EVALUATION OF

ECHO'S 2000 AND 2001 FUNDED ACTIONS IN CAMBODIA:

June 24 – August 23, 2002

HEALTH REPORT

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Executive summary

Evaluation of ECHO's 2000 and 2001 funded actions in Cambodia:

TECHNICAL HEALTH REPORT

Action evaluated : Post-emergency health sector aid provided to vulnerable populations in Cambodia.

Date of the evaluation : June 24 – August 23, 2002

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Purpose and methodology :

- The evaluators set out to obtain the information needed to improve future ECHO actions in health in Cambodia and to offer an independent opinion of the achievement of expected results in that field, as well as of the relevance, efficiency, effectiveness, impact and sustainability of six health projects financed by ECHO in 2001.
- Three priorities were followed :
  a) evaluating each project against its own merits and achievements in health as per their respective LFMs,
  b) assessing to what extent partners had made progress to hand-over these projects to long term development funding organizations, and
  c) recommending geographical areas of the country where ECHO should consider a continued involvement in health in the future.
- In depth reviews were made of documentation at all levels and interviews were held with Echo Brussels and Cambodia staff, the EU Delegation in P Penh and staff of partner NGOs.
- Field visits to all projects followed.
- Summary evaluation reports for each project are presented as annexes to the Synthesis Report.
- A debriefing was held for most of the partner NGOs (including those not evaluated); details in annex to the Synthesis Report. The EU Delegation also got a debriefing.

Main technical findings and conclusions :

Regarding relevance :

- Evaluators thought health interventions were well implemented.
- The choice and mix of interventions was adequate and the linkages with watsan, FS, road construction and mine clearance were very appropriate.
- Primary health care services have indeed been expanded: ECHO funding has allowed the installation of basic health infrastructures and services. But some shortcomings persist.
- A new referral system is making a good start.
- Provincial hospital interventions are considered an exception component in post-emergency short-term operations given the long-term commitments needed.
- At HC level, work was relevant. But there are still serious structural problems in the functioning of HCs.
- Through project interventions health centers are now working better; the question is for how long.
- Working in health posts, although not and MOH priority, is justified.
- Outreach work is needed particularly because of the unmet needs of the most vulnerable.

- Outreach teams have been instrumental in improving the overall health status of mothers and children.
- All projects trained VHWs that now come to monthly feedback meetings; evaluators think this has worked well and is sustainable.
- NGOs have proceeded to train and organize TBAs; this has had a positive impact.

Regarding efficiency :
- Project inputs have been efficiently and appropriately introduced.; the quality of those contributions is judged to be good.
- ECHO-supported HCs now treat between 300 and 1000 patients a month; the quality of those services has improved.
- Most NGO partners top-up drugs in HCs; this is unsustainable.
- Feedback committees work better than HC co-management committees; evaluators did not find evidence that beneficiaries are really participating in decision-making.

Regarding effectiveness :
- Physical access to health has improved both through outreach work and through HC services.
- Mine clearance operations have been crucial for safe access to health facilities.
- Outreach 'clinics' are well attended.
- Outreach work is still insufficient in quantity, but a very good start has been made.
- The quality of outreach work still has problems, but it is improving.
- Not all possible preventive work is done during outreach; there are still missed opportunities.
- Both quantity and quality of services in HCs has increased, but there is ample room for improvements.
- NGO staff and HC staff received ample training; evaluators cannot directly judge the quality of the same.
- HCs charge user fees; the fee for service system put in place provides a modest additional income for staff while not seeming to constrain the poor. Evaluators think the system does deter the poorest from coming.

Regarding impact :
- The impact of the health interventions implemented has been clearly positive for beneficiaries; whether it will be sustained is questionable.

Regarding sustainability and LRRD issues :
- Local communities have become more aware of their health needs and are using the services offered..
- Periodic meetings with community actors have a chance to provide continuity and some sustainability.
- All health partners evaluated counted on getting refunded by ECHO in 2002/03; if not funded, a loss of their project staff will clearly impinge on sustainability.
- LRRD issues have been slow in materializing.
- Exit strategies were not explicited by partner NGOs.

