC budget and donor funds.

<sup>41</sup> UNFPA, Towards realizing the full potential of Adolescents and Youth, Realizing Young People's Potential. UNFPA Strategy on Adolescents and Youth. November 2012.

the on-going process of decentralization, providing support to the process in selected provinces as well as at national level.

A more specific example of response to contextual change concerns UNFPA support to an emerging need for anesthetists in EmONC facilities of public referral hospitals, due to the retirement of a considerable number of these professionals combined with the earlier discontinuation of the anesthetist training at the medical training institute several years ago. 32 anesthetists were trained in an intensive 3 months in-service training programme in 2014 and another 64 were scheduled to be trained in 2015. Moreover, from 2011 to 2014, 60 medical doctors were trained in EmONC surgery and 456 midwives were trained in the basic EmONC skills which was primarily supported by UNFPA. These trainings filled an important capacity gap in the EmONC improvement plan and enhanced the quality of emergency obstetric surgery in national and sub-national referral hospitals, in this way addressing pregnancy and delivery complications and contributing to the reduction of maternal mortality.<sup>42</sup>

The topics of the monographs and analytical studies supported by UNFPA (see details in box 4 below) responded to the changing context in Cambodia, with attention to teenage fertility, aspects of urbanization, migration, and ageing.

## 2) Effectiveness

**Evaluation Question:** The CP evaluation will examine the degree of achievement of the country programme outputs, and progress made towards achieving the programme outcomes given the changes in the global and national policy environment, and identify reasons for this progress and/or discrepancies between plans and achievements

Findings on the evaluation criterion of Effectiveness will be guided by the outputs and outcomes of the CPAP planning and tracking tool and their indicators for each of the programme components. Some of these indicators of output and outcome level changes were adapted during the implementation of the programme to better reflect actual programme requirements. The programme monitoring data were used in this assessment of effectiveness and these data were triangulated with the data gathered during the field work of the evaluation at national and sub-national levels. For the assessment of the achievement of the indicators in each of the programme components the evaluation team made use of rating at four levels, two in green which signify sufficient achievement and two in orange/red, which signify insufficient achievement so far. Grey was used for those changes for which insufficient data proved available. Details on the specific meanings of the four ratings are provided in box 3, while use of the ratings is included in tables 6 to 8 below.

### Population and Development Programme Component

The PD component of the country programme focused on two outcome areas: mechanisms for participation in democratic decision-making and enhanced availability and use of population data and information for planning and budgeting. An overview of the outcomes, outputs and indicators concerned as well as their rating is provided in table 6 below, p 37-40.

Implementing partners of this component concerned the Ministry of Planning, including its General Directorate of Planning (GDP) and the National Institute of Statistics (NIS), National Committee for PD and the Department of Local Administration of the Ministry of Interior.

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<sup>42</sup> Based on interviews at national and sub-national level including Directors of provincial Health Departments and staff of referral hospitals.

### Box 3: Color Codes indicating level of achievement of indicators

**Dark Green: Fully achieved** –the target(s) on the indicator have already been fully achieved

**Light Green: Expected to be fully achieved** –the target(s) on the indicator have not yet been achieved but are likely to be achieved with a continued level of inputs

**Orange: Unlikely to be fully achieved** –the target(s) on the indicator cannot be expected to be achieved with the present level of inputs though achievement could be enhanced with additional inputs

**Red: Expected to remain fully unachieved** – for those indicators of the CPAP for which the target(s) can, for various reasons, not be achieved at all within the timeframe of the Country Programme Cycle

Grey: Not possible to make an assessment - *due to lack of required data*

**The first outcome area** focused on the enhanced participation of women and youth in emergent local decision-making processes. UNFPA support aimed to ensure that population issues, including SRH, gender, VAW, migration, ageing and children and youth concerns were taken into account in sub-national planning processes. This was to be addressed through support to the WCCC at provincial and district level and the CCWC at the commune level as well as support to the development of the national youth policy and support to the use of population data in Commune Investment Plans (CIP).

**Finding 4: The WCCCs and CCWCs were successfully established at the provincial, district and commune levels. In their functioning they started with a focus on responding to immediate issues of women and children, which proved an important achievement.**

Main initiative to enhance participation in democratic decision-making was UNFPA's support to WCCC at the provincial and district level and CCWC at the commune level with the aim to include social needs, in particular of marginalized and vulnerable groups into the local planning process. UNFPA supported the establishment of these committees by MOI and their capacity development in seven provinces<sup>43</sup>, including 48 districts and 346 communes and has provided the WCCCs and the CCWCs with an annual budget of USD 500 for each commune. This on top of an NCDD contribution to these committees of 500 – 1,000 USD.

At the end of 2014 WCCCs and CCWCs had been established in all selected provinces, districts and communes and were reported as functioning.<sup>44</sup> These committees have started to identify and discuss issues related to women, children and youth, through regular multi-sectoral meetings at provincial, district and commune levels.<sup>45</sup> The effectiveness of the committees as well as capacities concerned varies as was observed in the IP3 gender audit conducted. Moreover, less than regular participation of some of the members in monthly meetings and frequent changes of representatives to attend the meetings were identified as challenges.<sup>46</sup> These shortcomings were confirmed in the field visits of the evaluation team, which met with

<sup>43</sup> The seven provinces included Banteay Meanchey, Kampong Cham, Kampong Chhnang, Preah Vihear, Ratanakiri, Siem Reap and Stung Treng. With the division of Kampong Cham in 2 provinces, i.e. Kampong Cham and Tbong Khmum the programme covered eight provinces.

<sup>44</sup> The establishment was required by law, the functioning was reported in the UNFPA progress reporting.

<sup>45</sup> The achievement of the targeted outputs in the establishments of functioning WCCCs and CCWCs at sub-national level was confirmed in the thematic evaluation conducted on the Decentralization and Deconcentration component of the country programme. UNFPA, UNFPA Contribution to D&D thematic area programme area Decentralization and Deconcentration Reform Programme, Phnom Penh, August 2014.

<sup>46</sup> UNFPA, Standard Progress Report, Cambodia 2013, Population and Development programme component.

WCCCs and CCWCs in Banteay Meanchey, Ratanakiri and Kampong Chhnang provinces. Committees concerned in these three provinces proved to differ in terms of their capacities, the number of meetings conducted per year and the issues discussed during these meetings as well as frequency of member participation.

Most of the CCWCs in the selected provinces proved to provide platforms to discuss emerging issues on women and children which were either addressed at the commune level or were referred to the WCCC at the district level or upto the provincial level in case the issue could not be resolved locally. The latter could be due to insufficient local capacity or to the complexity of the issue concerned. This referral was enabled through the participation of CCWC focal points in the WCCC meetings at district level and district representatives participating in the provincial level WCCC.

Guidelines for social service investment, aimed at promoting the equitable inclusion of PD, SRH and Gender issues in commune development plans, were developed by DOLA with support from both UNFPA and UNICEF and used in the development of capacities of WCCC and CCWC members.<sup>47</sup> The committees were concerned with all social aspects of women and children, including mother and child health, education as well as violence against women and children. Discussion included cases of domestic violence and other cases of violence against women. In discussions with the committees concerned, members considered that issues of VAW had been identified and addressed in appropriate ways, in many cases seen as reducing instances of in particular domestic violence at the local level (see details under the gender component). The committees in all cases responded to emerging issues in a multi-disciplinary way, which was considered an important advantage of the committees by the members concerned.

Usage of UNFPA resources included costs of meetings and awareness raising activities as well as referrals of pregnant women to health facilities for delivery. Other needs identified at the local level, like bed nets or soap for hand washing could not be purchased from the budget, which at times resulted in a mismatch between local needs and programme requirements. Though the programme focus as such was useful, this focus at times limited the response to a selected number of SRH related immediate needs, at the expense of other urgent local needs. Also combination of meetings on different topics supported by different organizations in the busy harvesting season was officially not allowed but practiced in few cases which proved effective use of limited resources. Financial reporting requirements combined with limited local administrative capacities kept some of the CCWCs from spending all of the funds.<sup>48</sup>

A second indicator under this output concerns the development of the National Youth Policy. This policy was developed by the MoEYS over a considerable time period and endorsed by the Council of Ministers in June 2011. The process was supported by UNFPA though primarily as part of the previous programme cycle. The policy covered multiple areas but did not include a clear monitoring framework which meant that its results will be difficult to assess. This while a monitoring framework could provide an important means to assess the status of youth in a comprehensive way on a regular basis to inform youth development policies and plans.

**Finding 5: At the national level the need for social development budgeting in local development planning has been reflected in IP3-II, something which has been advocated for by UNFPA and partners. At the local level, however, Leverage of CIP resources from administration and development (physical infrastructure) budgets to social needs has been very limited due to administrative constraints and usage of disaggregated population data for local**

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<sup>47</sup> UNFPA, Standard Progress Reports, Cambodia 2011 - 2013, Population and Development programme component.

<sup>48</sup> Examples are from interviews during the field work of the evaluation and from the thematic study: UNFPA Contribution to D&D Thematic Programme Area, Decentralization and Deconcentration Reform Programme by Sokheang Hong, Phnom Penh, August 2014.

**planning has been thin on the ground, with local planning primarily guided by needs assessments.**

UNFPA and partners have been relatively successful at the national level in their advocacy efforts to promote investment on social sector needs, including SRH and gender issues, in commune development plans. The NCDDS is well aware of this need and social priorities have been reflected in the IP3-II, where relevant legal framework, policies and guidelines will need to be formulated and reviewed to allow for increased investment in social sectors by sub-national government.

The situation is quite different at the local level. The indicator on use of data for planning under this output concerns the use of population data in the Commune Investment Plans (CIPs) and budgets, in order for these plans to be gender sensitive and evidence-based. A study conducted on the CIPs in 2014 concluded that most commune plans included some (1 to 4) issues and responses on PD, SRH and gender, though it was found that only few of the commune investment plans (4 to 17 %) addressed 5 or more issues concerned. The study had some limitations, with the levels of responsiveness of the plans to population data ill defined. The study, moreover, focused on counting PD, SRH and Gender issues and responses rather than their relationship, while the latter could actually highlight whether one can call a response evidence-based or not given the relationship with the data included in the plan. As in several parts of the analysis the 'responses' proved to be at a higher level than the 'issues' identified, the qualitative relation between both can be questioned as well as whether this would concern evidence-based planning. The study did, moreover, not include whether plans were actually implemented and thus it remains unclear whether those plans that were more evidence-based actually resulted in better social services for local people.<sup>49</sup>

In the three provinces visited by the evaluation team the CIPs of the communes visited were all based on needs assessments conducted as part of the planning process. While population data were mentioned in the plans, these were not used to guide the planning process as such. This also as population data gathered on an annual basis at the village level, were usually not analyzed at the level of the commune. Gathered data were passed on to the district and provincial levels, where they were analyzed and only sometimes fed back to the communes concerned. Thus the plans were informed by local needs, but much less in terms of usage of disaggregated commune level data and not necessarily based on the requirements of vulnerable and marginalized groups, including youth and women of reproductive age.

In the practical implementation of the planning process, however, the room for maneuver appears limited, with CIPs informed by the aggregation of village level plans, and CIP budgets for administration (overhead costs), development (physical infrastructure) and social development strictly separated, with few opportunities to shift budget from one line item to another. Thus the opportunities for leverage of resources for social development at the local level, based on raised awareness concerning the need of planning and budgeting for social development issues, proved very limited. Only in few communes visited by the evaluation team resources had been transferred from the administration or development budget to social development issues with the amounts concerned very limited, in the range of the financial resources provided by UNFPA, i.e. USD 500 or about 0.8 – 2 % of the annual commune budget. As the MTR of IP3 indicated, the big challenge is to get mainstream funding to WCCCs and CCWCs for regular functioning and support to local social development.<sup>50</sup>

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<sup>49</sup> Royal Government of Cambodia, Ministry of Interior, Department of Local Administration and UNFPA, Summary Results, Assessment of Commune Investment Programme (CIP), 2014.

<sup>50</sup> Royal Government of Cambodia, The National Committee for Sub-National Democratic Development, Mid Term Review of the Implementation Plan 2011-13 (IP-3) being Phase – I of the National Programme for Sub-National Democratic Development (NP-SNDD / IP2). Draft Report. Phnom Penh, October 2012.

The issue of limited opportunities to prioritize social development at the local level appears to have been picked up by the recently released IP3-II, which states on social equity and inclusiveness:

“Systemic integration of gender/social equity based budgeting, poverty-based budget allocation need to be built into the planning and budgeting processes. In particular the activities related to the CWCC/WCCCs have been negatively impacted by existing financial management practices at the D/M (district/municipality) level. Streamlining the systems should make it easier to access approved funding for social service priorities identified by the WCCC and CWCC.”<sup>51</sup>

**Finding 6: With several outputs of outcome 1 achieved, the basics of the WCCC and CWCC in supported areas proved to be in place. Committees have so far focused much less on seeking opportunities to address the underlying causes of social issues, and to play a more active role in decentralized democratic decision-making, for which they do not necessarily yet have sufficient capacity, though the potential is there.**

The output level changes are meant to contribute to the outcome level change: *Effective mechanism for dialogue, representation and participation in democratic decision-making established and strengthened*. The indicator for assessment of this outcome is *the number of women elected candidates to representative bodies*. According to the programme monitoring data, which made use of the CPAP Planning and Tracking Tool, the percentage of elected female candidates in the National Assembly decreased from 22% based on the 2008 elections to 20% based on the 2013 elections. Proportion of women elected in commune councils increased from 14.6 per cent in 2007 to 17.9 per cent in 2012 elections. Moreover, women were appointed as Deputy Governors in all the provinces and the capital city in 2008 and in all 187 towns/districts/khans in 2009.<sup>52</sup> Notwithstanding the positive changes at the sub-national level, these improvements can be considered only indirectly related to programme implementation, with direct programme contribution to these changes being limited.

The effect of the support to CCWCs and WCCCs on the D&D process has remained limited in the programme cycle under review. The geographical coverage was limited with the initiative implemented in 7 out of 25 provinces<sup>53</sup>, though the initiative built on work on D&D in the previous country programme cycle with 7 other provinces targeted. The budget to support social development issues provided by UNFPA, though small, contributed in many cases to address relevant social development issues. The aim of enhancing the budget for social development at the local level through the use of local level population data and leveraging of resources from administration and development budgets, could not be achieved in any substantial way. Nevertheless, the WCCCs and CCWCs have been established and are functioning and this has resulted in additional attention to social development and issues related to SRH and VAW in the targeted programme areas.

Apart from the response to immediate issues identified, the committees proved much less active in terms of policy issues and pro-actively seeking out opportunities to address the underlying causes of VAW and other social issues. It is in particular such a more pro-active approach of the committees which would enhance their role in democratic decision-making and in the development process of the commune investment plan. This aspect of the committees has to date been limited, meaning a limited contribution to the outcome level

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<sup>51</sup> Royal Government of Cambodia, National Committee for Sub-National Democratic Development, 3 Year Implementation Plan Phase II (2015-2017) of the National Program for Sub-National Democratic Development (IP3-II), December 2014.

<sup>52</sup> Royal Government of Cambodia, Ministry of Planning, Cambodia Country Report, International Conference on Population and development beyond 2014. Phnom Penh, August 2013.

<sup>53</sup> While in the present country programme cycle the programme worked in 7 provinces since 2011, including Siem Reap, Kampong Cham, Banteay Meanchey, Preah Vihear, Ratanakikr, Kampong Chhnang and Stung Treng, since 2006 it had worked in 7 other provinces, including Koh Kong, Kratie, Battambang, Pailin, Mondulhiri, Odor Mean Chey, and Kampong Thom. Source: Selection of Target Provinces/Districts, Decentralization & Deconcentration (D&D) Programme.

change of participation in democratic decision-making. On the other hand, this shows a huge opportunity in further working with these committees at commune, district and provincial level and enhancing their capacities so that they can play constructive roles at the local level in an increasingly decentralized governance system.

The strength of the initiative is in particular as a learning opportunity which requires sufficient monitoring and documentation of results, including baseline assessment be able to compare end of programme results. It will be important to further build on these results as well as the results of the previous programme cycle in the next programme cycle.

**The second outcome area** of the PD component of the country programme focused on enhanced capacities for collection, access and utilization of population data. This included an enhanced capacity in collecting population data as well as the usage of such data in gender and child sensitive planning and budgeting at national and sub-national levels.

**Finding 7: Capacities of NIS and MOP for data gathering and analysis have been enhanced which has resulted in high quality population data available from the Inter-Census Population Survey (IPS) and an enhanced knowledge base on emerging population issues based amongst others on analysis of the CDHS 2010 data and the IPS data. The CDHS 2014 will further add to the population data available, including data on Domestic Violence which module was included to the survey with support of UNFPA. Quality of data gathered at village level remained limited while these data are important for local level planning.**

The first output of this outcome area focused on enhanced availability and use of disaggregated population data which was to be achieved through development of capacities for data collection, management, analysis and usage of data. Most important data collection initiatives during CP4 included the completion and analysis of CDHS 2010<sup>54</sup>, the Inter-Census Population Survey of 2013 and the preparation and implementation of the CDHS 2014, all supported by UNFPA. Capacities of MOP and NIS have been built in the fourth programme cycle in the process of the implementation of these initiatives.

UNFPA successfully supported the inclusion of a Domestic Violence module as part of the CDHS 2014. Such a module had been part of the CDHS of 2005 but had not been included in the 2010 cycle of the survey in Cambodia.

UNFPA has supported a variety of analytical studies that made use of existing data and some of which included additional data gathering processes. Important in this respect is UNFPA's support to the development of Cambodia's country report to the ICPD beyond 2014,<sup>55</sup> which takes stock of the population, SRH and gender issues in Cambodia. UNFPA supported analysis on a number of key population characteristics making use of the data of the Cambodia Inter-Censal Population Survey (CIPS). Through the Cambodian Rural Urban Migration Project (CRUMP) studies on migration were supported, examining the characteristics of migrants and assessing gender aspects of migration and the linkages between migration and ageing. Other studies analyzed data from the CDHS of 2010 on a variety of SRH related issues. In this way data have been turned into information on a variety of population and SRH related topics which has added to the knowledge base on population and SRH issues in Cambodia. The various studies were supported through TA on the topics concerned and benefitted from four MOP staff which had, with UNFPA support, completed

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<sup>54</sup> Royal Government of Cambodia, National Institute of Statistics, Ministry of Planning; Directorate General for Health, Ministry of Health and Measure DHS ICF Macro, Cambodia Demographic and Health Survey 2010, Phnom Penh, September 2011.

<sup>55</sup> This report was presented by the Cambodian delegation to the 6th Asia Pacific Population Conference. Royal Government of Cambodia, Ministry of Planning, Cambodia Country Report, International Conference on Population and development beyond 2014. Phnom Penh, August 2013.



an MSC degree on Population Studies in India.<sup>56</sup> An overview of studies supported is provided in box 4 below.

**Box 4: Analytical Studies supported by UNFPA during CP4 \***

**General Population studies and selected population topics**

- i. Cambodia Country Report, International Conference on Population and development beyond 2014
- ii. Demographics of Population Ageing in Cambodia, 2012
- iii. Integration of Demographic Perspectives in Development, Cambodia
- iv. Report on Urbanization and its linkage to Socio-Economic and Environmental Issues
- v. Reclassification of Urban Areas in Cambodia, 2011
- vi. Poverty in Cambodia – A New Approach, Redefining the poverty line

**Data Analysis of Cambodia Inter-Censal Population Survey (CIPS)**

- vii. Cambodia Inter-Censal Population Survey 2013, Analysis of CIPS Results, Report 5: Disability
- viii. Cambodia Inter-Censal Population Survey 2013, Analysis of CIPS Results, Report 1: Estimates of Fertility and Mortality
- ix. Cambodia Inter-Censal Population Survey 2013, Analysis of CIPS Results, Sex and Age Structure
- x. Cambodia Inter-Censal Population Survey 2013, Analysis of CIPS Results, Report 2: Spatial Distribution and Growth of Population
- xi. Cambodia Inter-Censal Population Survey 2013, Final Report

**Studies of Cambodia Rural Urban Migration Project (CRUMP)**

- xii. Migration in Cambodia: Report of the CRUMP
- xiii. Ageing and Migration in Cambodia, A CRUMP Series Report
- xiv. Women and Migration in Cambodia, A CRUMP Series Report

**Data Analysis of CDHS 2010**

- xv. Early Postnatal Care and its determinants in Cambodia, Further Analysis of the CDHS
- xvi. Factors Associated with Utilization of Health Services for Childhood Diarrhea and Fever in Cambodia, Further Analysis of the CDHS
- xvii. Levels and Trends of Contraceptive Prevalence and Unmet Need for Family Planning in Cambodia, Further Analysis of the CDHS
- xviii. Teenage Fertility and its Socio-Demographic Characteristics and Risk Factors, Further Analysis of the CDHS

\* For complete references of each of the studies see Annex 9

Data from CDHS and Inter-Census Population Survey are specified upto the provincial level and as such relevant for national level planning and policy making. However, these data do not provide the details that one needs for planning at the sub-national level.

<sup>56</sup> UNFPA, Standard Progress Reports, Cambodia 2011 - 2013, Population and Development programme component.

At the local level data are gathered by the village heads on an annual basis including population data and aspects of vulnerable groups. These data form an important source of information for local level planning. Capacities for local level data gathering have been built by MOP who provided the format for data gathering concerned. With a lack of guidance and sufficient local capacity on how the various terms are defined and how the data is meant to be collected, the village level data are difficult to be aggregated beyond the level of the community.

In some of the forms seen by the evaluation team there appeared to be inconsistencies in the data gathered. Some of the data that were requested were not necessarily known by the village head, including the causes of death that had occurred during the past year. In most instances data gathered were not compiled and analyzed at the local level.

**Finding 8: Results in terms of usage of population data and information to inform development planning and budgeting are mixed, with important results on usage of population data at the national level but more limited results at the sub-national and local levels.**

The second output of the outcome focuses on the use of disaggregated population data to inform national and sub-national development plans and budgets, making them evidence-based as well as gender and child sensitive. To enable the use of data, the results of all studies supported by UNFPA have been disseminated to RGC line ministries, development partners, NGOs and CSOs. The CO made these studies timely available as inputs for the development of the third rectangular strategy and the draft National Strategic Development Plan 2014-2018. Though Development Partners do not have a formal opportunity to engage in the latter, through the provision of relevant population background materials in the Khmer language the country office was able to support the development of the plan and to enhance its evidence base indirectly.

At the policy level UNFPA supported the revision of the National Population Policy in 2011 and again in early 2015 which process was informed by the various population studies supported in CP3 and CP4, which analyzed the population dynamics in Cambodia.

At the national level statistical data are reportedly being used by MOP, MOH and MOWA to inform the national development strategy, the health sector strategy and the second NAPVAW. Population data were used in the development of the NSDP, NR, Health Strategy, SRH strategy and Education strategy. Of importance at the national level is also UNFPA's support to the Cambodian Association of Parliamentarians on PD and the development of their Strategic Plan 2012-17.

Use of data at the level of provincial planning is less clear. The CPAP planning and tracking tool mentions a baseline of 10% with a target of 100% in 2015. A study on the plans of selected provinces is underway but results were not yet available at the time of the evaluation. In Kampong Chhnang socio-economic data were used to inform the planning process within the province, a process which required significant human resource inputs and multiple workshops during a four months' period.

At the outcome level the enhanced capacity to collect and use population data to develop and monitor policies and plans is assessed by the indicator *disaggregated data and information used to monitor NSDP, CMDGs, sectoral and sub-national plans*. Important in this respect is the establishment in 2012 of the National working Group for M&E of NSDP and CMDGs. Moreover, the inclusion of key emerging population issues in the new NSDP 2014-2018, provides the basis for inclusion of social development issues in the monitoring and evaluation of the plan.

**Table 6: Results Framework Population and Development Component UNFPA Cambodia**

Results	Indicator	Baseline Data	End Line Data	Remarks	Color Code
PD Outcome 1					
Effective mechanism for dialogue, representation and participation in democratic decision-making established and strengthened.	1. Number of women elected candidates to representative bodies	National Assembly 22% (2008 election)  14.6% elected female councilors (2007 election)	National Assembly 20% (2013 election)	Target at national level of 30%; target for commune council at 25% but no data	
PD Output 1					
Avenues and structures developed & strengthened to empower youth and women to participate in decision-making and planning at national and sub-national level.	1.1 Multi-sectoral National Youth Policy developed with reference to youth participation.	Under development before 2011 and adopted by Council of Ministers in 2011	National council on Youth development established and National Action Plan drafted by MOEYS	Youth Policy mostly achieved in previous UNFPA programme cycle. Other issues not included in indicator	
	1.2 Sub-national Women and Children Consultative Committees (commune, district, province) are established and functional in all locations.	Established: Province: 0% District: 0% Commune/Sangkat 100%  No information on actual functioning	At the end of 2014 all WCCCs and CCWCs established and functioning in UNFPA supported provinces at provincial, district and commune levels	Target of 100 % functioning in UNFPA supported provinces	
	UNFPA Specific CPIV indicator: 1.3 Number and % of local plans (Commune) in priority areas that are evidence based, gender sensitive and	With CP4 new target areas were selected on which no data are	In 2013 / 2014:	Targets set at 90% / 90% / 100% respectively. During the field visits it	

Results	Indicator	Baseline Data	End Line Data	Remarks	Color Code
	incorporate population, SRH and youth issues.	available on the indicator	81-88% of selected CIPs reflected population issues 85-87% of selected CIPs reflected SRH/HIV/Youth issues 100% of selected CIPs reflected gender issues	appeared that at times population data are provided in the CIP though actual planning remained based on a generic needs assessment	
PD Outcome 2					
Enhanced capacities for collection, access and utilization of disaggregated information (gender, age, target populations, region) at national and sub-national levels to develop and monitor policies and plans that are responsive to the needs of the people and incorporate priority population, poverty and development linkages.	2. Disaggregated data and information used to monitor NSDP, CMDGs, sectoral and sub-national plans.	Disaggregated data used to monitor NSDP, CMDGs and sectoral and sub-national plans	NSDP 2014-2018 reflects key emerging population issues CMDG report published New approach to poverty estimation developed	(see narrative on NSDP)	
PD Output 2					
Improved availability and utilization of disaggregated (gender, population, region) data and information.	2.1 Population data disaggregated by sex, age, income available through Census, CDHS, CSES, Commune database and other surveys.	Disaggregated population data from CDHS 2005, 2008 Census, CSES 2010, commune database and NIS surveys	CDHS data 2014 available; CIPS 2013 data available; CDHS 2010 data available; Off-line and on-line	Target qualitative / descriptive  For an overview of analytical	

Results	Indicator	Baseline Data	End Line Data	Remarks	Color Code
			Census Info and CamInfo in place; 18 analytical reports developed on population issues making use of statistical data	studies see box 4, page 35	
PD Output 3					
National and sub-national capacity to develop plans and budgets that are evidence based, gender and child sensitive and incorporate priority population, poverty and development linkages strengthened.	3.1 Proportion of national, sectoral and provincial plans and budgets that are evidence based, gender and child sensitive and incorporate population poverty and development linkages.	10% of national, sectoral and provincial plans and budgets are evidence based, gender and child sensitive and incorporate population, poverty and development linkages (it is not clear how this percentage has been established)	No quantitative data available yet Strategic Plans that incorporate population data include: NSDP 2014-18; Education, Youth and Sports Strategic Plan 2014-18; Gender Strategic Plan Neary Rattanak 2014-18	Target for 2012 was at 40% and for 2015 is at 100%. An assessment of provincial plans is underway and results are expected in the first quarter of 2015	
	3.1.1 The National Strategic Development Plan (NSDP) is evidence based, gender sensitive and incorporate population issues.	NSDP update 2009-13 incorporated key population, SRH and gender issues but hardly included in M&E framework	NSDP includes population, SRH and gender issues and is informed by analytical studies conducted in a timely way	Qualitative targets set on a yearly basis	

Results	Indicator	Baseline Data	End Line Data	Remarks	Color Code
	3.1.2 Sectoral plans (Health, Education, Women, HIV, and planning) are evidence based, gender sensitive and incorporate PD linkages.	Sectoral plans partially incorporate population, SRH and gender issues in health, education, women, HIV and planning	Health Strategic Plan 2008-15, National Strategy for Reproductive and Sexual Health 2013-16, Neary Rattanak IV 2014-18, Education Strategic Plan 2013-18 and Strategic plan MOP 2014-18 incorporate population, SRH and gender issues	All new strategies and plans are meant to comply	
	3.1.3 Proportion of provincial plans (in selected areas) that are evidence based, gender sensitive and incorporate PD linkages.	Provincial plans minimally incorporate population, SRH and gender issues and there is no monitoring framework	Provincial five year development plans and three years investment plans make use of statistical data in selected UNFPA supported provinces	Target set at 80%  An assessment of provincial plans is underway and results are expected in the first quarter of 2015	

### Sexual and Reproductive Health Programme Component

The SRH component of the country programme focused on four outcome areas: Outcome 1: Increased national and sub-national equitable coverage of quality reproductive, maternal, newborn, child health and nutrition services; Outcome 2: Enhanced national and sub-national institutional capacity to expand young people's access to quality life skills, including on HIV and technical and vocational education and training (TVET); Outcome 3: Strengthened multi-sectoral response to HIV; Outcome 4: Increase in national and sub-national capacity to provide affordable and effective national social protection through improved development, implementation, monitoring and evaluation of a social protection system.

