COUNTRY NOTE

EVALUATION OF UNFPA SUPPORT TO FAMILY PLANNING 2008-2013

COUNTRY CASE STUDY
CAMBODIA

EVALUATION OFFICE
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Evaluation of the UNFPA Support to Family Planning Services 2008-2013

Cambodia Case Study Note

Evaluation Manager:
Louis Charpentier Evaluation Office UNFPA

Reference group members:

1	Maha El Adawy	UNFPA ASRO
2	Nestor Azandegbe	UNFPA WCARO
3	Elizabeth Benomar	UNFPA Technical Division, HIV and AIDS Branch
4	Louis Charpentier	UNFPA Evaluation Office – Chair
5	Rita Columbia	UNFPA Technical Division, Commodity Security Branch
6	Ezizgeldi Hellenov	UNFPA EECARO
7	Desmond Koroma	UNFPA Technical Division, Commodity Security Branch
8	Laura Laski	UNFPA Technical Division, Sexual and Reproductive Health Branch
9	Shawn Malarcher	USAID Office of Population and Reproductive Health Bureau for Global Health
10	Farah Usmani	UNFPA Programme Division, Operational Support & QA Branch
11	Josiane Yaguibou	UNFPA ESARO
12	Selen Örs	UNFPA Evaluation Office/Programme Coordinator Turkey Country Office – Ankara

Euro Health Group (EHG) and Royal Tropical Institute (KIT) Evaluation Team:

1	Meg Braddock	Overall evaluation team Leader
2	Serey Phal Kien	National Consultant
3	Hermen Ormel	Cambodia case study team leader

A multicultural team of international and national experts authored this report. The report has been quality assured, including extensively fact-checked, by the UNFPA Evaluation Office and the UNFPA Country Office in Cambodia. The findings have been found to be sound and credible by the UNFPA Evaluation Office. The report has not, however, been subject to a professional copy edit or systematic editorial checks and may therefore vary in editorial quality.

Any enquiries about this report should be addressed to: Evaluation Office, United Nations Population Fund, e-mail: evaluation.office@unfpa.org

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ABBREVIATIONS AND ACRONYMS

ANC	Ante-Natal Clinic
APRO	Asia Pacific Regional Office
ART	Anti-Retroviral Therapy
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BBC	British Broadcasting Corporation
CBD	Community-Based Distribution
CDHS	Cambodia Demographic and Health Survey
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CMS	Central Medical Stores
CO	Country Office
COAR	Country Office Annual Report
CP	Country Programme
CP5	Fifth Country Programme
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
CWPD	Cambodian Women for Peace and Development
DFAT	Department of Foreign Affairs and Trade (Australia)
DHS	Demographic and Health Survey
DP	Development Partner
EC	Emergency Contraception
EmONC	Emergency Obstetric and Newborn Care
EW	Entertainment Workers
FP	Family Planning
FP2020	Family Planning 2020
GBV	Gender-Based Violence
GPRHCS	Global Programme for Reproductive Health Commodity Security
HC	Health Centre
HEF	Health Equity Fund
HIV	Human Immunodeficiency Virus
HQ	Headquarters
HRBA	Human Rights-Based Approach
HSSP	Health Sector Support Project
HSSP	Health Sector Strategic Plan
ICPD	International Conference on Population and Development
ID poor	Identification of Poor Household
IP	Implementing Partner

IUCD	Intra-Uterine Contraceptive Device
JPIG	Joint Partnership arrangement/development partner Interface Group
KII	Key Informant Interview
LA/PM	Long-Acting/Permanent Method
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LMIS	Logistics Management Information System
MCH	Maternal and Child Health
mCPR	Modern Contraceptive Prevalence Rate
MDG	Millennium Development Goal
MEF	Ministry of Economy and Finance
MMR	Maternal Mortality Rate
MoEYS	Ministry of Education, Youth and Sport
MoH	Ministry of Health
MoI	Ministry of Interior
MSI	Marie Stopes International
MSM	Men who have Sex with Men
NGO	Non-Government Organisation
NIDI	Netherlands Interdisciplinary Demographic Institute
NMCHC	National Maternal and Child Health Centre
OD	Operational District
PAC	Post-Abortion care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post-Natal Care
PPC	Post-Partum Care
PSK	Population Services Khmer
RACHA	Reproductive and Child Health Alliance
RGC	Royal Government of Cambodia
RGoC	Royal Government of Cambodia
RH	Reproductive Health
RHAC	Reproductive Health Association of Cambodia
RO	Regional Office
RSH	Reproductive and Sexual Health
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually transmitted infection
SW	Sex Workers
SWAp	Sector-Wide Approach
TA	Technical Assistance
TB	Tuberculosis

TFR	Total Fertility Rate
ToC	Theory of Change
TWG	Technical Working Group
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URC	University Research Co.
US$	United States Dollar
USAID	United States Agency for International Development
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
VHSG	Village Health Support Group
VMG	Vulnerable and Marginalised Group
WHO	World Health Organisation

INTERVENTION MAP

KEY FACTS

Indicator	2014	Source of Data
Population and Development		
Population, total	15,328,136	World Bank[1]
Population growth (annual %)	1.6	World Bank[1]
Urban Population (% of total)	21	World Bank[1]
Population Density (per sq. km of land area)	87	World Bank[1]
Life Expectancy at birth, total (years)	68.4	World Bank[1]
Literacy rate, population 15+ years (%)	73.9	World Bank[1]
Human Development Index (HDI)	0.555 (Rank 143 out of 188)	Human Development Report[2]
Economic growth rate (GDP growth annual %)	7.1	World Bank[1]
GINI Index	-	World Bank[1]
Gender Equality and Empowerment		
Gender Inequality Index	0.477 (Rank 104 out of 155)	Human Development Report[3]
Women representation in parliament, total (%)	20	World Bank[1]
Violence against women ever experienced (%)	22.3	Human Development Report[3]
Employment to population ratio, 15+, female (%) (modeled ILO estimate)	78	Human Development Report[5]
Ratio of girls to boys in primary and secondary education (%)[4]	-	World Bank[1]
Reproductive Rights and Reproductive Health		
Adolescent fertility rate (births per 1,000 women ages 15-19)	51	World Bank[1]
Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant)	-	World Bank[1]
Prevalence of HIV, both sexes (% ages 15-49)	0.6	World Bank[1]
Maternal mortality rate (per 100,000 live births)	167	World Bank[1]
Under 5 mortality rate (per 1,000 live births)	31	World Bank[1]
Contraceptive use, modern methods (%)	-	UN DESA[5]
Unmet need for family planning (%)	-	UN DESA[6]
Births attended by skilled health staff (% of total)	-	World Bank[1]

[1] World Bank. (2016). Zimbabwe. Retrieved from http://data.worldbank.org/country/zimbabwe

[2] United Nations Development Programme. (2016). Zimbabwe. Retrieved from http://hdr.undp.org/en/countries/profiles

[3] United Nations Development Programme. (2016). Table 5: Gender Inequality Index. Retrieved from http://hdr.undp.org/en/composite/GII

[4] This indicator is also labelled as "*Gross enrolment ratio, primary and secondary, gender parity index (GPI)*" by the World Bank. World Bank. (2016). Zimbabwe. Retrieved from http://data.worldbank.org/country/zimbabwe

[5] United Nations. (2016). UN DESA Population Division Estimates and Projections of Family Planning Indicators. Retrieved from http://www.un.org/en/development/desa/population/theme/family-planning/cp_model.shtml

1. INTRODUCTION

Family planning (FP) is a principal focus of the work of UNFPA worldwide. This country case study is part of a thematic evaluation of UNFPA support to family planning 2008-2013, whose objective is to assess progress against past and current strategic plans and inform future decision-making and policy formulation in family planning.

1.1 Objectives of the evaluation

Purpose

The purpose of the evaluation is to assess the performance of UNFPA in the field of family planning (FP) during the period covered by the Strategic Plan 2008-2013 and to provide learning to inform the implementation of the current UNFPA Family Planning Strategy Choices not Chance (2012-2020). The evaluation will also inform other relevant programmes such as the Global Programme for Reproductive Health Commodity Security (GPRHCS) (2013-2020) and the HIV/Unintended Pregnancies framework (2011-2015). Finally, the evaluation results will feed into the mid-term review of UNFPA current Strategic Plan 2014-2017.

Objectives

The primary objectives of the evaluation are to:

1. Assess how the framework as set out in UNFPA Strategic Plan (and revised Development Results Framework) 2008-2013 and further specified in the reproductive rights and sexual and reproductive health framework (2008-2011) as well as in the GPRHCS (2007-2012) and the HIV/Unintended Pregnancies framework (2011-2015), has guided the programming and implementation of UNFPA interventions in the field of FP
2. Facilitate learning and capture good practices from UNFPA experience across a range of key programmatic interventions in the field of FP during the 2008-2013 period to inform the implementation of both outcome 1 of UNFPA current Strategic Plan and the Choices not Chance 2012-2020 strategy; inform the GPRHCS (2013-2020) and the HIV/Unintended Pregnancies framework (2011-2015) as well as future programming of interventions in the field of FP.

1.2 Scope of the evaluation

The evaluation covers the period 2008-2013, taking into account information from 2014 when pertinent and necessary. It is both retrospective and forward-looking, including evaluation of past performance, analysis of lessons learnt, and conclusions and recommendations for future interventions.

The geographical scope covers all countries where UNFPA has carried out interventions, focussing on the 69 poorest countries with low rates of contraception use and high unmet need for family planning identified by the 2012 London Summit on Family Planning and FP2020 partnership, and also covering middle income countries where FP needs are still high due to inequality of access. Data collection and case studies cover all six UNFPA regions (Eastern and Southern Africa, Western and Central Africa, Asia and the Pacific, Latin America and the Caribbean, the Arab States, and Eastern Europe and Central Asia).

All UNFPA FP interventions are included in the evaluation, including those covered by core and non-core resources and those financed through the GPRHCS. Family planning is an integral part of UNFPA interventions in maternal health, adolescent and young people's sexual and reproductive health (SRH), HIV and AIDS, gender and humanitarian support. FP activities in these areas are included in the evaluation where appropriate, taking care not to duplicate work carried out in the Thematic Evaluation UNFPA Support to Maternal Health 2000-2011 (UNFPA 2012b), and the Adolescent and

Youth Sexual and Reproductive Health (AYSRH) evaluation which is being carried out concurrently with this evaluation.

The evaluation covers eight principal areas of investigation:

- UNFPA support to integration of FP with other SRH services
- UNFPA efforts for coordination to ensure national ownership and institutionalisation of FP programmes
- Extent of UNFPA efforts as a broker to promote FP, with particular attention to partnerships
- Extent of UNFPA support to creation of an enabling environment
- Level of focus on the needs of the most vulnerable groups and marginalised populations;
- Extent of implementation of a human-rights based approach
- UNFPA choice of different modes of engagement
- The extent to which UNFPA support for supply-side activities (including training, procurement and logistic systems) promotes rights-based and sustainable approaches and contributes to improved access.

1.3 Overview

The evaluation uses a contribution analysis approach based on a reconstructed theory of change, which is being tested through collection of data and information at different levels, and analysis of the eight evaluation areas and their associated assumptions.

There are twelve country case studies (five in-country and seven desk studies) in the data collection phase, which also includes review of documentation, key informant interviews (KIIs) at global and regional levels with UNFPA staff and other stakeholders, three on-line surveys and additional financial analysis.

The case studies are not evaluations of the FP effort in each country and do not present recommendations for on-going or future FP work. They are one important input into the data collection and analysis process for the eight areas of the UNFPA FP evaluation as a whole, and contribute to the overall evaluation by:

- Providing input from the country perspective for addressing the global evaluation questions
- Generating data for triangulation with other sources
- Contributing to identifying more clearly “how” and “why” change occurs and contributions of UNFPA to this
- Providing insights to the eight principal evaluation areas
- Identifying lessons learned across different contexts.

Contribution analysis was originally presented as an approach to programme design and monitoring and, to a lesser extent, to evaluation. This has left considerable freedom for evaluators to explore different approaches to operationalising contribution analysis and the use of Theories of Change (ToC). Different approaches have been used to apply contribution analysis in evaluations which include both country or sub-programme and global or synthesis levels of analysis.

For this evaluation at country level, the team has organised the country case study notes around the eight evaluation areas and has attempted to address most or all of the key assumptions in the overall ToC as they are realised (or not) at the country level. This method has the following strengths:

- It draws a clear link from the overall ToC as developed and presented in the inception report while allowing the country cases to reflect local contexts and realities and the UNFPA response

- It allows the country cases to include areas of UNFPA engagement and support and positive or negative results which may not have been captured in the reconstructed ToC[6]
- It simplifies the reporting of findings at country case level since it does not require the development of separate, country level ToC
- It still allows for a strong testing/challenge of the ToC at country level because it allows the evaluation team to verify the validity of key assumptions. In effect, this combines analysis of assumptions and risks (the main risks are usually that key assumptions are not realised)
- Using the common structure of the eight issues areas and their associated key assumptions will facilitate synthesizing the findings and conclusions of the country studies during the preparation of the overall evaluation report.

In this way the country case study notes are able to establish the link from the country level evaluation results to the overall theory of change for UNFPA support to FP.

This report covers the case study in Cambodia.

1.4 Structure of the country note

Section 2 of the report outlines the case study methodology. Section 3 gives a short overview of key elements of family planning in Cambodia and the UNFPA response and provides the necessary context for discussion of the specific evaluation questions and UNFPA contributions. Section 4 presents the findings of the case study along the eight evaluation questions, including progress and changes during the evaluation period and the UNFPA contribution to those changes. Section 5 presents a set of conclusions.