Technical recommendations :
- ECHO support to provincial hospitals can only be justified on a case-by-case basis.
- Partners topping-up medicines for project HCs is unsustainable and should be minimized.
- On-the-job training works better than classroom learning and should be preferred.
- Outreach work should be mostly preventive, but cannot ignore curative needs of patients.
- Outreach work has to start with the strengthening of HC staff.
- Health/nutrition education materials need to be more closely adapted to local needs.
- Dengue and cholera are genuine ECHO priorities.

In the future :

- ECHO-funded projects should concentrate on outreach activities, health and nutrition education , incentivating and training HC staff and providing staff to train and supervise field work.
- Strengthen diagnostic and curative work in HCs and streamline referrals.
- Engage more staff in health interventions requiring a behavior modification that can be achieved in the nine months of the project span.
- Concentrate efforts in the health sector in disaster-affected areas (by floods and drought); in new resettlement areas in former war affected areas; in newly opened areas where people have been living without any external support; and in remote areas that have been deprived of assistance, not necessarily for war reasons.
- In health, priority should be given to women and children, not forgetting the needs of women and children of female-headed households, widows, the elderly, the disabled and indigenous people

Lessons learned :

- The outreach activities in a post-emergency health project are probably more important than the fixed facility activities to improve services.
- On-the-job training for health staff works better and is more sustainable than classroom learning.
- Feedback committees work better and more regularly than HC co-management committees
- Hygiene and sanitation training done one time not sufficient.
- Good, formal baseline assessments of health and nutritional status are very necessary to assess progress.

Cambodia : The health context

In the last three decades, the health sector in Cambodia experienced a destruction of its physical infrastructure and the virtual loss of most of its professional and administrative cadres. This was followed by an extremely high birth rate during the post-war period all together resulting in a distorted population pyramid, both in terms of sex and age. The war also resulted in emotional, mental and physical trauma of the population including disabilities due to land-mine accidents.

About one in five Cambodian women who died in the seven years prior to 2000 did so from pregnancy or pregnancy-related causes; maternal deaths thus remain unacceptably high.
Infant and child mortality rates have actually risen over recent years; these rates signal a disturbing picture of child health in the country. Around half the children are malnourished and the burden of communicable diseases, especially malaria, TB and HIV is heavy.

More specifically, one in ten babies does not survive to his/her first birthday; chronic malnutrition among <5s is high, with 45% of them being moderately stunted and more than one in five being severely stunted; the number of new cases of TB has trebled over the last decade; the HIV epidemic seems to have peaked and, since 1999, rates of infection have dropped a bit.

With important amounts of foreign aid, health services and the PHC infrastructure have slowly been reinstated in the last decade or so. Facilities have been progressively rehabilitated and built, staff trained and deployed, all leading to a slow normalization of health care nationwide. Nevertheless, the motivation of staff remains a big problem primarily due to very low salaries. The fee-for service system underlying rehabilitation efforts certainly has been hard on the lowest income quartile of the population.

The provinces in the Northwest, where most of the evaluated projects are located, are remote and have been late-comers in this rehabilitation effort of the sector; they therefore still experience very significant deficits. It is against this picture that the projects evaluated have to be seen.

1. General technical findings and conclusions of the evaluation

[Some, but not all the findings and conclusions here are also found in the individual evaluation reports of the projects evaluated (i.e. the six with a health component: HU, MSF, ZOA x 2, MHD and CARE). Find them bound in a separate document submitted for this evaluation].

From a technical point of view, evaluators thought health interventions were, in general well implemented. But, as it turns out, this is not the full story. An excellent external evaluation of the long-term HU project in RK showed that intervening only in health and nutrition has improved the situation little over a period of 10 years; the evaluation calls for more comprehensive interventions incorporating more drastic economic and education measures along with what is being done so far.

1.2. Technical relevance of interventions

The choice and mix of interventions for what actually were post-emergency operations was judged to be adequate and the linkages with watsan, FS, road construction and mine clearance activities were very appropriate to maximize positive health outcomes.