An overview of the outcomes, outputs and indicators concerned is provided in table 7 below, p 48-52. Implementing partners of this component concerned the Ministry of Health, including the national reproductive maternal and child health programme, the department of personnel and the department of human resources, the Cambodian Midwife Council (CMC) and the Cambodian Midwife Association (CMA), the Ministry of Education, Youth and Sports (MOEYS), and selected NGOs including: Reproductive Health Association Cambodia (RHAC), Cambodian Women for Peace and Development (CWPD), British Broadcasting Corporation (BBC) Media Action, Children Surgical Center and INTHANOU.<sup>57</sup>

**Finding 9: The quality of reproductive, maternal, newborn, child health and nutrition services has been significantly improved and access increased across national and sub-national level. However, shortage of human resource, infrastructure and equipment remained persistent challenges, limiting access and quality in particular in remote health facilities.**

**The first SRH outcome area** focused on the increased national and sub-national equitable coverage of quality reproductive, maternal, newborn, child health and nutrition services.

During site visits to several health centers and referral hospitals, it could be observed that the quality of SRH, including family planning, skilled birth delivery, ANC/PNC, C-section, emergency obstetric care for mother and newborn services have improved in quality over the past few years. Most health centers and referral hospitals are able to provide a package of safe motherhood, newborn and child health services. As a result eighty-nine percent of birth in 2014 were attended by a skilled midwife compared to 32 percent in 2000. The evaluation team observed improvements in quantity and quality with regard to BmONC and CmONC facilities. Such improvements are observed mainly in skills and experience of the medical professionals which were supported by UNFPA, including capacity building for obstetric surgeons, anesthetists and EmONC skilled midwives to be deployed at the EmONC facilities. UNFPA has also supported the Cambodia Midwife Council (CMC) in order to improve skills of midwives through the Core Competency for Midwives Framework and Code of Ethics for midwives. The Core Competency Framework and Code of Ethics can be a model for other health professions and can be used to strengthen the technical skills of health professionals and contribute to improved quality of health services at public facilities.

The health facilities have, moreover, been provided with necessary medical instruments and in some cases infrastructure, so that the facilities can provide improved emergency services to prevent and manage intra-partum hemorrhages or other obstetric complication during labor, Caesarean sections, and other life-saving interventions which can significantly reduce maternal and neonatal deaths, for mothers and newborns. UNFPA support also increased the availability of seven life-saving medicines in maternal and reproductive health care, including magnesium sulfate and oxytocine, which is used to prevent and manage eclampsia in the peri-natal period. The EmONC has been supported by UNFPA as a programme priority through support to MoH's National Reproductive Maternal and Child Health programme. Some shortcomings remain, in particular in remote health facilities, including shortage of human resources and lack of medical infrastructure and equipment which means a need to further strengthen the quality on such EmONC services.

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<sup>57</sup> INTHANOU is not an acronym but a Khmer term meaning 'rainbow'.

Results of the CDHS 2014 show that the skilled birth attendant and antenatal care services have been significantly increased compared to 2005. In 2014, 89% of deliveries in public facilities were managed by skilled midwives whereas 95% of pregnant women had visited at least one ANC at the health facilities. UNFPA CO has been recognized as a key partner to support for the improvement of midwifery skills in both the pre-service and in-service training.<sup>58</sup> The Caesarian section service which is mostly operated at the public facilities increased from 2.56% in 2010 to 5.37% in 2014.<sup>59</sup>

Through collaboration with the MoH and other partners, the country office provided support to the national programme of family planning. Many stakeholders and partners recognized the significant support of UNFPA country office in this respect. The National Family Planning Policy and Guidelines are being recently updated to better reflect voluntary family planning programme. All health centers and health posts, now can provide and are equipped with at least three contraceptive methods, while pills and condoms are, moreover, made available through community-based distribution agents (CBD) in over 50% of the operational districts in the country. Prevalence of family planning use has increased gradually from 19% in the year 2000 to 39% in 2014.<sup>60</sup> Cambodia has made progress in reducing the total fertility rate (TFR) from 4.0 in 2000 to 3.0 in 2010 and 2.7 in 2014 and has already achieved the CMDG target for 2015.<sup>61</sup> Unmet need for family planning has reduced from 33% in 2000 to 13% in 2014; and percentage of demand for family planning satisfied has increased from 57% in 2000 to 69% in 2014. However, the use of contraceptive services at referral hospitals, where many women go for delivery and other reproductive health services, remains limited, resulting in lost opportunities for women and girls to access the integrated FP services when visiting a referral hospital. Moreover, hard-to-reach populations do not have sufficient access to FP services.<sup>62</sup>

In addition, one of CP4's indicators concerned health coverage through the Health Equity Fund (HEF) which would cover or subsidize the cost of health services for the poorest population segment. The target was set at 90 percent of Cambodia's population to be covered by the HEF. This target was reached as in 2014 upto 93% coverage was reached, as indicated in the country office monitoring, making use of the CPAP Tracking tool. UNFPA has contributed to this achievement along with other health development partners through the HSSP II. Based on the field observation in Ratanakiri province, which is amongst the poorer provinces and home to a large ethnic minority population, people can get access to the provincial referral hospital services through the HEF.<sup>63</sup> However, the HEF did not yet cover services at the level of the health centers and health post. The fund is expected to cover the latter two levels starting from 2015 onwards.<sup>64</sup>

The indicator 1.7 of the first output of SRH component concerns the Percentage of Operational Districts with at least 2 facilities providing (having staff trained in) adolescent friendly SRH care. The country office decided to drop this indicator during the CP4 period as the health information system of MoH was not able to generate this data, as they did not specify adolescent age group in their database.

Regarding indicator 1.8 Number of health facilities providing (having staff trained in) adolescent friendly SRH care: at the end of 2014, 684 health centers were trained in this kind of service, which is above the original target of 400 health centers.

Based on the health sector report, in 2014, 40% of Health financial resource were allocated to RMNCH component, which is assessed as indicator 1.9 of the first output.

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<sup>58</sup> CDHS 2014 and field observation.

<sup>59</sup> HMIS 2014, Ministry of Health.

<sup>60</sup> Source: CDHS 2014.

<sup>61</sup> Royal Government of Cambodia, Ministry of Planning, Annual Progress Report, CMDGs, 2013.

<sup>62</sup> UNFPA, Family Planning Thematic Evaluation Report, Phnom Penh, 2014.

<sup>63</sup> Based on field observations in Ratanakiri province.

<sup>64</sup> Informaiton from field interviews.



**The second output of the first outcome area** of the SRH component of the country programme focused on increased competency and availability of health human resources, particularly midwives and other professionals where skill gaps existed. This included an enhanced capacity/competency of midwives, surgeons and anesthetists both at national and sub-national level health facilities.

**Finding 10: The capacity and competency of health professionals, including midwives, surgeons, anesthetists was successfully enhanced and improved at various health facilities to provide appropriate reproductive, maternal and newborn services. But there have remained shortcoming in terms of human resources, including insufficient staffing in some remote health facilities and midwifery training does not adhere to the International Confederation of Midwives (ICM) global standards for Midwifery Education. This resulted in the skills of midwives often not in line with the ICM guidelines with in particular training of primary midwives limited so that they cannot be expected to avail of life-saving skills.**

Support to midwifery has been at the core of UNFPA's work in Cambodia. In CP4 the agency has focused its efforts on increasing the competency and availability of midwives. UNFPA has provided support to midwifery skill improvement through the government policy formulation, strategy development and financial support to national partners including HRD, Personal Department, NMCH, the public midwifery schools, CMC and CMA for a wide variety of activities in midwifery education, regulation, association and services.

Under the CP3 and CP4 period, the country office has supported the human resource department of MoH to update the national midwifery curriculum as a core strategy which curriculum is to be used by both training centers and private universities. Recently in 2014, the Core Competency Framework guideline for midwives was developed with financial and technical input of the UNFPA. This document will be introduced to all Cambodian midwives to strengthen their midwifery skills. The country office, in collaboration with the National Maternal and Child Health Center, has continuously supported the development of various Midwifery in-service training protocols and guidelines which can enable the sub-national levels to provide short-term midwifery trainings which include EmONC, family planning, life-saving care for mother and newborn, safe delivery, and pregnancy complication care and management. Presently, to some extent, capacity and midwifery skills could be observed to have improved, based on the field observations.

In collaboration with the Ministry of Health, UNFPA supported the national capacity for the in-service and pre-service trainings, recruitment and deployment of midwives at many facilities to enhance the quality of reproductive, maternal, newborn and family planning services for the health workforce at national, provincial, operational districts and health center levels.

At the end of 2014, 89% of all health centers had at least two midwives and 80% of health centers had one secondary midwife to provide obstetric care services, which exceeded the target of 68% for two midwives and 65% for one midwife respectively.<sup>65</sup> The number of secondary midwives increased from 1,994 in 2011 to 2,963 in 2014<sup>66</sup> which exceeded UNFPA's target. Senior MOH officials acknowledged UNFPA's contribution in this respect. National and international partners recognize the contribution of UNFPA as the main agency that initiates and sustains support to human resource development in health in particular for pre- and in-service trainings for midwives, obstetric surgeons and anesthetists.

Today there are more trained midwives in Cambodia than before and UNFPA's efforts concern an important contribution to the increased availability of midwives and their enhanced capacity which has been a

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<sup>65</sup> MoH, Health Sector Report, 2014.

<sup>66</sup> MoH, Health Sector Report, 2014.

contributing factor to reduce the maternal mortality as it stands now at 170 per 100 000 lives birth down from 206 in 2010 and 472 in 2005.<sup>67</sup>

Limitation concerns the quality of the trainings, which are not in line with the WHO/ICM guidelines. In particular primary midwives are trained during a one year period only and lack life-saving skills. During the CP4 period, 32 anesthetists, 60 EmONC surgeons, 456 Basic EmONC midwives were trained in order to enhance the capacity of EmONC services, a significant contribution towards the outcome area.<sup>68</sup>

The training of midwives was found not yet to be in line with the ICM Standards. Also the current national in-service training curriculum of midwifery is not sufficiently in line with the ICM standard and many of the public and private training institutions do not have sufficient equipment in place compared to these standards and guidelines.<sup>69</sup>

However, based on the field visit to three provinces of Ratanakiri, Banteay Meanchey and Kampong Chhnang, it was found that the deployment of midwives remained insufficient at the more remote health facilities in these provinces.

**The second outcome area** of the SRH component of the country programme focused on enhanced national and sub-national institutional capacity to expand young people's access to quality life skills, including on HIV/AIDS and technical and vocational education and training (TVET). This part of the programme was adapted to focus on the inclusion of comprehensive sexuality education (CSE) in the curriculum of primary and secondary school students.

**Finding 11: The national and sub-national institutional capacity to provide CSE to primary and secondary school students has been enhanced. But the quality and reach of CSE is still limited and needs follow-up.**

In collaboration with the Ministry of Education, Youth and Sport, UNFPA Cambodia has supported and introduced comprehensive sexuality education to students. CSE has been introduced simultaneously in schools at primary level (grades 5 and 6), lower secondary (grades 7 and 8) and upper secondary levels (grades 10 and 11) in 7 provinces. Since 2011 onwards, UNFPA has provided financial and technical support to the realization of CSE through curriculum development and training of teacher trainers in target provinces.

UNFPA has supported the MoEYS in shifting from a life skills approach including HIV education to an approach on comprehensive sexuality education. New curricula have been developed for three levels of education. A series of cascade in-service training workshops were implemented to train teachers in the use of the new curricula. UNFPA played a key role through the provision of technical support to the process of curriculum development and the training of teachers.

The output of this outcome area was adapted from enhanced access to and utilization of life skills training (and TVET) especially by disadvantaged young people and out of school children to access to CSE. Based on the CPAP Planning and Tracking tool, actual achievements could not be compared with a target as the target was set for HIV life skills.

In the three provinces visited by the evaluation team the CSE programme was implemented in most of the schools visited, though at times some quality concerns were identified. The capacity building of teachers is critical for CSE programme effectiveness. The in-service teacher training that is provided was generally well-conducted and considered beneficial by participating teachers but required follow-up and a more systematic

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<sup>67</sup> Krist'1 D'haene, Thematic Evaluation of Midwifery Programme, 2014, CDHS 2010 and CDHS 2005 data.

<sup>68</sup> Based on interviews with UNFPA CO staff and CO reporting as well as field observations and interviews with midwives.

<sup>69</sup> International Confederation of Midwives (ICM), ICM Global Standards for Midwifery Education 2010, amended June 2013, Companion Guidelines; and MOH, National Curriculum of Midwifery.

long-term approach to professional capacity building. Pre-service and in-service training would enable the CSE programme to be factored into capacity building planning which would be managed by the MoEYS.

The evaluation team during its field visits confirmed the findings of the thematic evaluation report<sup>70</sup> that the CSE has been developed in line with many of the characteristics of effective sexuality education programmes which include: an effective curriculum development process, relevant curriculum content; well-designed and implemented teacher training programme and well-designed teachers' guides.

Important achievement concerned the ministry accepting CSE as part of the current primary and secondary education reform. Though there were many priorities on the agenda for inclusion in the curriculum, such as hand washing, hygiene, culture, entrepreneurship, MOYES has accepted to allocate 11 hours per year to CSE in grades 5 and 6 of primary school, 7, 8 of lower and 10, 11 of secondary schools.

An important success, moreover, was that the MoEYS allocated part of its own national budget to strengthen the CSE implementation including sustaining the capacity of school teachers, and providing out-of-school education using the same CSE curriculum to young people in selected communes. At the same time, other partners active in CSE, such as UNESCO and RHAC, started to provide the training to second year teacher training students.

There are, however, also gaps and areas that need to be addressed in terms of the CSE programme. These include: a lack of ongoing support and follow up for teachers at school level; a need to consider teacher selection for CSE in secondary schools; a lack of information how teaching is actually meant to take place in the classroom and how sexuality is meant to be linked to other subjects; lack of engagement with pre-service teacher training; an expressed need for student learning materials and additional teaching resources; a lack of clear standards for teaching and learning; and a need for more robust M&E arrangement.

**The third outcome area** of the SRH component of the country programme focused on strengthened multi-sectoral response to HIV. This included an enhanced national and sub-national capacity to target key populations at risk with effective HIV prevention interventions.

**Finding 12: The national and sub-national capacity regarding an effective HIV prevention interventions has been enhanced in order to reach the populations at risk including entertainment workers and youth. Monitoring of results has proved problematic.**

Under this outcome, UNFPA has collaborated to work closely with the Joint UN Team on HIV/AIDS (JUTH) and as part of the division of labour between UN agencies and UNAIDS co-sponsors, UNFPA has taken the lead among the UN agencies on addressing the needs of entertainment workers (EWs) by supporting policy, strategy and capacity development for HIV prevention for this target group, their clients and partners and supporting the capacity development of networks among EWs.<sup>71</sup>

UNFPA in partnership with NCHADS, MOWA, BBC Media, Inthanou and CWPD, contributed to reducing the vulnerability of adolescents, youth, women and girls to HIV and addressing gender and HIV issues through the support to the implementation of prevention, advocacy and awareness-raising elements of MOWA's Strategic Plan on Women, the Girl Child and HIV/AIDS as well as reducing the HIV and SRH issues among most-at-risk women including EWs in 8 provinces.

Capacities of MOWA, CCWC and CWPD have been built in the fourth programme cycle in the process of the implementation of HIV awareness promotion. MOWA sub-national level and line authorities of CCWC together put effort to promote HIV prevention and other SRH issues at commune level.

The field visit to three provinces confirmed that peer educators' capacities in the SMART Girl programme, which focuses on EWs, have been enhanced with support from UNFPA during the CP4 cycle and resulted in

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<sup>70</sup> UNFPA Cambodia, Thematic Youth and Comprehensive Sexuality Education report, Phnom Penh, 2014.

<sup>71</sup> UNFPA, Standard Progress Reports, Cambodia 2011 - 2013, Reproductive Health programme component

enhanced use of counseling, HIV rapid testing, access to family planning and referral to public health services, where the majority of Entertainment Workers (EWs) had previously no access to such services. The evaluation team was informed during the field visit that the risk behaviour assessment was introduced to EWs and follow-up provided in all 8 target provinces by CWPD. The approach of the Smart Girl Programme has been well developed and is considered to be a model and used by other partners including other national NGOs like KHANA and local NGOs.

Along with other partners and the national programme, UNFPA support has contributed to the outcome level change of CMDG6 with the prevalence of HIV reduced to 0.7%.<sup>72</sup>

**The fourth outcome area** of the SRH component of the country programme focused on increase in national and sub-national capacity to provide affordable and effective national social protection, through improved development, implementation, monitoring and evaluation of a social protection system. This included an enhanced national and sub-national capacity for emergency preparedness and response to reduce and mitigate vulnerabilities to disasters, both environmental and health, of the poorest and most marginalized, especially women, children, youth and people living with HIV. Related to first indicator of output 5, the country office supported, the development of a national, multi-sectoral contingency plan for emergency response.

**Finding 13: The key contribution of UNFPA to the development of the national emergency preparedness and response plans is the highlighting of the minimum initial service package for SRH.**

UNFPA has supported, jointly with other partners, national and sub-national agencies engaged in emergency preparedness and response to mitigate RMH and GBV impacts of emergencies through contributing to the development of emergency preparedness and response plans, which cover early warning, prevention, and mitigation, meeting international standards, and moreover, supporting national and sub-national training on the Minimum Initial Service package for SRH in crisis situations, with a particular focus on disaster-prone locations.<sup>73</sup> The country office did not engage in emergency response activities during CP4 as based on assessments made there appeared to be no real demand for such response in the timeframe concerned.

**Finding 14: UNFPA's support to the Love9 programme provided a useful means to convey SRH messages to youth, and can be considered an effective means for information dissemination to youth and generating discussion of SRH topics amongst youth and between youth and their parents, and to build personal capacities on SRH attitudes and behaviors. This approach is complementary to the service provision oriented support of the country programme.**

The Love9 soap like TV programme concentrated of three young women who open a café in Phnom Penh and show their relationships with men in their lives. The programme included a number of SRH messages targeted for a youth audience (see details in box 5 below).

**Box 5: Topics addressed by the Love9 programme so far**

- STI and HIV risk
- Pregnancy and choices around it
- Methods of Family planning
- Understanding your body
- Relationships and respect for others

<sup>72</sup> Source: The National Health Information system, MOH, 2014..

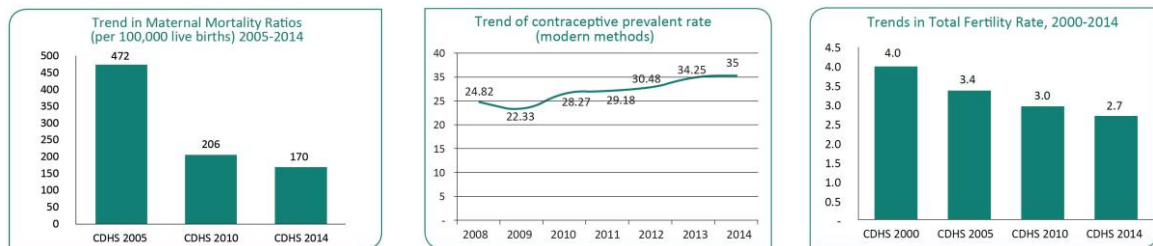
<sup>73</sup> UNFPA, Standard Progress Reports, Cambodia 2011 - 2013, Reproductive Health programme component and confirmed by field observation in three provinces.

The TV show was complemented by a talk show in which a Cambodian family was invited to talk about the latest episode. This was considered necessary in order to have youth discuss with their parents on TV and support inter-generational discussion. This, moreover, complemented the school based learning on sexuality, which is very knowledge and less discussion oriented. A third part of the programme concerned a magazine which contains the factual part on the episodes and information on SRH and related issues. The TV programme is made in-house in Cambodia in Khmer language which means that the programme also contributes to capacity development of national producers who are trained in all aspects of the production of a TV show with educational messages. The programme is very popular amongst Cambodian youth.

**Finding 15: The recently released data of the CDHS 2014 show improvements on several fronts including reduction in MMR, increased prevalence of contraceptives and declining fertility rate.**

The data from the CDHS 2014 that became available after the fieldwork of the evaluation, and other MOH data sources, show considerable progress on several SRH indicators (see figure 2 below). Through support to the intermediate level changes identified in the UNFPA results framework, UNFPA has contributed to these changes.<sup>74</sup>

**Figure 2: Trends of Key Indicators till 2014.**



Source: CDHS 2014

Source: National Reproductive Health Program 2014

Source: CDHS 2014

<sup>74</sup> RGC, MoH, Leaflet on CDHS 2014 results.

**Table 7: Results Framework Sexual and Reproductive Health Component UNFPA Cambodia**

Results	Indicator	Baseline	End Line	Remarks	Color Code
SRH Outcome 1					
Increased national and sub-national equitable coverage of quality Reproductive, maternal, new-born, child health and nutrition services.	1. Percentage of women with unmet need for family planning (13% in CDHS 2015)	25.5% (CDHS 2005)	12.5% (CDHS 2014)	Target at 21% Achieved	
SRH Output 1					
Increased national and sub-national capacity to increase availability, accessibility, acceptability, affordability, and utilization of quality reproductive, maternal, new-born, child and nutrition health services.	1.1 Proportion of births attended by skilled health personnel (89% in CDHS 2015)	71% (CDHS 2010)	89% (CDHS 2014)	Achieved against 87% target for 2015	
	1.2 Percentage of pregnant women who delivered by caesarean section (4.3% in Health Sector Report)	2.43% ( HIS 2011)	5.35% (HIS 2014)	Achieved against 4% target for 2015	
	1.3 Number of basic/ comprehensive EmONC per 500,000 population	BmONC: 0.7 CmONC:0.9 (HIS 2009)	BmONC: 3.62 CmONC: 1.22	BmONC is achieved against 3.5 target for 2014 (but not yet 2015 target of 4) CmONC is achieved against 1.0 target 2015	
	1.4 Percentage of population living under the poverty line protected by health equity funds	73% (DPHI, MoH 2011)	93% (Health Sector report 2013)	Achieved against target of 90% for 2015	
	Percent of pregnant women with 2 and 4 Antenatal care consultations (ANC)	ANC2:83% (HIS 2009) ANC4: 53% (HIS 2009)	ANC2:95% ANC4:75.6%	ANC2 is under-achieved against 98% target of 2014	

Results	Indicator	Baseline	End Line	Remarks	Color Code
				ANC4 is achieved against 60% target for 2015	
	1.6 Contraceptive prevalence rate among currently married women (any modern methods) (39% in CDHS 2015)	35% (CDHS 2010)	39% (CDHS 2014)	under-achievement of 57% target in 2014	
	1.7 Percentage of Operational Districts with at least 2 facilities providing (having staff trained in) adolescent friendly sexual and reproductive health care (AFSRH)	No data available	No data available by MoH	The CO has proposed to drop this indicator	
	1.8 Number of health facilities providing (having staff trained in) adolescent friendly sexual and reproductive health care (AFSRH)	110 HCs (in 2009)	684 HCs (NRHP 2014 report)	Over-Achievement against 450 health facilities in 2015	
	1.9 Percentage of health financial resources allocated to RMNCH	27% (MOH, DPHI)	40% (health sector report)	Over-Achievement against 32% target in 2015	
<b>SRH Output 2</b>					
Increased competency and availability of health human resources, particularly midwives and other professionals where skill gaps exist.	2.1 Percentage of health centres with at least two midwives (any type 89% vs 70%)	55% (MoH 2009)	89% (MoH 2014)	Over-achievement against 70% target in 2015	
	2.2 Percentage of health centres with at least one secondary midwife (80% vs 70%)	50% (MoH 2009)	80% (MoH 2014)	Over-achievement against 70% target in 2015	

Results	Indicator	Baseline	End Line	Remarks	Color Code
SRH Outcome 2					
Enhanced national and sub-national institutional capacity to expand young people's access to quality life skills including on HIV and technical and vocational education and training (TVET).	2.1 Percentage of young adults who successfully completed life skills programs.			MoEYS decided to drop this indicator, no data available	
	2.2 Percentage of young people who successfully completed SRH/HIV life skills programme	0%	Primary: 26.5% Secondary: 25%	Target set was for HIV life skills while the programme turned to CSE approach	
SRH Output 3					
Enhanced access to and utilization of life skills training [and TVET] especially by disadvantaged young people and out of school children.	3.1. Percentage of primary and secondary schools integrating and implementing core life skills training including HIV.	Primary level: 0% Secondary level: 0%	Primary: 28% Secondary: 26%	Target set was for HIV life skills while the programme turned to CSE approach	
	3.2. Number of disadvantaged, vulnerable and at risk young people reached by special programs-hotline counselling	0	8,727 individuals	This indicator has no clear target	
	3.3 Number of young people who were in the functioned CLCs and LCs learned LSE & YD topics (18 - 20 hours) per year starting from 2013" Data will be available next year.	Community Learning Centre: 102 Literacy classes: 1,093	No data available	No end line data available	
SRH Outcome 3					
Strengthened multi-sectoral response to HIV	3.1 HIV prevalence among general adult population (15-49 years)	0.9% (2007, MOH/NCHADS)	0.7% (2012, NCHADS)	Slightly under-achieved with target at	



Results	Indicator	Baseline	End Line	Remarks	Color Code
				<0.6 for 2014 and 2015	
SRH Output 4					
Enhanced national and sub-national capacity to target key populations at risk with effective HIV prevention interventions.	4.1 Percentage of condom use by most at risk populations entertainment workers (EW), men who have sex with men (MSM), injecting drug users (IDU), disaggregated by: sex, age	Consistent condom used: FSWs who had less 2 clients per day: 81.5%. FSWs who had more than 2 clients per day: 89.2%. (HSS 2010) MSM: 80% (TRaC 2010) IDU: regular partners 30%, non-regular partners 61% Non-IDU: regular partners 35%, non-regular partners 64%. (NCHADS)	EWs Consistent Condom used in the past 3 months with clients 80.5% EWs Consistent Condom used in the past 3 months with sweethearts 36% MSM, always condom used with paid client (68%); with non-paid men (79%) in the past month	Results cannot be compared due to different definition of baseline and end line indicators and the lack of targets identified	
	4.2 HIV prevalence in most at risk populations, disaggregated by sex and ages	SSS 2011 EWs all types 2.6 EWs who has more than 7 partners per week 10.8% EWs who has less than	No data available	No end line data available	

Results	Indicator	Baseline	End Line	Remarks	Color Code
		seven partners per week 3.1% MSM 1.5% (SSS 2011?)			
SRH Outcome 4					
Increase in national and sub-national capacity to provide affordable and effective national social protection through improved development, implementation, monitoring and evaluation of a social protection system	4.1 Percentage of affected vulnerable groups receiving emergency assistance including food, sanitation, water, shelter and other immediate response interventions within prescribed timeframes. (disaggregated by sex, age, rural-urban, and socio-economic characteristics)	No data	No data		
SRH Output 5					
Increased national and sub-national capacity for emergency preparedness and response to reduce and mitigate vulnerabilities to disasters, both environmental and health, of the poorest and most marginalized, especially women, children, youth and people living with HIV.	5.1 Develop national, coordinated, realistic, integrated multi-sectoral contingency plan for emergency response, which covers early warning, prevention, and mitigation meeting international standards	-	The National Contingency Plan for emergency response in place	Achieved	
	5.2 Minimum Initial Services Package of Reproductive and Sexual Health in Crisis and Post Crisis training/workshops rolled out to national and sub-national level.		24 provinces		

## Gender Programme Component

The Gender component of the country programme focused on four main areas: Outcome 1: A harmonized aid environment that promotes gender equality and the empowerment of women; Outcome 2: Strengthened and enhanced gender-mainstreaming mechanisms at national and sub national levels; Outcome 3: Enhanced participation of women in the public sphere at national and sub national level; Outcome 4: Improved societal attitudes and preventive and holistic responses to gender-based violence. An overview of the outcomes, outputs and indicators concerned is provided in table 8 below, p 57-61.