2 METHODOLOGY

2.1 Selection of country case studies

The five in-country case studies include three from West and Central/Eastern and Southern Africa regions, one from Asia-Pacific region, and one from Latin America and Caribbean region. The sample maximises the breadth and depth of insights into the evaluation questions and gives a broad picture of the UNFPA contribution to family planning (FP) over time in different contexts, giving insights into the country perspective on the evaluation questions, providing examples of externalities and risks and how they have been addressed, and complementing the information collected from other sources. This section summarises the process and results of country selection for visits and desk studies. A full description of the case study selection is given in the Evaluation Inception Report (UNFPA 2014b).

The selection started with a purposeful sample based on criteria which cover the dual purpose of the evaluation: looking back to assess UNFPA performance in the field of FP, and providing learning for the on-going UNFPA Strategic Plan. Criteria included poverty indices, levels of UNFPA spending and past performance in FP taking into account both change in modern contraceptive prevalence rate (mCPR) and unmet need.

From the purposeful sample, countries were selected for in-country and desk studies taking into account the following criteria, to ensure a spread and contrast in the set of case studies:

[6] The reconstructed ToC was developed in the inception phase of the evaluation, based on the pertinent UNFPA strategy documents, which include family planning during the period. Expected pathways of change were identified and mapped for each of the eight evaluation areas (see annex of inception report) (UNFPA 2014b).

- UNFPA FP spending per capita
- The need to include at least one country with Global Programme for Reproductive Health Commodity Security (GPRHCS) Phase 1 Stream 1 support[7]
- Availability of sufficient and sufficiently reliable data and information on past UNFPA support and the overall country context
- The need to include at least one fragile state or humanitarian situation, at least one high-population country and one or more countries with a One UN (delivering as one country) programme
- Varying degrees of government support for FP
- Changes in UNFPA modes of engagement and implementation risks
- The need to avoid concurrent implementation of in-country case studies with other UNFPA thematic and country evaluations
- The potential of the country study to contribute to analysis of the hypotheses in the evaluation matrix.

The resulting sample is spread across the UNFPA Strategic Plan business model's four quadrants, which show need for FP interventions vs. capacity to finance such interventions, although application of the sample selection criteria clearly favours countries in the quadrants representing countries with relatively higher levels of need and lower levels of financing ability (UNFPA 2013). Aside from Cambodia, the other countries selected for the field phase are: Bolivia, Burkina Faso, Ethiopia, and Zimbabwe (UNFPA 2014b).

2.2 Selection of Cambodia as a case study

Cambodia was selected for a case study as it has characteristics regarding UNFPA support to family planning that offer important insights into the country perspective on the evaluation questions in a specific context. Relevant characteristics of the country and the UNFPA country programmes in the evaluation period include:

- Example of a UNFPA strategic plan red quadrant country[8] that has a relatively low modern contraceptive prevalence growth rate paired with high unmet need for FP. Red quadrant countries are seen as potentially requiring UNFPA support to all four main areas of business: advocacy and policy dialogue; capacity development; knowledge management and service delivery and as such are interesting to include as a case study
- Availability of sufficient and sufficiently reliable data and information on past UNFPA support and the overall country context
- Important programmes for specific vulnerable and marginalised groups (VMGs) including adolescents, migrant garment factory workers and entertainment workers, as well as development of an evidence base for work with these groups
- Involvement of a considerable number of development partners (DPs) in FP over the years, implying the need for proper coordination.

2.3 Scope of the study and data collection methods

The country study covered all UNFPA FP work during the period under evaluation, including interventions funded by core and non-core resources and FP as a component of other sexual and reproductive health (SRH) projects and programmes. Interventions at central government, provincial, district and commune levels were included.

[7] Stream 1 countries are those selected for priority attention by GPRHCS for multi-year, flexible and predictable funds to help countries develop more sustainable approaches to Reproductive Health Commodity Security

[8] Annex 6; the countries in the "red quadrant" are defined as countries with high need and low financial capacity

The study was carried out during May 2015 by a team of two consultants (one international and one national). UNFPA country office (CO) staff participated fully in the preparation of the study and related logistics, including interviews with officials of relevant government institutions, non-government organisations (NGOs) and development partners, and in visits to sites around Phnom Penh and in Takeo and Kampot provinces; and in internal discussions and interviews within the CO, analysis of information and financial data and the de-briefing session.

Preliminary work (prior to the country visit) included:

- Collection and review of key data of Cambodia including country background; country health sector and other sectors relevant for SRH/FP; health and other SRH/FP-relevant indicators
- Desk analysis of UNFPA response in the country
- Preparation of a detailed timetable for interviews and other activities during the country visit (in consultation with the CO).

In-country work was designed to provide evaluation evidence relevant to the eight evaluation areas. Activities included briefing and de-briefing with CO staff and interviews with UNFPA staff, government officers, bilateral donors, United Nations (UN) organisations, national and international NGOs, health service delivery personnel and service clients, all intended to give a balance of different points of view of UNFPA support to FP and the current context of FP programmes and services. A focus group discussion was held with entertainment workers, while group discussions also took place with female and male community members (actual or potential FP users).

There was a field visit of two days to the Takeo and Kampot provinces, where UNFPA had supported FP activities. The purpose of the field trips was to gain insights on rights holders' needs, duty bearers' responses and programme successes and challenges in the context of Cambodia where decentralization is in progress, and to add context-specific examples to the overall country picture.

Data and information collected from documents, interviews, field trip observations and the focus group discussions was collected in an evaluation matrix which collates data relating to each of the eight evaluation areas and their assumptions (see Annex 3). Activities and progress in each evaluation area were analysed to identify the changes, which have occurred, and the contribution of UNFPA to those changes. At the end of the visit the team presented preliminary findings to the UNFPA CO staff for their comments and feedback.

A list of people interviewed and focus group discussion participants is provided in Annex 2. Documents consulted are shown in the list of references (Annex 1). Interview guides and focus group discussion guides are presented in the evaluation inception report (UNFPA 2014b).

Limitations on the data collected include:

- Time and budget constraints implied that only a limited number of informants could be interviewed during the eight in-country working days; these cannot be expected to be fully representative of the varied range of UNFPA implementing partners, co-development partners, national and international NGOs and government agencies and their staff.
- For logistical reasons, the field trips for programme site visits were chosen relatively close to Phnom Penh, and, as such, are not representative of the UNFPA country programme implementation sites as a whole.
- The envisaged users' focus group discussion in two separate locations did not materialise as such, due to community dynamics. In the first community, a large group of over 40 women and many children gathered, without separate space to sit aside with eight to ten participants for a focused discussion. Thus, only a loose form of group discussion took place. In the second community, a similarly-sized group of women, men and children gathered, and the team invited a number of

men for a group discussion. In the end, it was not possible to collect data on user perspectives as foreseen.
- Detailed financial information on UNFPA FP spending within other SRH projects is based on estimates by CO staff. This approach was chosen due, primarily, to challenges in obtaining FP expenditure through the use of the UNFPA financial management platform (Atlas). For the period under evaluation, the UNFPA financial management platform did not often explicitly track FP expenditure and, when it did so, did not capture all/the full range of FP expenditure (which was often integrated within other projects).

Despite these limitations, the evaluation information collected in Cambodia can be seen as a valid illustrative sample of UNFPA contributions in FP in the country. The interviews and group discussions undertaken were not intended to provide a statistically valid, random sample of programming results in Cambodia.

3 SHORT DESCRIPTION OF FAMILY PLANNING IN CAMBODIA

Country background

The Kingdom of Cambodia is a parliamentary constitutional monarchy which has been politically relatively stable (Noij, Kasumi et al. 2015), ever since it emerged from decades of civil war and harsh violence after the signing of the Paris Peace Accord in 1991 (UNFPA 2011, RGoC 2014). This has aided a steady current and expected economic growth rate of around seven percent during 2013-2017 (World Bank 2015c). Currently, around 18 percent of the population still live under the basic need poverty line, which is however 50 percent less than in 2008. Cambodia ranks 136 out of 187 countries and territories on the 2013 Human Development Index (UNDP 2014) and has an estimated gross domestic product (GDP) per capita of around US$ 700 and an adult literacy rate of 74 percent.[9]

Weak public service delivery is seen as impeding inclusive development (World Bank 2015a). The United Nations believe that there is a need for *"more mature political institutions that facilitate participation and dialogue*" (United Nations 2014: 54). Civil society organisations (CSOs) are increasingly active in demanding political participation and attention for human rights (ibid.). The government initiative to pass a law on associations and non-government organisations (NGOs) to regulate NGO operations in Cambodia has generated considerable criticism from civil society and development partners (DPs) alike. Apart from a lack of consultation, there are concerns that the law, which was passed in August 2015, could be used to curtail NGO operations, including human rights-related activities (United Nations 2014, HRW 2015, Lee, Flowers et al. 2015).

The total population of Cambodia is estimated to exceed 15 million, of which 20 percent are urban. The population density for the country is medium, with 86 people per km^2. The population growth rate is moderate at 1.8 percent per year (up from around 1.5 percent in 2008), and total fertility is 2.7 (down from 3.0 in 2008). The population is going through a demographic transition, with 32 percent in the age group of 10-24 years and around 60 percent below 24 years of age (Noij, Kasumi et al. 2015). Cambodia is also moving towards a more urbanised society, with many of the large cohort of young people migrating from rural to urban areas (United Nations 2014).

The country is relatively homogenous in terms of ethnicity and religion. About 90 percent of the population belongs to the Khmer ethnic group and over 95 percent are Buddhist. Indigenous people, however, constitute a majority in the North-Eastern provinces of Mondulkiri and Rattanakiri where socioeconomic and health indicators are comparatively less favourable (UNFPA 2011).

[9] A complete list of key indicators is provided in annex 6

Health System

The *Ministry of Health* (MoH) is the steward of the health sector in Cambodia; it administers health services through 25 provincial health departments, 88 operational districts (several per province), 97 referral hospitals and 1,105 health centres (Ministry of Health 2008b, WHO and Ministry of Health 2012). There is a large, mostly unregulated, private-for-profit sector. A number of national and international NGOs operate a series of programmes, partly in direct support of the government health sector (Vathiny and Hourn 2009). This includes the delivery of health promotion and disease prevention programmes and activities through health centres (WHO and Ministry of Health 2012).

Some of the larger *NGOs* offering health care services, mostly on a fee-for-service basis, are those also specialised in sexual and reproductive health (SRH) including family planning (FP), such as the Reproductive Health Association of Cambodia (RHAC), the Reproductive and Child Health Alliance (RACHA), Marie Stopes International (MSI) Cambodia and Population Services Khmer (PSK).

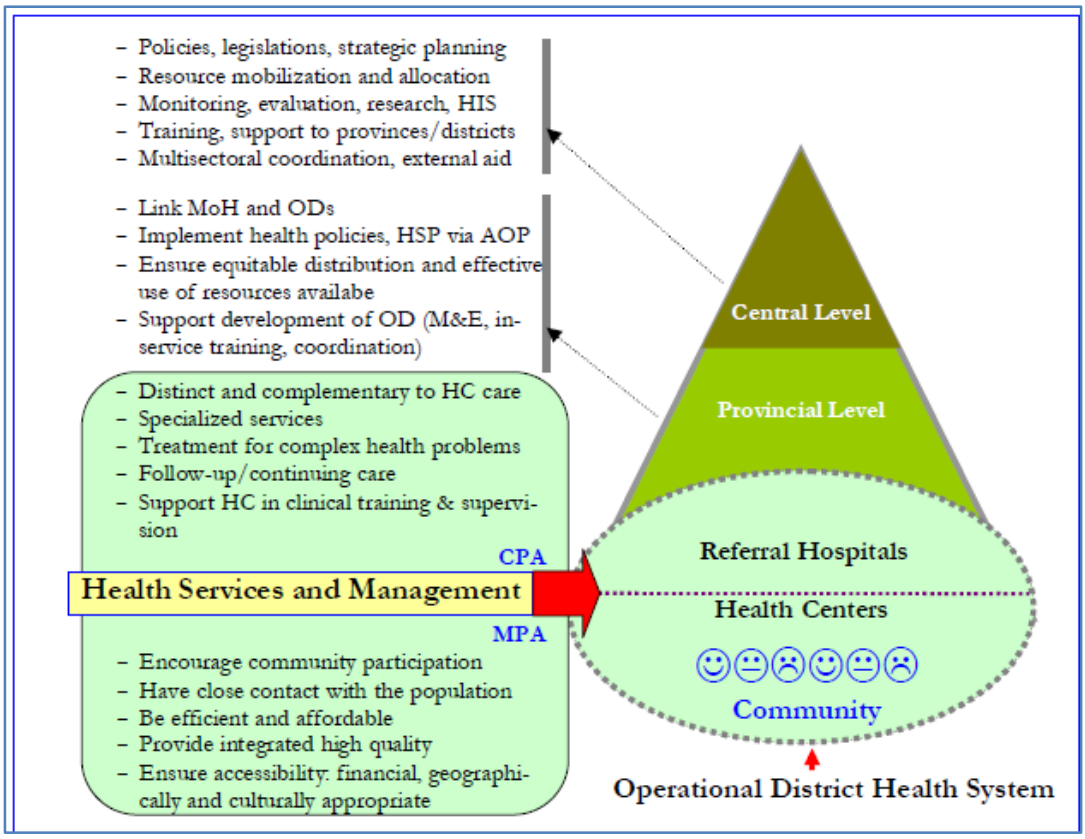
At *community level*, village health support group volunteers (a kind of community health workers) are often active. They are the primary contacts for health activities at community level, ideally managed and supported by health facility staff. Activities include surveillance, vital registrations, identifying people living in poverty so they can be exempt from user fees as well as health education and promotion, including FP (Ministry of Health 2008a).