Through the projects evaluated, primary health care services have indeed been expanded: ECHO funding has allowed the installation of basic health infrastructures and services (construction/repair of health

centers, training cum follow-up of staff, supply of essential drugs and other); the same have had a significant impact on the population. But some shortcomings persist: Coverage rates of EPI and FP/ANC in the outreach work of the projects with a health component have in fact increased, but still have a long way to go.

A new referral system is making a good start: Referrals from outreach locations to HCs and from there to a hospital, when needed, have been streamlined quite a bit.

1.1.1 At provincial hospital level

In Oddar Meanchey province, ECHO funding through MHD also permitted rehabilitating the (provincial) referral hospital providing it with water, electricity, drugs, a functioning lab, a better TB ward and a working surgical theater among other. This funding for a provincial hospital is considered an exceptional and very expensive component in post-emergency short-term operations given the long-term commitments needed. In this case, it was argued that it was needed to support all work done by MHD at the HC and community level if referrals were to be handled properly at this higher level; evaluators tend to agree with this rationale.

1.1.2 At HC/health posts level

Work at this level has been relevant. But there are serious structural problems in the functioning of HCs. Staff is poorly motivated and poorly qualified --both probably a result of the very low salaries. Almost all HC staff have a parallel private practice. HCs often close mid-morning not to reopen till the next day. People know this and tend not to come for consultation especially if they have long travel to make. No project inputs can revert this situation fully. But through project interventions (upgrading, equipment, staff training) plus the topping-up of salaries, project health centers are working better and seeing more patients; the question is, of course, for how long.

Through the influence of MHD and their work with ECHO funds, the MOH has accepted adding a new HC for the town of O'Smach in their national plan; construction is now starting with WB funding. This will mean closing (in Feb 2003) the O'Pork HC (11 Km away) which has been fully run and staffed with ECHO/MHD funding. All other HCs supported by ECHO projects are official MOH HCs.

The MOH does not accept the opening of health posts --except in Rattana Kiri due to the many remote areas. This not withstanding, MHD and CARE have been working with posts in O. Meanchey in a move that evaluators feel is justified for now.

1.1.3 In outreach work and role of VHWs/TBAs

Outreach work is the obvious need if the most vulnerable people are not coming to the HCs; and the ECHO projects have done just that. They have trained HC staff to go with project staff to different locations to do EPI, FP, nutrition and sometimes ANC work. Motorcycles provided have made a crucial difference in outreach programs.

Doing mostly preventive work, outreach teams have been instrumental in improving the overall health status of mothers and children living in the project areas. Due to government policy, they only occasionally provide curative care during outreach; they rather refer patients to the HC.

Outreach work being done by MHD for commercial sex workers is commendable; the problem is one of the many problems found in border town resettlement areas (see the MHD evaluation report).

Other than organizing outreach work from the HCs, all projects have trained VHWs (two per village, one female); they come to well-attended monthly feedback meetings in which VHWS report on work done, on health conditions in their villages and receive refresher and new training. Evaluators think this has worked well and is sustainable. As an incentive, they get exemption of fee for service at the HC for themselves and immediate family.

Health interventions requiring behavior modification (e.g. hygiene/sanitation education) were often done only once in a village; this is of little help and is not cost-effective without follow-up.

Several NGOs have proceeded to train and organize TBAs which, strictly speaking, is against MOH policy; evaluators think it has had a very positive impact.

1.2. Efficiency, technical quality and appropriateness of interventions

Project inputs to the health sector were, in the opinion of the evaluators, efficiently and appropriately introduced by partners in all projects. The quality of those contributions was judged high in all cases.

With the exception of the HCs in RK where utilization rates are very low (and are not directly supported by HU), ECHO-supported HCs now treat between 300 and 1000 outpatients per month (the higher figure corresponds to O'Pork HC run by MHD). The improved quality of services was confirmed by patients interviewed.

Most NGO partners top-up drugs when shortages occur in HCs; this is obviously unsustainable.
Solar energy refrigerators for EPI have worked well despite not being in the national policy.