Implementing partners of this component concerned the Ministry of Women's Affairs (MOWA), Ministry of Health (MOH), Ministry of Planning (MOP), and the Department of Local Administration (DOLA) of the Ministry of Interior (MOI), and the civil society organizations Cambodian Women's Crisis Center (CWCC), and Paz y Desarrollo (PYD).

In order to assess the effectiveness of the support of UNFPA in the Gender component, four CP outcomes are analyzed below.

**Finding 16: The evaluation results shows that some progress has been made to achieve a harmonized aid environment that promotes gender equality and the empowerment of women, but the process has been slow, with limited prospects to be fully achieved by the end of 2015.**

Since the beginning of the current country programme, UNFPA has been one of the key players in promoting aid-effectiveness and harmonization among the UN team for gender mainstreaming.<sup>75</sup> This coordination role was taken over by UN WOMEN to lead gender related work from 2014 onwards. For coordination on aid-effectiveness and harmonization, the Technical Working Group (TWG) on Gender was established, with UNDP and JICA as co-chairs and UNFPA has been participating in this mechanism. The Joint Monitoring Indicators that measure the achievements of the TWG-Gender functions have been regularly assessed, with UNFPA input into the assessment process. TWG-Gender has been primarily an information sharing venue where a large number of stakeholders working on gender issues regularly gather, and it is expected that this mechanism coordinates a more harmonized process within the framework of a Program-Based Approach (PBA) (see details on PBA below).

Furthermore, an overall goal to materialize Programme-Based Approach (PBA) with a road map, has been delayed, due to Cambodian Development Council's instruction to harmonize the approach to build up a PBA road map. Partnership principle is being discussed as a guiding principle for the PBA but the benchmark to be endorsed is not yet agreed. MOWA has been leading this process, which will be serving as a foundation of the PBA for three thematic areas; Gender Based Violence (GBV), Women's Economic Empowerment (WEE), and Political Participation of Women.

A newly approved 2nd NAPVAW can be the basis for a shared programmatic approach for gender initiatives, making a model for other program-based approaches and creating the comprehensive and holistic PBA approach for gender mainstreaming. With no implementation plan in place yet (as of March 2014), it is difficult to estimate when the implementation plan will be in place with PBA framework to be assisting the process. A costed implementation plan for 2nd NAPVAW has not yet been developed.

**Finding 17: The capacity of the Gender Mainstreaming Action Group (GMAG) of Ministry of Health (MOH) and Ministry of Planning (MOP) has been enhanced with support from UNFPA and both GMAGs are implementing an increased number of initiatives, including at the sub-national level. However, budgetary measures have been insufficient and there has**

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<sup>75</sup> UNFPA's role and contribution to the policy dialogue in this respect was confirmed in the thematic evaluation report on gender: UNFPA Cambodia, *Thematic evaluation of UNFPA Gender-Based Violence programme*, Phnom Penh, August 2014.

**been no formal assessment conducted on the achievements of these two ministry's GMAGs, nor of GMAG capacities in other line ministries.**

At an institutional level, UNFPA has supported RGC's institutional capacity development for gender mainstreaming which encompasses many different sectors. It has done so through support, together with multiple other stakeholders, to the development of the 2nd National Action Plan to Prevent Violence Against Women (NAPVAW),<sup>76</sup> support to the third Cambodian Gender Assessment (CGA) in 2014, and the formulation of the national gender mainstreaming policy, Neary Rattanak 4, the MOWA's five year strategy, which was endorsed in 2015. The Neary Rattanak 4 was developed based on the findings and recommendations from the CGA of which the health sector part was fully supported by UNFPA. However, despite formulation of those key strategies policies, it is not clear what amount of resources has been allocated to their implementation.

UNFPA has advocated for the gender mainstreaming mechanism at national and sub-national level through building capacities of government institutions to analyze gender related issues in policy making. The CO has supported MOH and MOP to develop their respective GMAP in a participatory process to ensure ownership of the GMAP amongst those ministry's GMAGs. Other partners such as UNDP, JICA, ADB and KOICA have also supported selected GMAGs.

At national level, GMAG is a driving force to mainstream gender issues and perspectives into their respective ministries' policies and activities. UNFPA CO has supported quarterly meetings among all GMAGs in line ministries, to share successes and challenges, which provided effective information sharing opportunities. However, national budget to implement GMAPs are generally limited.

A challenge has been identified with regard to the monitoring system and assessment in terms of GMAG technical and financial capacities. Despite some achievements and progress reported by GMAG members, no comprehensive assessment has been done to date with regard to the implementation of GMAPs, nor has the degree of improved capacities of GMAPs been identified. Gaps in implementation of GMAP have not been identified; thus challenges remain unidentified except for the lack of budget and limited capacities of officials. So far, no responses have been developed to overcome those challenges. Cambodian National Council for Women (CNCW) plays an important role to support GMAGs in its capacity developments, but no assessment has been conducted by CNCW to measure the improved mechanisms to gender mainstreaming in technical ministries. Coordination has been supported by UNFPA but it remains difficult to assess its contribution to GMAG implementation.

At sub-national level, with support from UNFPA, MOH and MOP have established GMAGs in all provinces. Capacities of MOH's sub-national gender mainstreaming mechanism were developed through workshops and training courses held with facilitation of the national level GMAG of MOH. Gender mainstreaming of MOP at national level has been strengthened with UNFPA support to implementing the GMAP though functions and capacities of GMAPs at sub-national level remain limited and are not fully functional. There was no monitoring system put in place and the results of GMAG activities at sub-national level have not been assessed, and cannot be ascertained.

**Finding 18: More women are participating in the democratic decision making process at the sub-national level and many interventions from different partners have contributed to such progress.**

Women's participation in decision making processes has been advanced at the sub-national level, while at national level it has been relatively stable between the last two national election processes. The percentage of

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<sup>76</sup> The importance of UNFPA's role in the development of the second NAPVAW was also documented in the thematic evaluation report on gender: UNFPA Cambodia, *Thematic evaluation of UNFPA Gender-Based Violence programme*, Phnom Penh, August 2014.

female members in the Senate has been stable, standing at 14.75 per cent since 1999 while the proportion of women elected as members of parliament slightly decreased from 21.1 per cent to 20.3 percent in 2013. Female participation in decision-making at provincial governments remained low although some progress has been made.

Capacity building initiatives targeting female representatives at sub-national level have been supported by a variety of stakeholders, both governmental and non-governmental. Female leaders have been creating a vertical network led by WCCC at provincial level, often with close cooperation and support of provincial Department of Women's Affairs. Leaders in vertical line have been sharing information at regular meetings supported by UNFPA and emerging issues that need immediate response, which are often related to VAW, have usually been dealt with in a quick manner making use of such networks.

Partnership among MOWA Women for Prosperity and other NGOs, has produced a training curriculum for female leaders at sub-national level, and participants to the training commented positively on the outcomes from the training. The participants who met with the evaluation team appreciated this intervention supported by UNFPA in cooperation with UNICEF, and female leaders' confidence was strengthened with improved knowledge and skills in leadership. However, no assessment was made of training results

NGOs are also noted to play important roles in terms of capacity development on gender in many parts of the country, which interventions are usually conducted together with the provincial department of women's affairs. Most of these interventions are conducted ad hoc, based on time bound requests, without a longer term vision of support in alignment with the RGC priorities. Coordination among NGOs and PDoWA has been limited. More coordination at sub-national level is essential to produce synergy from the various capacity development initiatives of various stakeholders.

The evaluation found that female leaders participation into the policy making process at sub-national level needs to be further enhanced. Female leaders have been joining in the series of meetings for planning but their advocacy capacities to mainstream gender concerns and prioritize gender issues have remained limited. Though many female leaders at the sub-national level have a good understanding of the gender issues in their area, they often lack the analytical skills to present the gender concerns and therefore often do not get access to budget to address these issues.

**Finding 19: People's perception towards violence against women and gender equality has been improving, and service delivery to survivors has become more holistic in Banteay Meanchey province.**

There has been a variety of interventions made to raise awareness about issues of violence against women and people's understanding about it has been substantially improving.

In 2005 and 2009 MOWA conducted baseline and follow-up surveys that measured perceptions about VAW. In 2005, 64 per cent of respondents of the survey reported physical abuses of husbands against their wife. In 2009, the incidents have decreased to 53 per cent, which may imply a decline of domestic violence. The comparison of the results in two surveys could also relate to the Law on the Prevention of Domestic Violence and the Protection of Victims which was put into place in 2005. 96 per cent of men considered the law very helpful, and 98 per cent of women also agreed in 2009.

However, comprehensive comparison within the current CPAP about the perception change as in the outcome indicator should await the result from CDHS 2014, which will be available later in 2015. With UNFPA technical support and advocacy, CDHS 2014 included a module on domestic violence and perception about gender equality. The results of this module can further enhance the evidence base of UNFPA's interventions in this respect.

Raising awareness among the general population is key for the prevention of violence against women, and reduction of GBV in the community. For this, the WCCC at provincial and district levels, and the CCWC at

commune level, are all actively engaging in information dissemination sessions making use of the financial support of UNFPA. The key player to this activity is CCWC, who are actually visiting almost all villages throughout the year to conduct a half-day session on SRH, gender, violence against women, and related issues. Most of CCWC members that were met by the evaluation team were very enthusiastic to carry out those activities, despite difficulties they face in transportation to remote areas. However, materials that they are using for such sessions in villages are mostly old, and their knowledge was usually obtained some years ago with no refresher training to brush up their knowledge and skills.

The referral system to holistically support survivors of violence has been created and became functional in some areas visited by the evaluation team.<sup>77</sup> In Banteay Meanchey, the Cambodian Women's Crisis Center (CWCC), with support from UNFPA, created a prevention network, which is functioning as referral network in selected districts. Involvement of health sector staff and police to this network, and linking to the health network, has meant the development of a holistic mechanism to support survivors for quick and effective referral. The existence of a safe shelter for women provides an effective mechanism to practically provide support for survivors, as the safety of the women and girls concerned is of paramount importance. However, such mechanism did not exist in Ratanakiri and Kampong Chhnang, the other provinces visited by the evaluation team. Lack of a prevention network has resulted in ad hoc and spontaneous responses, mostly led by the vertical network of WCCC-DWCC-CCWC. Lack of adequate financial resources within the government structure has resulted in a slow response. Lack of safe space for survivors to escape from abuse remains a serious concern. Mostly WCCC-DWCC-CCWC are functioning to support administrative aspects for survivors, as they are not trained for social service, which is a missed opportunity to provide relevant services to survivors.

At output level, UNFPA intervention aimed to improve the service provision to GBV survivors to become a more holistic approach. This has been achieved to some extent in Banteay Meanchey, where CWCC is operating the safe shelter for female survivors of GBV. The existence of the shelter backed up with the prevention mechanism, which also serves as a protection mechanism is a good model to promote and enables and facilitates the holistic service provision. Most service providers in the referral system are CCWC members, with CWCC staff support, with improved capacity for counseling and taking care of survivors in Banteay Meanchey as well as other provinces. The health sector is also involved, but engagements of midwives, who are often the first care provider at the medical facilities, are not well trained in counseling, and are not able to provide the type of counseling support required.<sup>78</sup>

At a policy level, UNFPA supported the formulation of the 2nd National Action Plan to Prevent Violence Against Women (NAPVAW), particularly with regard to the service provision. With CO's advocacy, it became possible that service provision was directed through health sectors to VAW survivors. Though an implementation of 2nd NAPVAW has not yet started, the operational plan is under preparation, and UNFPA can contribute to the process from a health perspective by linking dialogues for intervention to be holistic and more effective especially through an utilization of the national guideline for managing violence against women and children in the health system and the clinical guideline for health officials.

At the outcome level, the assessment of the achievement needs to await the result from the CDHS 2014 as the data on VAW module of the CDHS were not yet available at the time of CPE reporting.

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<sup>77</sup> These findings were, moreover, confirmed by key partner to UNFPA in the thematic evaluation report on gender: UNFPA Cambodia, *Thematic evaluation of UNFPA Gender-Based Violence programme*, Phnom Penh, August 2014.

<sup>78</sup> The thematic evaluation on GBV of 2014 noted that expansion of engagement from health professionals, including midwives, was of crucial importance but remained a challenge because of the high demands already placed on staff in the health sector. UNFPA, *Thematic evaluation on Gender-Based Violence programme*, Phnom Penh, August 2014.

**Table 8: Results Framework Gender Component UNFPA Cambodia**

Results	Indicator	Baseline Data	End Line Data	Remarks	Color Code
Gender Outcome 1					
A harmonized aid environment that promotes gender equality and the empowerment of women.	1.1.Road map for PBA on gender mainstreaming is endorsed by all stakeholders and implemented	No roadmap in place	Draft Partnership Agreement	The gender strategy Neary Rattanak IV (2014-2018) includes PBA as gender main streaming approach	
Gender Output 1					
Increased UN leadership and facilitation of a programme based approach to promote gender equality and the empowerment of women	1.1.PBA developed and DP funds flowing through PBA modalities	No PBA in place	Draft Partnership Agreement No national budget for GMAG in MOH; Limited national budget for GMAG activities in MOP	Target of PBA developed and DP funds flowing through PBA modalities not reached	
Gender Outcome 2					
Strengthened and enhanced gender mainstreaming mechanisms at national and sub-national levels.	2.1.Percentage of Technical Working Groups (TWGs) a) Work plans, and b) JMIs that are gender responsive against criteria developed by TWG-G	Policies: 25% (2009 data) JMIs: 25% (2009 data)	No data available	No data collected on indicator; Target for both at 40%	
Gender Output 2					
Enhanced capacity of Gender Mainstreaming Action Groups (GMAGS)	2.1.Percentage of GMAGs accessing national government budget to implement activities	45% of GMAGs accessing national government budget to implement GMAP	17 ministries out of 27 (or 63%) received national budget for GMAP implementation	Target of 30 % was reached from the start including the establishment of	

Results	Indicator	Baseline Data	End Line Data	Remarks	Color Code
in all line ministries/institutions (24+3) at national and sub-national level.		GMAGs established in all Line Ministries	All line ministries have GMAG (a total of 27 GMAGs)	GMAGs which were all in place in 2011	
	2.2. GMAG in MoH access to annual national budget allocation	Limited national budget allocated for gender mainstreaming activities in MoH Senior officials in MoH were aware of gender mainstreaming activities in their Ministry	GMAP of Ministry of Health integrated in the AOP of MoH. National budget has been allocated for MOH to carry out activities for gender mainstreaming at both national and sub-national level but the amount to be allocated is not recorded/reported	MOH is spending their own national budget to train provincial GMAGs at selected locations on gender issues in cooperation with national GMAG members.	
	2.3. GMAG in MoP access to annual national budget allocation	No RGC budget allocated, but budget supported by UNFPA  Senior government officials in MoP sensitized on gender mainstreaming activities and gender concerns in planning sector	GMAG of the Ministry of Planning received national budget for a few gender activities such as the celebration of International Women's Rights Day.	No data collected on the amount of allocated budget.	
Gender Outcome 3					



Results	Indicator	Baseline Data	End Line Data	Remarks	Color Code
Enhanced participation of women in the public sphere, at national and sub-national levels	3.1.Percentage of candidates that are women within National Assembly, Commune	National Assembly: 21.1% (2008) Commune Council: 14.1% (2007)	NA:20% CC:18%	Targets: NA: 30% CC: 25%	
	3.2.Percentage of members of sub-national councils that are women, disaggregated by: Province, District, Commune	Province: 10% District: 13% Commune: 14%	Province: 13.23% District: 13.85% Commune: 18%	Targets: Province: 15% District: 20% Commune: 25%	
Gender Output 3					
Enhanced opportunities and mechanisms to strengthen women's capacity to participate in the public sphere at national, sub-national and community levels.	3.1.Percentage of sub-national female a) candidates and b) councillors that receive capacity building training	Training conducted in UNFPA supported areas for candidates of 5 main parties Provincial councillors 100%; in UNFPA supported areas No trainings at district and commune level conducted yet.	Trainings provided but no data on indicator Provincial councillors 100%; overall sub-national 60% in UNFPA supported areas Others no data	Targets: 80% in UNFPA supported areas CCs: 100% District councillors 80% Provincial councillors 80%, in UNFPA supported areas	
	3.2. Number and percentage of WCCCs that received capacity building/training	Provincial WCCC 100% in UNFPA supported areas District WCCC 100% in UNFPA supported areas	Provincial WCCC 100% in UNFPA supported areas District WCCC 100% in UNFPA supported areas	Targets (UNFPA supported areas): Provincial WCCC 100% District WCCC 100%	

Results	Indicator	Baseline Data	End Line Data	Remarks	Color Code
Gender Outcome 4					
Improved societal attitudes and preventive and holistic responses to gender-based violence.	<p>4.1. Percentage of population aware that violence against women is wrongful behaviour and a criminal act Disaggregated by: Sex, Age, Urban/rural, ethnic and social background</p> <p>Additional indicators included in 2013 review meeting:</p> <ul style="list-style-type: none"> <li>•60% Knowledge of general people on GBV as illegal action (CDHS 2010-15)</li> <li>• 35 % of all Women agree that a husband is justified in heating his wife for one or more reasons. (Base line CDHS 2010: 46%)</li> <li>• 15 % of all men agree that a husband is justified in heating his wife for one or more reasons. (Baseline CDHS: 22%)</li> </ul>	More than 50% of the local authorities and police indicated they knew that physical violence was illegal, in contrast to 80% of the general population.	No data	No updated data since MOWA 2009 Follow up survey. CDHS 2014 includes questions on these issues but data not yet available.	
Gender Output 4					
Increased institutional capacity to provide multi-sectoral mechanism for protection of women's rights, gender equality and prevention of GBV	4.1. Costed annual work plans for the National Action Plan to Combat Violence Against Women Developed	none	2nd NAPVAW endorsed but not yet with a costed plan	Within the current CPAP it is unlikely to be achieved	
	4.2. Number of provinces with local level response and referral systems linking government and non-government victims support institutions together (medical services, crisis centers and counselling, legal aid and police, local authorities and women and children's committee	0%	1 (Banteay Meanchey), three districts	Target was initially set at 2 provinces but changed to 1 province and 2 districts within the province	

Results	Indicator	Baseline Data	End Line Data	Remarks	Color Code
	4.3. Number of GBV victims utilizing the following services: Health services Counseling Shelter Legal services	no baseline data available	Data 2014 first 3 Q.: Health Service: 53 cases by CWCC and at least 1,257 by health personnel who are members of DBMSN both direct or indirect involvement Counselling 132 cases by CWCC and 234 by district-based networks (including 8 survivors referred to CWCC) Shelter 163 cases (95 survivors+ 68 relatives) Legal: 75 cases registered and file complaint at court	Newly added indicator; Target set at 150 GBV victims at least use one of the four services in UNFPA pilot provinces; Indicator is not specific as to “geographical coverage” and “service provider” ;	
	4.2. Number of local authorities and key stakeholders in target area, especially CCs, CCWCs and police that understand their responsibility to intervene in GBV cases in their community	Newly added indicator, no baseline data available	106 CCWC (F=92), 319 police officers and 87 local authorities attended DV forums.	Target set at 180 for 2014 This data will be generated from the CDB records in early 2015 by MoWA.t	

### 3) Efficiency

**Evaluation Question:** To what extent has the UNFPA CO made good use of its human, financial and technical resources in pursuing the achievement of the results defined in the country programme?

#### Financial Resources and Management

**Finding 20: Programme expenditures are in line with the budgeted resources across the three programme components. The relative size of the budget for SRH is in line with the importance of this component in the country programme and its centrality in the bull's eye of the new strategy. Financial audits have been conducted and minor issues identified have been addressed.**

The total budgeted resources for the Country Programme amounted to 24.2 million USD for the five year period of the CP4. This included 18 million USD from regular UNFPA resources and 6.2 million USD from other resources. The SRH component was planned to absorb most of the resources with 62 per cent of the budget allocated to this component. PD and gender had 25 and 9 per cent of resources allocated respectively. Actual expenditures (as of mid-November 2014) indicate a similar distribution across programme components. With about a year to go 2.3 million USD remained, i.e. 9.5 per cent of the total budget. For details see table 9 below.

**Table 9: Financial structure of the UNFPA Fourth Country Programme in Cambodia**

Programme Component	Regular resources	Other resources	Total	Percentage of Total
<b>Budgeted Resources 2011-2015 (in million USD)</b>				
Sexual and Reproductive Health	10.0	5.0	15.0	62 %
Population and Development	5.0	1.0	6.0	25 %
Gender	2.0	0.2	2.2	9 %
Programme Coordination / Assistance	1.0	-	1.0	4 %
<b>Total</b>	<b>18.0</b>	<b>6.2</b>	<b>24.2</b>	<b>100.0 %</b>
<b>Actual Expenditures from 2011 till July 2014 (in million USD)</b>				
Sexual and Reproductive Health	9.1	4.9	14.0	64 %
Population and Development	4.9	0.5	5.4	25 %
Gender	1.7	-	1.7	8 %
Programme Coordination / Assistance	0.9	-	0.9	4 %
<b>Total</b>	<b>16.6</b>	<b>5.4</b>	<b>21.9</b>	<b>100.0 %</b>

Source: UNFPA Final Country Programme Document for Cambodia. July 2010 and UNFPA CP4 financial details.

Financial audits were conducted for key partners and reports available to the evaluation team from 2011 to 2013 show that in all cases the financial reports presented the actual eligible expenditures and funding had been used in conformity with the applicable contractual conditions. Observations made included one instance

of limitations in record keeping and the lack of the use of competitive bidding in few cases, which issues were addressed subsequently.<sup>79</sup>

### Human Resources

**Finding 21: UNFPA human resources have been of high quality. The composition of senior management positions has enabled UNFPA to play a significant role in the management of HSSP II and in advocacy across the country programme. Given the partnership approach of the country programme, the UNFPA team does not directly implement. The number of programme staff positions during CP4, however, did not allow for sufficient interaction with counterpart Government and civil society agencies in each of the programme components.**

The country programme is headed by the UNFPA Representative with the programmatic staff headed by the Deputy Representative and the Assistant Representative, who led on gender (Deputy) and SRH and PD (Assistant) respectively. The Deputy Representative moreover headed the Operations part of the country office (though some of these arrangements were changed more recently). Part of the staff of the SRH and PD components was based in the offices of MOH and MOP respectively. Many of the programme staff have been with the organization for a considerable time and are well aware of the context concerning each of the programme components. The International position of Deputy Representative was replaced recently with the period that the function was vacant limited to a few months. The new human resource pool system is seen as accounting for this. Details on staffing structure for most of the period of CP4 is presented in Annex 8.

The division of programmes and programme support functions between the Deputy Representative and the Assistant Representative mean that both had a manageable number of direct reports. Within this set-up the Representative had sufficient space to engage with high level RGC officials in all programme components and to play a significant role in HSSP II, chairing the Joint Partner Implementation Group (JPIG) for nearly two years and mobilizing additional support and resources.

A staff position had been created for a Monitoring and Evaluation Officer in 2013 but the position proved difficult to fill. At the same time, APRO's monitoring and evaluation position became vacant, which limited regional M&E support concerned at that time. The country office managed the situation by adding M&E responsibilities to the job descriptions of the Assistant Representative and the Local Governance Programme Officer. However, for the next programme cycle it would be pertinent to recruit a separate staff member for the M&E position.

Both the SRH and the PD component of the programme had one programme specialist and one programme officer in term of human resource capacity. Both positions became vacant at the start of the programme cycle which meant a considerable constraint in the start-up of the programme. It proved particularly difficult in the Cambodian context to recruit a gender specialist for the gender programme component. The SRH component, moreover, had two programme assistants while the PD component had additional administrative support. The gender component had only one programme analyst, which position was upgraded from National Office A position to B in 2011 (with levels concerned running from A to D).

The limitation to one or two key technical staff for each of the programme components meant that these staff had limitations in their dealings with the multitude of partners in each of the components in Cambodia. This was reflected in discussion with many stakeholders. Though support of UNFPA was highly valued, the limited time that technical staff could be available for partners at national as well as sub-national level was a major concern for many. The inability to fill the M&E position has constrained the M&E activities of the programme components and limited the efforts of building counterpart capacities in this respect.

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<sup>79</sup> NEX Audit reports 2013, 2012 and 2011.

In addition to the regular staff, UNFPA makes use of short term consultancies for the implementation of the country programme, in order to recruit specific technical capacity for short term assignments. The APRO has been instrumental in identification of many of the international consultants. Annual APRO support plans were used in the management of this process.

For programme implementation UNFPA worked closely with RGC and civil society partners, providing technical and financial support to them. Capacity assessments were conducted for civil society partners making use of the Implementing Partner Capacity Assessment Tool which included aspects of governance and leadership, human resources, programme, M&E, financial management, procurement system, comparative advantage, knowledge management, and partnerships. Based on these assessments recommendations for capacity building of the organizations concerned were identified.

Notwithstanding the limitations in staffing the evaluation found that most of the activities were implemented in a timely manner, through working with counterpart agencies. Some delays occurred but concerned issues beyond the control of the country office, like the policy development for VAW in which many stakeholders were involved. No large underspending was recorded.

### **Programme Implementation**

**Finding 22: Participation of UNFPA in HSSP II has added to the efficiency of the programme in terms of a harmonized management system. The unforeseen move towards the application of a discreet funding approach for UNFPA support for most of the time, though reducing aspects of harmonization, allowed for fast tracking some of the initiatives concerned.**

Funding to HSSP II started off with a mixed funding approach, primarily through pooled fund for country wide efforts and discreet funding for selected provinces with low SRH / FP indicators (about 14 provinces). However, based on requirements for financial procedures from UNFPA HQ the CO had to move all of its resources through discrete funding, while remaining part of the health sector strengthening approach. This meant in practice a fast track financial mechanism, faster than the pooled fund, disbursements of which usually encountered substantial delays. The approach did not really affect the building of financial systems capacities, as the pooled fund itself was also not channeled through the treasury, due to limitations of the capacity of the government financial management system.

Finding 23: The support provided to WCCC and CCWC was channeled directly through DOLA to communes and not through the treasury. Though this did not result in capacity development of financial systems, it did prove to be a timely way of delivering support, suitable for the limited amounts concerned.

The support to WCCC and CCWC was channeled through DOLA and to the communes rather than through the National Treasury as was the case for the support by UNICEF. While the latter was affected by large delays (upto six months) the UNFPA funds reached communes, districts and provinces in a timely manner. Downside was that in this way building of the RGC financial systems could not be addressed, though the amounts of USD 500 were relatively small to be able to make a difference in these systems.

**Finding 24: Capacity Development in the gender component has been successful but the modality of support has varied and appeared not always the most efficient. While capacity assessments have been conducted, including for the GMAG in MOH, their results have not always been sufficiently used to guide the implementation of trainings.**

Efforts made by UNFPA to support capacity building for both national and sub-national levels in mainstreaming gender has been highly appreciated by senior management levels in the partner ministries, MOH and MOP. However, the modality of support proved rather complicated: one modality was that UNFPA provided resources to MOWA, who in turn worked with the Line Ministry, while in other instances Line Ministries obtain direct support from UNFPA. In terms of efficiency it would seem more useful to conduct

interventions directly with selected Line Ministries, with technical support from MOWA in terms of mainstreaming gender.

#### Synergy across programme components

**Finding 25: The three programme components have been interlinked in various ways though linkages could be further strengthened by a strategic orientation of the PD and Gender components on issues of SRH.**

The teenage fertility report which makes use of the CDHS data and data from other population surveys and the inclusion of the GBV module in the CDHS are good examples of an integrated approach across programme components. In order to support the country programme implementation and coordination across the components the office has several mechanisms in place, including programme meetings, technical meetings and joint annual programme review meetings with partners.

The programme components of PD and Gender have outcome level changes which go beyond the ‘bull’s eye’ of the UNFPA new strategic plan. This includes ‘mechanisms for participation in democratic decision-making’, and ‘a harmonized aid environment that promotes gender equality and the empowerment of women’. These objectives limited the extent to which the programme created linkages across the three components. An explicit focus of both the PD and gender components on aspects related to SRH can enhance the synergy across the three components of the country programme.