At *health centre level*, services usually include consultations and initial diagnosis, emergency care and first aid, chronic disease care, FP ("birth spacing advice"), maternal and child care, immunisation and health education and referral (WHO and Ministry of Health 2012).

In 2010, only 43 percent of health centres provided the full minimum package. Constraints include lack and competencies of human resources, deficient essential drugs support and lack of other inputs required as per operational guidelines (ibid.). On a bigger scale, the government has focused on improving the coverage of public health services; however people in rural and remote areas, as well as poor and vulnerable groups, experience major difficulties in accessing public health services. Furthermore, quality of care needs attention (WHO and Ministry of Health 2012, United Nations 2014). These overall challenges also affect FP service provision.

Figure 1 presents the organisation of the Cambodian health system.

Figure 1: Cambodia health system organisation



Source: (Ministry of Health 2008b: 15)

CPA = Complementary Packages of Activity
HIS = Health Information System
MPA = Minimum Packages of Activity
HC = Health Centre
M&E = Monitoring and Evaluation
OD = Operational District

Health sector spending, overseas development assistance and UNFPA contributions

In 2013, 87 percent of health care funding was domestic, while 13 percent derived from foreign aid. Total expenditure on health per capita was US$ 76; almost double from that in 2008. Sixty percent was paid for by households (out-of-pocket expenditure) and 20 percent by the government (including foreign aid). The share of all government spending allocated to health was 8 percent (WHO 2014).

Out-of-pocket payments in Cambodia are among the largest in the Western Pacific Region (WHO and Ministry of Health 2012). Equity implications are that *"poor families… cannot afford qualified health care*" (Ministry of Health 2008b: 21). Health equity funds partly remedy this situation; they reimburse health providers for services delivered to eligible people living in poverty and meet some of the client's costs related to access. This system is used in the majority of operational districts and has been demonstrated to increase service utilisation and reduce health-related debt for clients (WHO and Ministry of Health 2012). Respondents indicate that only 40 percent of eligible clients actually have access to these services, due to opportunity costs and administrative issues.[10]

UNFPA/Netherlands Interdisciplinary Demographic Institute (NIDI) data show that total donor funding to Cambodia for population assistance fluctuated during 2008-2012, with a low of US$ 66 million in 2008 and a high of US$ 102 million in 2011 (UNFPA 2014c). For 2013, NIDI identified the Cambodia national budget for population activities with a family planning component as being

[10] Assumption 4.2 and 5.2, Annex 3

around US$ 44 million, of which 24 percent came from domestic and 77 percent from international sources. Total government expenditures for FP amounted to US$ 4 million, with US$ 800,000 (20 percent) from domestic sources (NIDI 2015). It is worthwhile noting that data on the private sector role in FP, such as corporation with FP-related activities and insurance companies including FP as part of insurance coverage, were not available to be analysed and included in the report.

Regarding donor spending on RH and FP in Cambodia, as well as the UNFPA share of the same, relevant sources present substantially different estimates (see Table 1). The Kaiser Foundation estimates considerably less overall donor spending on reproductive health (RH) and FP compared to WHO estimates, and UNFPA Cambodia estimates are again lower. The Kaiser Foundation identifies the key donors to be the United States of America (31 percent of the total), UNFPA (22 percent) and Switzerland (13 percent). The UNFPA/NIDI data on financial resource flows show a much higher overall figure than WHO for the period 2008-2011, but refers to a fully costed population package as well as NGO sector donations.

Table 1: Estimates of spending on reproductive health/ family planning, 2008-2012

	WHO estimates (WHO 2013)	Kaiser Foundation estimates (Kates, Michaud et al. 2014)	UNFPA/NIDI estimates (UNFPA 2014c, NIDI 2015)	UNFPA Cambodia estimates[11]
Donor spending on RH/FP, 2011	US$ 24 million (= 14% of total ODA for health; up from US$11.7 million (9%) in 2008)			
Donor spending on RH/FP, 2009-2011	US$ 73 million	US$ 18.9 million		
UNFPA spending on RH/FP, as share of total donor spending, 2009-2011		13% (2009-2011)		8% (2011), US$ 1.9 million
Donor and NGO spending on population package, as share of total donor spending[12], 2008-2012			Range US$ 66-102 million per year (fluctuating range 37-60%)	

ODA = Official Development Assistance (as defined by OECD)
OECD = Organization for Economic Co-operation and Development

In summary, the UNFPA financial contributions are reasonably significant alongside those of other donors in the field of SRH/FP. It has gained itself a relatively strong position by using its resources strategically, paired with other operational assets such as adequate technical support and a way of working that creates trust.

Sexual and reproductive health and family planning

[11] Annex 4

[12] In this study, the 'costed population package' included: family planning services; basic reproductive health services; STI/HIV/AIDS prevention activities; and basic research, data and population and development policy analysis (UNFPA 2014c).

Cambodia has seen important progress in maternal health outcomes as well as SRH trends over the past years. However, there are a few areas which are stagnant as compared to other countries in the region (UNFPA Cambodia 2014e: 57).

Sexual and reproductive health overview

Maternal mortality has decreased dramatically between 2008 and 2013, from 461 to 170 deaths per 100,000 live births.[13] *Unsafe abortion* was considered a key driver of the high maternal mortality rate. Since 1997, abortion is legally accessible in Cambodia without justification in the first trimester of pregnancy, but many people do not know that abortion is legally available; it is still a sensitive issue (Ministry of Health 2012).

The 2010 Cambodia demographic and health survey (CDHS) indicated that five percent of women 15-49 years of age reported they had one or more abortions in the five years preceding the survey, down from eight percent in 2005 (NIPH, NIS et al. 2006, NIS, DGH et al. 2011). Abortion rates among garment factory workers and entertainment workers are high, however, and this can probably be interpreted as an indication of unmet need for family planning (Sovannarith 2014, UNFPA Cambodia 2014e).[14] Private clinics and pharmacies are preferred places for abortion services. UNFPA found that this *"raises serious concerns of unsafe abortion practices and the inadequate use and access to family planning methods. As such interventions should be revisited to promote increased use of family planning methods as well as provide targeted information regarding safe abortion practices and the availability of public clinics/skilled providers for this high risk group"* (UNFPA Cambodia 2014e: 22).

A 50 percent increase in *teenage pregnancies* from 8 to 12 percent was recorded between 2010 and 2014 (Sovannarith 2014, Ministry of Planning, Ministry of Health et al. 2015).[15] "*Cambodia's adolescent fertility rate in 2012 of 44 births per thousand women aged 15-19 is higher than many other countries in Southeast Asia*" (UNFPA Cambodia 2014e: 5).

Cervical cancer is the most frequent cancer among women and also among women 15-44 years of age; 795 die from the disease each year. With an age−standardised incidence rate of 23.8 per 100,000 women per year and mortality at 13.4 per 100,000, Cambodia is the highest among South-East Asia countries on both accounts. Cervical cancer is linked to HPV, one of the most common sexually transmitted infections (Bruni, Barrionuevo-Rosas et al. 2015).

Family planning

The CDHS reports clearly show that use of modern *family planning methods* among currently married women has increased in the past decade, as evidenced by the modern contraceptive prevalence growth from 27 to 39 percent between 2005 and 2014. Unmet need for FP among the same group decreased from 25 to 12 percent (NIPH, NIS et al. 2006, NIS, DGH et al. 2011, Ministry of Planning, Ministry of Health et al. 2015). Total demand for FP[16] has remained stable at 68-69 percent since 2010; in 2014 this was composed of 39 percent demand for modern methods, 18 percent traditional methods and 12 percent unmet need. The percentage of demand satisfied for FP has increased from 68% in 2008 to 82% in 2014.[17]

The 2014 survey also found indications that, "*unexpectedly, the use of traditional methods has increased, particularly among rich, educated, urban and peri-urban women*" (Ministry of Health

[13] Annex 6
[14] Assumption 3.3, Annex 3
[15] Assumption 3.3, Annex 3
[16] Total demand for family planning is the sum of unmet need and met need (for all methods) (Ministry of Planning, Ministry of Health et al. 2015: 14).
[17] Annex 6

2012: 15). *Traditional contraceptive methods* are gaining ground among women with higher levels of education and in urban areas. In urban areas women use traditional methods almost as much as modern methods (33 percent modern, 27 percent traditional), something not observed in rural areas (40 and 16 percent) (Ministry of Planning, Ministry of Health et al. 2015). This finding poses an interesting challenge for those involved in designing strategies to further reduce unmet need.

During the period under evaluation, the method mix has expanded from pills, condoms, injectables and intra uterine contraceptive devices (IUCDs) (in health centres) and male and female sterilization (in referral hospitals) to implants and emergency contraception, both at UNFPA initiative. UNFPA also supported the introduction of the female condom in 2009, but this was withdrawn due to lack of demand, and female condoms are currently not available in public facilities (Ministry of Health 2012).[18] At the same time, unfavourable community attitudes limit access to contraceptive services by adolescents and unmarried women.[19]

In 2010, oral contraceptives were the most used modern method (15.4 percent), followed by injectables (10.4 percent). Long-acting methods such as IUCDs and implants and permanent methods (male and female sterilization) are used by just 5.9 percent of married men and women; access to these methods is limited for people living in remote and rural areas. Male condoms were used by few users (1.7 percent). The public sector is the source of around 52 percent of all modern contraceptives, while 30 percent originates from the private medical sector and 18 percent from other sources.[20]

Development partners (DPs) procured contraceptive supplies for Cambodia for more than a decade. In recent years, they have begun to gradually reduce their role in commodity procurement and announced that it would end by end-2015.[21]

Gender equality

Gender equality is guaranteed by the Cambodian Constitution, and this has been translated into a number of national policies and laws. While there is progress in both public and private spheres, Cambodia finds itself at the bottom of the medium human development group (ranking 105 out of 152 countries in the 2013 gender inequality index).[22] Society shows traditional attitudes and behaviours that constitute barriers to women's participation (UNFPA 2011). Power relation between men and women are still unequal and women's decision-making power regarding SRH remains limited (United Nations 2014: 21).

Gender-based violence (GBV) is widespread; 13 percent of women reported physical violence by their intimate partner in the 2005 CDHS (NIPH, NIS et al. 2006, Noij, Kasumi et al. 2015). In 2010, almost half of women stated that a husband is justified in beating his wife for at least one of six specified reasons (NIS, DGH et al. 2011).

HIV

HIV prevalence has been declining over the past years to a relatively low prevalence of 0.7 percent among the general population 15-49 years of age. The epidemic continues to be concentrated among key affected populations, including entertainment workers, men who have sex with men (MSM), transgender people, people who inject drugs and people deprived of liberty. HIV prevalence

[18] Assumption 8.2, Annex 3
[19] Assumption 5.2, Annex 3
[20] Annex 6; assumption 8.2, Annex 3
[21] Assumption 8.2, Annex 3
[22] Annex 6

among these population groups ranges from 2.1 percent to 24.8 percent (National AIDS Authority 2014: 1-2).

In 2014, only 38 percent of young women (15-24 years) and 46 percent of young men had comprehensive correct AIDS knowledge, with higher scores in urban than rural areas. In 2010, scores for both young women and men were 44 percent, which means that women's knowledge deteriorated (NIS, DGH et al. 2011, Ministry of Planning, Ministry of Health et al. 2015). Women and girls are at a relative high risk of HIV infection due to persisting gender inequalities and GBV. In addition, women working in the entertainment industry are at risk of sexual exploitation and gender-based violence (United Nations 2014).

Sexual minorities
Although same-sex relationships are not criminalised in Cambodia, lesbian, gay, bi-sexual, transgender and intersex (LGBTI) people are exposed to stigma and discrimination in many spheres of life due to judgemental attitudes and behaviours combined with a lack of legal protection. This limits their access to sexual health, HIV services and health services overall (United Nations 2014).

In summary, the main challenges in the areas of SRH/FP are:
- Major urban/rural differences in SRH status as well as between regions and wealth quintiles
- Gender-based violence and gender inequities limiting access to SRH services
- The current "youth bulge" in the population structure (requiring major efforts to meet SRH/FP needs and take advantage of the "demographic dividend")
- Limited access of adolescents and unmarried women and men to FP services
- The ongoing urbanisation due to increasingly mobile population groups
- The relatively high fertility paired with a relatively high unmet need for FP
- The relative weight of traditional compared to modern methods of contraception
- Decreasing knowledge levels about HIV among young women
- Weak health system features, including quality issues (Ministry of Health 2012).

Government policy on family planning:
The principal policy and strategy documents relevant to FP are shown in Table 1 below.