Feedback committees are functioning and work better, more regularly and with greater attendance than HC co-management committees set up by the projects so far; transport allowances often make a difference in the attendance. Even when functioning, evaluators could not find evidence that beneficiaries are really participating in decision-making in these co-management committees; they provide a good link with the community and seem to mostly act as sounding boards.

1.3. Effectiveness

1.3.1. Physical access and utilization

Physical access to health has improved both through outreach work and through HCs and posts; to this, one can add access to basically trained VHWs and TBAs. Mine clearance operations and road rehabilitation under ECHO funding have been crucial for safe access to some facilities.

Utilization of services offered in HCs suffer from the shortcomings elaborated-on above under
Outreach 'clinics' are well attended by women and children in the villages as confirmed by evaluators in unannounced visits.

Particularly worrisome is the situation of the HC supported by CARE; the HC has to vacate the premises it functions in by September 2002 and has found no place to go yet (see CAREFr evaluation report).

1.3.2. Quality and quantity of services:

Outreach work is still, by far, insufficient in quantity. But short post-emergency projects such as the ECHO ones cannot possibly cope with the need despite the fact that a very good start has been made.

The quality of outreach work still has problems, but is improving, e.g., EPI cold chain and aseptic techniques have improved and recording has improved. But one has to understand that one is starting from levels of very low skills, particularly in Rattana Kiri.

Not all preventive work is done during outreach; there are still some missed opportunities; but partners judged that starting with a few interventions and solidly consolidating them is the preferred strategy; evaluators agree.

Quantity and quality of services in HCs and posts has increased through better equipment, staff training, use of national treatment protocols, better records keeping and other, but there is ample room for improvement through follow-up and support supervision. The low salaries issue hangs in the background as a hard one to crack.

1.3.3. Training

NGO staff and HC staff have received ample training in seminars, on-the-job, by being sent for internships or exchange visits to other districts and by bringing trainers from outside (including from provincial hospitals and from Thailand). Evaluators cannot directly judge the quality of the same, but it seems to be good. The training was mostly on clinical/lab/equipment maintenance skills and some on health information systems; little training was done on health management.

NGOs also trained village health workers and organized them into feedback groups to increase the penetration of services and the referrals to HCs. Some projects additionally trained TBAs.

1.3.4. Economic access, reaching the poorest

In most cases, HCs charge user fees that are (with the exception of Anlong Veng) fixed in discussions with the community. One partner (MHD) runs a HC that serves a high proportion of urban patients and charges much higher fees (fourfold), but the HC exempts up to 40% of the (poor) patients consulting since their travel costs are already high mostly coming from O'Smach.

The fee for service system put in place provides a modest additional income for staff while not seeming to constrain the poorest who seem to be getting exemptions. The latter could not be confirmed by the evaluators since in many HCs no records are kept of the exemptions. Evaluators have reason to believe that the fee for service does deter the poorest from coming; the fee adds to their transportation and other opportunity costs.

Particularly worrisome is the situation in Anlong Veng where, after MSF completed the project at the end of June 2002, the district authorities have tripled user fees to make up for lost project revenue used for recurrent costs and for salary top-ups (see MSF evaluation report).

1.4. Impact so far and over time

The impact on the target beneficiaries of the bulk of health interventions in the projects evaluated has been clearly positive in the short time the projects were run. Whether the impact will be sustained at the level attained during the projects is questionable if the respective NGO withdraws from the area.

Program-wise, very good impact has been achieved in the fight against malaria in the newly opened areas; activities implemented in the Northwestern areas have had an impressive impact in reducing malaria prevalence and mortality (not all due to ECHO, but also WHO and UNHCR funding though).

1.5. Sustainability

[Note that sustainability may be a more distant aim of short ECHO projects. Nevertheless, evaluators feel that it should be equally considered (as the preceding four parameters) in all projects --and the present evaluation consequently does so].