#### 4) Sustainability

**Evaluation Question:** To what extent are the results of the UNFPA CO supported activities likely to last after the termination of the development assistance?

**Finding 26: National budget line for contraceptives procurement has been added to the national budget, which was advocated by UNFPA and DFAT, and which has enhanced the sustainability of Family Planning interventions.**

UNFPA together with DFAT successfully advocated for the inclusion of a budget line for the purchase of contraceptives as part of the national budget, to ensure the availability of contraceptive commodities for the longer term in Cambodia. This would, moreover, enable UNFPA and development partners to end their financial support to this procurement which has been on-going for over 20 years with few RGC contribution. Both a technical and economic case were made for the need of contraceptive commodities. The technical case focused on immediate and longer term benefits of contraceptive use and results of birth spacing on infant mortality and child nutrition. The economic case focused on the saved costs of contraception in terms of reduced maternal and neonatal services costs. The savings ratio of health costs related to unintended pregnancies, live births and abortions was estimated to be around a factor 1:5.6 of the investment costs for contraceptives.<sup>80</sup> In 2015 RGC contribution to contraceptive procurement amounted to USD 200,000 which was double the amount of 2014. RGC further committed to procurement in 2016.

**Finding 27: Capacities at various levels of health facilities have been enhanced but not necessarily yet at sustainable levels and in particular in more remote locations human resources and physical infrastructure remain insufficient.**

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<sup>80</sup> UNFPA / DFAT, Establishing Contraceptive Commodity Security for Cambodia, Estimates for 2014 to 2016. Internal paper.

Notwithstanding considerable improvements, RGC has not necessarily yet reached sustainable capacity levels in the health system. This goes in particular for EmONC facilities in remote locations where standards for infrastructure, medical instruments and equipment are often not met. Moreover, the capacity and skills of midwives, obstetric surgeons and anesthetists in those locations was observed to be at times not meeting the required standards.

**Finding 28: The CCWC's were found to function well and the injection of USD 500 to support the functioning of the committees had a relative large effect compared to the amount concerned. However, the provision of USD 500 is not sustainable in the longer run.**

The activities of the CCWCs have been supported by UNFPA through a yearly budget of USD 500. Though a limited amount for each of the CCWCs, the effects of the support were relatively large (as reported under effectiveness). With the development budget of a commune varying between USD 20,000 to 60,000, the amount concerns 0.8 - 2.5 % of the budget of the CIP. As it proved possible to redirect small amounts of the investment budget to social development, this could prove to be a way to provide a sustainable solution to the funding of the CCWC.

**Finding 29: The partnership approach applied by UNFPA in all programme components has strengthened aspects of ownership and supported building of capacities, aspects conducive to sustainable results. However, strategies to ensure the sustainability of results achieved with UNFPA support and scale-up successes have not always been in place.**

UNFPA has worked through partnership arrangements to implement the programme, including RGC and civil society partners. This approach as such has enhanced the national and sub-national ownership of the initiatives and capacities were built in the process. In various initiatives it was, however, not made clear from the start of the activities how UNFPA and its partners were going to ensure the sustainability of the results that were expected to be achieved, who will take over some of the financial burden of implementation, who will bring activities to scale and how UNFPA support can transform over time from supporting the initiating of an initiative, implementing it on a pilot basis towards expanding it to other regions and groups. Such a strategy is essential to enable UNFPA to adapt its support to the development phases of an initiative and to modify the roles it plays during these phases.

## ***5) Programme Monitoring and Reporting***

**Finding 30: A considerable amount of annual and joint field monitoring has been conducted in all three components which has been the basis of a variety of component and country office based reports. Given the limitations of the results framework, its indicators at output and outcome levels and the focus on activities of joint field visits, monitoring has not sufficiently enabled results-based management of the programme and its components.**

A variety of monitoring activities has been conducted in each of the programme components including field monitoring, joint monitoring visits and annual monitoring. Internal reporting used to be organized per programme component but this has changed to Standard Progress Reports per output of each of the components. With PD having 3 outputs the component thus produced three reports. The country office reports to the regional office made use of the Country Office Annual Report format. This was more recently changed to the My Results report format, in line with the new UNFPA Strategic plan. Both reports make use of organization wide indicators, which differ from the indicators of the CPAP results framework as these need to be aggregated at the regional and global level. HSSP monitoring made use of the RGC system to assess results, including joint quarterly review meetings and joint monitoring visits on a 6 monthly basis.

In annual monitoring use was made of the CPAP Planning and Tracking Tool. This tool enabled the tracking of key performance indicators on a yearly basis and included baseline data as well as annual targets. As such the tool was meant to enhance programme management based on results achieved at output and outcome



levels, with supposedly the output level changed under the management control of the country office, identifying the contribution of UNFPA, and the outcome level changes, which need to occur in order to reach the goals of each of the programme components, beyond the management control of the country office.

However, the results framework of the programme had several shortcomings. An important shortcoming concerns the imprecision of many of the outcome and output level changes. An example concerned the following:

PD component, Outcome 1: Effective mechanisms for dialogue, representation and participation in democratic decision-making established and strengthened.

It is not clear what is meant with democratic decision-making, what the geographical reach is meant to be and at what level this needs to be assessed, i.e. national, provincial, or local level.

Eight of the ten outcome level changes of the country programme have one output level change, while the other two outcomes have two outputs each. In particular in the eight outcomes concerned, the single output level change is usually unlikely to result in the outcome level change as many other conditions would need to be in place. This means that there is no strong relationship between the level of achievement of the output and realization of the outcome. Moreover, realization of the outcome level change could only be connected with a limited contribution of UNFPA. An example concerns the following:

Gender Component, Outcome 4: Improved societal attitudes and preventive and holistic responses to gender based violence

Output level change: Increased institutional capacity to provide multi-sectoral mechanisms for GBV and community awareness on prevention intervention

Enhanced institutional capacities as such do not directly result in improved societal attitudes nor in preventive and holistic response to GBV as many other aspects need to be in place to change people's attitudes.

Output level changes are at times beyond the control of UNPFA and thus cannot identify the contribution of UNFPA as inputs of other stakeholders are needed to realize the change. An example concerns the following:

SRH Component Output of Second Outcome: Enhanced access to and utilization of life skills training (and TVET) especially by disadvantaged young people and out of school children

The access and utilization of life skills training is not under the control of the programme as it depends on many factors beyond the programme.

The indicators of outcome and output level changes are often not 'SMART' enough so that it is difficult to assess them and compare results over time. An example concerns the following:

PD Component, Output 1: Sub-national Women and Children Consultative Committees (commune, district, province) are established and functional in all locations

As the committees are established by law, their establishment as such is less relevant to assess while no criteria for functioning are provided and geographical coverage and time frame not specified.

Field visits were conducted for all programme components together with counterparts. Based on the reports made after each of the field visits concerned, the field visits appear to have started with a focus on activities and financial management with only in a later stage more attention to results achieved as indicated by output and outcome level changes. What was missing is a systematic set-up of the field visits, so that the monitoring visits, with a proper methodological underpinning, can better serve management needs of the programme.

These limitations of the results framework and the indicators as well as the ways that field visits have been conducted have limited practicing of results-based management in each of the components of the country programme during the fourth programme cycle. This has affected the extent to which UNFPA can show

outcome level results as well as the output level changes that it has contributed towards those results. This shortcoming of the monitoring and reporting system of the country office was also highlighted in the review of the Multilateral Organization Performance Assessment Network (MOPAN) 2014, in which Cambodia was one of the country offices assessed by the MOPAN team but which showed otherwise positive results on indicators concerned.<sup>81</sup>

In 2012/3 the CPE of the third country programme cycle was conducted (as referred to in the introduction). The country office prepared a management response to the evaluation results, which was subsequently implemented.<sup>82</sup> Though several aspects of the recommendations have been addressed, some limitations remained including the broadness of the programmatic focus and weaknesses in the results framework, in particular concerning the indicators meant to assess progress on outcome and output level changes. A capacity development strategy was developed, in response to the CPE recommendations, details of which were provided in the introduction. This strategy was developed towards the end of CP4 and could therefore not sufficiently inform programme implementation. Moreover, it is not clear to what extent the strategy was based on capacity assessments of the main partners, which was one of the recommendations of the CPE.

## 6) UNCT Coordination

**Evaluation Question:** To what extent has the UNFPA CO contributed to the good functioning of coordination mechanisms and to an adequate division of tasks within the UN system in Cambodia?

**Finding 31: UNFPA is regarded as a valuable partner by RGC and other UN agencies and open to coordination, cooperation and collaboration with other agencies. It has played a significant role in the TWGs on D&D and TWG-Gender/GBV, while in health it has played a significant role in the management of HSSP II programme and the Joint Partners Implementation group (JPIG).**

There is a total of 22 UN agencies active in support to Cambodia. UNFPA has been regarded as a valuable partner by RGC agencies of all three components and has created good relationships with other UN agencies. The UNFPA country programme was in line with the UNDAF. The outcome level changes of each of the three programme components were aligned with UNDAF outcomes and the timeframe of the country programme corresponded with the UNDAF timeframe.

Within the UN, UNFPA has been leading on support to SRH, FP, population policy and data and youth related issues. Regarding the latter UNFPA chaired the UN Youth Task Force<sup>83</sup> which supports the UN Youth Advisory Panel. The objective of the panel is to guide the UN Country Team in its prioritization for youth related issues and to involve young people and youth-service organizations in advising the UN in the design of youth-friendly policies, strategies and programmes. The panel is meant both to inform the UN on the

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<sup>81</sup> Multilateral Organisation Performance Assessment Network, Technical Report, United Nations Population Fund (UNFPA) Volume I, Results by Micro-indicator and by Country. Draft, October 2014.

<sup>82</sup> Source: Management Response to the CPE 3.

<sup>83</sup> The UN Youth Task Force was established in October 2012. The Task force supports a variety of youth related issues, including: interagency knowledge sharing, monitoring progress on programming for youth as part of the UNDAF, identify common programming themes, networking with youth associations, advise and regular reporting to the UNCT on youth issues, advocacy for development issues of youth and young people and identification of areas and themes for operational research. Source: TOR for UN Task Force on Youth and Young People in Cambodia. Phnom Penh, December 2012.

perspectives on youth as well as to inform youth on the role of the UN and its role in the development process in Cambodia.<sup>84</sup>

Achievements of the UN Youth panel included the participation of the youth representatives in the discussions on the Post – 2015 agenda dialogue in two rounds as well as the national validation meeting, on-line discussion with the UN Secretary General’s envoy on youth, participation of the member in various UN agency thematic discussions and events and participation in the organization of International Youth day and Women’s days. This resulted in enhanced linkage of the UN Country Team and the agencies concerned to youth networks and organizations in Cambodia.

There has been particularly a close partnerships of UNFPA with UNICEF, WHO, UNDP, UNAIDS and UN Women in Cambodia. Examples of the kinds of collaboration included UNCT coordinated approach to gender as part of the UNDAF, led by UN Women, collaboration with H4+ partners in support of SRH, and UNCT joint advocacy on MDG5. As mentioned earlier, UNFPA played a significant role in the management of HSSP II, chairing the JPIG meetings for almost two years and providing high quality technical inputs to the policy dialogue, implementation, and monitoring of the programme.

In the support to D&D UNFPA closely collaborated with UNICEF on support to social sector priorities and capacity building of WCCCs and CCWCs, with each of the agencies covering different geographical areas with limited overlap, making use of a similar approach to support of social development in local development planning. This proved to be an efficient way to cover more provinces and district on social development issues, which would have been beyond the UNFPA budget limitations. Each of the organizations, however, did focus on those aspects directly linked with their own mandate. UNFPA put emphasis on population issues, migration, youth and adolescents, family planning, safe delivery, HIV/AIDS prevention and VAW while UNICEF focused on birth registration, ECD and child protection and child development issues.

UNFPA was an active partner of the JUTH, coordinated by the UNAIDS Secretariat, contributing to the national AIDS response through advocacy, policy support, capacity development and technical and financial support.

For the aid-effectiveness and harmonization in gender sector, TWG-Gender has been a central mechanism where UNFPA is actively taking part as a member in the dialogue, with UNDP leading the UN country team. UNFPA has been more actively involved in the subcommittee on GBV, currently facilitated by UNWOMEN and GIZ. The detailed functions of the subcommittee are being developed through the formulation of three TORs for more specific technical working groups.<sup>85</sup>

## 7) UNFPA Added Value

<p><b>Evaluation Question:</b> What are the main UNFPA comparative strengths in the country- particularly in comparison to other UN agencies? What is the main UNFPA added value in the country context as perceived by national stakeholders?</p>
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<sup>84</sup> UN Country Team, The UN Country Team in Cambodia UN Youth Advisory Paner, Terms of Reference. Drafted 2007, updated May 2014.

<sup>85</sup> The thematic evaluation report on GBV noted in this respect that UNFPA’s strength in supporting the health sector can assist GBV sub group of TWG Gender to link with service providers in the health sector in the implementation of the second NAPVAW. UNFPA, *Thematic evaluation on Gender-Based Violence programme*, Phnom Penh, August 2014.

**Finding 32: National stakeholders appreciated the work of UNFPA in Cambodia during CP4. As added value they consider in particular UNFPA's expertise in the following topics:**

- Population policy
- Population data gathering and knowledge management
- Sexual and Reproductive Health including health policy, protocols, guidelines and technical processes
- Family Planning
- HIV/AIDS prevention
- Reduction of VAW

An important comparative strength of UNFPA acknowledged by its partners, is its support to the development and implementation of population policy. This in turn links to UNFPA's support to population data gathering and analysis and the building of a knowledge base, in order to inform the population policy and support the on-going monitoring of population and development issues.

UNFPA has been well recognised by national and international partners for its effort to improve the national and sub-national capacity of the public health system. UNFPA has played an important role in the policy dialogue with other development partners to support SRH as part of the sector strengthening approach in health and has mobilised much needed additional resources. The comparative advantage of UNFPA Cambodia includes the strengthening of the EmONC Improvement Plan and the EmONC services provided in health facilities and their infrastructure/equipment. Family planning programme and services have expanded and more choices have been introduced with UNFPA technical and financial support. Moreover, UNFPA's expertise in issues of midwifery is well recognized including curriculum development, standards, norms and regulations for midwifery training, and the development of the Midwifery Core Competency Framework.

For the gender component of the programme, UNFPA is primarily regarded for its support to eradicate VAW. UNFPA's efforts have been making progress in developing a multi-sectoral approach to support survivors of GBV, particularly in Banteay Meanchey province. Despite progress made to date with UNFPA support, UNFPA is not sufficiently visible with regard to gender mainstreaming and political participation of women in governance, as there are many other players in this field. Coordination across parties in particular at the sub-national level has been limited, reducing opportunities for synergies across interventions. What stands out is UNFPA support to gender mainstreaming in MOH and MOP, which support was highly appreciated by both ministries and which links gender with the other organizational core competencies.

## 5. Conclusions

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### 1) *Strategic*

UNFPAs added value centres around SRH, FP and HIV prevention, support to Cambodia's population policy and gender equality, in particular reduction of VAW. UNFPA is a valued member of the UNCT, who actively participated in the TWG sub-committee on VAW. The country office, moreover, played an important role in coordination of development support in the health sector through its participation in the HSSP II sector strengthening approach. In this respect UNFPA has been able to leverage resources and expand its reach beyond the financial and human resources of the country programme.

The PD and Gender components focus respectively on aspects of decentralized governance and women's empowerment, going beyond a focus on SRH. In order to adjust these components to the limited resources and manpower of the country office and to align with the new UNFPA strategic plan, the objectives of the PD and Gender components need to relate more closely to the SRH goals of the programme. This can sharpen the focus of these two components and provide a more integrated programmatic approach together with the SRH component of the programme.

While Cambodia is rapidly moving towards reaching MIC status, it will take a longer period of 3 to 4 years before it can be expected to graduate from LDC status, as this requires additional social indicators to be met. This time frame provides a window of opportunity to make use of the advantages of LDC country status to accelerate social development. In order for UNFPA to play an important role in this process the country office will need to take the opportunity to gradually phase-out its direct delivery support and to focus on capacity development, knowledge management and policy advocacy, which are the ways of engagement that are identified in the new UNFPA strategic plan as suitable in an MIC context. However, this will need to take into account government capacities as well as the need to generate evidence for policy change through support to work on the ground. Moreover, a balance need to be maintained in terms of national and sub-national support, ensuring that national level policies are implemented at sub-national level and have the desired results, contributing to the decentralization process with social development functions allocated to sub-national levels in the implementation of IP3-II. With enhanced capacity of RGC in an MIC context, UNFPA will moreover, need to focus its support increasingly towards enhancing access and quality of SRH services in under-served, vulnerable and hard-to-reach groups and areas.

### 2) *Programmatic*

**Relevance** of the programme was high in terms of alignment with RGC national and sector strategies, alignment with needs of targeted groups and with the UNFPA strategic plan 2008-2013 as well as in terms of adaptation to the new corporate strategic plan 2014-2017. Moreover, the programme design was responsive to the Cambodian context and implementation responded to changes in this context. This concerns in particular Cambodia's move towards MIC status and the CO has been preparing to move out of a direct delivery mode of initiatives and terminating funding of overhead costs. Geographical focus is relevant and is being further sharpened by the UNFPA team.

In terms of **effectiveness**, the country programme has achieved substantial results in each of the three programme components in the fourth programme cycle, in particular at the level of programme outputs, which have started to contribute to outcome level changes. There have, however, been limitations to achievements in each of the components which need to be further addressed.

In the **PD** Component of the Country Programme the functioning of the WCCC and CCWC at the sub-national level in UNFPA supported provinces has provided a mechanism to deal with women and children's issues in a multi-disciplinary way, including a referral mechanism from the commune to the district and provincial level. What has been less successful is the leveraging of resources for local level social

development objectives with the amount provided by UNFPA being modest and meant to leverage additional local level investment budget. It is in particular the financial procedures of local resource use that proved to be a constraining factor. Further support to the WCCCs and CWCC need to focus on their more pro-active role in addressing the underlying reasons of poverty and vulnerability and their active participation in democratic decision-making, which could bring the outcome level change of an effective mechanism established for dialogue, representation and participation in decision-making in sight, the first outcome level change of the component, which has not been sufficiently contributed towards so far.

Important result of the PD component concerns the enhanced capacities to collect and use population data to inform national and sub-national decision making and enhance the evidence base of development policies and planning processes. Support to inter-census survey and CDHS 2014 and analytical studies making use of quantitative population data have considerably enhanced the knowledge base. In terms of data use, results have been significant at the national level, with relevant information made available for the development of the NSDP 2014-2018. Results have been more limited at the sub-national level. As survey data are not disaggregated beyond the province, local level decision-making remained dependent on the commune database, of which the quality is limited and management data of Provincial and District level Departments.

With the focus of the decentralization process, as outlined in IP3-II, at the district level with oversight and support from the provincial level, UNFPA would need to focus support on evidence based policy making at the district and provincial levels, further building capacities concerned. As census and survey data do not specify details at this level, use will need to be made of management data from line agencies at the local level and data from the commune database, supporting the enhancement of the quality of these data and their analysis at the sub-national level.

In the **SRH Component** of the Country Programme considerable results have been achieved in terms of increased access and use of quality reproductive, maternal, new-born health services as evidenced by reduction of MMR, increased rate of caesarean section, the use of modern family planning methods, decrease in fertility rate, increased contraceptive prevalence rate, increased incidence of delivery by skilled midwives, and enhanced access to obstetric and neonatal emergency care and surgeries. Moreover, the quality of public health services has been improved substantially over the period of the CP4.

The focus of UNFPA support on increasing the competency and availability of midwives through supports to a variety of aspects has delivered results and towards the end of CP4 there are more midwives working in Cambodia than ever before. Together with the support to the availability of emergency obstetric care, this has been an important contributing factor to the reduction of MMR. It is particular the normative guidelines for midwives which are now used as an example of how to develop standards for other health professions. The Core Competency Framework and Code of Ethics can be a model for other health professions such as medical doctor, surgeon and nurse, and can be used to strengthen the quality of health services in public facilities.

Intensive investments in strengthening capacity of the core national health system programmes of the Ministry of Health have obtained important results. The training of skilled midwives, anesthetists, nurses, surgeons and the intensive rolling out of the EmONC Improvement Plan together with outreach activities has meant that most health centers and referral hospitals are able to provide a package of safe motherhood, newborn and child health services.

Issues remaining to be addressed include the shortage of skilled midwives at remote health facilities, providing follow-up to midwives trained in the form of on the job coaching and development of a human resource development plan, and enhanced targeting of SRH and family planning interventions to the specific needs of hard-to-reach populations including youth/adolescent, garment factory workers, mobile workers and entertainment workers.

Regarding the **Gender component** results have been encouraging in the establishment and capacity development of GMAGs, in particular in MOH and MOP where UNFPA has provided specific and

continuous support. Limitation concerns the limited budget allocated to implement the plans developed by the GMAGs.

In terms of women's participation in the public sphere, trainings were conducted and most of the targets reached. This did, however, not result in any significant change in the outcome of enhanced participation of women in the public sphere. This increased at the commune level though not as much as the targeted amount and did not increase at the national level.

Though the capacities in terms of understanding GBV and related responsibilities to intervene in cases of VAW at local level have been enhanced, the number of provinces with a local level response and referral system remains low and no costed action plan has so far been developed, neither at national nor at sub-national level.

Rather than focusing on gender equality as such, it is important for UNFPA to relate its gender work to the SRH and PD components, where it can add most value and where its strengths is recognized by RGC, other UN agencies and Civil Society actors. With MOH to be one of the key focus Ministries in the implementation of the 2nd NAPVAW, it is important, in line with the new organizational strategic plan, that UNFPA links its gender work to SRH and VAW issues. In terms of support to the eradication of VAW a more focused intervention is essential by prioritizing the usage of the national guidelines for managing VAW in the health system and the clinical guidelines for a more coordinated approach and to include the role of men and boys in the reduction of VAW.

Results in terms of programme **efficiency** were found to be mixed. UNFPA has overall made good use of its human resources which are qualified and with a profound knowledge of the context of the programme. UNFPA implemented activities through partnerships with RGC and civil society partners. The human resource set-up of UNFPA staff proved relatively limited for the thematic and geographical spread of the programme and in the next programme cycle, expansion of staff would be required in order to allow for more interaction of the UNFPA team with RGC counterparts as well as with other UN agencies and with civil society organizations at national and sub-national levels.

With the country office headed by a three person senior management team this provided the programme the opportunity to provide support at the policy level and to promote aspects of the three programme components to senior level government staff and to play a substantial role in HSSP II management, the sector strengthening approach in health. Especially the latter made possible the leverage of human and financial resources beyond those available to UNFPA.

The country office made use in several programmes, including HSSP II and support to D&D of a discreet funding approach, based on organizational financial management requirements. The advantage was that it meant a fast track for activities concerned. The possible disadvantage that this could have had was that it would not have contributed to the development of national or sub-national financial systems and capacities. This turned out to be not relevant in the cases concerned as the HSSP II pooled fund was not dispersed through the Treasury due to current limitations of the capacity of the financial management system of RGC and the UNFPA provided funds to D&D at the local level were small so that it would have been unlikely for these to have been able to make a significant difference.

Though there have been some clear successes in terms of **sustainability** of results, this cannot yet be taken for granted. This goes for the results in SRH as well as for PD and gender. The partnership approach that UNFPA applied to all its programming enhanced the ownership of the initiatives, and built capacities of partners during the implementation process, which can be seen as enablers for sustainability of results. However, what has been missing in various cases is an explicit approach to obtain sustainability of results in some of the programme components.

In terms of the PD and gender components, which were in CP4 limited to seven selected provinces (and later eight provinces with the division of Kampong Cham), it is not clear how the limited geographical coverage can be broadened and scaled up so that it can benefit a larger proportion of the population.

Capacity assessments have been used to inform capacity building initiatives for civil society partners. It would be useful to make use of capacity assessments with RGC partners, to ensure that required capacities to sustain results will be built, making use of a facilitated self-assessment procedure in order to enhance the ownership of the assessment results. Subsequent assessments can be used in terms of monitoring progress of capacities concerned. This will particularly be useful in the decentralization process where a substantial amount of capacities at the sub-national level will need to be developed and monitored.

UNFPA's support at the local level to WCCC and CCWCs has been successful and when the funds provided annually to these committees can be covered through local investment budgets, UNFPA could move to the next stage of further developing capacities, in particular at provincial and district level for a more pro-active oriented approach to the committees, their role in democratic decision-making and their dealings with the underlying causes of poverty and vulnerability.

Implementation of a relatively complex programme as UNFPA CP4 in Cambodia would have benefitted from the application of a **results-based management** approach from the start of the programme cycle, through which the achievement of output and outcome level changes could be timely identified. Due to a variety of shortcomings in the results framework and the indicators concerned the actual monitoring conducted was primarily oriented towards completion of activities and compliance with financial procedures. Output and outcome level changes were included in a later stage, which meant that the monitoring system did not realize its full potential in terms of enabling results based management from the start.



## 6. Recommendations

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### 1) Country Programme level

**a. Reorient the programme to the new UNFPA strategic directions and adapt the focus of the PD and gender components of the programme to relate directly with SRH issues, bringing them in line with the comparative advantage of UNFPA in Cambodia.**

1. Focus the programme around the four strategic directions of the new UNFPA strategic plan
2. Adapt the focus of the D&D and the gender initiatives of the programme through a direct linkage of each of these initiatives with aspects of SRH and FP, in this way reducing the focus of each of these components while at the same time enhancing the synergy across the programmatic directions
3. Keep participating in the health sector strengthening approach, as a follow-up to HSSP II, combining participation in the programmatic and management aspects of the sector strengthening approach with a discreet funding approach, based on UNFPA organizational financial requirements
4. Remain engaged at the national as well as the sub-national level in support of the social development aspects of the process of administrative decentralization of RGC. Engage in the D&D process of IP3-II in close coordination with other parties concerned.
  - Ensure the inclusion of relevant SRH, population and gender aspects taken into consideration in the review and re-assignment of government functions and services to the sub-national level as part of a more in-depth D&D reform agenda and support data and information availability in order to contribute to evidence informed policy making
  - Support the development of capacities at district and provincial level in terms of government functions that are planned to be reassigned to the sub-national level in selected provinces. Provide in particular support to the transfer of functions of the MOWA, MOH and other key RGC partners to the sub-national level, as planned in IP3-II, including attention to the role of Councilors and with a focus on aspects of social equity and inclusiveness
  - Adapt the geographical focus of the sub-national aspects of the country programme based on criteria of poverty and near poverty, vulnerability and underserved groups and areas, in this way contributing to more equitable development
5. Keep engaged in gender with a focus on reproductive, maternal and newborn health and GBV, including a focus on engaging men in GBV as well as other aspects of gender based work
6. Start identifying the needs for urban programming in Phnom Penh as well as in provincial urban centres, making use of the urbanization study conducted by UNFPA

**b. Review the human resource capacity for the next programme cycle and align the number of programmatic staffing positions with the requirements of the program. Increase staffing positions in line with the complexity of the programme and the needs for a combined engagement at national and sub-national levels.**

1. Increase staffing in line with UNFPA support to the IP3-II guided process of decentralization of social development functions to the district level and support functions at the provincial level.
2. A distinct position on M&E could enhance results based management, while at the same time free up time from assistant representative for respective program components. A distinct M&E staff

position would need to be located in the staffing structure above all three programme components and in particular be tasked with supporting monitoring and evaluation in each of the programme components, ensuring quality of M&E outputs and support building required capacities within RGC counterpart agencies, other partners as well as within UNFPA. Moreover, the person would need to share experiences and lessons learned from other country offices and promote and support a culture of results based management in the country office.