Table 2: Strategic documents related to family planning and contraception

Current documents	Draft documents (under review)	Document title
1995	2015	Birth Spacing Policy in Cambodia
2003	2015	National Population Policy of Cambodia
2007-2015		National Family Planning Commodity Security, Forecasting And Costing
2008-2015	2016-2020	Health Sector Strategic Plan 2 (2010-2015) and 3 (2016-2020)
2008/2007	2015	National Guidelines Adolescent Reproductive and Sexual Health Services (2008) and Manual (2007) National Guideline and Training Manual for Youth Friendly Health Service (2015/16)
2010-2015	2016-2020	The Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality
2011-2015	2016-2020 (NSP IV)	National Strategic Plan for a Comprehensive and Multi-Sectoral Response to HIV/AIDS III
2011		National Youth Policy
2012-2016		National Strategy on Reproductive and Sexual Health 2
2013		"Rectangular Strategy" for Growth, Employment, Equity and Efficiency, Phase III

2014		National Strategic Development Plan 2014-2018. For Growth, Employment, Equity and Efficiency to reach the status of an upper-middle income country
2014-2018		National Action Plan to Prevent Violence Against Women
2015		National Guidelines for Managing Violence Against Women and Children
2014-2018		Education Sector Plan
2008-2015	2016-	Health Sector Support Program II (2008-2015) and III (2016-)

The initial MoH Birth Spacing Policy formulated in 1995 stated that its aim was "*to promote maternal and child health through greater birth intervals*" (Ministry of Health 1995: 3), stating that both individuals and couples should have access to these services. Since then, attention for FP in key government strategies has increased over time. The current 2014-2018 National Strategic Development Plan and its accompanying 2013 Rectangular Strategy framework, a document delineating Cambodia long-term vision on development, mention *birth spacing* among government priorities.[23] The development plan enumerates key interventions that include "*increase demand for and access to sexual reproductive health services, information, counselling and services including contraception […]*" (RGoC 2014: 182).

This vision is elaborated upon in the sectoral strategies (Ministry of Health 2008b). The National Strategy on Reproductive and Sexual Health 2012-2016 firmly positions family planning as an independent component under SRH, with "increasing usage of contraception services" as one of the priority strategies to improve SRH service quality (Ministry of Health 2012: 21). This document continues to frame *birth spacing* in a maternal health context, as it focuses on FP as "*a best investment for development and … shown to contribute to reducing maternal, neonatal and child mortality*" (Ministry of Health 2012: 14).[24] FP is a component of the essential SRH service package (ibid.: 34) adopted in 2012, which is implemented throughout the country's health centres.[25]

An updated FP policy is currently being elaborated. The 2015 draft version refers to rights-based FP as being part of efforts to achieve universal access to SRH and reproductive rights. It states that key principles are, among others: universal human rights (referring to free choice and a range of methods), non-discrimination (mentioning VMGs), gender equality and equity, evidence-based national relevance and accountability (Ministry of Health 2015b).[26]

Since 2006, family planning and related SRH contents have been integrated by the Ministry of Education, Youth and Sport into the extra-curricular comprehensive sexuality education programme, for learners in grades 5-8 and 10-11, as well as for out-of-school youth. This is also in line with the Ministry National Youth Policy (2011), which refers to reproductive health information and education, sexual attitudes and practices, teenage pregnancy, sexual exploitation and access to related services (MoEYS 2012).

UNFPA responses

Overview

The period under evaluation is covered by the third UNFPA country programme (CP), 2006-2010 (United Nations 2005) and the fourth CP 2011-2015 (United Nations 2010) currently under implementation. Both programmes address major SRH priorities in the country, including politically and socially sensitive issues such as FP and work with VMGs.

[23] Assumption 2.2, Annex 3
[24] Assumption 2.2, Annex 3
[25] Assumptions 1.3 and 8.1, Annex 3
[26] Assumption 6.1, Annex 3

The *third country programme* had a total budget of US$ 27 million, US$ 18 million from core resources and US$ 9 million from non-core funding. Of the three focus areas (reproductive health, population and development, and gender) the RH component had the largest share of the budget at US$ 11 million. It was aligned with the national priority of capacity building and human resource development in the social sectors, and focused on: increased contraceptive prevalence, antenatal care, deliveries by skilled attendants, increased availability of skilled midwives, and youth-friendly services. The population and development component worked towards implementing and monitoring the 2003 national population policy, a national priority and basis for mainstreaming population concerns. The gender component was focused on developing the capacity of gender-mainstreaming action groups and women's and children's committees, and the development and implementation of the National Action Plan to Prevent Violence towards Women and the Strategic Plan on Women, the Girl Child and HIV/AIDS (United Nations 2010).

The country programme evaluation (CPE) of 2011 concluded that the third CP strengthened the recruitment, training, and deployment of secondary midwives and supported the coverage by health equity funds that subsidise the cost of medical care for the poorest segments of the Cambodian population. Overall, relevance of the programme was seen as high, while results in terms of effectiveness were qualified as mixed, with insufficient means to assess programme performance. Impact directly attributable to UNFPA was considered limited, this was in part due to the organisation's limited resources in comparison with other stakeholders (United Nations 2005).

The *fourth country programme* has a slightly lower budget at US$ 24 million, of which US$ 18 million are core resources and US$ 6 million non-core funding. The reproductive health and rights component has the largest share (US$ 10 million) and is intended to:

- Improve national capacity to increase the availability, accessibility, acceptability, affordability and utilization of good-quality reproductive, maternal, newborn and child health and nutrition services, including the quality of and access to FP
- Increase competency and availability of health-related human resources
- Enhance access to and utilisation 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
- Enhance national capacity to target key populations at risk with effective interventions to prevent HIV
- Increase national capacity for emergency preparedness and response, to reduce and mitigate the vulnerability of the poorest and most marginalised persons.

As regards the reproductive health and rights component, the CPE concluded that it had contributed to increase the use of modern FP methods and improve quality of public health services with a special focus on access for adolescents and youth. The evaluation found that it was likely that these results had contributed to a reduction of the fertility rate and a decrease of the maternal mortality rate. This was achieved as UNFPA "*successfully advocated for the inclusion of comprehensive sexuality education in the curriculum of primary and lower secondary schools*" (Noij, Kasumi et al. 2015: xii). It furthermore concluded that support to the *Love9* multi-media programme of BBC Media Action enhanced access to SRH information for adolescents and youth. Also the CPE found that UNFPA had supported HIV and AIDS prevention for entertainment workers via the *SMARTgirl* programme, enhancing their access to SRH/FP services (ibid.).

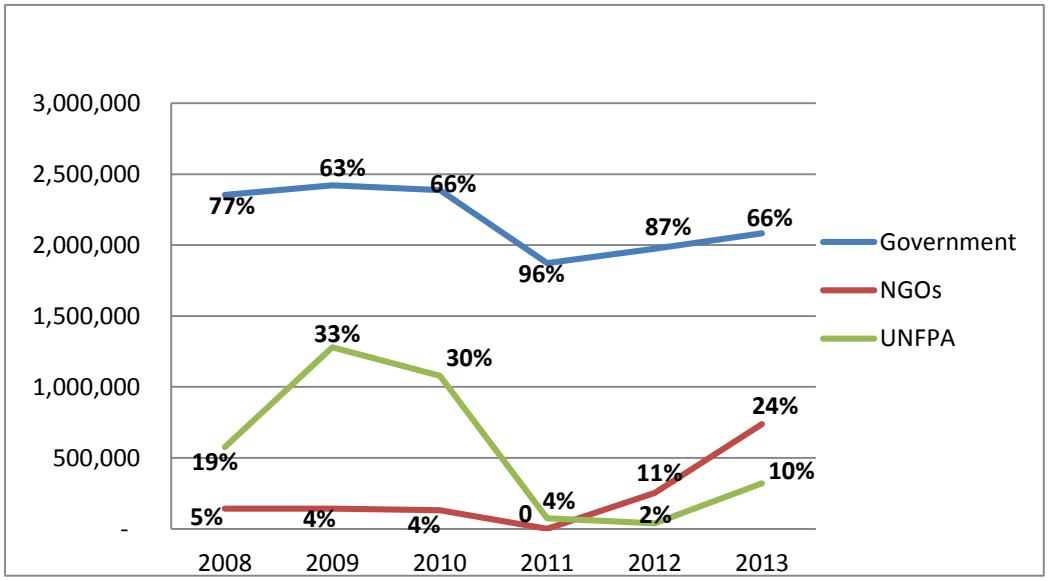
Implementing partners

Although UNFPA has worked with implementing partners (IPs) in the public and NGO sectors (see complete list in Annex 5), its principal counterpart for SRH and FP work has been the government (see figure 2). Specifically, UNFPA worked with the Ministry of Health (receiving the largest funding

by far), Ministry of Planning, Ministry of Interior and the Ministry of Education, Youth and Sports. Furthermore, technical support and policy input to government at all levels are major areas of UNFPA FP work and have been financed by core funding. On the other hand, projects with NGO implementing partners have focused on community-based awareness creation and distribution of contraceptives as well as work with priority VMGs such as entertainment workers. Government and NGO partners alike were funded through core and non-core resources combined.

Figure 2 shows trends in financial support to implementing sectors during the evaluation period. Although the support of UNFPA for FP activities fluctuated, support to government partners remained relatively stable (in absolute terms) over six years.

Figure 2: Support to Family Planning by Implementing Sectors, UNFPA Cambodia (2008–2013) (US$)



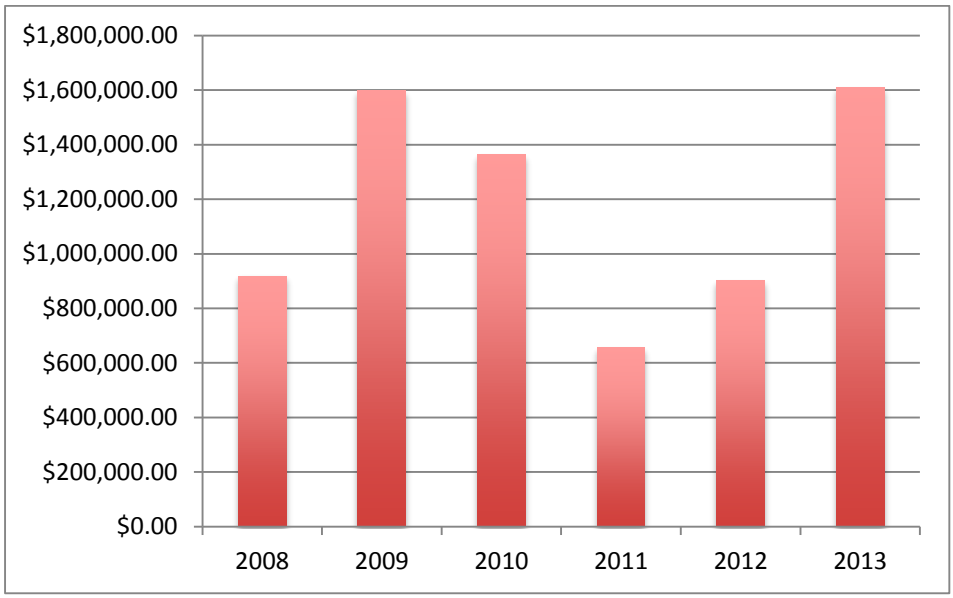
Source: UNFPA Cambodia Country Office, May 2015

Annex 4 shows that, from 2008 through 2013, out of 25 projects, five were jointly implemented by government and UNFPA, one by an NGO and UNFPA (on entertainment workers) and one by the government and NGOs (on community-based distribution). The country office hardly benefitted from the Global programme for reproductive health commodity security (GPRHCS) funding, except for one small project in 2009 (to procure emergency contraception and Implanon implants).

UNFPA spending on family planning

Analysis of ATLAS data from the period 2008-2013 shows a total expenditure of nearly US$ 18million on sexual and reproductive health and rights (SRHR) and FP over the period 2008-2013. Just over 39 percent (US$ 7million) of this amount was specific FP spending, of which US$ 372,000 (five percent) was GPRHCS; figure 3 shows expenditure over the years.

Figure 3: Expenditure on family planning, UNFPA Cambodia (2008-2013) (US$)

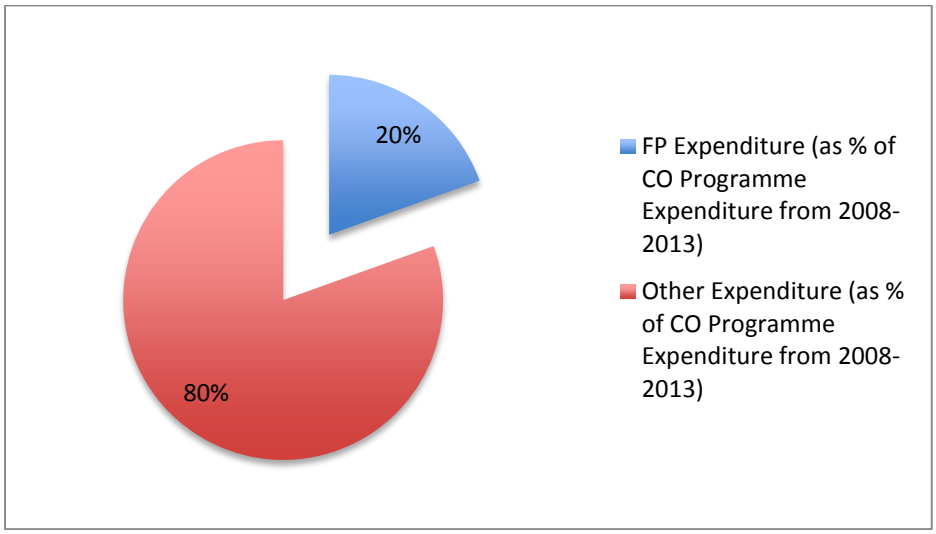


Source: UNFPA Cambodia Country Office, May 2015

Annex 4 provides more detail of spending on UNFPA SRHR interventions in Cambodia for the period under evaluation, showing the FP component of other SRHR projects identified by the CO. Those with a high FP component (estimated at over 40 percent of total spending) are projects addressing Ministry of Health service delivery capacity, community-based distribution of contraceptives and small projects for contraceptive procurement. Furthermore, it appears that the projects that were 100% dedicated to FP (seven projects – as detailed in the table in Annex 4) were funded on both core and non-core resources.