1.5.1 Community participation

Through the different project interventions, the local communities have become more aware of their health needs and are using the services offered. VHWs, TBAs and members of HC co-management committees have been trained and are back in the community sensitizing villagers and bringing feedback from there to the HC. It is hoped that the periodic meetings with these community actors will continue and the chance of it in the medium range is probably good.

1.5.2. Other sustainability issues:

Only one partner (MSF) has not stayed in the project area after the completion of their ECHO-funded health project (despite their continuation of a malaria project in the area, funded from elsewhere). Other partners have either continued for a while with their own funds, gotten another two months contract from ECHO (MHD), or gotten other short-term funding to continue their health work (CARE got funding from USAID). But all health partners evaluated (other than MSF) are counting on getting refunded by ECHO in 2002/03. Otherwise they may have to consider dropping project staff. A loss of that staff will clearly impinge on sustainability.

1.6. LRRD issues

LRRD issues have, if at all, been slow in materializing for health projects. Belgian aid may specifically support work through NGOs in Oddar Meanchey from next year. MHD is working with them.

ECHO is to take into account that Seth Koma --the UNICEF child's rights program-- is also moving in to all districts in O. Meanchey province and has health an nutrition components built-in when fostering village health plans.

Exit strategies were not explicited by NGOs --perhaps in the hope to be refunded for one more year by ECHO.

2. Recommendations (Technical recommendations related to health and nutrition)

For hospital work :
ECHO support to provincial hospitals can only be justified on a case by case basis when the absence of a reasonably reliable second level of care must be assured to justify health interventions at the community and HC level.

For HC work :
Partners topping-up medicines for the project HCs is unsustainable; evaluators feel it should be minimized.

For outreach work :
On-the-job training for health staff for outreach work works better than classroom learning and should be preferred .

Outreach work should be mostly preventive (as per MOH regulations), but cannot ignore curative needs of patients consulting (especially when staff strongly feels they will not come to the HC for treatment). Outreach work has to start with the strengthening of HC staff, and then, partner staff should go to the field with them to supervise them.

Health/nutrition education materials need to be more closely adapted to the actual needs of the local people.

Other :
MUAC (mid-upper arm circumference) nutrition surveys to assess levels of malnutrition are unreliable; weight for age should be preferred even with the difficulties in establishing a child's exact age.

Future Priorities :
ECHO should continue to support or start health interventions in new resettlement areas in former war affected areas; in newly opened areas where people have been living without any external support (no NGOs, no donor-funded projects) after the war; and in remote areas that have been deprived of assistance, not necessarily for war reasons.

The identification of the neediest beneficiaries has to get the greatest attention.

Dengue and cholera epidemics are genuine ECHO In health, priority should be given to women and children, not forgetting the needs of women and children of female-headed households, widows, the elderly, the disabled and indigenous people priorities although other projects should pick up more on the preventive work.

In the future, ECHO-funded project should concentrate on the following project components:
Outreach activities to improve EPI, CDD, ANC, FP, and health and nutrition education are the highest priority; this passes through incentivating and training HC staff and providing partner-paid staff to do this training and to supervise field work.

Referrals from outreach work to the HC, as well as the PHC needs of the population require that projects give priority to strengthening diagnostic and curative work in HCs; streamlining the referrals to the hospital is also needed.

Engaging more staff in health interventions requiring behavior modification of the population that can be achieved during the life of the project is considered a must for a more continuous presence in the field to reinforce messages over and over.

[Note that phasing out cannot possibly be linked to the project having surpassed certain cut-off points or having achieved a certain level for some of the major indicators used to measure progress in health. Each situation is peculiar and a weighted set of criteria will have to help in deciding how and when to phase out].

3. Main lessons learned

The outreach activities in a post-emergency health project are probably more important than the fixed facility activities to improve services there.

On-the-job training for health staff works better and is more sustainable than classroom learning. Feedback committees (made up of VHWs trained) work better and more regularly than HC co-management committees set up so far; transport allowances for members often make a difference in the attendance.

Hygiene and sanitation training done one time (only) in a village is not sufficient; this activity needs follow-up.

Good, formal baseline assessments of health and nutritional status --even if quick—are necessary to assess progress.