**c. Enhance results based management of the country programme and its components**

1. In preparation of the new CPD, review the monitoring system and processes concerned, adapt the results framework and include sufficiently SMART indicators,<sup>86</sup> ensuring outputs are within the management control of UNFPA (in this way identifying UNFPA's contribution to outcome level changes), with annual reviews for each of the outcome areas and formal documentation of the process
2. Enhance the systemic aspects of country programme monitoring and evaluation by planning for and implementing an interrelated set of monitoring and evaluation activities over the period of one year, aimed at informing results based management of each of the programme components and the country programme as a whole
3. Integrate a number of evaluative assessments in the annual M&E plan, focused on key output and outcome areas, with the assessments building up over the period of the new country programme. Include in this plan:
  - CIP assessments, including qualitative assessments of a limited number of cases and a quantitative assessment of a sample of CIPs
  - KAP towards SRH in areas where CCWC and WCCCs have been supported in order to assess the results of the dissemination and awareness raising activities at the local level
  - An in-depth analytical study on the results on VAW (CDHS 2014) in conjunction with other prevalence study on VAW such as WHO multi-country study in order to adapt the strategy, including regarding the engagement of men and boys in the prevention of VAW and to draw a better response to service provision

## **2) The level of the UNFPA Strategic Directions**

**a. Increased availability and use of Sexual and Reproductive Health Services**

1. Continue to focus on key interventions that have proven successful including family planning, skilled birth attendance and midwifery training and access to quality EmONC services, in particular in remote areas and where lack of access is persistent.
2. Provide technical and financial support to MoH for the development of a Human Resource Capacity Assessment and Improvement Plan, identifying skill gaps of midwives and other medical staff. In response to the capacity gaps, UNFPA should support the MoH's Department of Human Resource and the national reproductive health programme to update the national midwifery curriculum to be standardized in line with the WHO/ICM Standard. Moreover, providing routine coaching/supervision of midwives trained and further follow up on the regulations/norms/standards for midwifery training in order to enhance the quality of EmONC services.

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<sup>86</sup> SMART stands for: Specific, Measurable, Achievable, Realistic and Timely. Source: UNFPA, Independent Evaluation Office, *Handbook, How to Design and Conduct a Country Programme Evaluation at UNFPA*, New York, October 2013.

3. Include a focus on awareness raising / interventions on family planning including men in the approach to family planning

**b. Priority on Adolescents and Youth**

1. Increase attention to access to quality SRH/FP information and services of youth, including youth friendly clinical services, in particular vulnerable and marginalized groups including mobile/migrant workers, EWs and un-reached youth. Continue support to the SMART girl programme, CSE for school students and out of school youth and support to the Love9 programme.
2. Play a leadership role in addressing teenage and unwanted pregnancies, making use of the quantitative data of the CDHS and advocating for adequate national and sub-national responses. Provide support to address teenage pregnancies, including attention to the age of first marriage, educational performance, exposure to family planning messages on mass media and of use of contraceptives by youth, all identified as entry points in the UNFPA supported study on teenage pregnancy in Cambodia.<sup>87</sup> Seek linkage with other UN agencies as part of the UNDAF process to address the issue of teenage pregnancies from multiple perspectives, making use of an integrated holistic approach.
3. Continue support to the Youth Advisory Panel and chairing of the UN Youth Task Force by UNFPA as part of the focus on youth and adolescents in the programme, further developing cooperation on youth across the UN agencies
4. Work with civil society organizations on youth and adolescents' voice, their access to information and their role in accountability regarding access to and quality of SRH and VAW services. Provide support to ensure that adolescents and youth, in particular women and girls and other vulnerable groups, can make use of adequate means and platforms to raise their voices and make their needs known, especially during government planning processes at national and sub-national levels.
5. Support the development of a simple monitoring mechanism to the youth development policy and train selected stakeholder in target provinces to use this tool to assess local situation of youth. Follow up on the implementation of the youth policy
6. Support to the development of student learning materials for the implementation of the CSE curriculum and strengthening of the quality of CSE programme through close follow-up and monitoring of results

**c. Advanced Gender Equality and women's and girls' empowerment**

1. Prioritize and concentrate UNFPA support to VAW with a focus on SRH by utilizing the national guideline for managing violence against women and children in the health system and the clinical guideline for health officials. Support the effective involvement of men and boys to the prevention of VAW through strengthening the multi-coordinated response mechanism in pilot areas in coordination with all relevant stakeholders including WCCC/CCWC, PDoWA and other line departments at provincial level, police, health officials and civil society organizations.
2. Support the implementation and monitoring and evaluation of the NAPVAW II, including the assessment of intermediate level changes in the period in between the assessment of higher level VAW indicators through the CDHS

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<sup>87</sup> Royal Government of Cambodia, Ministry of Planning, National Institute of Statistics, Ministry of Health, Directorate General for Health, *Teenage Fertility and its Socio-Demographic Characteristics and Risk Factors, Further Analysis of the Cambodia Demographic and Health Survey*. Phnom Penh, April 2013.

3. Focus UNFPA's intervention to gender mainstreaming in the MOP and MOH as a core area and provide direct support to those two GMAGs, with technical support from MOWA. Assist MOP and MOH to secure the essential national budget for GMAG work through supporting and strengthening MOWAs advocacy role
4. Continue contributing to the PBA in gender in order to enhance aid-effectiveness and to ensure coordination of UNFPA support with the inputs of other development partners in a harmonized approach in line with Government policies on VAW and NAPVAW II.

**d. Strengthened policies through evidence-based analysis of population dynamics**

1. Continue support to the CDHS, Census data gathering and the preparations for the census of 2018 as well as support to other population related surveys
2. Support planners of selected line Ministries (in particular MOH, MOWA and MOEYS) at national and sub-national levels (in UNFPA focus areas at the sub-national level) to enhance statistical capacities and skills in analysis of disaggregated data, increasing in this way the use made of available data
3. Continue support to the review of the Cambodia Population Policy and to support the development of policies on key population issues as these emerge, including ageing, migration and urbanization
4. Continue support to Provincial and District councils in their strengthening of the WCCC at provincial and CCWC at district and commune levels
  - Continue support to sensitization of sub-national administration (provincial and district councils) on SRH, maternal health, family planning, VAW, and youth SRH priorities and advocate for increased resource allocation to these priority interventions as part of social development issues
  - Focus efforts at the district level which is the main level for allocation of decentralized social development functions in the IP3-II, with a focus on support functions of the province and implementation functions at selected communes within each of a number of selected districts
  - Phase out the payment of USD 500 and use these resources to focus on capacity development for a more pro-active role of the committee in the democratization process, making use of sharing of learning across WCCCs and CCWCs
  - Advocate for the allocation of at least a few percentage points of total commune investment budget to social development issues to compensate for the loss of UNFPA budget
  - Enhance monitoring at district and provincial level with inputs from commune level, in order for experiences and learnings to be captured so that the initiative can serve as a model for other regions in Cambodia
  - Work with NGOs on the demand side of the equation, strengthening citizen's engagement and aspects of accountability through district and commune councils
  - Agree with UNICEF on a division of support in geographical terms and sharing of experiences and learnings on a regular basis
5. Explore options to support strengthening data gathering of local level population database to enhance quality and their use for sub-national planning

**ANNEX 1:**

**Terms of Reference of the Evaluation of UNFPA – Cambodia  
Fourth Country Programme Cycle 2011-2015**



**FINAL VERSION**

**Terms of Reference**

Country Programme Evaluation (CPE)

Cambodia Fourth Country Programme (2011-2015)

1. Introduction

The Cambodia Country Office is planning to commission the evaluation of the UNFPA Cambodia Fourth Country Programme (2011-2015) in 2014 as part of the UNFPA biennial budgeted evaluation plan (DP/FPA/2014/2), 2014-2015 approved by the UNFPA executive board in 2014, and in accordance with the UNFPA 2013 evaluation policy (DP/FPA/2013/5).

Evaluation at UNFPA serves three main purposes that support the organization's drive to achieve its intended results: (a) It is a means to demonstrate accountability to stakeholders on performance achieved; (b) It supports evidence-based decision-making; and (c) It contributes important lessons learned to the knowledge base of the organization.

UNFPA Cambodia commenced its operations by opening its Cambodia Country Office (CO) in 1994 at the request of the Royal Government of Cambodia (RGC) following the UN-sponsored national elections in 1993. Since then UNFPA has steadily increased its technical and financial assistance to Cambodia through its successive programmes of assistance.

This CPE intends to take stock of performance and actual achievements and provide independent and actionable recommendations for adjustments to the current CP, where advisable, and especially formulation of the next CP (2016-2018) which is the basis for future UNFPA support in Cambodia, which needs to be in line with the new UNFPA Strategic Plan 2014-2018 including the Business Model. The evaluation also aims to provide an independent and quality assessment of the future UNFPA country programmes and the continued role for UNFPA support in Cambodia in the context of support to the Government in its commitments towards attaining the goals of ICPD and the MDGs as well as any ICPD Beyond 2014 and the post-MDG agenda if foreseeable.

The results of this evaluation are intended for UNFPA, Government Partners, as well as other development partners in which evaluation findings will be considered for lessons learned and capturing good practices from past implementation as well as in determining the way forward for the next programming cycle.

The evaluation will be managed by the Country Office and conducted by a team of independent evaluators, in close consultation with the evaluation reference group.

2. Context

Cambodia has experienced rapid economic growth since the 2000s leading the country's poverty rate reduced from 47.8 per cent in 2007 to 22.9 in 2009, 21.1 per cent in 2010 and 19.8 per cent in 2011. Therefore, the country is well on the way to reaching the Millennium Development Goals (MDGs) by 2015. Cambodia has indeed made great strides in reducing poverty through implementing its National Strategic Development Plans, focusing on investments in population programmes in particular on reproductive, maternal and child health including family planning adhering to reproductive rights that promote choices. This growth is

obviously in large part influenced by the shifts in the country's major population dynamics—low fertility and mortality, change of age structure, migration and urbanization, not to mention the improved social infrastructure, political stability and other major enabling factors which contributes to increased foreign direct investments, in particular in the industrial and service sectors.

Currently, UNFPA Cambodia is implementing its fourth country programme (CP4) 2011-2015, the goals of which are to support the RGC in its pursuit of meeting the goals of the International Conference on Population and Development Programme of Action (ICPD-PoA) and MDG's through the implementation of Cambodia's National Strategic Development Plan (NSDP) and the United Nations Development Framework (UNDAF) 2011-2015.

The three main areas of the UNFPA Cambodia's focus in its assistance are: i) Population and Development; ii) Reproductive Health and Rights; and iii) Gender. *The Reproductive health and rights component* contributes to the UNDAF priorities in the areas of health and education, governance, and social protection with four outcome areas and five outputs. The four outcome areas are: (a) increased equitable coverage, at national and subnational levels, of good-quality reproductive, maternal, newborn and child health and nutrition services; (b) enhanced national and subnational institutional capacity to expand young people's access to good-quality life skills, including on HIV, and technical and vocational education and training; (c) strengthened multi-sectoral response to HIV; and (d) increased national and subnational capacity to provide affordable and effective national social protection through improved development, implementation, monitoring and evaluation of a social protection system.

*The population and development component* contributes to the UNDAF priority in the area of good governance under two outcome areas and three outputs: (a) effective mechanisms for dialogue, representation and participation in democratic decision-making are established and strengthened; and (b) enhanced capacity for collecting, accessing and utilizing data disaggregated by sex, age, target population and region, at national and subnational levels, to develop and monitor policies and plans that are responsive to the needs of the people and incorporate priority population, poverty and development linkages.

*The Gender equality component* contributes to the UNDAF priority in the area of gender. Within this component, UNFPA will support four outcome areas and five outputs, focusing on gender-based violence and decentralized capacity-building. The four outcome areas are: (a) a harmonized aid environment that promotes gender equality and the empowerment of women; (b) strengthened and enhanced gender-mainstreaming mechanisms at national and subnational levels; (c) enhanced participation of women in the public sphere at national and subnational levels; and (d) improved societal attitudes and preventive and holistic responses to gender-based violence.

UNFPA's support to Cambodia has increased since 1994. The first country programme (1997-2000) was worth US\$16 million, with US\$26 million for the second country programme (2001-2005), with US\$27 million for the third country programme (2006-2010), and the fourth country programme (2011-2015) has a value of US\$24.2 (nine million of which was mobilized from other resources). The CP4 enjoyed significant financial contributions from the Governments of Australia towards both RH and PD programmes and the Government of the United States of America (USAID) for RH programme. In addition, the UNFPA-initiated Maternal Health Thematic Fund launched in 2008 and UNAIDS' UBRAF support to maximize UN's response to AIDS also make up part of the CP resources.

Under the CP, the CO has entered into strategic partnership with a number of key implementing partners in order to deliver the intended results. Those implementing partners are: 1) The Ministry of Planning, 2) Ministry of Health, 3) Ministry of Women's Affairs, 4) Ministry of Education, Youth and Sports, 5) Ministry of Interior, 6) National Committee for Population and Development (Office of The Council of Ministers)<sup>88</sup>,

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<sup>88</sup> NCPD was an implementing partner of UNFPA until the first quarter of 2012.

7) Cambodian Women Crisis Center (CWCC), 8) Reproductive Health Association of Cambodia (RHAC), 9) Reproductive Health and Child Alliance (RACHA), 10) Cambodian Women for Peace and Development (CWPD), 11) Children's Surgical Centre (CSC), 12) BBC Media Action (BBCMA), 13) INTHANOU, 14) Paz y Dessarollo (PyD) and 15) CARE.

3. Evaluations and reviews prior to the 2014 CPE

The evaluation of the UNFPA third country programme (2006-2010) was conducted in 2011 and as a result a number of useful recommendations were provided for the UNFPA CO in an effort to strengthen certain areas of the country programme. All of the accepted recommendations have been taken into account and implemented by the UNFPA CO in its current country programme.

Additionally, an in-depth review of five UNFPA supported thematic programme areas (youth and comprehensive sexuality education; midwifery; family planning; gender-based violence/violence against women; and Decentralization and Deconcentration Reform) was conducted in order to generate in-depth and more focused knowledge and evidence on the strategic position of UNFPA CO and the relevance of these support areas with the corporate and national contexts. The results of these reviews have been made available and useful for programming direction for those particular thematic areas. The evaluation team is therefore strongly encouraged to consult with these thematic review reports, among other key documents, as part of literature review tasks.

4. Evaluation purpose, objectives and scope

4.1 Purpose

UNFPA CPE is meant to ensure both the accountability of UNFPA Cambodia to its donors, partners and other stakeholders and to facilitate learning with a view to improving the relevance and performance of its country programme.

4.2 Objectives

The overall objectives of this CPE are:

- an enhanced accountability of UNFPA for the relevance and performance of the country programme 2011-2015;
- a broadened evidence-base for the design of the next programming cycle (2016-2018) in line with the corporate and national needs and strategies and the UNDAF 2016-2018.

Specific objectives of CPEs:

Towards the achievement of these overall objectives, this CPE will be able to:

- provide an independent assessment based on the Organization for Economic Co-operation and Development (OECD)/Development Assistance Committee (DAC) evaluation criteria (relevance, effectiveness, efficiency and sustainability) of the progress of the country programme (2011-2015) towards the expected outputs set forth in the results framework;
- provide an assessment of the CO positioning within the developing community and national partners, in view of its ability to respond to national needs while adding value to the country development results;
- draw key lessons from past and current cooperation, including the results of the UNFPA in-depth thematic programme evaluations, and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programming cycle (2016-2018) by well taking into account relevant aspects of the UNFPA Strategic Plan 2014-2017, including the Business Model, the UNDAF 2016-2018 and the NSDP 2014-2018 and the agenda of the ICPD Beyond 2014 and the post-MDGs development, where foreseeable.

### 4.3 Scope

The evaluation will cover UNFPA assistance funded either from its own resources or with complementary/other resources. Geographically, the evaluation will cover the whole national territory of Cambodia and is defined by the territorial scope of UNFPA interventions in the country at both national and sub-national levels. The evaluation will also take into account the relevant UNFPA Strategic Plans (2008-2013 and 2014-2017), the UNDAF 2011–2015 for Cambodia, development reports for Cambodia and the key government and sectoral strategic planning documents.

The evaluation will focus on the outputs achieved through the implementation of the CP to date. The evaluation will cover all activities planned and/or implemented during the period 2011-2014 within each programme component. Besides the assessment of the intended effects of the programme, the evaluation also aims at identifying potential unintended effects.

The evaluation will assess the extent to which the current CP, as implemented, has provided the best possible modalities for reaching the intended objectives, on the basis of results to date. The end-programme evaluation will provide recommendations for the upcoming CP (2016-2018) development and subsequent annual work plans and direction for the design of future UNFPA interventions in Cambodia in line with the national context and the UNFPA Strategic Plan 2014-2017 including its Business Model.

The scope of the evaluation will include an examination of the relevance, effectiveness, efficiency, sustainability, coordination with UNCT and added value of UNFPA support as well as its ability in delivering the results as stated in the agreed outputs, as listed in the table below, under the current CP.

CP/CPAP Outcomes	CP/CPAP (2011-2015) Outputs
<b>PD Outcome 1:</b> Effective mechanism for dialogue, representation and participation in democratic decision-making established and strengthened.	<b>PD Output 1:</b> Avenues and structures developed and strengthened to empower youth and women to participate in decision-making and planning at national and sub-national level.
<b>PD Outcome 2:</b> Enhanced capacities for collection, access and utilization of disaggregated information (gender, age, target populations, region) at national and sub-national levels to develop and monitor policies and plans that are responsive to the needs of the people and incorporate priority population, poverty and development linkages.	<b>PD Output 2:</b> Improved availability and utilization of disaggregated (gender, population, region) data and information. <b>PD Output 3:</b> National and sub-national capacity to develop plans and budgets that are evidence based, gender and child sensitive and incorporate priority population, poverty and development linkages strengthened.
<b>RH Outcome 1:</b> Increased national and sub-national equitable coverage of quality reproductive, maternal, newborn, child health and nutrition services.	<b>RH Output 1:</b> Increased national and sub-national capacity for emergency preparedness and response to reduce and mitigate vulnerabilities to disasters, both environmental and health, of the poorest and most marginalised, especially women, children, youth and people living with HIV. <b>RH Output 2:</b> Increased competency and availability of health human resources, particularly midwives and other professionals where skill gaps exist.



<p><b>RH Outcome 2:</b> Enhanced national and sub-national institutional capacity to expand young people's access to quality life skills including on HIV and technical and vocational education and training (TVET).</p>	<p><b>RH Output 3:</b> Enhanced access to and utilization of life skills training [and TVET] especially by disadvantaged young people and out of school children.</p>
<p><b>RH Outcome 3:</b> Strengthened multi-sectoral response to HIV.</p>	<p><b>RH Output 5:</b> Enhanced national and sub-national capacity to target key populations at risk with effective HIV prevention interventions.</p>
<p><b>RH Outcome 4:</b> Increase in national and sub-national capacity to provide affordable and effective national social protection through improved development, implementation, monitoring and evaluation of a social protection system</p>	<p><b>RH Output 6:</b> Increased national and sub-national capacity for emergency preparedness and response to reduce and mitigate vulnerabilities to disasters, both environmental and health, of the poorest and most marginalised, especially women, children, youth and people living with HIV.</p>
<p><b>Gender Outcome 1:</b> A harmonized aid environment that promotes gender equality and the empowerment of women</p>	<p><b>Gender Output 1:</b> Increased UN leadership and facilitation of a programme based approach to promote gender equality and the empowerment of women</p>
<p><b>Gender Outcome 2:</b> Strengthened and enhanced gender mainstreaming mechanisms at national and sub-national levels</p>	<p><b>Gender Output 2:</b> Enhanced capacity of Gender Mainstreaming Action Groups (GMAGS) in all line ministries/institutions (24+3) at national and sub-national level.<sup>89</sup></p>
<p><b>Gender Outcome 3:</b> Enhanced participation of women in the public sphere, at national and sub-national levels.</p>	<p><b>Gender Output 3:</b> Enhanced opportunities and mechanisms to strengthen women's capacity to participate in the public sphere at national, sub-national and community levels.</p>
<p><b>Gender Outcome 4:</b> Improved societal attitudes and preventive and holistic responses to gender based violence.</p>	<p><b>Gender Output 4:</b> Increased community awareness and involvement in the promotion and protection of women's rights, gender equality and prevention of GBV.</p> <p><b>Gender Output 5:</b> Increased institutional capacity to provide multi-sectoral mechanisms for protection of women's and rights, gender equality and prevention of GBV.</p>

In addition, the evaluation should provide feedback regarding the contribution of the CP to RGC's efforts to attain the goals of the ICPD, including the relevant UNFPA Strategic Plans (2008-2013 and 2014-2017) and the Cambodian MDGs.

5. Key evaluation criteria, questions and issues

<sup>89</sup> The CO and the Ministry of Women's Affairs decided in an Annual Review Meeting in December 2012 to remove two Gender outputs (Output #2 and #5).

UNFPA is strongly committed to complying with principles of the OECD/DAC in terms of development programme evaluation. A number of key evaluation questions/ issues are proposed below and the evaluation team will initiate their own steps and approaches toward getting answers to those questions, which will thereafter lead to conclusion and recommendations. However, these evaluation questions are indicative at this stage and will be finalized during the design phase of the evaluation after proper consultation with the CO evaluation manager (EM) and the evaluation reference group (RG). Under each evaluation criteria, there are a number of questions which are essential to be addressed, whereas some other questions are desirable to be addressed.

#### RELEVANCE

The evaluation will assess the CP's relevance with the UNFPA Strategic Plans, the NSDP Update 2009-2013, the UNDAF 2011-2015 and other key sectoral planning documents.

Issues essential to address:

- Is the formulation of UNFPA's interventions in the different areas relevant to: a) national needs and priorities of Cambodia, b) the needs of target populations; and c) focuses of the CP outputs are in line with the organizational and regional strategies manifested in the ICPD-PoA, relevant UNFPA Strategic Plans, the Cambodia MDGs and the UNDAF in the country?
- Has the current CP been aligned with the priorities as set out in the UNFPA Strategic Plan 2014-2017 and its Business Model?
- To what extent was the country office able to respond to changes in the national development context?
- Has UNFPA applied the appropriate strategy with regard to the political, economic and social context in Cambodia?

Issues desirable to address:

- How well did the CP's design respond to and reflect the current trends, future challenges in the Cambodian context including those of the regional bloc - Association of South East Asian Nations (ASEAN)?
- Has the CP taken into account the country's evolution towards the Middle Income Countries (MIC) status as well as the changing donor context?
- Were gender, equity and human rights dimensions effectively incorporated into the CP's design?

#### EFFECTIVENESS

The CP evaluation will examine the degree of achievement of the country programme outputs, and progress made towards achieving the programme outcomes given the changes in the global and national policy environment, and identify reasons for this progress and/or discrepancies between plans and achievements.

Issues essential to address:

- To what extent have the expected results of the programme been achieved or likely to be achieved? If so, to what degree? What were the factors that influenced the achievement and/or the non-achievement of the results?
- What was the intervention coverage – were the planned geographic areas and target groups especially those of the marginalized ones appropriately and equitably reached?

Issues desirable to address:

- How complementary and well-coordinated were the RH, PD and Gender components of the CP?

- What were the constraining and facilitating factors and the influence of context on the achievement of results?
- How adequate and effective were the monitoring and evaluation tools of the programme, including the baseline and end line survey instruments?

#### EFFICIENCY

To what extent has the UNFPA CO made good use of its human, financial and technical resources in pursuing the achievement of the results defined in the country programme?

Issues essential to address:

- What was the timeliness of inputs; timeliness of outputs?
- How could more efficient use of resources be made given the country context?

Issues desirable to address:

- What was the quality of output achieved in relation to the expenditures incurred and resources used?

#### SUSTAINABILITY

To what extent are the results of the UNFPA CO supported activities likely to last after their termination?

Issues essential to address:

- Has the programme incorporated appropriate exit strategies and developed the capacities of partners to ensure the sustainability of outputs?
- Have conditions and mechanisms been developed and enhanced to ensure that national partners will take ownership of them upon completion of UNFPA intervention?

#### UNCT COORDINATION

To what extent has the UNFPA CO contributed to the good functioning of coordination mechanisms and to an adequate division of tasks within the UN system in Cambodia?

- To what extent does the UNDAF fully reflect the interests, priorities and mandate of UNFPA in the country?

#### ADDED VALUE/CAMPARATIVE ADVANTAGES

- What are the main UNFPA comparative strengths in the country – particularly in comparison to other UN agencies?
- What is the main UNFPA added value in the country context as perceived by national stakeholders?

The evaluation team should organize the questions into an evaluation matrix (see template #5 in the Handbook) that indicates the: evaluation questions, the assumptions to be assessed, its respective indicators (both qualitative and quantitative), proposed data sources and tools for data collection (document review, key informant interviews, field visit, etc.) to address each of the evaluation questions. Evaluators must use it throughout the data collection process with a view to structuring and recording all collected information. At the design phase, the matrix displays the data requirements (sources and collection methods) to respond to the evaluation questions while at the field phase evaluators shall organize the data and information collected with a view to responding to the evaluation questions. The completed evaluation matrix shall be included in the final report as an annex.

#### 6. Methodology and approach

The evaluation team will need to properly consult with the methodological guide – Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA - introduced by the Evaluation Office of

UNFPA, which provides clear steps, recommended methodologies and tools and templates to be used for UNFPA country programme evaluations.

The evaluation will use a multiple-method approach including : a) the review of documents including the relevant Strategic Plans, UNDAF, NSDP, Country Programme Documents, Country Programme Action Plan, Annual Work Plans, standard progress reports, country office annual reports, annual review reports, mission reports, sectoral plans and their progress reports; b) site visits to UNFPA targeted areas (*number of provinces is to be determined in the design phase*); and c) interviews with key stakeholders including national counterparts, implementing partners and development partners and target beneficiaries.

It is expected that the selection of provinces will be done in consultation with the CO EM and the RG and based on the agreed criteria. The collection of evaluation data will be carried out through a variety of techniques that will range from direct observation to informal and semi-structured interviews and focus/reference groups, where feasible. The analysis will build on triangulating information obtained from various stakeholders' views as well as with secondary data and documentation reviewed by the evaluation team. The Evaluation Team will use a variety of methods to ensure the validity of the data collected. Besides a systematic triangulation of data sources and data collection methods and tools, the validation of data will be sought through regular exchanges with the CO programme managers.

Worthy of being noted is that the UNFPA CP4 uses the Cambodia Demographic and Health Survey (CDHS) as a key source of data, among others, to measure the progress of most CP indicators. However, since the next round of CDHS will be conducted in 2014 with the results expected to be made available at some point in 2015, end-line data to measure the progress of these indicators will not be available. Therefore, the evaluation team is expected to do their utmost to minimize this challenge and clearly stipulate the necessary approach in the design report of their attempts to do so.

An inclusive approach, involving a broad range of partners and stakeholders, will be taken. The evaluation team will perform a stakeholder mapping in order to identify both UNFPA direct and indirect partners (i.e. partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context). These stakeholders may include representatives from the Government, civil-society organizations, the private-sector, UN organizations, other multilateral organizations, bilateral donors, and most importantly, the beneficiaries of the programme.

## 7. Evaluation process

The timeframe for the evaluation is **five months**, from the start of the preparation phase through to distribution of the final evaluation report. The evaluation process will be divided into four phases, each consisting of various stages. The evaluation process will be conducted on an independent basis, and will actively involve the Cambodia CO, the evaluation reference group, the government institutions and civil society organizations.

### Phase 1: Preparation and Desk review

**Desk review:** This will be performed by the evaluation team in cooperation with the CO and will involve the identification, collection and mapping of documents and other relevant data. The review will include an assessment of general documentation on the human development situation, national planning documents, studies and a full overview of UNFPA country programme during the period under evaluation.

**Stakeholder mapping:** Basic mapping of the country stakeholders relevant to the evaluation will be performed by the evaluation team in cooperation with the CO. The mapping exercise will include state and civil society stakeholders, and should go beyond traditional UNFPA partners.

**Design Report:** The evaluation team shall produce a design report which contains the logic underlying the intervention, background to the evaluation, evaluation questions, detailed methodology, information sources, instruments and a plan for data collection, data analysis design and format of final report. The design report will need to be agreed upon with the Cambodia CO prior to conducting data collection.

Phase 2: Mission and data collection

**Field visit:** The evaluation team will undertake a **four-week mission** in Cambodia (both in Phnom Penh and in selected field sites) to gain an in-depth understanding of the development challenges and the different perspectives of the stakeholders regarding the role of UNFPA in meeting these challenges within its specific mandate. The field visit focus will be, but not limited to, on visiting health centers, referral hospitals, women and children consultative committees (WCCC) and commune committee for women and children (CCWC), which will provide an opportunity for interaction with target beneficiaries as well as other relevant stakeholders. During the visit, data will also be collected and validated. The team will visit different parts of the country where interventions and activities are implemented in order to obtain a more complete view of the execution of the programme.

**Presentation of preliminary results:** The field visit will end with a meeting with CO staff to present preliminary results, receive comments and validate the preliminary analysis.