Seventy-seven percent of total SRHR and FP spending come from core funding and 23 percent from non-core funding (including the small GPRHCS funding). Of specific FP spending, 81 percent derived from core funding. Expenditure on FP amounted to one-fifth of total country programme expenditure (Figure 4).

Figure 4: Expenditure on family planning as share of overall CP expenditure, UNFPA Cambodia (2008-2013) (US$)



Source: UNFPA Cambodia Country Office, May 2015

4 FINDINGS

The country case study findings for each of the eight evaluation areas are presented in sub-sections 4.1 to 4.8 below. For each area, we first present an overview of progress and UNFPA responses during the period under evaluation, followed by an analysis of the contribution made by UNFPA. Each sub-section concludes with a paragraph relating the findings directly to the assumptions formulated within the evaluation matrix (see Annex 3). This approach allows for a testing of the validity of the assumptions at country level, and will serve as a basis for the synthesis of findings emerging from the case studies and other data collection elements in view of the overall evaluation analysis and report.

The findings are built upon the data and information collected during fieldwork and document review; they also take into account the feedback and comments from UNFPA Cambodia country office (CO) and other stakeholders. Findings are systematically referenced to the corresponding sections (ordered by evaluation question and related assumptions) in the evaluation matrix where the reader will find the key data and information on which the analysis is based.

The case study was designed to provide input and illustrative examples for the eight evaluation questions. It does not aim to assess the performance of the Cambodia CO in relation to the family planning (FP) outputs of the two country programmes, which span the period under evaluation.

4.1 Integration of family planning with other sexual and reproductive health services

Q1) To what extent has UNFPA supported integration of family planning with maternal health, HIV/STI and GBV services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • It is likely that UNFPA and in-country partners have part similar, part divergent understanding about the meaning and importance of service integration. • UNFPA has been effective in stimulating integration of FP with other services at policy and strategy level. Yet, in following government policy, this effort was skewed towards maternal health services, at the cost of other services and target groups. Therefore, while UNFPA has strongly supported integration through actual service provision, results have been limited outside the traditional group of maternal health service clients. In practice, adolescents and unmarried women and men do not have access to adequate public health services. • There is little evidence that UNFPA integration efforts have contributed to enhanced quality of FP services.

Progress and activities

In Cambodia, family planning has been addressed in an integrated way ever since the Ministry of Health (MoH) formulated its birth spacing policy in 1995 (Ministry of Health 1995, Ministry of Health 2015a).[27] Family planning has predominantly been framed in a maternal health context ever since.[28]

Family planning is clearly integrated with other sexual and reproductive health and rights (SRHR) services at policy level, as described in the Health Strategic Plan 2008-2015 and the national sexual and reproductive health (SRH) strategy 2012-2016 (Ministry of Health 2008b, Ministry of Health 2012). The latter explicitly refers to the inclusion of FP in: maternal health services, post-abortion

[27] Assumption, 1.1, Annex 3
[28] Assumption 2.2, Annex 3

care, HIV prevention and care, and services for entertainment workers and rape survivors (emergency contraception). Condoms are promoted for dual protection against unintended pregnancy and HIV. More implicitly, FP is also made part of adolescent SRH services, through supporting the inclusion of FP services in essential services and integration with programmes like HIV and gender based violence (GBV), and of SRH services in emergency settings, through UNFPA support for Minimum Initial Service Package training with National Centre for Disaster Management engagement.[29]

Family planning is a component of the essential SRH service package (Ministry of Health 2012: 34) adopted in 2012, which is implemented by the health centres throughout Cambodia.[30] Extensive training on FP, including youth-friendly services, has been provided to staff in most health centres country-wide to this end, focusing on midwives who are the facility staff usually responsible for this service.[31] Midwives are thus well-suited and prepared to ensure service integration regarding maternal and post-abortion care aspects. This integration has however not been achieved to the same extent for other groups, notably unmarried women and men generally, and especially adolescents which would benefit from more integrated services. While these large population groups in theory are welcome to seek FP services, in practice, the setup of services, prevailing provider attitudes and concerns of the young people towards privacy and confidentiality (in addition to unfavourable community attitudes) prevent them from accessing these services, as recognised by the MoH itself.[32] This issue is further discussed in section 4.5.

Although policies are in place and training is provided, referral hospitals largely fail to contribute to a relatively easy dimension of FP integration, i.e. integration with maternal health services and especially post-delivery and post-partum care. This contributes to prolonging the pre-existing "silos" reflective of non-integration, whereby health centres remain responsible for ante-natal care (ANC) and FP, while hospitals focus on delivery and post-partum care.[33]

Meanwhile emergency contraception (EC) after unprotected sex or in the event of a rape is not readily available to all those who may need it. Although reliable data are not available, interviewees indicate that, in practice, provision is often limited and information on its availability restrained, due to, in particular, the *"fear of creating undue demand."*[34]

Contribution of UNFPA to family planning outputs and outcomes

UNFPA has played an important and leading role, together with partners, in advocating and providing technical support for integration of family planning with other public SRH services, including maternal health, post-abortion care, adolescent SRH, HIV, GBV and emergency responses.[35]

This has been visible through the key support of UNFPA to policy making and strategy development (see Table 2). Key national partners and stakeholders acknowledge the strong advocacy and technical role UNFPA played in the development of these policies and strategies. This has contributed, directly or indirectly, to a common understanding of the meaning and importance of service integration across stakeholders.[36] At the same time, interviews indicate that the Ministry of Health prefers the term "linking" over "integration" in order to maintain focus on what is deemed

[29] Assumption 1.3, Annex 3
[30] Assumptions 1.3 and 8.1, Annex 3
[31] Assumptions 5.2 and 8.2, Annex 3
[32] Assumption 5.2, Annex 3
[33] Assumption 8.2, Annex 3
[34] Assumptions 1.3 and 8.2, Annex 3
[35] Assumptions 1.3 and 8.3, Annex 3
[36] Assumptions 1.3 and 3.3, Annex 3

important such as the HIV programme.[37] This implies that a focus different from FP is preponderant, posing a challenge to FP integration.

UNFPA paired this policy and strategy-level engagement with strong investments towards implementation to ensure that family planning would actually be made available through integrated services. To this effect, the CO supported the training of health staff across the board, in particular through the development of the "core competency framework for midwives" and related support for the midwifery regional training centres. The CO also supported the training of staff on youth-friendly services in 80 percent of the nearly 1,100 health centres, hence surpassing its initial target of 400 health centres.[38]

However, one-off initial trainings are not sufficient and this has contributed to concerns over the continuing low levels of quality FP counselling in the public health sector, expressed in interviews with the ministry, development partners (DPs), non-government organisations (NGOs) and UNFPA alike.[39]

The extent of integration of FP with other SRH activities by UNFPA itself is not readily visible in the spending figures as shown in Annex 4. Only about one quarter of overall spending on FP is linked to integrated FP-SRH projects, while most FP funding goes to FP specific projects. This, however, does not mean that specific FP funding is not used for integrated purposes. For example, UNFPA support to the ministry of health for FP involves training not only to strengthen the 'traditional' family planning services for married women, but also the services to adolescents, post-partum services and HIV-related services.

Despite major UNFPA efforts, interviewees largely agree that others than the "traditional" clients (married women) have very limited access to public sector FP services. This is especially the case for adolescents and unmarried young women and men, as the envisaged youth-friendly services for which so many staff were trained (staff in 80 percent of the nearly 1,100 health centres[40]), never really materialised; a missed opportunity, according to a 2012 external evaluation.[41]

UNFPA ensured that access to key family planning services was included in emergency preparedness and response plans through providing support to the Joint Plan of the National Committee for Disaster Management and supporting training on the minimum initial service package.

While robust data are not available, interviews and document findings indicate it is likely that integration has improved access for married women seeking maternity services, while it is unlikely to have improved much for other important groups like adolescents and unmarried women and men.[42]

Quality of health service including FP in the public sector is improving gradually but it remains unclear to which extent integration efforts by UNFPA and other stakeholders contribute to this. In its 2014 situational evidence review report, the UNFPA CO noted that *"low levels of quality counselling and service provision of family planning remains a challenge in the public health sector*" (UNFPA Cambodia 2014d: 20).

[37] Assumption 4.2, Annex 3
[38] Assumptions 5.2 and 8.1, Annex 3
[39] Assumption 8.1, Annex 3.
[40] Assumptions 5.2 and 8.1, Annex 3
[41] Assumptions 1.3, 5.2 and 8.2, Annex 3
[42] Assumptions 1.3, 5.2, 8.1 and 8.2, Annex 3

4.2 Coordination and national ownership

Q2) To what extent has UNFPA successfully contributed on its own and in coordination with others to strengthening national leadership of family planning and improving sustainability?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has actively participated in, supported and led mechanisms to raise the profile of FP. • UNFPA efforts and acknowledged leadership, alongside those of other partners, have strongly contributed to national leadership and ownership of FP policies and programmes. • UNFPA has made an important contribution to the institutional sustainability of FP programmes. It has also contributed to creating some degree of social sustainability, although the limited access to FP services for, among others, adolescents indicates that further support is needed. UNFPA has been key to achieving financial sustainability through increasing government budget commitment to fully finance contraceptive supply from 2016 onwards.

Progress and activities

Key strategic and policy documents clearly illustrate that the government has assumed strong ownership for family planning as an important component of cross-sectoral policies and programmes, aiming to reduce maternal mortality and unmet need for contraceptives. Importantly, these commitments are evidenced by public statements by high-level office bearers, such as during the pivotal national FP conference (2014); and the inclusion of contraceptive services in the health equity fund scheme.[43] This was also illustrated by the tangible expansion of the FP method mix and choice and related extensive MoH investment in training of public health workers on FP methods, counselling and integration. Finally, the government's ownership materializes with the first ever national budget commitment towards contraceptive commodity procurement, from 2014 onward,[44] which "*has enhanced the sustainability of Family Planning interventions.*" (Noij, Kasumi et al. 2015: 65)

These strong political commitments form important building blocks towards the institutional and financial sustainability of FP related programmes. Sustainability is also supported by the increase in the public sector share as source of modern contraceptives, from 40 percent in 2005 to 52 percent in 2010.[45]

Financial sustainability in terms of explicit government financial commitment was substantially improved by the government agreement to absorb the full cost of annual contraceptive procurement in its 2016 and subsequent budgets.[46]

The social sustainability of FP policies and programmes is illustrated by the steady increase in the modern contraceptive prevalence rate (mCPR) among married women (from 27 to 39 percent between 2005 and 2013) and the decreasing unmet need (from 25 to 13 percent between 2005 and 2014).[47] This is falling short of the SRH national strategy target (an mCPR of 52 percent in 2016) and far below the *national* millennium development goal target (60 percent by 2015); the latter was deemed too ambitious by the government and UNFPA informants alike. However, several

[43] As described in section 3, health equity funds substitute user fees for clients unable to pay through a third party financing mechanism
[44] Assumptions 2.2, 3.3, 5.2, 8.1 and 8.2, Annex 3
[45] Annex 6
[46] Assumption 2.2, Annex 3
[47] See Annex 6

respondents interpreted the improved use of contraceptives as increasing community support towards FP.[48]

Sections of the same communities appear to have reservations or expressed opposition regarding access to FP services by important potential client groups other than married women, including adolescents and unmarried people in general.[49] From the perspectives of the latter client groups, this could well be seen as an undesirable and thus unsustainable approach, which would imply that there are contradictory perspectives as to whether FP programmes are sustainable.
In public facilities, the term *birth spacing* appears to be explicitly preferred to the reference to *family planning* services. This preference for *birth spacing* is also reflected in recent (English-language) high-level government documents.[50] Although the national SRH strategy uses the term *family planning,* the indicators are, again, defined in terms of birth spacing and birth limiting.[51] This choice of words resonates well with one of the strong rationales of government to promote FP, i.e. reducing the high maternal mortality ratio, and has proven to be effective to this end. The risk, however, is that this might communicate the idea that FP is meant predominantly for those wanting (more) children. This semantic choice can also be seen as the English equivalent of the Khmer term which invariably refers to 'birth spacing' even when addressing adolescents or unmarried adults; it is then particularly important to offer a relevant explanation of the purpose of such services.