Phase 3: Development and production of the draft evaluation report

**Analysis and report:** during this phase, the data collected will be analysed, cross-checked and triangulated. The evaluation team will prepare a first strong draft evaluation report and submit to the Cambodia CO for review.

**Review:** The draft will be subject to a review process by the Cambodia CO and the evaluation reference group. The evaluation team will complete the evaluation report on the basis of the comments received.

Phase 4: Follow up

**Management response:** The evaluation team will ask the Cambodia CO to prepare a management response to the recommendations contained in the final evaluation report.

**Communication and dissemination:** The evaluation report will be distributed to the relevant stakeholders. The evaluation report will be available to the Executive Board as a companion document to the Cambodia CO new country programme document (2016-2018). In addition, the evaluation report and the management response will be published on the CO web page and will be available to the public.

The provisional timeline is provided in a section below in order to guide the evaluation process. However, this is a mere indication and may be subject to further refinement by the evaluation team in order to meet the actual requirements if deemed necessary.

The evaluation team shall have no conflict of interest or any connection to the design, planning, or implementation of the current or upcoming country programme. Any such conflict should be brought to UNFPA's attention immediately.

8. Specific Outputs (Deliverables)

The **ICTL** will assume overall coordination and evaluation responsibilities of the UNFPA CP evaluation and will provide appropriate guidance and support to the national consultants, accompanying her/him to all stakeholder meetings if necessary and providing other support as required. The **ICTL** in consultation with the CO Evaluation Manager and inputs from the National Consultants will be responsible for the following tangible outputs (the outlines of which especially the design and final reports are available in the Handbook on How to Design and Conduct a CPE at UNFPA) at an acceptable level of quality and in a timely manner:

- Design Report (data collection instruments and clear timeline)
- Draft the CPE report (with inputs from the team members following the standard evaluation approach and methodology for the CPE)
- Debriefing presentation at the end of the field phase;

- Final CPE report and evaluation brief
- 1. **Design Report:** The ICTL shall commence the assignment and within one week of award of contract, the evaluation team shall submit an electronic copy of a draft design report (*template to be provided*) to UNFPA. The design report should include a clear work plan specifying methodological and organizational aspects of its work, including any provisions for needed meetings, interviews, travel, formal events of consultations etc., as well as the necessary working days foreseen for key components of the work plan (refer to the methodological guide). The design report provides an opportunity for UNFPA, the RG and the evaluation team to ensure that their interpretations and understanding of the CPE ToR are mutually consistent. The design report, once agreed and approved, will serve as an agreement between UNFPA and the evaluation team on how the evaluation will be conducted. This design report shall:
  - Explain the evaluation team’s understanding of what is being evaluated and why;
  - Describe the team’s strategy for ensuring the evaluation’s utility and applicability to the needs of UNFPA and those of key stakeholders;\*
  - Describe the evaluation team’s plans to engage and involve these stakeholders in the design (e.g., questions, objectives, methods, data-collection instruments), data collection, data analysis, and development of recommendations;\*
  - Explain how the evaluation questions will be addressed with respect to all evaluative criteria indicated above by way of proposed methods, evaluation designs, sampling plans, proposed sources of data, and data-collection procedures;\*

Note: The evaluation team is encouraged to suggest refinements to the TOR and to propose creative or cost- or time-saving approaches to the evaluation and explain their anticipated value.

- For each of the evaluative criteria, describe the measurable performance indicators or standards of performance that will be used to assess progress towards the attainment of results, including outputs;\*
- Discuss (a) the limitations of the proposed methods and approaches, including sampling, with respect to the ability of the evaluation team to attribute results observed to UNFPA’s efforts especially when there is no consideration of a valid counterfactual and (b) what will be done to minimize the possible biases and effects of these limitations;\*
- Explain the team’s procedures for ensuring quality control for all deliverables;
- Explain the team’s procedures to ensure informed consent among all people to be interviewed or surveyed and confidentiality and privacy during and after discussion of sensitive issues with beneficiaries or members of the public;\*
- Explain how the evaluation will reflect attention to and mainstreaming of gender concerns and identify the member of the evaluation team who will be responsible for doing so;\*
- Indicate familiarity with and agreement to adhere to (a) the requirements of the *Standards for Evaluation in the UN System*, especially standards 4.1 through 4.18 and (b) UNFPA’s Evaluation Quality Standards, which will be provided to the evaluation team; and,
- Provide a proposed schedule of tasks, activities, and deliverables consistent with this TOR.

Note: Items marked with an asterisk should also be discussed in the evaluation report.

- 2. **Draft evaluation report:** The ICTL shall draft and submit an electronic copy of a draft evaluation report to UNFPA (see timeline below). The draft report should be thoroughly copy edited to ensure that comments from the UNFPA and other stakeholders especially the Reference Group on content,

presentation, language, and structure can be reduced to a minimum. The ICTL should try as far as possible to develop a strong first draft report, since this has been proved very useful in facilitating clear and constructive feedback and generates confidence by the reviewers in the competence of the evaluation team.

3. **Final report:** After UNFPA's and Reference Group's review of the draft report, the evaluation manager of UNFPA office will provide consolidated written comments to the evaluation team. Based on these comments, the team shall correct all factual errors and inaccuracies and make changes related to the report's structure, consistency, analytical rigor, validity of evidence, and requirements in the TOR. The team will not be required to make changes to conclusions and recommendations unless they are regarded as qualitative improvements. After making the necessary changes, the evaluation team will submit a revised draft evaluation report to UNFPA. After the second round of review and, if necessary, further revision to the draft evaluation report, will be made and the evaluation team can then submit the final report pending UNFPA's approval.

The final report will follow an agreed outline and format based UNFPA Evaluation Guidelines and should not exceed 30-40 pages, including annexes. The evaluation report should go beyond a mere description of implementation and outcomes and include an analysis, based on the findings, of the underlying causes, constraints, strengths on which to build on, and opportunities.

Conclusions need to be substantiated by findings consistent with data collected and methodology, and represent insights into identification and/ or solutions of important problems or issues. Conclusions regarding attribution of results, which are most often tentative, require clear detailing of what is known and what can plausibly be assumed in order to make the logic from findings to conclusions more transparent, and thereby increase the credibility of the conclusions.

For accuracy and credibility, recommendations should be the logical implications of the findings and conclusions, formulated in a clear and concise manner. Additionally, recommendations should be prioritized to the extent possible. Recommendations should be firmly based on evidence and analysis, be relevant and realistic, with priorities for action made clear.

An abstract of the evaluation shall be produced by the ICTL and submit to UNFPA along with the full final evaluation report. UNFPA will provide the evaluation team with the recommended outlines for the final report and the abstract. All deliverables must be in English and in both hard and electronic (editable) copies.

#### 9. Tentative work plan

Below is an indicative timeline which covers the whole process of a country programme evaluation. However, some flexibility is expected in order to respond to actual situation. The actual CPE exercise and its key phases are expected to commence in **September until December 2014**.

Phase	Key activities	Timeframe	Place	Responsible parties
Preparatory phase	- Develop and finalize evaluation terms of reference	05 weeks		- UNFPA CO evaluation manager - APRO M&E Advisor - Evaluation Office
	- Establish an evaluation reference group (government, DP and CSO partners)			- UNFPA CO evaluation manager

	<ul style="list-style-type: none"> <li>- Compile initial list of documentation</li> <li>- Stakeholder mapping and compilation of list of ATLAS projects</li> </ul>			<ul style="list-style-type: none"> <li>- UNFPA CO evaluation manager (with support from Programme Assistant)</li> </ul>
	<ul style="list-style-type: none"> <li>- Identify a list of potential consultants (one international team leader and three national consultants)</li> <li>- Finalize the short-list and award of contract</li> </ul>	04 weeks		<ul style="list-style-type: none"> <li>- UNFPA CO evaluation manager</li> <li>- APRO M&amp;E Advisor</li> <li>- Evaluation Office</li> </ul>
Desk review	<ul style="list-style-type: none"> <li>- Collect documents, reports, evaluations, financial information; initial research</li> <li>- Assess the UNFPA intervention logic in Cambodia based on examination of a series of key documents</li> </ul>	02 weeks	Home-based	<ul style="list-style-type: none"> <li>- All evaluation team members</li> </ul>
	<ul style="list-style-type: none"> <li>- First meeting with the CO Management</li> <li>- First meeting with CO programme officers on programme key achievements, facilitating and constraining factors</li> </ul>	01 week	Cambodia	<ul style="list-style-type: none"> <li>- All evaluation team members</li> <li>- CO management</li> <li>- CO evaluation manager</li> <li>- CO programme officers</li> </ul>
	<ul style="list-style-type: none"> <li>- Prepare design report (including the evaluation matrix with the evaluation criteria, evaluation questions, data collection methods and sources)</li> <li>- Present draft design report with the CO and Reference Group for comments and feedback</li> </ul>	02 weeks	Home-based	<ul style="list-style-type: none"> <li>- All evaluation team members</li> <li>- Reference Group</li> <li>- CO Evaluation Manager</li> </ul>
	<ul style="list-style-type: none"> <li>- Finalizing the <i>design report</i> based on comments from CO and RG</li> </ul>		Cambodia	<ul style="list-style-type: none"> <li>- All evaluation team members</li> </ul>
Field	In-country mission			<ul style="list-style-type: none"> <li>- All evaluation team members<sup>90</sup></li> </ul>

<sup>90</sup> The primary responsibility is rested with the International Consultant/Team Leader, supported by his/her national consultant team, to submit all evaluation deliverables at an acceptable quality and in a timely manner.



	<ul style="list-style-type: none"> <li>- Data collection, interviews with partners, travel to different departments (national and sub-national), analysis of information</li> </ul>	04 weeks	Cambo dia	<ul style="list-style-type: none"> <li>- All evaluation team members</li> </ul>
Reporting	<ul style="list-style-type: none"> <li>- Write first draft of evaluation report</li> </ul>	03 weeks	Cambo dia	<ul style="list-style-type: none"> <li>- All evaluation team members</li> </ul>
	<ul style="list-style-type: none"> <li>- Present preliminary findings and draft conclusion and recommendations to UNFPA and Reference Group for feedback and comments</li> </ul>			<ul style="list-style-type: none"> <li>- All evaluation team members</li> <li>- Reference Group</li> <li>- CO Evaluation Manager</li> </ul>
	<ul style="list-style-type: none"> <li>- Conduct the first EQA of the draft report submitted by evaluation team</li> </ul>	01 week	Cambo dia	<ul style="list-style-type: none"> <li>- Reference Group</li> <li>- CO Evaluation Manager</li> </ul>
	<ul style="list-style-type: none"> <li>- Finalize draft of full evaluation report and evaluation abstract based on comments from Reference Group and submit to UNFPA<sup>91</sup></li> <li>- Present the <b><u>final and full evaluation report</u></b> including <b><u>evaluation abstract</u></b> to the UNFPA CO and Reference Group</li> </ul>	01 week	Home- based	<ul style="list-style-type: none"> <li>- All evaluation team members</li> </ul>
	<ul style="list-style-type: none"> <li>- Conduct the second EQA of the final report submitted by evaluation team</li> </ul>	01 week		<ul style="list-style-type: none"> <li>- CO Evaluation Manager and APRO M&amp;E advisor</li> </ul>
Dissemination	<ul style="list-style-type: none"> <li>- CPE report distributed to stakeholders in country, RO and UNFPA headquarters, with a view to obtaining responses to recommendations (management response)</li> <li>- CPE report, final EQA and management response published on CO website and UNFPA evaluation database</li> </ul>	01 week		<ul style="list-style-type: none"> <li>- CO Evaluation Manager</li> <li>- UNFPA CO</li> </ul>

<sup>91</sup> The final evaluation report will need to be submitted to UNFPA CO by the indicated timeline as this CP evaluation report will be required to accompany the next country programme document (CPD) for review and approval by the Executive Board in New York in 2015.

Total	25 weeks		
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Notes: Blue text tasks are mainly driven by the CO.

Phases/deliverables	Dates
1. Preparatory Phase <ul style="list-style-type: none"> <li>- Drafting of the ToR</li> <li>- Approval of the ToR by the EO</li> <li>- Selection and recruitment of the evaluation team</li> </ul>	<ul style="list-style-type: none"> <li>- Two weeks (May/June 2014)</li> <li>- Three weeks (June 2014)</li> <li>- Four weeks (July/ Aug 2014)</li> </ul>
2. Design Phase <ul style="list-style-type: none"> <li>- Design mission</li> <li>- Submission of the draft design report</li> <li>- Comments from the ERG</li> <li>- Final design report</li> </ul>	<ul style="list-style-type: none"> <li>- Two weeks (Sep 2014)</li> <li>- One week (Sep 2014)</li> <li>- One week (Sep 2014)</li> </ul>
3. Field Phase <ul style="list-style-type: none"> <li>- Preliminary findings to CO and Government partners</li> </ul>	<ul style="list-style-type: none"> <li>- Four weeks (Oct 2014)</li> </ul>
4. Reporting phase <ul style="list-style-type: none"> <li>- 1<sup>st</sup> draft final report</li> <li>- Comments from the ERG</li> <li>- 2<sup>nd</sup> draft final report</li> <li>- Stakeholder workshop</li> <li>- Final report</li> </ul>	<ul style="list-style-type: none"> <li>- Three weeks (Nov 2014)</li> <li>- One week (Nov 2014)</li> <li>- One week (Dec 2014)</li> <li>- One week (Dec 2014)</li> <li>- Two weeks (Dec 2014)</li> </ul>

#### 10. Composition of evaluation team

The evaluation will be carried out by a team consisting of **an International Consultant/Team Leader (ICTL)** and three national consultants. The evaluation team will be working under the UN Special Service Agreement with 30 working days for the **ICTL** and 20 working days for the national consultants at an agreed rate. The evaluation team will sign a contract with UNFPA Cambodia for a period of 12 weeks and will be paid based on the number of working days cited above. All deliverables to be produced by the evaluation team under this TOR will need to be submitted to UNFPA Cambodia within the contract period. The **ICTL** will be responsible, with support for his/her national consultants, for submitting all the deliverables under this consultancy at acceptable quality and in a timely manner.

It is envisaged that the **ICTL** will have technical expertise in at least one area among the programme component of Reproductive Health, Population and Development, or Gender. The national consultants will collect information, conduct desk reviews based on the assessment framework, developed by the **ICTL**, and undertake/assist with interviews and site visits with the **ICTL**. The **ICTL** shall ensure that all the national evaluation team members selected to work under his/her supervision are fully briefed about the whole evaluation process, objectives, methodology framework, and key milestones/deliverables. The **ICTL** shall be responsible for ensuring the completion of all deliverables, including a final evaluation that meets all of UNFPA's Evaluation Quality Standards.

The **ICTL** will be an international expert in monitoring and evaluation of development programmes with:

- Advanced degree in social sciences or related fields
- Experience leading evaluations in the field of development for UN organizations or other international organizations
- Experience in conducting complex programme and/or country level evaluations including knowledge of evaluation methods and techniques for data collection and analysis
- Knowledge of Cambodian country-specific development context or general regional knowledge in particular to Cambodia is preferable
- Experience in/knowledge of the region
- Excellent leadership, communication ability and excellent drafting skills in the language of the report

The **national consultants** (preferably with a mix of male and female candidates) will have the following criteria (*Please refer to the ToR for National Consultants*):

- Master's Degree in social sciences (with specialization in relevant health, population and gender/GBV areas)
- Experience conducting evaluations/research in the field of development for UN organizations or other international organizations in the relevant areas (health, population & development or gender/GBV)
- Experience in the relevant areas (health, population & development or gender/GBV)
- Experience in/knowledge of the region especially the Cambodia development context
- Excellent drafting skills in the language of the report and communication ability

#### 11. Payment of Consulting Fees

Payment of the evaluation team will be made in three tranches, as follows:

- First payment (20% of total): Upon UNFPA's approval of design report (detailed evaluation matrix with the evaluation criteria, evaluation questions, data collection methods)
- Second payment (40% of total): Upon the submission/presentation of the first draft (with key findings, conclusion and recommendations); and
- Third/final payment (40% of total): Upon UNFPA's acceptance of the final evaluation report.

#### 12. Management and conduct of the evaluation

A **CO evaluation manager** will be assigned to interact on a day-to-day basis with the evaluation team and who, together with the evaluation reference group, will ensure that all the necessary aspects of CP evaluation are well taken into account by the evaluation team.

The evaluation manager is the country office M&E Officer and will manage the overall evaluation, and will carry out the following functions:

- To ensure consistency throughout the evaluation process (from ToR to dissemination of results and follow-up of recommendations) and assumes day-to-day responsibility for managing the evaluation
- To develop the TOR for the Country Programme Evaluation, with support from APRO and EO
- To correspond with the reference group members at strategic points throughout the evaluation
- To provide/facilitate the provision of documents and other resources available in the country office
- To support the evaluation team in the development of the evaluation design report, which includes the provision of tools and templates (i.e. stakeholder mapping tool, evaluation matrix, CPE Agenda)

- To organize, supervise all phases of the evaluation and assesses the quality of related deliverables (design report, draft and final evaluation reports)
- To be the first point of contact and bridge the communication between CO staff, senior management, and evaluation team throughout the evaluation

UNFPA emphasizes meaningful stakeholder involvement in its evaluations. In the conduct of country evaluation, an evaluation reference group (RG) will be constituted with members from relevant national implementing partners, development partners, civil society organizations, UNFPA regional office and the CO evaluation manager, which is charged with providing key guidance to the whole evaluation process as well as necessary inputs to all key evaluation deliverables/milestones.

Therefore, the evaluation team will need to properly consult and involve this RG throughout the key evaluation phases before the evaluation team can produce and submit the intended deliverables to the UNFPA CO.

Such involvement and consultation can include, but not limited to, participating in the formulation of design report (questions/objectives, methods, data collection instruments, evaluation matrix, and so on), or developing recommendations, and other roles as appropriate for the evaluation. However, such involvement and consultation should not affect the independence and impartiality of the evaluation. Participation in surveys or interviews is not the same as meaningful and effective stakeholder involvement.

The above evaluation reference group (RG) will be tasked with the following activities:

- Provide comments on the CPE Terms of Reference;
- Review and provide comment on draft design report and feedback to the evaluation team;
- Review and provide comment on draft evaluation report, its conclusion and recommendations and feedback to evaluation team;
- Review and provide comment on draft final report which will enable the evaluation team to finalise the evaluation report;
- to provide the evaluation team with relevant information and documentation on the programme under assessment;
- to facilitate the access of the evaluation team to key informants during the field phase; and
- to assist in feedback of the findings, conclusions and recommendations from the evaluation into future programme design and implementation.

Members of this reference group will be composed of the following officials and representatives:

1. Dr. Derveeuw Marc. G.L., UNFPA Representative (**Chairperson**)
2. Mr. Samreth Chetha Phirum, Director of UN Agencies Aid Coordination Department, Council for the Development of Cambodia (CDC) (Member)
3. Ms. Eiko Narita, Programme Specialist, UNFPA APRO (Member)
4. Prof. Tung Rathavy, Director of NMCHC and NRHP (Member)
5. HE. Mr. Theng Pagnathun, Director General of Planning, Ministry of Planning (Member)
6. HE. Ms. Hang Lina, Director General of NIS, Ministry of Planning (Member)
7. Mr. The Chhun Hak, Deputy Director General, MoWA (Member)
8. Mr. Chea Bunheng, Director of DoLA/MoI (Member)
9. Dr. Yung Kunthearith, Deputy Director of School Health, MoEYS (Member)

10. Mr. Soeung Saroeun, Executive Director, Cooperation Committee for Cambodia (CCC) (Member)
11. Ms. Claire Van der Vaeren, Resident Coordinator, UN Resident Coordinator Office (Member)
12. Ms. Wenny Kusuma, Country Director, UN Women (Member)
13. Mr. Sydney Nhamo, Planning and Monitoring Specialist, UNICEF (Member)
14. Dr. Momoe Takeuchi, Deputy Representative, WHO (Member)
15. Dr. Chris Vickery, Health Advisor, Australia's Department of Foreign Affairs and Trade (DFAT) (Member)
16. Mr. Saky Lim, UNFPA Programme Officer (CO Evaluation Manager)

Proposed meetings of the reference group:

In addition to a few necessary physical meetings (noted below), members of the Reference Group will mainly communicate through email correspondence.

1. **First meeting:** group introduction, review and endorse the CPE terms of reference
2. **Second meeting:** introduction between the RG and evaluation team; and review and endorse design report (inception report)
3. **Third meeting:** presentation of draft findings, conclusions and recommendations by evaluation team; provide feedback to evaluation team

Overall guidance will be provided by the UNFPA CO Representative and technical supervision and coordination by the CO evaluation manager. UNFPA CO will provide the evaluation team with all the necessary documents and reports and refer it to web-based materials as part of the desk review exercise. One Senior Secretary/Programme Assistant will be assigned as the evaluation team's counterpart to provide support in terms of gathering documentation as required.

The UNFPA evaluation manager will liaise with the UNFPA programme managers to ensure that the thematic component reports are provided to the evaluation team as these are critical inputs to the programme evaluation. UNFPA management and staff will make themselves available for interviews and technical assistance as appropriate. The CO will also provide necessary logistical support in terms of providing space for meetings, assistance in making appointments and arranging travel and site visits. Appropriate office space and computer equipment with access to internet and printing services will be provided to the evaluation team.

The UNFPA Asia and Pacific Regional Office (APRO) as well as the evaluation reference group (ERG) will provide support at several stages. At the preparatory stage, the tools for assessment will be reviewed and approved by the Country Office (in consultation with APRO and ERG). Consultations will be undertaken during the course of the evaluation/key evaluation stages to provide inputs and validate findings; provide inputs during the briefing and debriefing sessions; and review the draft reports. UNFPA APRO team and ERG will provide a combination of on-site, where necessary, and off-site support.

## ANNEX 2:

### Evaluation Matrix for CPE Cambodia 2011-2014

Assumptions to be assessed	Substantiating Evidence	Sources of information	Methods and tools for the data collection
<b>RELEVANCE:</b> To what extent is the country programme in line with the intermediary UNFPA Strategic Plan 2011-2013 and the current UNFPA Strategic Plan 2014-2017, the NSDP update 2009-2013, the UNDAF 2011-2015 and other key sectoral planning documents?			
(i) The UNFPA programme design reflects national needs and priorities, needs of target populations	<ul style="list-style-type: none"> <li>- Evidence that the international, national and sub-national policies are reflected in the CPAP and its components, including UNFPA Strategic Plan, ICPD, UNCT and MDGs Strategic plans</li> </ul>	<ul style="list-style-type: none"> <li>- CPD</li> <li>- CPAP</li> <li>- NSDP</li> <li>- Rectangular Strategy</li> <li>- Sectoral Strategies</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with MOP</li> <li>- Interviews with relevant line ministries including MOP, MOWA, MOH, MOEYS, MOI</li> </ul>
(ii) The outputs of the UNFPA programme are in line with the organizational and regional strategies as reflected in the ICPD-PoA, UNFPA strategic plans, the CMDGs and the UNDAF	<ul style="list-style-type: none"> <li>- Evidence that the organizational and regional strategies as reflected in the ICPD-PoA, UNFPA strategic plans, the CMDGs and the UNDAF are reflected in the CPAP and its components,</li> </ul>	<ul style="list-style-type: none"> <li>- UNFPA strategic plans 2008-2013 and 2014-2017</li> <li>- UNFPA CO alignment documents</li> <li>- ICPD-PoA</li> <li>- CMDGs</li> <li>- UNDAF</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with UNFPA senior management</li> <li>- Interviews with UNFPA Regional staff supporting UNFPA Cambodia</li> <li>- Interviews with senior management staff of other UN agencies</li> </ul>
(iii) The UNFPA programme is aligned with the new UNFPA strategic plan 2014-2017 and its business model	<ul style="list-style-type: none"> <li>- Evidence that the programme is in line with the UNFPA strategic plan 2014-2017</li> <li>- Adaptations made to the results framework of the programme</li> <li>- Business model used in CP4 and its compliance with organizational requirements</li> </ul>	<ul style="list-style-type: none"> <li>- UNFPA strategic plan 2014-2017</li> <li>- Strategic Plan 2014-2017: Implementation action plan for the UNFPA Cambodia CO</li> <li>- UNFPA Cambodia annual reports</li> <li>- UNFPA Office Management Plan 2014</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with UNFPA senior management</li> <li>- Interviews with UNFPA programme specialists and officers</li> <li>- Interviews with UNFPA operations manager</li> </ul>

Assumptions to be assessed	Substantiating Evidence	Sources of information	Methods and tools for the data collection
(iv) The UNFPA programme is appropriate to the country context and has responded adequately to changes in the country context, including development of the ASEAN	<ul style="list-style-type: none"> <li>- Evidence of recognition and response to changing development priorities and needs, including humanitarian crises</li> <li>- Evidence that UNFPA's response to changing context was considered relevant by Government and other parties</li> <li>- Evidence that ad hoc requests for assistance received an adequate response in line with UNFPA's mandate and strategy</li> <li>- Evidence of support to preparations for ASEAN in particular the changes in 2015</li> </ul>	<ul style="list-style-type: none"> <li>- New National laws and national and/or sub- national policies / strategies related to women and youth, RSH, PD or gender, issues</li> <li>- Humanitarian crises</li> <li>- Humanitarian Action Proposals and Reports</li> <li>- Trends in PD data; population dynamics (fertility, mortality, migrations);</li> <li>- Performance information</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with Govt , sub-national and UN officials (including humanitarian agencies where relevant), and UNFPA CO staff</li> <li>- Interviews with implementing partners</li> </ul>
Desirable (v) The needs of the marginalized and worst of groups such as youth, adolescents, low-income households, and the population living in remote areas and gender concerns were taken into account during programme design	<ul style="list-style-type: none"> <li>- Evidence of adequate and accurate identification of vulnerable populations and their needs prior to the programming of components of CPAP and AWP, including women, adolescents and in particular young girls, people living in remote or isolated villages and low income households</li> <li>- Disaggregation of data along gender and other aspects of vulnerability and capacities to do so</li> </ul>	<ul style="list-style-type: none"> <li>- CPAPs, AWP, regular reports</li> <li>- Situation analysis, baseline data analysis</li> <li>- SPRs</li> <li>- PD material including survey questionnaires and reports</li> <li>- Research reports</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with CO staff</li> <li>- Interviews with IPs or their staff</li> <li>- Interviews/focus groups with beneficiaries,</li> <li>- PD documentation and data</li> </ul>
<b>EFFICIENCY</b> - To what extent has UNFPA made good use of its human, financial and technical resources, in pursuing the achievement of the results defined in the country programme?			

Assumptions to be assessed	Substantiating Evidence	Sources of information	Methods and tools for the data collection
UNFPA has appropriately used its human, financial and technical resources to pursue the achievement of the CP4 outcomes and outputs	<ul style="list-style-type: none"> <li>- Evidence of sound CO Human Resource management, financial management in both programme components and across the components</li> <li>- Evidence that technical challenges have been addressed in all programme components</li> <li>- Evidence that capacities of CO staff have been developed in terms of negotiation skills, advocacy skills, critical and analytical thinking</li> </ul>	<ul style="list-style-type: none"> <li>- CPAP, AWP, SPRs, COARs</li> <li>- UNFPA CO Organogram</li> <li>- Financial documents (budgets and reports)</li> <li>- UNFPA CO learning plan</li> <li>- National Execution Audit reports</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with staff</li> <li>- Interviews with partners</li> <li>- Field visits</li> </ul>
UNFPA has appropriately mobilized and used additional resources for regular CP activities and for humanitarian response	<ul style="list-style-type: none"> <li>- Evidence of additional resources mobilized for individual programme components and for humanitarian response</li> <li>- Advocacy activities for additional support</li> </ul>	<ul style="list-style-type: none"> <li>- Annual Reports</li> <li>- Financial documents</li> <li>- Inter-agency humanitarian coordination</li> <li>- Proposals and reports on humanitarian action</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with UNFPA staff,</li> <li>- Staff from other UN agencies and</li> <li>- Staff from government counterpart agencies</li> <li>- Field visits</li> </ul>
Outputs have been delivered adequately in terms of quantity as well as quality of results and have been achieved timely	<ul style="list-style-type: none"> <li>- Evidence of timely delivery of outputs of sufficient quality and in required quantity</li> </ul>	<ul style="list-style-type: none"> <li>- AWP</li> <li>- Joint Monitoring reports</li> <li>- Annual reports</li> <li>- CO reports</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with Govt staff at national and sub-national level</li> <li>- Interview with UNFPA staff and other UN officials,</li> <li>- Interviews with other stakeholders</li> </ul>
Desirable: Outputs were achieved in economically efficient terms	<ul style="list-style-type: none"> <li>- The human resource and economic costs of producing the outputs has been economical compared to alternative options of producing the same output</li> </ul>	<ul style="list-style-type: none"> <li>- AWP</li> <li>- Joint Monitoring reports</li> <li>- Annual reports</li> <li>- CO reports</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with Govt staff at national and sub-national level</li> <li>- Interview with UNFPA staff and other UN officials,</li> <li>- Interviews with other stakeholders</li> </ul>



Assumptions to be assessed	Substantiating Evidence	Sources of information	Methods and tools for the data collection
Desirable: Components of the UNFPA programme were well coordinated and proved complementary to one another	<ul style="list-style-type: none"> <li>- Evidence on the linkages between national level capacities developed and sub-national level initiatives</li> <li>- Evidence on synergy across programme components at national and sub-national level</li> </ul>	<ul style="list-style-type: none"> <li>- CPAP</li> <li>- Survey reports (CDHS, CIPS, CRUMP and its in-depth analysis reports)</li> <li>- Thematic evaluations conducted in CP4</li> <li>- Annual reports</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with Govt staff at national and sub-national level</li> <li>- Interview with UNFPA staff and other UN officials,</li> <li>- Interviews with other stakeholders</li> </ul>
Desirable: Monitoring and evaluation tools of the programme were adequate and informed programme management	<ul style="list-style-type: none"> <li>- Quality aspects of the results framework of the programme</li> <li>- Monitoring information on the indicators of the CPAP results framework</li> <li>- Baselines and end line studies conducted</li> <li>- Evaluation of trainings conducted</li> <li>- Evidence of the use of M&amp;E information in management</li> </ul>	<ul style="list-style-type: none"> <li>- Annual reports</li> <li>- Evaluation reports</li> <li>- Monitoring framework</li> <li>- CPAP planning and tracking tool</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with Govt staff at national and sub-national level</li> <li>- Interview with UNFPA staff and other UN officials,</li> <li>- Interviews with other stakeholders</li> </ul>
<p><b>EFFECTIVENESS</b> -= What has been the degree of achievement of the country programme outputs, and what progress has been made towards achieving the programme outcomes, given the changes in the global and national policy environment? What are the reasons for the progress made and/or the discrepancies between plans and achievements?</p>			
<b>PD1:</b> An effective mechanism for dialogue, representation and participation in democratic decision-making has been established and strengthened	<ul style="list-style-type: none"> <li>- Evidence of an increase in the number of women that get elected in representative bodies</li> <li>- Multi-sectoral national youth policy developed with reference to youth participation</li> </ul>	<ul style="list-style-type: none"> <li>- UNFPA Annual Reports</li> <li>- RGC relevant reports</li> <li>- National Youth Policy (draft / final report)</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interview with the National Committee for Sub National democratic development of DoLA</li> <li>- Interviews with UN organizations</li> <li>- Interviews with NGOs</li> <li>- Document review and analysis</li> <li>- Interview with staff of MoEYS</li> </ul>

Assumptions to be assessed	Substantiating Evidence	Sources of information	Methods and tools for the data collection
	<ul style="list-style-type: none"> <li>- Sub-national WCCC established and functional at province, district and commune levels</li> <li>- Commune level plans in priority areas which make use of evidence in their design, are gender sensitives and address population, RH and youth issues</li> </ul>	<ul style="list-style-type: none"> <li>- UNFPA annual reports</li> <li>- CIPs</li> </ul>	<ul style="list-style-type: none"> <li>- Interviews with Youth working Groups</li> <li>- Interviews with local authorities at provincial, district and commune level</li> <li>- Interview with NCDD and DoLA</li> <li>- Interviews with representatives of WCCC at province, district and commune levels</li> <li>- Interviews with commune leaders and village leaders</li> <li>- Interview with commune members including youth and women</li> </ul>
<p><b>PD2:</b> Enhanced capacities have been developed for collection, access and utilization of disaggregated information at national and sub-national levels and these have been used to develop and monitor policies and plans so that these are responsive to the needs of the people and incorporate priority populations, poverty and development linkages</p>	<ul style="list-style-type: none"> <li>- Evidence of improved capacities of NIS in gathering of population data</li> <li>- Evidence of enhanced availability of population data for governmental and non-governmental stakeholders</li> <li>- Evidence on the enhanced capacity of line ministries in the use of population data for evidence-based national (incl. NSDP and MDG monitoring) and sector (health, education, women, HIV) planning, policy formulation and monitoring</li> <li>- Evidence on the enhanced capacity at sub-national level in the use of population data for evidence-based national planning, policy formulation and monitoring</li> </ul>	<ul style="list-style-type: none"> <li>- Census monographs and other studies</li> <li>- MDG monitoring reports</li> <li>- CDHS report</li> <li>- CIPS report</li> <li>- CSES Report</li> <li>- CAM Info</li> <li>- Commune profiles</li> <li>- National plans and budgets</li> <li>- NSDP monitoring framework</li> <li>- NSDP annual reports and mid-term review</li> <li>- Sectoral plans and budgets and annual reports</li> <li>- Provincial plans and budgets and annual report</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with NIS</li> <li>- Interviews with MOP, NCPD</li> <li>- Interviews with MOH, MOEYS, MOI and MOWA</li> <li>- Interviews with UN agencies</li> <li>- Interviews with donors and NGOs</li> <li>- Interview with Provincial Authorities and Planning Departments</li> <li>- Interviews with District authorities and planning agencies</li> <li>- Interviews with Commune authorities and officials responsible for planning</li> <li>- Interviews with community members</li> </ul>

Assumptions to be assessed	Substantiating Evidence	Sources of information	Methods and tools for the data collection
		<ul style="list-style-type: none"> <li>- District / Commune plans / profiles and budgets and reports concerned</li> </ul>	
<p><b>SRH1:</b> Equitable coverage, at national and sub-national levels, of good-quality reproductive, maternal, new-born, child health and nutrition services has been increased</p>	<ul style="list-style-type: none"> <li>- Evidence on the UNFPA’s role in the support of development of RH policies/strategies for the national and sub-national implementation plans.</li> <li>- Evidence on achievements of results on key performance indicators on the CPAP framework</li> <li>- Evidence on the enhanced capacity/skills of MoH and other implementing partners in providing health services</li> <li>- Evidence of increased competency and availability of human resources including midwives</li> <li>- Evidence on the improved health infrastructure and service quality</li> <li>- Evidence of the availability of relevant health services at national and sub-national level</li> <li>- Evidence of functional equipment, materials, commodities/drugs available for reproductive, maternal, new-born, child health and nutrition services</li> <li>- Evidence of the availability and provision of adolescent/youth friendly</li> </ul>	<ul style="list-style-type: none"> <li>- RH policies/strategies/plans</li> <li>- AWP’s</li> <li>- CO reports</li> <li>- CPAP</li> <li>- CDHS</li> <li>- HMIS</li> <li>- CMDGs progress reports</li> <li>- MoH’s reports</li> <li>- HSSP2 progress review reports</li> <li>- RMH research reports</li> <li>- EmONC Improvement plan and progress reports</li> </ul>	<ul style="list-style-type: none"> <li>- Documentary analysis</li> <li>- Interview with UNFPA staff</li> <li>- Interview with the implementing partners</li> <li>- Interview with other development partners and other UN staff. (JPIG members)</li> <li>- Interview with health beneficiaries</li> <li>- Health facility and service provision observation</li> </ul>

Assumptions to be assessed	Substantiating Evidence	Sources of information	Methods and tools for the data collection
	<p>services integrated into the CPA/MPA health facilities</p>		
<p><b>SRH2:</b> National and sub-national institutional capacity to expand young people's access to good-quality life skills, including on HIV, and technical and vocational education and training has been enhanced</p>	<ul style="list-style-type: none"> <li>- Evidence on the UNFPA's role in the support of development of life skill policies/strategies for the national and sub-national implementation plans.</li> <li>- Evidence of improved capacities of the implementing partners in quality life skills and curriculum trainings</li> <li>- Evidence of primary and secondary schools integrating core life skills training including HIV</li> <li>- Evidence of life skills training for disadvantaged young females and males and school drop-outs</li> <li>- Evidence of improved knowledge and behaviour changed in regard to HIV and SRH.</li> <li>- Evidence of increased service utilisation (SRH) among most at risk young people and in and out of school young people.</li> </ul>	<ul style="list-style-type: none"> <li>- Life skill SRH policies/strategies/plans</li> <li>- Thematic Sexuality Education evaluation report</li> <li>- AWP's</li> <li>- CO reports</li> <li>- CPAP</li> <li>- CDHS</li> <li>- CMDGs progress reports</li> <li>- MoH's reports</li> <li>- MoEYS's reports</li> <li>- Life skill baseline and end line reports</li> </ul>	<ul style="list-style-type: none"> <li>- Documentary analysis</li> <li>- Interview with UNFPA staff</li> <li>- Interview with the implementing partners</li> <li>- Interview/focus group with target direct beneficiaries</li> <li>- Health facility and service provision observation</li> <li>- School life skill activity observation</li> </ul>
<p><b>SRH3:</b> Strengthened multi-sectoral response to HIV</p>	<ul style="list-style-type: none"> <li>- Evidence on the UNFPA's role in the support of development of HIV policies/strategies for the national and sub-national implementation plans.</li> <li>- Evidence of improved capacities of the implementing partners/stakeholders(MoWA, CWPDP)</li> </ul>	<ul style="list-style-type: none"> <li>- HIV policies/strategies/plans</li> <li>- AWP's</li> <li>- CO reports</li> <li>- CPAP</li> <li>- CDHS</li> <li>- CMDGs progress reports</li> </ul>	<ul style="list-style-type: none"> <li>- Documentary analysis</li> <li>- Interview with UNFPA staff</li> <li>- Interview with the implementing partners (MoWA, CWPDP)</li> <li>- Interview/focus group with target direct beneficiaries (women, girls and EWs)</li> </ul>

Assumptions to be assessed	Substantiating Evidence	Sources of information	Methods and tools for the data collection
	<ul style="list-style-type: none"> <li>in HIV prevention targeting at risk groups</li> <li>- Evidence of improved life skills among EWs and other target groups regarding HIV prevention</li> <li>- Evidence of service uptake by the EWs, MSMs and IDUs</li> </ul>	<ul style="list-style-type: none"> <li>- MoWA's reports</li> <li>- MoWA's strategic plan HIV/AIDS</li> <li>- CWPD's reports</li> <li>- EWs mapping</li> </ul>	<ul style="list-style-type: none"> <li>- Service provision observation</li> <li>- Entertainment workplace observation</li> </ul>
<p><b>SRH4:</b> National and Sub-national capacity to provide affordable and effective national social protection through improved development, implementation, monitoring and evaluation of a social protection system</p>	<ul style="list-style-type: none"> <li>- Evidence on the UNFPA's role in the support of development of social protection policies/strategies for the national and sub-national implementation plans.</li> <li>- Evidence of improved capacities of the implementing partners/stakeholders in the emergency preparedness and response to mitigate the impact of RMH and GBV</li> </ul>	<ul style="list-style-type: none"> <li>- Emergency Preparedness and Response Plans</li> <li>- AWP</li> <li>- CO reports</li> </ul>	<ul style="list-style-type: none"> <li>- Documentary analysis</li> <li>- Interview with UNFPA staff</li> <li>- Interview with the implementing partners</li> <li>- Interview/focus group with target direct beneficiaries</li> <li>- Field visit</li> </ul>
<p><b>G1:</b> A harmonized aid environment that promotes gender equality and the empowerment of women</p>	<ul style="list-style-type: none"> <li>- Evidence of a harmonized aid environment with monitoring scheme for coordination for tangible improvements</li> <li>- Evidence of policy documents / road map for gender mainstreaming (NT4 and CGA) as a product of harmonized aid environment</li> <li>- Evidence of UN facilitation of PBA on gender equality and empowerment of women</li> </ul>	<ul style="list-style-type: none"> <li>- AWP</li> <li>- CO reports</li> <li>- TWGG/TWGG-GBV reports</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with UNFPA staff</li> <li>- Interview with staff from other UN agencies and co-chairs of TWGG (UNDP and JICA)</li> <li>- Staff from government counterpart agencies, particularly secretariat for TWGG and TWGG-GBV</li> </ul>

Assumptions to be assessed	Substantiating Evidence	Sources of information	Methods and tools for the data collection
<p><b>G2:</b> Strengthened and enhanced gender-mainstreaming mechanisms at national and sub national levels.</p>	<ul style="list-style-type: none"> <li>- Evidence of gender-mainstreaming mechanism, including gender mainstreaming policies of line ministries</li> <li>- Evidence of national ownership to financially support gender mainstreaming policies</li> <li>- Evidence of enhanced capacity of GMAGs in Line Ministries and Departments at national and sub-national levels</li> <li>- Evidence of monitoring system and its improvements based on monitoring and evaluation</li> <li>- Gaps and challenges identified for gender mainstreaming policy's implementation at MoH and MoP and policies are updated with monitoring framework</li> </ul>	<ul style="list-style-type: none"> <li>- AWP</li> <li>- CO reports</li> <li>- NSDP progress reports</li> <li>- CMDS progress reports</li> <li>- NR3 review reports</li> <li>- GMAP implementation progress reports of line ministries (particularly MoH and MoP)</li> <li>- NCDD reports</li> <li>- WCCC reports in selected provinces</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with UNFPA staff</li> <li>- Interview with staff from other UN agencies and co-chairs of TWGG (UNDP and JICA)</li> <li>- Staff from government counterpart agencies, particularly secretariat for TWGG and TWGG-GBV</li> </ul>
<p><b>G3:</b>Enhanced participation of women in the public sphere at national and sub national level</p>	<ul style="list-style-type: none"> <li>- Evidence of increased representation of women in the public sphere at national and sub-national levels</li> <li>- Evidence of cooperation among MoWA and NGOs in capacity building for women in public decision making at sub-national level</li> <li>- Enhanced opportunities or mechanisms to strengthen women's capacities to</li> </ul>	<ul style="list-style-type: none"> <li>- AWP</li> <li>- CO reports</li> <li>- MoWA NRT review reports</li> <li>- MoWA CGA reports</li> <li>- NCDD reports</li> <li>- NSDP progress reports</li> <li>- CMDGs reports</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with officials from MOWA and MOI</li> <li>- Interview with staff from NGO (partners to UNFPA program, Women for Prosperity, Khemara, Banteay Srei)</li> </ul>

Assumptions to be assessed	Substantiating Evidence	Sources of information	Methods and tools for the data collection
	participate in the public sphere at national and sub-national levels - Results from the mid-year and annual review meetings for WCCCs		
<b>G4:</b> Improved societal attitudes and preventive and holistic responses to gender-based violence.	<ul style="list-style-type: none"> <li>- Evidence on increased awareness on GBV as wrongful behavior / criminal act</li> <li>- Evidence of GBV education included in curriculum of secondary public schools</li> <li>- Evidence of positive social change among men to prevent GBV</li> <li>- Evidence of cooperation and referral among stakeholders in providing services for GBV survivors</li> <li>- Evidence of positive impact from the media campaign to increase awareness about GBV</li> <li>- Evidence of multi-sector approach and referral system at local level</li> <li>- Evidence of interventions of local authorities and service providers in GBV cases at the local level</li> </ul>	<ul style="list-style-type: none"> <li>- AWP</li> <li>- CO reports</li> <li>- MoWA NRT review reports</li> <li>- MoWA CGA reports</li> <li>- OSSC report</li> <li>- 2nd NAPVAW</li> <li>- NSDP progress reports</li> <li>- TWGG-JMI reports</li> <li>- TWGG-GBV reports and its sub-committee</li> <li>- Project partners' reports (CWCC and PYD)</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with officials from MOWA, MOH and MOEYS</li> <li>- Interview with key development partners for GBV including primary prevention of GBV (GIZ, DFAT, WHO, and UNICEF)</li> <li>- Interview with NGO (PYD and CWCC)</li> </ul>
<b>SUSTAINABILITY</b> - To what extent are the results of the UNFPA CO supported activities likely to last after termination of support?			
Clear exit strategies are part of each of the three programme components and organizational and financial capacities are in place to	<ul style="list-style-type: none"> <li>- Organizational capacities of agencies concerned to produce results on PD, RH and Gender</li> </ul>	<ul style="list-style-type: none"> <li>- COAR</li> <li>- Survey reports</li> <li>- MDG report</li> </ul>	<ul style="list-style-type: none"> <li>- Documentary analysis</li> <li>- Field visits</li> <li>- Interviews with staff and government counterparts</li> </ul>

Assumptions to be assessed	Substantiating Evidence	Sources of information	Methods and tools for the data collection
ensure sustaining of results achieved	- Staff capacities of Ministry of Planning and Line Agencies have been enhanced sufficiently	- Other research reports and studies	
Conditions and mechanisms have been developed which ensure that national partners will take ownership of results upon completion of UNFPA supported interventions	- Financial resources have been allocated by Government at national and sub-national levels for RH, PD and Gender initiatives	- Annual reports of Line Agencies - Annual plans and budgets	- Documentary analysis - Interviews with staff and government counterparts - Field visits
<b>STRATEGIC POSITIONING UNFPA WITHIN UN COUNTRY TEAM (UNCT)</b> - To what extent has the UNFPA Country Office contributed to the good functioning of coordination mechanisms and an adequate division of tasks with the UN system in Cambodia?			
UNFPA has successfully coordinated with other UN agencies and with RGC in the country programme and each of its components	- Evidence of acknowledgement and satisfaction of coordination by other UN partners, RGC partners and civil society partners	- Inter-UN agency strategies and workplans - Annual reports of the UNCT - UNFPA Annual reports	- Documentary analysis - Field visits - Interviews with UN staff from other agencies, RGC partners and civil society organizations
The UNDAF fully reflects the interests, priorities and mandate of UNFPA in Cambodia	- UNDAF reflects the outcome level changes of the three programme components - UNDAF reflects a focus on gender and youth - UNFPA's contribution to UNDAF results	- UNDAF document - UNDAF monitoring framework	- Document review and analysis - Interview with RC - Interview with other UN agencies - Interview with MOP
<b>ADDED VALUE OF UNFPA:</b> What are the main UNFPA comparative advantages in the country – in particular in comparison to other UN agencies? What is the main UNFPA added value in the country context as perceived by national stakeholders			



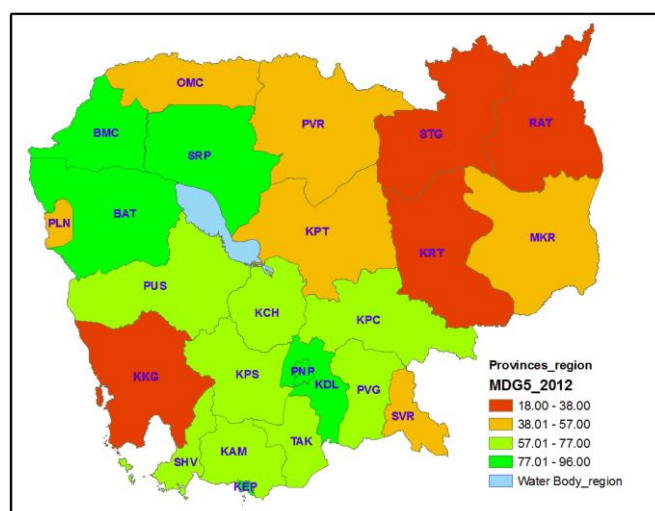
Assumptions to be assessed	Substantiating Evidence	Sources of information	Methods and tools for the data collection
UNFPA specific strengths have allowed a unique kind of support that no other UN agency could have provided in each of the programme components	<ul style="list-style-type: none"> <li>- Evidence of UNFPA strategic approach targeted to the population groups most in need, compared to the approach of other UN agencies</li> </ul>	<ul style="list-style-type: none"> <li>- UNFPA Strategic plan</li> <li>- UNFPA CPD and CPAP</li> <li>- AWP, UNFPA annual reports</li> </ul>	<ul style="list-style-type: none"> <li>- Document review and analysis</li> <li>- Interviews with UNFPA staff</li> <li>- Interviews with government counterparts</li> <li>- Interviews with other UN agencies and development partners</li> </ul>
National stakeholders appreciate the added value of UNFPA in Cambodia	<ul style="list-style-type: none"> <li>- The added value that RGC, civil society, development partners and other UN agencies identify as specific for UNFPA in Cambodia in CP4</li> </ul>	-	<ul style="list-style-type: none"> <li>- Interviews with government counterparts</li> <li>- Interviews with development partners, other UN agencies and civil society organizations</li> </ul>

**ANNEX 3:****Details on Evaluation Methodology****1) Methods for Data Collection and Analysis****Table: Methodologies for Data gathering and key characteristics**

<b>Method</b>	<b>Description</b>	<b>Objective</b>	<b>Comments</b>
<b>Desk review and Review of the monitoring data gathered at a variety of levels</b>	Study and review of selected documents relevant to the present evaluation	To get informed on the background and context as well as documented details of the country programme and its results through secondary resources	Main learnings from the desk review have been used to develop this design report, which details the approach and methodology applied in the evaluation process
	Assessment of the regular monitoring data gathered at the level of the CPAP and individual initiatives	To assess the quantity and quality of monitoring data gathered at the various levels and to inform result level changes achieved	Review of monitoring data is meant to inform both the assessment of the monitoring system as well as the results achieved at the various levels of programme implementation
<b>Semi-structured interviews including Skype discussions with stakeholders not present in Cambodia</b>	Face-to-face interviews in Phnom Penh and selected provinces, districts and communities	To gather qualitative and quantitative data on the programme, including its design and implementation at national and sub-national levels	Topics for discussion informed by the desk review and guided by the evaluation matrix
	Interviews with selected stakeholders not present at site in Cambodia	To include stakeholders that support the UNFPA country programme from APRO and UNFPA Headquarters	With selected stakeholders
<b>Focus Group discussions</b>	Discussions in groups of selected participants on identified topics in selected districts, communes and schools and with members of WCCC and CCWC (the latter at district as well as commune level)	To gather information at the sub national level including province, district and community	Topics for discussion informed by the desk review and guided by the evaluation matrix
<b>Observation</b>	Structured and unstructured observations in selected health facilities and statistics offices	To gather data on the actual practices and related capacities of staff and the use of equipment and facilities	Structured observation will be limited with the number of facilities to be visited being limited by the time frame of the in-country data gathering



**Map: Provincial Scores on MDG 5 Achievement in 2012 (100 is maximum score)**



Source: RGC, Scorecard of the implementation of Cambodia Millennium Development Goals at sub-national level by Capital, Provinces, Municipalities, Districts, Khans in Year 2012. July 2012.

### 3) *Methods for Data Analysis*

**Stakeholder analysis:** Identification of the stakeholders and their relationship to the country programme and its two components. Stakeholders were identified at the national as well as at the sub-national level.

**SWOT analysis:** Assessment of strengths and weaknesses in terms of internal capabilities of organizations concerned, while looking at opportunities and threats to highlight external factors. Strengths and opportunities were used to assess aspects to be further developed and reinforced, while weaknesses and threats were used to identify those internal as well as external issues to address and mitigate against.

**Analysis of the Results Framework:** The results framework provides a logical sequence between activities, their direct outputs, more indirect outcome level changes and the impact that these have on people's lives. It concerns a people-focused approach and provides a framework for assessing whether objectives are likely to be achieved through a stepped approach of monitoring of indicators at the various levels concerned. As the Country Programme had a logical framework which provided the basis of the monitoring and evaluation of the programme, this approach was suitable for the country programme evaluation.

### 4) *Process Overview*

#### **Design Phase**

The design phase of the evaluation included the desk review of the secondary information of the programme and related documentation. As part of the design phase discussions with the UNFPA Senior Management team and with the programme specialist of each of the programme components were conducted in Phnom Penh. These discussions were held in the first week of December, during which the evaluation team, moreover, had various internal meetings to inform the preparation of the design report.

#### **Field Phase**

First Week: Meetings in Phnom Penh

The first week of the in-country data gathering was focus on stakeholders at the national level in Phnom Penh, including staff of UNFPA and RGC partners, other UN agencies, Civil Society partners and bilateral development agencies. Towards the end of the week the evaluation team conducted an internal team meeting in order to analyse the data gathered at the national level and to identify remaining gaps, for which meetings

in the fourth week of the country visit were scheduled. The planning of the visits was agreed with the Evaluation Reference Group and supported by the Evaluation manager.

#### Second and Third Week: Site Visits

The second and third week of the in-country data gathering consisted of field visits to provinces where UNFPA has provided support with respect to one or more programme components. The evaluation team visited the three provinces identified, where support to most of the components were combined in order to assess the levels of results achieved and the ways in which combinations of support have reinforced results at the local level.

#### Fourth Week: additional meetings in Phnom Penh and validation meeting

The fourth week of the in-country data gathering focused on additional meeting in Phnom Penh. This concerned both meetings with partners that were not available in the first week as well as meetings in order to fill gaps in data identified during preliminary analysis of the data gathered.

The team was able to use the weekends during the in-country data gathering to travel between field sites and to conduct internal team discussions. Moreover, towards the end of the field visit this time was used by the evaluation team to prepare for the debriefing and validation meeting.

The preliminary findings of the evaluation team were presented to the ERG at the end of the field phase on Friday February 6th in order to validate the findings and to inform preliminary conclusions and recommendations. This was an important event which informed further analysis of the evaluation results and the preparation of the draft and final evaluation report.

**Table: Work plan for the Country Programme Evaluation in Cambodia**

Phases/Specific activities/milestones/deliverables	Dates
<b>1. Preparatory Phase</b>	
Develop and finalize evaluation terms of reference, establish ERG, prepare documentation for desk review, select independent consultants	by Sept 2014
<b>2. Design Phase</b>	
Desk review of documentation	24 Nov – 12 Dec 2014
Design the evaluation by the evaluation team	8 – 31 Dec 2014
Submit the draft design/inception report of the country programme evaluation (CPE) to the CO	31 Dec 2014
Review the draft design report for quality assurance	1 – 9 Jan 2015
Consolidate comments and share with the evaluation team	10 Jan 2015
Finalize the design/inception report by the evaluation team	11-12 Jan 2015
Final approval of the design report	16 Jan 2015
<b>3. Field Phase</b>	
Meetings with the CO staff and presentation by programme officers of programme key achievements, facilitating and constraining factors	12 -16 Jan 2015
Meetings with national level stakeholders in Phnom Penh	

Phases/Specific activities/milestones/deliverables	Dates
Data collection, interviews with partners at sub-national levels in three selected provinces	19 – 30 Jan 2015
Additional Meetings with national level stakeholders in Phnom Penh and preparation of the debriefing with ERG	2 - 5 Feb 2015
Present preliminary findings and draft conclusion and recommendations to UNFPA / ERG for feedback and comments	6 Feb 2015
<b>4. Reporting Phase</b>	
Send the draft of the evaluation report to UNFPA	12 Mar 2015
Consolidated ERG group comments on the draft evaluation report	19 Mar 2015
Finalize draft evaluation report with evaluation brief	31 Mar 2015
<b>5. Dissemination and follow-up Phase</b>	
CPE report distributed to stakeholders in country, RO and UNFPA headquarters, with a view to obtaining responses to recommendations (management response)	April 2015
CPE report, final EQA and management response published on CO website and UNFPA evaluation database	April 2015

### 5) Evaluation Team Composition and Distribution of Tasks

The evaluation team consisted of three members:

- Frank Noij, Team Leader, Specialist in Complex Evaluation and Population and Development
- Nakagawa Kasumi, Gender Specialist
- Em Sovannarith, Specialist in Reproductive Health

Each of the team members covered the programme component related to their specialty as well as linkages with other programme components, while the team leader covered the Population and Development component as well as the overall perspective of the programme.

With the interrelationship across the three components an important focus of the present evaluation a large part of the meetings were conducted by all three team members, each focusing on their own sub-set of issues. Moreover, selected meetings were conducted by a sub-set of the evaluation team, which allowed for coverage of more ground during the in-country data gathering. This set-up was followed in the meetings at national level, in Phnom Penh, as well as in the meetings at the sub-national level.

Team members reported on the meetings conducted from the specific perspective of their specialty to the team leader. Moreover, team leader and team members provided specific inputs into the draft and final evaluation report as agreed upon at the outset of the in-country data gathering process.