UNFPA contribution to results on government leadership and sustainability
The government, DPs and NGOs alike strongly credit UNFPA for its "friendly influencing" approach to strengthening national ownership. UNFPA is seen as the most trusted partner of the government for maternal health and FP issues. Development partners appreciate its professionalism and added value, technically and as a broker vis-à-vis other organisations engaging with the government. This is an important achievement in any political context, more so around a sometimes sensitive topic for which visible progress is not easily achieved. "*The current government commitment to RH/FP is UNFPA's doing,*" said one development partner interviewee. This is supported by several external evaluations.[52]

UNFPA efforts, alongside those of other partners, have thus contributed to national leadership and ownership, through its continuous advocacy and technical support for the series of key national FP-related policies and strategies. These efforts were greatly aided by the strong engagement of UNFPA in a series of high-level policy forums, technical coordination mechanisms and other partnership platforms.[53]

UNFPA also supported national ownership in various other ways. Its advocacy efforts were key to ensuring government agreement to budget for the full cost of annual contraceptive procurement as from 2016.[54] It played a key role towards the inclusion of contraceptive services in the health equity fund scheme and, moreover, used its leverage to achieve adjustments in the health equity fund reimbursement system (to address the bias towards more expensive methods).[55] Despite its limited financial means, UNFPA made an important contribution to the Health Sector Support Programme II,

[48] Assumption 2.3, Annex 3
[49] Assumptions 4.2 and 5.2, Annex 3
[50] Assumption 2.2 and 2.3, Annex 3
[51] Assumption 6.1, Annex 3
[52] See Shah 2010, Tobin, Toptosseda et al. 2011, Sovannarith 2014, , MOPAN 2014, Noij, Kasumi et al. 2015 (and assumptions 3.2 and 3.3, Annex 3)
[53] Assumptions 3.2 and 3.3, Annex 3; see also section 4.3 for more on UNFPA participation in coordination forums and mechanisms
[54] Assumption 2.2, Annex 3
[55] Assumptions 2.2 and 4.2, Annex 3

through which a number of multilateral and bilateral organisations support the MoH policies and programmes. UNFPA was lauded for its advocacy efforts with parliamentarians.[56]

The most recent (2015) country programme evaluation (CPE) highlights the partnership approach used by UNFPA in all programmes, as a good example of how to strengthen national ownership and build capacity. At the same time, the CPE observes that strategies to make UNFPA achievements more sustainable were not always in place,[57] an issue that – given the limited UNFPA funding available and its intended shift away from direct service delivery support – one would expect should receive more attention.

UNFPA has contributed to socio-cultural sustainability through its support for community-based distribution and demand creation.[58] Its support for work with adolescents, garment factory workers and entertainment workers appears rooted in a rights-based and empowerment approach, which favours the social sustainability of the programmes implemented among these vulnerable and sometimes marginalised groups.[59]

4.3 Brokerage and partnerships

Q3) To what extent has UNFPA acted as a broker at global, regional and country levels to promote family planning, acting in partnership with the public, private and non-state sector service providers?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA makes good use of its comparative advantage as a broker, at national and also sub-national level, building on its focused expertise, being part of the UN system and its close working relationship with the government and civil society. • UNFPA brokers partnerships among a variety of stakeholders and engages with them in a vast number of coordination forums and working groups; UNFPA has a sufficiently strong profile and visibility at country level to continue brokering such relationships. • Some stakeholders would like to see a stronger UNFPA leadership role regarding a variety of topics, including government support for improving access for young people to contraception and creating awareness around safe abortion services in public facilities.

Progress and activities

In Cambodia, a series of high-level policy forums, technical committees and coordination mechanisms address issues relevant to family planning, all of which enjoy substantive participation by the UNFPA CO. Several of these bring together government representatives, development partners and civil society, and entail discussions on policy, technical and funding issues. The most relevant are: the sub-technical working group for health on maternal and child health (MCH), deemed one of the most active mechanisms by some;[60] the contraceptive security working group; the reproductive, maternal, newborn and child health and nutrition task force; the joint review mission; and the maternal health fast track initiative.[61]

Other forums and mechanisms are in place and aim at improving development partner coordination and coherence of support towards government and non-state actors, like the joint partnership

[56] Assumption 2.2, Annex 3
[57] Assumption 2.3, Annex 3
[58] Assumption 4.2, Annex 3
[59] Assumptions 4.2 and 5.2, Annex 3
[60] Assumption 8.1, Annex 3
[61] Assumption 3.2, Annex 3

arrangement/development partner interface group (JPIG) related to the health sector support programme II;[62] the health partners group meeting; the gender-based violence coordination group; the joint UN team on HIV/AIDS; and the UN Youth Task Force and UN Youth Advisory Panel.[63]
In addition, key FP stakeholders also interact around events taking place at certain intervals. An important example, aided by UNFPA policy, advocacy and leading roles, was the National Family Planning Conference celebrated at the end of 2014. The conference brought together government, civil society, private sector, and multi- and bilateral development partners. It involved coordination among development partners, NGOs, private sector and the government, brokering regional expertise and knowledge sharing and resulted in the adoption of a combined conference statement.[64]

UNFPA contribution
UNFPA makes good use of its comparative advantage as a policy and advocacy agent, at national as well as sub-national levels. It builds on its focused expertise, being part of the UN system, and close working relationship with the government; thereby using its relatively small financial weight strategically. UNFPA thus manages to advance partnerships among DPs, NGOs and government stakeholders, sometimes at programme level and, most importantly, as a key player in a vast number of coordination forums and working groups. UNFPA plays a prominent role in the MCH sub-technical working group, where it has been trusted with a lead role on several agenda items. The Fund also chairs the JPIG, a position offering ample opportunities to influence the agenda, advancing important SRH/FP issues and pursue relevant policies and strategies.[65]

The role of UNFPA and the way it fulfils this role is seen in a positive light by virtually all stakeholders interviewed for this evaluation. They see UNFPA as "*involving all stakeholders and not assuming a competitive position,"* and stressed that *"UNFPA work is team work."*[66]

External evaluators agree and credit UNFPA with having adopted a partnership approach in its programming under both the third and fourth CPs.[67] This has brought together development partners from diverse corners and has helped to bridge differences between government entities and others partners. One recent example is the 2014 National Family Planning Conference, "Choices not Chance." The CO successfully advocated with private sector, civil society and development partners to jointly support the event, securing exceptional financial contributions from pharmaceutical companies.[68] Another example is the participation of UNFPA in the health sector strategic plans (HSSP) I and II (with HSSP III currently under negotiation), where UNFPA joined other donors to bring momentum to the RH component of the programme, including strong attention for FP.[69]

UNFPA engages to a certain extent with private sector companies to commit to SRH service provision to their employees (such as the garment sector) and to co-fund capacity development and research

[62] HSSP II has a development objective to *"support the implementation of the Government's health strategic plan 2008-2015 in order to improve health outcomes through strengthening institutional capacity and mechanisms by which the Government and program partners can achieve more effective and efficient sector performance"* (World Bank 2015b). Partners are or were the World Bank, DFAT (Australian government), AfD (ended 2013), BTC (ended in 2012), DFID (ended in 2011), KfW, KOICA, UNICEF and UNFPA.
[63] Assumption 3.2, Annex 3
[64] Assumption 3.2, 3.3 and 4.1, Annex 3
[65] Assumption 3.3, Annex 3
[66] Assumption 3.2, Annex 3
[67] Assumption 3.2, Annex 3
[68] Assumption 3.2, Annex 3
[69] Assumption 3.2, Annex 3

activities, such as towards funding for research on Implanon and training of trainers on Implanon NXT at the national level.[70]

UNFPA has good visibility, "*even though that is not their intention,"* as one partner said, due to its strong technical role, position of trust with government and openness to work with both government and civil society. Partners indeed recognise these comparative advantages, combining key advocacy and technical assistance, generating leverage and influence with government. Also, UNFPA gained credibility by developing evidence for debates on reproductive health and by combining activities both at policy and operational level.[71]

As another concrete example of its brokerage position, UNFPA played a key role in securing government commitment to establish a first-ever separate budget line for contraceptive procurement in the national budget. This required not only advocacy with the MoH but also assisting the ministry to make its case towards the Ministry of Economy and Finance.[72]

In terms of stakeholder expectations, some respondents indicated they would like to see stronger UNFPA leadership regarding advocacy with parliamentarians (which in fact UNFPA has already taken up); strengthening government support for making contraceptive services available to young people; and knowledge generation, such as research on FP user perspectives, monitoring progress and identifying challenges to be addressed. While CO staff emphasised they already had taken up to engage a group of parliamentarians, the fact that certain stakeholders were not aware implies UNFPA efforts may not be visible enough.

Various sources referred to the need for UNFPA to assume a stronger role in awareness creation around the availability of legal, safe abortion services in public facilities,[73] as awareness is very limited.[74] This can be seen in the light of unintended pregnancies and rising teenage pregnancies (Sovannarith 2014, Ministry of Planning, Ministry of Health et al. 2015),[75] currently being regulated through an increase in contraceptive prevalence paired with the use of abortion.[76] This relationship between contraception and safe abortion was also observed by UNFPA in its 2014 Situational Evidence Review report, in which it suggested promoting increased uptake of FP methods to create awareness regarding safe abortion practices (UNFPA Cambodia 2014e: 22). Despite this stance, and the position of UNFPA that "*where abortion is legal, national health systems should make it safe and accessible,*"[77] it has been repeatedly reported that the country office has been hesitant to address safe abortion, even when this is requested by government.[78] In this context it is noteworthy that the Cambodian government is open about the need to strengthen access to safe abortion and FP in conjunction.[79]

[70] Assumption 3.2, Annex 3

[71] Assumption 3.3, Annex 3

[72] Assumptions 2.2 and 3.3, Annex 3

[73] "*Abortion was legalised in Cambodia in 1997, and is available without justification in the first trimester of pregnancy*" (Ministry of Health 2012: 16). Also see Assumption 3.3, Annex 3

[74] Assumption 3.3, Annex 3, see entries Vathiny and Hourn 2009, Sopheab 2014

[75] Assumption 3.3, Annex 3, see entries Sovannarith 2014 and Ministry of Planning, Ministry of Health et al. 2015

[76] Assumption 3.3, Annex 3, see entries Westoff, Bietsch et al. 2013: xi, UNFPA Cambodia 2014e. Along the same lines, the apparent high rates of abortion among garment factory workers can be seen as an indication of unmet need for family planning (Sovannarith 2014, UNFPA Cambodia 2014e and Assumption 3.3, Annex 3)

[77] See (UNFPA 2014a)

[78] Assumption 3.3, Annex 3, see entries (Shah 2010: 13, UNFPA 2012b: 27)

[79] The National Strategic Development Plan states: "*Despite having no legal age restrictions on access to reproductive health services, including for contraceptives and access to abortion, there is a lack of understanding on how easily young people could make use of such services*" and "*Key interventions … are …: … Increase demand for and access to … [SRH] services and services including … safe abortion …*" (RGoC 2014: 77, 182).

4.4 Enabling environment

Q4) To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information and exercise of rights?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has identified key enabling factors and made major efforts to strengthen these. • These interventions however were more focused on policy rather than the implementation level, with less attention for increasing availability of quality SRH and FP service for adolescents and unmarried women and men. • Uptake of modern FP methods has increased; UNFPA contributed to this through a series of programmes implemented by state and non-state actors. This increase reflects some strengthening of the enabling environment for FP. • Efforts towards knowledge generation have been limited, while they could help to identify more clearly enablers on the demand side.

Progress and activities

Key enabling environment factors to ensure family planning information and exercise of rights include: the policy framework, political commitment, legal frameworks, space for involvement and capacity building of non-state actors, community attitudes and participation and a coherent vision on SRHR (UNFPA 2014b: 34, 68). The policy framework, paired with political commitment, is supportive of FP programmes, with partial integration with SRH components.[80]

However, the government initiative to pass a law, ultimately adopted in August 2015, that regulates NGO operations, was not received favourably by civil society organisation and development partners, as discussed in section 3.[81]

Use of modern FP methods has increased in the past decade, as evidenced by the mCPR growth (from 27 to 39 percent between 2005 and 2013), increased percentage of demand satisfied for FP (from 68 to 82 percent between 2008 and 2014), and reduction of the unmet need for FP (from 25 to 13 percent between 2005 and 2014).[82] This has been the result of, among others, behaviour and awareness raising interventions including media interventions and community-based awareness creation on and distribution of contraceptives.[83] It is worthwhile noting that for this purpose, village health support group volunteers have been engaged by the MoH (with UNFPA support) and NGOs for distribution of FP methods. These volunteers are supposed to be supported and coordinated by public facility health staff – but on average may receive little support or guidance. Incentives are limited or non-existent, while potential profits from sales of contraceptives are small.[84]

UNFPA contribution to the development of an enabling environment for family planning information and exercise of rights

UNFPA has used its advocacy, technical and knowledge management roles to strengthen the enabling environment for repositioning family planning in Cambodia. This was predominantly at policy level, among others by strategically pointing to FP as a key intervention towards reducing maternal mortality through public services, and increasingly focusing on also addressing the needs

[80] Sections 4.1 and 4.2

[81] See section 3, where we reported that there are concerns that the law could be used to curtail NGO operations, including human rights-related activities (United Nations 2014, HRW 2015, Lee, Flowers et al. 2015).

[82] Assumptions 2.3 and 4.2, Annex 3 and Annex 4

[83] Assumption 4.2, Annex 3

[84] Assumption 4.2, Annex 3

and rights of other groups, such as adolescents, unmarried women and men and entertainment workers.[85]

The environment for operationalisation of important policy components received less attention. It is difficult to discern an overall coherent vision on SRHR and the embedment of FP therein, given the bias that is generated by predominantly framing FP as part of maternal health (see sections 4.1 and 4.2) and by the strong emphasis by virtually all stakeholders on long-term contraceptive methods (see sections 4.6 and 4.8). Both issues contribute to limiting opportunities for improving access to quality SRH and FP services for the current large cohort of young Cambodian people, as well as unmarried women and men in general.[86] UNFPA is addressing some of these issues in its fifth CP 2016-2018 (United Nations 2015).

Under the past and current CPs, UNFPA has already promoted an active role for civil society in the field of FP generally, through its engagement with and funding of a limited number of NGOs – the Reproductive and Child Health Alliance of Cambodia (RACHA), the Reproductive Health Association of Cambodia (RHAC) and the Cambodian Women for Peace and Development (CWPD), each supporting different programmes; RACHA the community-based distribution of contraceptives, RHAC both the IUCD and garment factory programmes, and CWPD the *SMARTgirl* programme among entertainment workers.