### 6) Resource Requirements and Logistic Support

The team received support from the UNFPA country office in terms of logistics, in particular in terms of transport in-country during the in-country data gathering process in Phnom Penh and in selected provinces. Moreover, the team was provided with a translator for those meetings conducted in Khmer. For most of the meetings at national and sub-national level introductions were provided by UNFPA or partner staff. UNFPA staff involved in the management and implementation of the programme refrained from participation in meetings. In this way the independence of the evaluation and its results was ensured, in line with the UNEG standards and guidelines on evaluation.

## **ANNEX 4:**

### **Stakeholder Mapping**

#### **1. National Government**

- Ministry of Women's Affairs (MOWA)
  - Gender Equality and Economic Development Department
  - Legal Protection Department
  - Women and Health Department
- National Committee for Sub-National Democratic Development (NCDD) Secretariat
- Ministry of Interior (MOI) (D&D)
  - Department of Local Administration
- Ministry of Planning (MOP) (GMAG)
  - General Directorate of Planning
  - National Institute of Statistics (NIS)
  - GMAG
- Ministry of Health (MOH),
  - HSSP2 focal point (responsible for the implementation of HSSP2 pooled fund and UNFPA's discreet fund; GMAG)
  - National Maternal and Child Health center (MCH, FP, EmONC, Adolescent Friendly Services)
  - Human Resource Department (HRD) (Capacity development of midwives and doctors)
  - Personnel Department (PD) (Deployment of human resources into health service facilities)
  - Cambodian Midwife Association (Responsible for quality assurance of midwives)
  - Cambodian Midwives Council
  - NCHADS (Joint coordination working group for the integration of HIV and FP)
  - Preventive Medicine Department (PMD)
  - Department of Drugs and Food
  - DPHI
  - GMAG
  - Regional Training Centers (Kampong Cham, Kampot and Stung Treng)
- Ministry of Education, Youth and Sports (MOEYS), Inter-Departmental Committee for HIV/AIDS and Drugs (Implementation of the Life Skills Education in schools in seven provinces)
- Cambodian Association of Parliamentarians on Population and Development (CAPDD)
- National AIDS Authority
- Cambodia National Council for Women (CNCW)

#### **2. Sub-National Stakeholders**

##### **Provincial Level**

- Provincial Department of Health (24 provinces), Director and MCH Chief (Responsible for provincial SRH implementation plan, General leadership, VAW, health - GBV coordination system)
- Provincial Hall, Director (Women in leadership, GBV coordination system)
- Provincial Department of SAVY, director (GBV coordination system)
- Provincial Referral Hospital (EmONC improvement plan and other SRH services)
- Provincial Department of Education Youth and Sports (Comprehensive Sexual Education / Life Skills Curriculum)
- Regional Training Centre (responsible for the midwifery in-service training)
- Provincial committee for Disaster Management (Responsible for the implementation of the Emergency Preparedness intervention)
- CWCC, Regional Manager, survivor at shelter (GBV response, referral system)
- Provincial WCCC, male and female member (VAW, women empowerment, health, leadership)
- PDoWA (General,- leadership, VAW, health- GBV coordination system)

#### **District Level and Commune Level**

- Operational District Office, MCH chief, director (Responsible for the implementation of the RH programme)
- District Referral Hospital (EmONC and SRH services)
- District Committee for Disaster Management (Responsible for the emergency preparedness intervention)
- Health center (Service provision of SRH)
- Schools (teachers and pupils/students who benefitted from the Life Skills training)
- Cambodia Women Crisis Centre (CWCC)
- District WCCC
- CCWC
- Police
- Commune Chief, village chief
- Direct beneficiaries (women who made use of a variety of RH and FP services and participants in DV , HIV, Leadership initiatives and forums)

### **3. UN Agencies**

- Office of the UN Resident Coordinator
- UNICEF (HSSP2 and D&D initiative of the PD component)
- UN Youth Task Force
- World Bank (HSSP2 focal point)
- WHO (Maternal and Child Health (MCH) team, support to the RH programme)
- UN Women (VAW programme and D&D)
- UNDP (VAW program, Governance and policy issues)



#### 4. Civil Society Organizations

- Cambodian Women for Peace and Development (CWPD) (Responsible for the implementation of the 'Smart Girl' initiative)
- CWCC (Shelter, multi-sectoral service system)
- RHAC (Responsible for the implementation of community based family planning)
- BBC Media Action (Responsible for the implementation of the 'Love 9' SRH programme)
- National Committee for Disaster Management (responsible for the implementation of the emergency preparedness intervention of RH component)
- National Maternal and Child Health Center (NMCHC)
- Reproductive and Child Health Alliance (RACHA)
- Children Surgical Center (CSC)
- Cambodian Midwives Association (CMA)
- Cambodian Midwives Council (CMC)
- CARE International (VAW with Youth 2012)
- INTHANOU
- Coordinating Committee for Cambodia (CCC)
- Women for Prosperity
- SILAKA
- GBV Multi-sectoral network
- Paz Y Desarrollo (PYD) and partner NGO (Good men campaign)
- JICA (Japan) (MCH focal point, joint coordination roles in HSSP2 platform)
- URC
- PSK
- Volunteer Services Overseas (VSO)

#### 5. Development Partners

- HSSP II Secretariat
- DFAT (Australia) (HSSP2 focal point, support to the joint HSSP2 programme)
- German Government
- GIZ (Health Programme focal point, support to the joint HSSP2 programme; VAW/Domestic Violence)
- KfW (Family Planning programme advisor, supported the family planning programme)
- USAID (MCH programme team, supported the RH programme)
- Spanish Agency for International Development Cooperation (AECID)
- European Union
- AfD (France)
- Koica (Republic of Korea)

## ANNEX 5:

### List of Persons Consulted at the National Level

Date	Name	Institution	Position
5-11 Dec 2014 / 12 Jan 2015	Dr Marc Derveeuw	UNFPA	Representative
	Ms Catherine Breenkamkong	UNFPA	Deputy Representative
	Mr Tum	UNFPA	Assistant Representative
	Dr Sokun Sok	UNFPA	RH Specialist
	Ms Thou Kagnabelk	UNFPA	RH Programme Officer
	Mr Soktha Yi	UNFPA	Population/Development Analyst
	Mr Saky Lim	UNFPA	Local Governance Officer
	Ms Sokroeun Aing	UNFPA	Gender Analyst
	Dr Vandara Chong	UNFPA	Youth/HIV Programme Officer
	Mr Solim Ly	UNFPA	Operations Manager
13 Jan	Mr. Chea Bunheng	DoLA	Director
	Ms. Tith Poly	DoLA	Deputy Director
	Ms. Nicole Butcher	BCC	Team Leader
	HE Keth Sam Ath	MOWA	Advisor
	Ms Keth Mardy	MOWA	Director, Legal Protection Department
	Ms Hou Nirmita	MOWA	Director, Health Department
	Mr Te Chhum Hak	MOWA	Vice Director General
	Ms Mia Hyun	UNDP/MOWA	Senior Policy Advisor, PGE
	Mr Bory Pen	UNDP/MOWA	Governance Specialist, PGE
14 Jan	Dr Chhay Kim Soteavy	MOEYS	Director School Health
	Dr Chhunrith	MOEYS	Deputy
	Dr Kim Sam	MOEYS	Deputy
	HE Tauch Chooun	MOEYS	Director General ICHAD
	Mr Savoeung Saroeun	MOEYS	Deputy director, Youth department
	HE Ngan Chamroeun	MOI/NCDD	Deputy Secretary General
	Ms. Claire Van der Vaeren	UN	UN Resident Coordinator
	Mr. Bun Hok,	UN	UN Coordinator Specialist
15 Jan	Ms. Meach Sotheary	CWPD	Director
		CWPD	Programme Officer

Date	Name	Institution	Position
	H.E Tuon Thavrak	MOP	Secretary of State
	Dr. Var Chivorn	Associate Executive Director	RHAC
	Prof. Tung Rathavy	NMCHC	Director
	Ms. Chhay Sveing Chea Ath	NMCHC	President of CMA
	Mr. Shaun Ellmers	DFAT	First Secretary
	Ms. Margot Morris	DFAT	First Secretary, Chair of JPIG
	Mr. Chris Vickery	DFAT	Health Advisor
16 Jan	HE Tan Vouvh Chheng	MOH	Secretary of State
	HE. Hou Samith	CNCW	Acting Director
	Dr Kiri	MOH	
	HE. Ouk Damry	CAPPD, National Assembly	
	HE. Hang Lina	MOP / NIS	Director General
	Mr. They Kheam	MOP / NIS	
	Mr. Sok Kosal	MOP / NIS	
	Mr Bunthon	MOP/NIS	
	Ms Setsuko Yamazaki	UNDP	Country Director
2 Feb	HE. Theng Pagnathun	NSDP	
	HE. Hou Samith	CNCW / MoWA	Acting Director
	Ms. Megan MacBain	BBC Media Action	Director
3 Feb	Dr. Etienne Poirot	UNICEF	Head of Health and Nutrition
	Mr. Chea Vibol	UNICEF	Social Policy Specialist on D&D
	Ms. Laura L. Rose	World Bank	Senior Health Economist
	Ms. Ly Nareth	World Bank	Health Operations Officer
4 Feb	HE. Sy Define	MoWA	Secretary of State
	Dr. Dagmar	GIZ/MoWA	Technical Advisor
	Mr. F. Nishi	NIS/MoP	JICA Expert
	Ms. Wenny Kusuma	UN Women	Representative
	Ms. Inala Fathimath	UN Women	Consultant
5 Feb	Ms Polin Ury	UN AIDS	UN Youth Task Force Member
	Mr Pery Lody	ILO	UN Youth Task Force Member
	Ms Vandara Chong	UNFPA	UN Youth Task Force Member

Date	Name	Institution	Position
	Freya De Clercq	UNFPA	Facilitator UN Youth Advisory Panel
	Ms. Ing Rada	MOH	President CMC
	Ms. Pok Panhavichectr	CWCC	Director
6 Feb	Ms. Loun Monyl	INTHANOU	Director

## ANNEX 6:

### Ethical Code of Conduct for UNEG/UNFPA Evaluations

Evaluations of UNFPA-supported activities need to be independent, impartial and rigorous. Each evaluation should clearly contribute to learning and accountability. Hence evaluators must have personal and professional integrity and be guided by propriety in the conduct of their business. In particular:

1. To avoid conflict of interest and undue pressure, evaluators need to be independent, implying that members of an evaluation team must not have been directly responsible for the policy-setting/programming, design, or overall management of the subject of evaluation, nor expect to be in the near future. Evaluators must have no vested interests and have the full freedom to conduct impartially their evaluative work, without potential negative effects on their career development. They must be able to express their opinion in a free manner.
2. Evaluators should protect the anonymity and confidentiality of individual informants. They should provide maximum notice, minimize demands on time, and respect people's right not to engage. Evaluators must respect people's right to provide information in confidence, and must ensure that sensitive information cannot be traced to its source. Evaluators are not expected to evaluate individuals, and must balance an evaluation of management functions with this general principle.
3. Evaluations sometimes uncover suspicion of wrongdoing. Such cases must be reported discreetly to the appropriate investigative body.
4. Evaluators should be sensitive to beliefs, manners and customs and act with integrity and honesty in their relations with all stakeholders. In line with the UN Universal Declaration of Human Rights, evaluators must be sensitive to and address issues of discrimination and gender equality. They should avoid offending the dignity and self-respect of those persons with whom they come in contact in the course of the evaluation. Knowing that evaluation might negatively affect the interests of some stakeholders, evaluators should conduct the evaluation and communicate its purpose and results in a way that clearly respects the stakeholders' dignity and self-worth.
5. Evaluators are responsible for the clear, accurate and fair written and/or oral presentation of study limitations, evidence based findings, conclusions and recommendations.

For details on the ethics and independence in evaluation, please see UNEG Ethical Guidelines and Norms for Evaluation in the UN System.

<http://www.unevaluation.org/search/index.jsp?q=UNEG+Ethical+Guidelines>

[http://www.unevaluation.org/papersandpubs/documentdetail.jsp?doc\\_id=21](http://www.unevaluation.org/papersandpubs/documentdetail.jsp?doc_id=21)

## ANNEX 7:

### Fourth Programme Cycle of UNFPA in Cambodia

#### Results and Initiatives of the Population and Development Component

**Outcome 1:** Effective mechanism for dialogue, representation and participation in democratic decision-making established and strengthened

**Output 1:** Avenues and structures developed and strengthened to empower youth and women to participate in decision-making and planning at national and sub-national level.

Work under this outcome area makes use of the entry point of the on-going process of sub-national democratic development, ensuring that women and youth can participate in emergent local decision-making structures and processes. This is done in close collaboration with other development partners active in the area of sub-national democratic development, including UNICEF, UNDP, World Bank, GIZ and the EU.

Key initiatives include:

- Building the capacity of the key emergent institutions charged with promoting social sector development issues as part of the decentralization process including the Women and Children's Consultative Committees (WCCC) at provincial and district levels as well as the Commune Committee for Women and Children (CCWC) at the local level.

This is expected to result in increased voice and participation of women, youth and vulnerable groups in local planning and budgeting, increase awareness on key population, gender and reproductive health issues, ensure essential social sector issues are included in local planning and budgeting and improved responsiveness of social services to the needs of women, young people and vulnerable groups.

This part of the PD component of the programme is implemented in collaboration with the Department of Local Administration (DoLA) of the Ministry of Interior (MoI). The activities were implemented in 48 districts in seven provinces with selection favouring relatively remote and marginal communities with poor health indicators and few external support but with high commitment to improve health sector performance.<sup>92</sup>

**Outcome 2:** Enhanced capacities for collection, access and utilization of disaggregated information (gender, age, target populations, region) at national and sub-national levels to develop and monitor policies and plans that are responsive to the needs of the people and incorporate priority population, poverty and development linkages.

**Output 1:** Improved availability and utilization of disaggregated (gender, population, region) data and information.

Work under this outcome area entails support to the collection, dissemination and utilization of disaggregated data and building capacities for evidence-based planning and budgeting at national and sub-national levels. This will be done in close cooperation with the General Department of Planning of the Ministry of Planning (MOP), NCPD, the National Institute of Statistics (NIS) and other UN agencies and development partners.

The key initiatives under output 1 include:

- Developing the capacity of partners to provide timely and comprehensive population data and statistics;

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<sup>92</sup> From 2011 this part of the programme focused on selected districts in Siem Reap, Kampong Cham, Banteay Meanchey, Preah Vihear, Ratanakiri, Kampong Chhang and Stung Treng provinces. Source: UNFPA, *Note on Selection of Target Provinces / Districts in the Decentralization and Deconcentration (D&D) Programme*.

- Promoting networking of national partners involved in population data collection and utilization;
- Improving the coordination and management of data storage at the National Institute of Statistics;
- Promoting disaggregated data analysis, utilization and dissemination at national and sub-national levels;
- Supporting the development and use of CAM-Info tools;
- Strengthening NIS capacity in IT, programming, data processing and analysis.

Key data collection, analysis and dissemination initiatives during CP4 include:

- Completion of the analysis and dissemination of the 2010 CDHS;
- Planning, implementation and analysis of the 2013 Inter-census Population Survey
- Planning and implementation of the 2015 CDHS.

**Output 2:** National and sub-national capacity to develop plans and budgets that are evidence based, gender and child sensitive and incorporate priority population, poverty and development linkages strengthened.

Work under this outcome area will focus on sensitization and research on emerging population issues and capacity development for national and sub-national evidence-based planning and budgeting.

The key initiatives include:

- Enhancing the capacity of policy-makers, parliamentarians and planners to utilize population, poverty and development data for planning, M & E and reporting;
- Strengthening the Ministry of Planning's capacity to prioritize and mainstream gender issues, through support to the GMAG and GMAP<sup>93</sup>

Focus of activities with NCPD include:

- Development of training and advocacy materials on priority and emerging population issues;
- Sensitization and training on priority and emerging population issues;
- Compiling and disseminating policies and plans related to population and development;
- Integration of key issues into NSDP reporting;
- Conducting and disseminating research into priority and emerging population issues.

### **Results and Initiatives of the Sexual and Reproductive Health Component**

**Outcome 1:** Increased equitable coverage, at national and sub-national levels, of good-quality reproductive, maternal, newborn and child health and nutrition services

Under the first outcome, UNFPA continues to work as part of HSSPII to support the reproductive and maternal health elements of the health strategic plan.

**Output 1:** Improved national and sub-national capacity to increase the availability, accessibility, acceptability, affordability and utilization of good-quality reproductive, maternal, newborn and child health and nutrition services

UNFPA provides support to:

- The development and revision of relevant national strategies, policies, guidelines and protocols.
- On key emerging RMH issues to inform policy, strategy and guideline development.

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<sup>93</sup> See also Outcome 2 of the Gender Equality Programme where support to GMAGs is described in more detail.

- The implementation and monitoring of the EmONC Improvement Plan and FTIRM;
- The provision and quality improvement of RMNH services, including the integration of HIV and AIDS and SRH services and other reproductive services including those addressing reproductive cancers.
- Promotion of community based activities including community notification of maternal death, birth preparedness, community based distribution (CBD) of contraceptives and outreach by health service providers.
- Capacity development, sensitization, protocol development and behavior change communication in relation to the identification, management and referral of GBV cases in pilot provinces.
- Ensure family planning commodity security
- Introduction of new and long-term family planning methods.
- Support for integration of adolescent/youth friendly services as part of the CPA and

MPA, including development of referral systems for young people.

- Support for financial mechanisms such as Health Equity Funds, which enable poor people to access services.
- Support for behavior change communications, particularly those addressing harmful practices and misconceptions affecting health-seeking behavior and practices related to sexuality, pregnancy and delivery.

**Output 2:** Increased competency and availability of health-related human resources, particularly midwives and other professionals, where gaps in skills exist.

Under this output, UNFPA will focus on supporting the improved availability and competency of human resources in the areas of reproductive, maternal and neonatal health, particularly emergency obstetric and neonatal care doctors and midwives.

The key initiatives to promote capacity development of relevant human resources include:

- Support for improved midwifery training, deployment, registration, licensing and practice through pre-service training and the recruitment, appropriate deployment, licensing and registration of midwives.
- Support for in-service training to develop improved competency for family planning, skilled birth attendance and EmONC.
- Support for improved competency to provide youth friendly clinical services, GBV identification, clinical management and referrals and HIV and STI.
- Support the roles and functions of professional organizations for midwifery, the Cambodian Midwives Council and the Cambodia Midwives Association.

**Outcome 2:** Enhanced national and sub-national institutional capacity to expand young people's access to good-quality life skills, including on HIV, and technical and vocational education and training

**Output 3:** Enhanced access to and utilization of core life-skills training, including on HIV, and technical and vocational education and training, especially for disadvantaged young people and out-of-school children.

UNFPA has focused on increasing the availability of and access to information for young people including vulnerable and most at risk young people by:

- Supporting the integration of SRH and HIV and AIDS into life skills training
- Providing direct support for life skills implementation in selected geographical areas for in and out of school young people



- Strengthening the linkages between life skills education and ASRH services
- Promotion of the participation of most at risk young people in policy dialogue on SRH and reproductive rights and youth outreach activities.

The activities under this output will be implemented in partnership with relevant governmental agencies and civil society organizations. These include the Interdepartmental Committee on HIV and AIDS and Drugs of MOEYS and youth organizations, including those working with most at risk young people.

**Outcome 3:** Strengthened multi-sectoral response to HIV

**Output 4:** Enhanced national and sub national capacity to target key populations at risk with effective interventions to prevent HIV.

Under this outcome, UNFPA has continued to work closely with the JUTH and as part of the division of labour between UN agencies and UNAIDS co-sponsors UNFPA will continue to take a lead among the UN family on addressing the needs of sex and entertainment workers by:

- Supporting policy, strategy and capacity development for HIV prevention with entertainment and sex workers, their clients and partners.
- Supporting the capacity development of networks among entertainment and sex workers.

UNFPA in partnership with MOWA and CWD, aims to contribute to reducing the vulnerability of women and girls to HIV and addressing gender and HIV issues through support to the implementation of prevention, advocacy and awareness-raising elements of MOWA's Strategic Plan on Women, the Girl Child and HIV/AIDS as well as reducing the HIV and SRH issues among most-at-risk women.

**Outcome 4:** Increased national and sub-national capacity to provide affordable and effective national social protection through improved development, implementation, monitoring and evaluation of a social protection system

**Output 5:** Increased national and sub-national capacity for emergency preparedness and response, to reduce and mitigate the vulnerability of the poorest and most marginalized persons, especially women, children, elderly, youth and people living with HIV, to environmental and health disasters.

UNFPA has supported the national and sub-national agencies engaged with emergency preparedness and response to mitigate RMH and GBV impacts of emergencies through:

- Contributing to the development of emergency preparedness and response plans
- Supporting the rollout of national and sub-national training on the Minimum Initial Service package for SRH in crisis situations, with a particular focus on disaster-prone locations.

### **Results and Initiatives of the Gender Component**

**Outcome 1:** A harmonized aid environment that promotes gender equality and the empowerment of women

**Output 1:** Increased United Nations leadership and facilitation of a programme-based approach to promoting gender equality and empowering women.

Work under this outcome area entails working closely with the UNRC Office and United Nations Country Team to improve gender responsiveness and coordination, mostly in the capital city of Phnom Penh.

The key initiatives include:

- Contributing to joint UN support for improved gender responsiveness and coordination in the UNCT;
- Participation in development and implementation of a proposed PBA for gender equality and women's empowerment;

- Contributing to joint support for the development of new MOWA five-year strategic plan, Neary Rattanak IV;
- Contributing to joint support for third Cambodia Gender Assessment.

**Outcome 2:** Strengthened and enhanced gender-mainstreaming mechanisms at national and sub national levels.

**Output 2:** Enhanced capacity of gender mainstreaming action groups in line ministries and institutions at national and sub national levels.

The key initiatives include support to:

- Capacity development of Gender Mainstreaming Action Groups (GMAG) in the Ministry of Health (MoH) and in the Ministry of Planning (MoP)
- Capacity development on gender analysis and advocacy at national and increasingly at sub-national level.

For output 2, capacity development for GMAGs in other line ministries will be integrated into the annual work plans of MOP and MOH as implementing partners under the PD and RH components. UNFPA directly supports those two ministries in Phnom Penh, and quarterly meeting among all GMAG have been held with technical support from UNFPA as a regular monitoring process.

**Outcome 3:** Enhanced participation of women in the public sphere at national and sub national levels

**Output 3:** Enhanced opportunities and mechanisms to strengthen women's capacity to participate in the public sphere at national, sub national and community levels.

This work will complement the activities described above under the PD component as part of support to SNDD aligned with the IP3. Under the gender equality component the focus will be on supporting the capacity development of Women and Children Consultative Committees (WCCCs) with reference to social sector issues through the following key initiatives:

- Support to MOWA at national level developing capacity and providing technical assistance, coaching, mentoring and follow-up of activities;
- Engage NGOs to provide training to strengthen capacity of WCCCs, including women councillors;
- Support mid-year and annual review meetings for WCCCs;
- Arrange exchange visits for exchange and learning between WCCCs in different locations.

**Outcome 4:** Improved societal attitudes and preventive and holistic responses to gender-based violence.

There are two outputs under this Outcome, which is mainly focusing on the gender-based violence (GBV) related intervention.

**Output 4:** Increased community awareness of and involvement in the promotion and protection of women's rights and gender equality, and the prevention of gender-based violence.

The focus is on creating an enabling environment for the prevention of GBV and the protection of women's and children's rights through:

- Support to activities targeting men to play a positive role in promoting gender equity and preventing GBV
- Advocacy to encourage key stakeholders in communities, including local authorities and law enforcement officers, to intervene in GBV cases
- Support for research on GBV issues

- Support media and communications activities to increase public awareness and involvement in protection of women's rights and prevention of GBV.

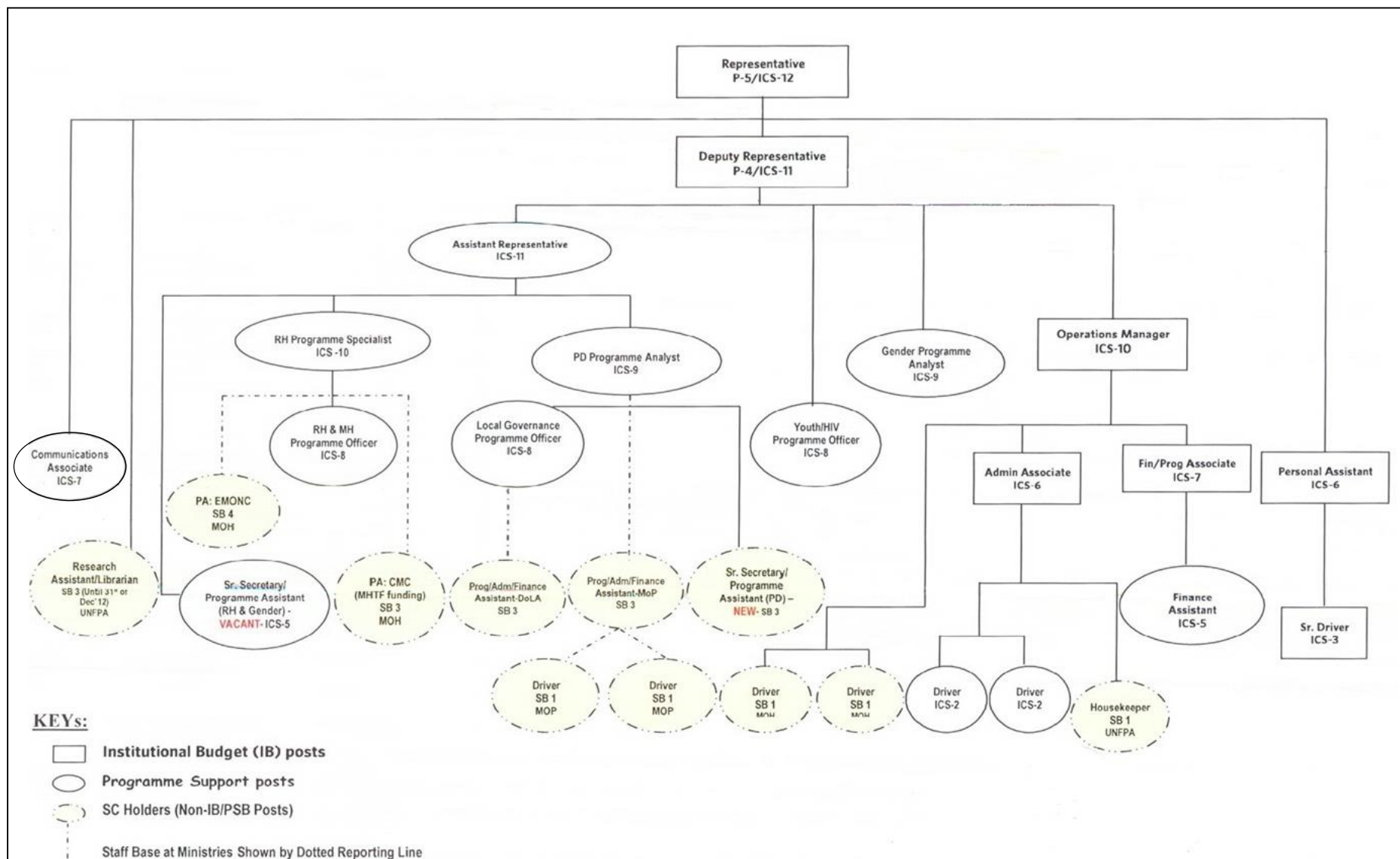
Public awareness raising on GBV is conducted through the nation-wide media campaign "*Good Men Campaign*", and at sub-national level public forums on Domestic Violence have been organized by PoDWA in selected provinces such as Preah Vihear and Kampong Cham.

**Output 5** (Second output under Outcome 4): Increased institutional capacity to provide multi-sectoral mechanisms to protect women's rights, promote gender equality, and prevent gender-based violence.

UNFPA has engaged in establishing multi-sectoral mechanisms for the protection of women's rights and the prevention of and response to GBV by:

- Collaborating with other development partners to supporting the implementation and monitoring of the National Action Plan to Prevent Violence against Women (NAPVAW)
- Developing model multi-sectoral prevention, referral and response mechanisms at the provincial level in selected provinces (Banteay Meanchey)
- Advocating for a national standard or mechanism for a multi-sectoral response to GBV.

**ANNEX 8: Organizational structure of the UNFPA Cambodia Country Office, updated May 2012**



## ANNEX 9:

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