UNFPA intervention case example[87]
Box 1 – 'Entertainment workers are becoming SMART girls'

Entertainment work is stigmatised in Cambodia and the estimated 40,000 workers are at risk of sexually transmitted infections (STIs), HIV and unintended pregnancies; they are also vulnerable to sexual violence. Condom use with paying sexual partners is relatively high but is low with "sweetheart partners." The 2008 Law on Suppression of Human Trafficking and Sexual Exploitation, together with the 2011 Village Community Safety Policy, had the side-effect that SRH and HIV-related outreach and services for these at risk populations became more constrained.

UNFPA and partners support CWPD to target entertainment workers. This programme, "SMARTgirl", addresses SRH, rights, HIV and FP. People with a background in entertainment work were engaged to serve as group leaders and outreach workers to reach the hardest-to-reach young entertainment workers. The programme covers 14 provinces, reaching 14,000 (38 percent of all) entertainment workers.

The recent CPE found that the capacity of peer educators (outreach workers with a background in entertainment work) had been enhanced and that access to services has been increased for information, HIV counselling, FP, emergency contraception. Programme monitoring data, however, suggest that some key indicators[88] may be worsening rather than improving as compared to the general entertainment work population while consistent condom use with sweetheart or husband is improving; two other key indicators seem to worsen (consistent condom use with clients, abortion).

UNFPA was a driving force, together with partners, behind the 2014 National Conference of Family Planning, which was explicitly aimed at strengthening the enabling environment, and which involved many non-state actors.[89] It also recently took a public stance, together with four other United

[85] Section 4.2
[86] Assumption 5.2, Annex 3
[87] Text based on Assumption 5.2, Annex 3
[88] The indicators will be further explained in section 4.5.
[89] Section 4.3

Nations organisations, in favour of civil society and was critical of the government in the management of the process around the draft law on associations and nongovernmental organisations, especially regarding the lack of transparency and consultation (Lee, Flowers et al. 2015). This has reinforced UNFPA credibility among civil society partners and can potentially increase its influence in the debate around the issue of maintaining space for civil society participation in SRHR.

Demand creation received considerable attention in UNFPA country programming, as also confirmed by external evaluations, and this has contributed to the increased uptake of modern FP. UNFPA advocated for inclusion of contraceptives under the pro-poor health equity fund arrangements. It provided technical, financial, capacity-building and knowledge support for initiation of services for garment factory workers (mostly young female migrants); expansion and quality-improvement of public health facility-based FP services; airing of the popular TV "edutainment" show *Love9,* targeting young people; and community-based awareness creation and distribution of contraceptives (via NGOs RACHA and RHAC) in a number of provinces. The community-based distribution programme however is seen as not being very effective overall.[90]

There are opportunities for UNFPA to contribute to more clearly identifying enablers on the demand side, including attention for the constructive engagement of men in FP decision-making[91] and uptake and improved knowledge generation. Regarding the latter, interviews with UNFPA and stakeholders identified several issues:

- User fee variations across health facilities (a study UNFPA has initiated in 2015)
- Determinants of the observed 50 percent increase in the teenage pregnancy rate
- Socio-cultural barriers at community level (paired with similar research among service providers at the supply side).

Also, it would be useful to identify best practices from within Cambodia and other relevant contexts for generating demand where this is clearly warranted from a rights and public health point of view. Another challenge would be to define adequate responses to the 2014 demographic and health survey (DHS) results, which indicate that traditional contraceptive methods are gaining ground among women with higher levels of education and in urban areas (Ministry of Planning, Ministry of Health et al. 2015).

4.5 Vulnerable groups and marginalised populations

Q5) To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalised groups, including identification of needs, allocation of resources, and promotion of rights, equity and access?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has generated substantial knowledge to identify VMGs needs and has contributed to promoting sexual and reproductive rights; collecting best practices has received less attention. • Effects of the substantial UNFPA efforts towards youth-friendly services in public facilities seem to be limited. Evidence is available for the entertainment workers' programme, but it shows mixed results. • Strategies to strengthen unmarried young women's access to FP services need reconsideration and coordination with partners, as foreseen in the new country programme.

[90] Assumption 4.2, Annex 3
[91] Assumption 4.2, Annex 3

- UNFPA has made substantial contributions to promoting the sexual and reproductive rights of various groups. Support for capacity building of these groups and their active participation in programmes was still limited.

Progress and activities

The main vulnerable and marginalised groups (VMGs) identified in Cambodia are young people, people living in poverty (rural and urban), entertainment workers, people living with HIV (PLHIV), migrant workers and ethnic minorities.[92] These groups have limited access to family planning services and face difficulties in exercising their rights due to attitudes of health staff, lack of awareness, stigma and discrimination and cost of services.[93] UNFPA and stakeholders provide considerable attention to these groups in their policies and programming, which was also visible during the 2014 National Family Planning Conference.[94]

Uptake of modern contraceptive methods by **young people** is low for women aged 15-19 years (20 percent) (Ministry of Planning, Ministry of Health et al. 2015: 14), and teenage pregnancy is on the increase, from 8 to 12 percent between 2010 and 2014.[95] Young people have low levels of knowledge on SRH issues and do not use conventional services due to concerns about confidentiality and staff behaviour.[96] This is compounded by the choice of wording around contraceptives, family planning and birth spacing, which has been predominantly framed in a maternal health context.[97] Unfavourable community attitudes also make adolescents and unmarried women shy away from seeking contraceptive services.[98]

The envisaged youth-friendly services, which many public health staff were trained for, in reality rarely materialised.[99] While health staff during interviews confirm they are willing to attend to the needs of young people, other stakeholders are less positive about the readiness of public health services and envisage a bigger role for NGOs and the private sector.[100]

Indeed, a number of non-state actors, including national and international NGOs (such as RACHA, RHAC, Marie Stopes International (MSI), Population Services Khmer (PSK)) and for-profit services (pharmacies, private clinics), play important roles in catering for young people's needs.[101] While this is important to generate evidence for effective interventions, current opportunities to scale-up such services are limited due to financial constraints and related sustainability concerns.

Entertainment work is stigmatised in Cambodia. Entertainment workers indicate they experience regular violence and discrimination. Female, male and transgender entertainment workers all reported inconsistent condom use.[102] In a focus group discussion, five out of nine entertainment workers said they were using a contraceptive other than condoms.[103]

[92] Other VMGs mentioned in key documents and interviews, include: people living with disabilities, women survivors of violence, men having sex with men and LGBTI people (Assumption 5.2, Annex 3).
[93] Assumptions 5.1 and 5.2, Annex 3
[94] Assumption 5.1, Annex 3
[95] Sections 3.3, 4.3 and 4.4; assumption 3.3, Annex 3
[96] Assumption 5.2, Annex 3
[97] See sections 4.1 and 4.2
[98] Assumption 5.2, Annex 3
[99] Assumptions 1.3, 5.2 and 8.2, Annex 3
[100] Assumption 5.2, Annex 3
[101] Assumptions 4.2 and 5.2, Annex 3
[102] Assumption 5.2, Annex 3
[103] Assumption 5.2, Annex 3

Attention for the SRH and contraceptive needs of **migrants** has risen fast in recent years, in parallel to the rise in migration itself. It is estimated that half a million people, mostly young women (18-30 years of age), work in garment factories and are exposed to high risk of unintended pregnancy.[104]

People living in poverty are more likely to live in underserved, remote areas.[105] The urban poor recently receive more attention from government and development partners.[106] National health equity funds are available to cover health service user fees for poor people, including for contraceptive services. Nonetheless, some interviewees stated that less than half of those eligible for free-of-charge services actually had access to services, due, in particular, to opportunity costs.[107]

People living with HIV face particular challenges regarding their reproductive rights, as health workers often advise to refrain from having (more) children, terminate a current pregnancy or to use sterilisation as a contraceptive option.[108] HIV-related services for PLHIV, meanwhile, are readily available.[109]

Stakeholders, including government, indicate that more assessments of VMGs needs and effective interventions are needed.[110]

UNFPA contribution to family planning needs of vulnerable and marginalised groups

UNFPA is increasingly generating evidence on the needs and challenges of VMGs, including studies related to teenage fertility, unmet need for FP and comprehensive sexuality education.[111] It also funded a literature review (plus interviews) on the SRHR of migrant garment factory workers and has commissioned a study on urban poor.[112] Work on identification of best practices and interventions that have proven to be effective remains underdeveloped.

UNFPA has made substantial contributions to promoting sexual and reproductive rights of many groups, including adolescents, migrant garment factory workers, entertainment workers and, to some extent, women survivors of violence, people living with HIV, and lesbian, gay, bisexual, transgender and intersex (LGBTI) people. For adolescents, this is flanked by the programme on comprehensive sexuality education in schools in nine provinces, through the Ministry of Education, Youth and Sport, to be accelerated under the new country programme.[113] The *SMARTgirl* programme supported by UNFPA, caters for 16,000 entertainment workers and addresses SRH, rights, HIV and FP.[114]

UNFPA has also invested in programmes seeking to improve access to and quality of services for young people (through the MoH), garment factory workers (via RHAC) and entertainment workers (via CWPD). It is too early for measuring the impact on garment factory workers, and results for entertainment workers are mixed (see Box 1 in section 4.4). Regarding youth-friendly services, the impact seems to be limited[115] (except for married young women), due in part to persisting issues

[104] Assumption 5.2, Annex 3
[105] Assumption 5.2, Annex 3
[106] Assumption 5.2, Annex 3
[107] Assumption 5.2, Annex 3
[108] Assumption 5.2, Annex 3, see entries (CPN+ 2010, APN+ 2012, Ministry of Health 2012)
[109] See section 4.1
[110] Assumption 5.1, Annex 3
[111] Assumption 5.1, Annex 3
[112] Assumption 5.1, Annex 3
[113] Assumption 5.2, Annex 3
[114] See section 4.4
[115] Assumption 5.2, Annex 3

related to socio-cultural community and service quality (staff attitude). Several stakeholders expressed the view that UNFPA should do more for adolescents.[116]

Strategies to strengthen the access to FP services of unmarried young women therefore need reconsideration and coordination with partners.[117] The new country programme proposes to continue or expand current work on comprehensive sexuality education in schools, the TV "edutainment" show *Love9*, services to garment factory workers, and adolescent-friendly public health services. Garment factory workers, predominantly young migrant women, form a specific group supported by UNFPA through RHAC. They work with 17,000, mostly young, female workers in 18 factories; UNFPA is a lead partner in this area.[118]

UNFPA intervention case example
Box 2 – Love9: Innovative inspiration for youth to discuss sexual health

Young people have low levels of knowledge on SRH issues. Uptake of modern contraceptives is low for women aged 15-19 years (20 percent) and teenage pregnancy is on the increase. Unfavourable community attitudes make adolescents shy away from seeking contraceptive services. Young people hardly use conventional health services due to concerns about confidentiality and staff behaviour.

It is worthwhile mentioning that, in 2013, UNFPA, jointly with USAID, supported a multimedia initiative for youth education on SRHR, called *Love9*. Implemented by BBC Media Action Cambodia, the TV "edutainment" show became very popular among young people, not least as it combines TV airing with a radio programme and telephone hotline, social media (website, Facebook, YouTube) and links to the school-based comprehensive sexuality education.[119]

The programme covers SRHR-related issues including STI and HIV risk, pregnancy and choices around it, contraceptive methods, understanding your body, and relationships and respect for others. The fourth CPE concluded that support to *Love9* enhanced access to SRH information for adolescents and youth.[120]

The CO acknowledges that no robust data on results are available. Its 2014 UNFPA annual report states that "*reaching poor and vulnerable adolescents and youth through this Love9 intervention remains to be verified*" (UNFPA Cambodia 2014a: 10). The same report shares doubts about the financial sustainability of the programme (ibid.).[121]

Many stakeholders interviewed, however, including several multilateral and bilateral development partners, do not see public services having the comparative advantage to effectively provide adolescent-friendly services, and this may also apply to other VMGs. Therefore, stronger advocacy with government and development partners on the contraceptive needs of young people and other VMGs in the context of SRH could open the way for increased NGO involvement, and some forms of private sector involvement in addressing barriers and creating and responding to demand. Also, community engagement regarding the needs of adolescents and unmarried women, as well as other VMGs, may need more attention.

[116] Assumption 5.2, Annex 3
[117] Assumption 5.2, Annex 3
[118] Assumption 5.2, Annex 3
[119] Assumption 5.2 and UNFPA Cambodia 2014a: 9-10
[120] Assumption 5.2, Annex 3
[121] Assumption 5.2, Annex 3

UNFPA successfully advocated for the inclusion of contraceptives in the pro-poor health equity fund schemes.[122] In parallel, it supports the IUCD voucher scheme implemented by RHACs so that incentivised providers can choose whether to charge RHAC or the health equity fund. The mechanism is sustainable as the government has indicated it would continue with the system in the event that development partners decide to pull out.[123]

The UNFPA Cambodia 2011 Country Programme Action Plan emphasized that indigenous populations needed special attention for SRHR and related inequities.[124] There is no evidence that this has happened.[125] Also other groups, such as underserved rural communities, urban poor and young men, received less attention during the period under evaluation, although this is in part set to change with the new country programme. UNFPA is actively involved in programmes seeking to constructively involve young men; the CO is the UN-lead for the *Good Men* campaign that addresses gender-based violence and also mentions contraception.

Via its implementing partners, UNFPA has supported capacity development activities among VMGs and their participation in programme planning, implementation and monitoring. More directly, it worked towards empowering entertainment workers through their active participation and dialogues in national and sub-national forums.[126]

4.6 Human-rights based approach

Q6) To what extent has UNFPA implemented a human rights-based approach to family planning, in particular regarding access to and quality of care, and through support from HQ and RO for a rights-based approach in country?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA staff and key partners show a shared understanding of the meaning and importance of a rights-based approach to FP. This approach is well-reflected in key public policies, towards all of which UNFPA has actively contributed. • The operationalisation of this approach by the UNFPA CO reflects a number of the HRBA elements described by the official UNFPA definition and puts special emphasis on respecting, protection and fulfilment of rights of VMGs. Programming thus incorporates human rights principles. • Emphasis on starting with or switching to long-term methods by various UNFPA-supported programmes appears to contradict UNFPA advocacy for elimination of any use of incentives or fee structures to favour provision of one method over another and warrants close monitoring to ensure compliance with the rights-based approach to FP. • The contribution of UNFPA to insights regarding rights-based approaches towards FP is largely indirect but growing, through studies on client needs and satisfaction. • Insufficient information is available on the views of rights holders regarding duty bearers' understanding of rights.

Progress and activities

[122] Assumption 5.2, Annex
[123] Assumption 5.2, Annex 3
[124] Assumption 5.2, Annex 3
[125] Immediately prior to the period of evaluation (2007), UNFPA organized a Consultative Meeting on Indigenous People's Reproductive Health, Gender and Population. It is unclear whether this could have been the start of a strong programme for and with indigenous peoples (see Assumption 5.2, Annex 3).
[126] Assumption 5.4, Annex 3

The UNFPA human rights-based approach (HRBA) to programming is described in the HRBA training manual. The HRBA to family planning focuses on fulfilling the "right to health services," which should be available, acceptable, accessible and of the highest possible quality, emphasising participation of rights holders and accountability of duty bearers (UNFPA 2010). The specific UNFPA webpage on HRBA summarises this as focused on the fulfilment of people's rights rather than needs, whereby a rights-based approach develops the capacity of duty-bearers (usually governments) to meet their obligations and encourages rights holders (service clients and community members) to claim their rights. "*Governments have three levels of obligation: to respect, protect and fulfil every right."* It then emphasizes that the HRBA is especially focused on those who are most marginalised, excluded or discriminated against (UNFPA nd).

In official documents, the government has committed to a rights-based approach to FP ever since the birth spacing policy was first put on paper in 1995. Subsequent key policy documents maintained and reinforced this vision. The draft version of the 2015 Birth Spacing Policy in Cambodia refers to rights-based FP as being part of efforts to achieve universal access to SRH and reproductive rights.[127]

Most interview respondents defined the rights-based approach to FP in terms of a clients free and informed choice from among a range of contraceptive methods, quality counselling about options and side-effects and lack of any form of coercion, but also improved access by VMGs.[128]

At operational level, services do not always reflect policies as they are intended. Resource limitations have limited the full roll-out of the Comprehensive Sexuality Education Programme by the Ministry of Education, Youth and Sport. Access to permanent contraceptive methods in referral hospitals and to emergency contraceptives in general is severely limited, despite policies being in place. Judgemental staff attitudes keep adolescents, unmarried women and probably other VMGs such as PLHIV and entertainment workers away from public health services. A weak system and staff capacities lead to lower than desired quality of care during counselling, when all available methods, potential side-effects and recourse to reversal of long-term methods need to be explained at the client's level of understanding. These health service supply-side constraints are compounded by demand-side challenges, such as socio-cultural values and taboos at community-level that disapprove of unmarried people seeking contraceptive services.[129]

In Cambodia, public sector and NGO demand creation programmes for FP, including those supported by UNFPA through the health equity fund and voucher schemes, promote the use of, and shift from other methods to, long-term methods, with a strong emphasis on intra-uterine contraceptive devices (IUCDs).[130] This includes incentives for providers offering IUCD services[131] and for volunteers referring clients to such services, as well as client-oriented incentives; some development partners programmes offer food rations to clients. The rationale behind this drive is cost-effectiveness of FP programming, growing client demand for "limiting" versus "spacing" of births and, to some extent, correction of misinformation among clients regarding IUCDs.[132]

There is a potential tension between the rights-based approach towards FP and offering incentives to providers and clients for specific contraceptive methods, especially when the incentivised

[127] Assumption 6.1, Annex 3; details were presented in section 3.
[128] Assumption 6.1, Annex 3
[129] Sections 4.1, 4.4, 4.5 and 4.8
[130] Assumptions 4.2 and 8.2, Annex 3. While promoting long-term methods, there is less emphasis on implants as this method is seen as relatively expensive and has had stock out problems
[131] Assumptions 4.2 and 8.2, Annex 3. This involves higher reimbursements for IUCD insertion under the programme voucher schemes than under the health equity fund scheme
[132] Assumptions 4.2 and 8.2, Annex 3

methods are not client-controlled methods, as is the case with IUCDs. At the same time, provider-initiated studies show low number of rejecters of IUCDs and implants, however it has been suggested that this may be because counselling services in the private sector are generally of higher professional quality than in the public sector.[133]

UNFPA contribution to results on a rights-based approach

UNFPA and partners share a similar understanding of what a rights-based approach towards family planning entails, focusing on equity, proper information, quality counselling and free choice from an expanded range of methods. This approach is well-reflected in key public policies, towards all of which UNFPA has actively contributed involving both duty bearers and rights holders.[134]

UNFPA operationalises its HRBA partly by focusing on improving equity and access for underserved vulnerable and marginalised groups. It thereby supports interventions for a number of VMGs, with a focus on young people, migrant garment factory workers, entertainment workers and, increasingly, people living in poverty.[135] In this context, health staff may need more training in the rights-based approach and dealing with own values. UNFPA furthermore flanks this with ongoing empowerment strategies for women and young people (United Nations 2015).

Emphasis on long-term methods by UNFPA-supported and other programmes seems to contradict the principled recommendation UNFPA provided in 2012: to "*expand the reach of family planning and improve services by adopting a human rights-based approach … governments should monitor for and eliminate any use of incentives, targets or fee structures that incentivize health care providers to advocate for adoption of specific methods, or for incentives to use contraception*" (UNFPA 2012a: 99, our emphasis).

This latent tension refers to a potentially interesting debate. As a minimum, the emphasis on long-term methods warrants ongoing monitoring by UNFPA and other concerned stakeholders regarding potential undue influencing of clients' choice and undue provider bias. UNFPA started addressing this by commissioning a study into potential provider bias regarding implants.

UNFPA is increasingly generating evidence on FP client needs and satisfaction (see box 3), indirectly contributing to insights as to the role of a rights-based approach in family planning services. It has used this to advocate for rights issues with the government and other stakeholders[136] and will use it to strengthen its programmes targeting young people as well as factory and entertainment workers; however a substantial evidence base to be used for rights promotion is as yet missing.

UNFPA intervention case example

Box 3 – UNFPA: generating evidence on family planning client needs and satisfaction

UNFPA Cambodia has co-commissioned the following published studies that, among others, contribute to the evidence-base on client needs and satisfaction:

- Cockcroft, M. 2014. Literature review on sexual and reproductive health and rights of migrant garment factory workers in Cambodia. Phnom Penh, United Nations Population Fund Cambodia
- Loun, M., C. Phan and S. Mao. 2013. Levels and Trends of Contraceptive Prevalence and Unmet Need for Family Planning in Cambodia: Further Analysis of the Cambodia Demographic

[133] Assumption 4.2, Annex 3
[134] See above and Assumptions 6.1 and 6.2, Annex 3
[135] Section 4.5
[136] Assumptions 1.3, 4.2, 5.2 and 6.2, Annex 3

and Health Survey. Phnom Penh, National Institute of Statistics, Ministry of Planning and Directorate General for Health, Ministry of Health
- Meng, K., M. Po and C. Thiep. 2013. Teenage Fertility and its Socio-Demographic Characteristics and Risk Factors: Further Analysis of the Cambodia Demographic and Health Survey. Phnom Penh, National Institute of Statistics, Ministry of Planning and Directorate
- Sovannarith, E. 2014. Family planning thematic evaluation report. Phnom Penh, United Nations Population Fund Cambodia
- UNFPA Cambodia. 2014. Situational Evidence Review Report. Sexual and Reproductive Health and Rights, Gender Equality and Women's Empowerment, Population and Development. Phnom Penh, United Nations Population Fund Cambodia
- Westoff, C., K. Bietsch and R. Hong. 2013. Reproductive Preferences in Cambodia. DHS Further Analysis Reports No. 87. Calverton, Maryland, ICF International

Unfortunately, the team was unable to consistently collect data regarding client views on the attitude of service providers. There is little other information available on user perspectives regarding provider understanding of their rights to family planning.

4.7 Different modes of engagement

Q7) To what extent has UNFPA adapted its mode of engagement[137] to evolving country needs in different settings, using evidence and best practice?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA has monitored and responded to the changing national context and needs. It continues to slowly move its modes of engagement upstream. • UNFPA has invested in quantitative knowledge generation, and increasingly complements this with qualitative research. CO staff competencies would need to adapt to facilitate greater application of the knowledge generated. • UNFPA has contributed to increased institutional and financial sustainability and, more modestly, to social sustainability. The changing modes of engagement can themselves be seen as contributing to sustainability, as can the inclusion of contraceptives in the health equity funds. • UNFPA has identified a number of lessons learned and good practices regarding contraception and SRH work, which can be applied.

Changing country context and modes of engagement

The UNFPA global strategy 2014-2017 assigns Cambodia to the category of countries in potential need of all modes of engagement, i.e. a country with relatively major needs and limited ability to fund social development interventions.[138] This enables the CO to continue to potentially employ a full package of interventions, including support for service delivery, capacity building, advocacy and knowledge management.

Over the past years, however, the CO already gradually started to move away from the more traditional downstream modes, as documented in the CO Strategic Plan,[139] as the country situation

[137] 'Modes of engagement' refers to the four modes of engagement in the current UNFPA strategic plan 2014-2017 (support for service delivery, capacity building, advocacy, knowledge management). This concept is fully discussed in the inception report (UNFPA 2014b).

[138] Assumptions 7.2, 7.3, Annex 3 and (United Nations 2015)

[139] Assumption 7.2, Annex 3

and stable political commitment to family planning[140] allowed this, while other modes appeared as more strategic and sustainable. This meant slowly changing from an emphasis on commodity provision and direct service delivery support to more upstream modes involving policy advocacy, capacity development and knowledge management.

UNFPA convinced its implementing partners they could assume programme running costs of most activities.[141] For a number of years, UNFPA has not used core funds for regular contraceptive procurement, partly in response to other development partners assuming a strong role in this area.[142]

The government aims to graduate the nation into the realm of upper middle-income countries.[143] If economic improvements are paired with ongoing improvements in social indicators, UNFPA could accelerate the move upstream, i.e. increasingly relying on policy and advocacy, knowledge management and capacity building.

The change in modes of engagement will be pursued in the new country programme (United Nations 2015). It implies an increasing need for CO competencies for and focus on policy advocacy, negotiation over sensitive issues and service quality and innovation.[144] It also implies further investing in quantitative knowledge generation, among others to show impact – currently at initial stages, with the *SMARTgirl* programme assessment as best example (UNFPA Cambodia 2015) – and increasingly complementing this with qualitative research. Research is a regular component of the CO approach to interventions, as evidenced by a series of studies conducted or commissioned.[145] Several stakeholders also suggested UNFPA could put more emphasis on knowledge generation and its application to policies and programming.[146]

UNFPA contribution to the sustainability of family planning and sexual and reproductive health
UNFPA made an important contribution to the institutional sustainability of family planning programmes through its dedicated efforts to strengthen national leadership, ownership and political commitment. It also contributed to some degree of social sustainability through its support for community-based distribution and demand creation (albeit with some reservations as some groups may benefit while others may feel left out).[147] Family planning programming, or at least its contraceptive commodity security component, is also set to become more financially sustainable with increased national budget support as decided by the government, and to which UNFPA advocacy greatly contributed.[148]

It is not feasible to identify the contribution of different modes of engagement *per se,* although movement away from direct support to service delivery and towards upstream activities as such already constitutes a more sustainable approach; as capacity development and policy advocacy contribute more to institutional and maybe also cultural sustainability than paying for services.

[140] Section 2
[141] Assumption 7.2, Annex 3
[142] Annex 4
[143] As declared on the cover page of the National Strategic Development Plan 2014-2018, "*For Growth, Employment, Equity and Efficiency to reach the status of an upper-middle income country*" (RGoC 2008).
[144] Assumption 7.2, Annex 3
[145] See section 4.5; see also the box in section 4.6
[146] Assumptions 3.3 and 5.2, Annex 3
[147] Section 4.2
[148] Sections 2.2 and 3.3

UNFPA capacity building efforts for FP in public services have been partially successful, with obvious benefits for clients seeking maternal health-related "spacing or limiting" services; benefits for others such as adolescents and unmarried women are however less evident.

UNFPA successfully worked towards inclusion of contraceptives in the pro-poor health equity fund schemes. This enables people identified as poor to access FP services free of charge[149] and contributes to sustainability, as government has indicated it will continue to sustain the health equity funds even if development partners no longer do.[150]

UNFPA contribution to identification and application of best practices

UNFPA has identified several good practices and lessons learned regarding contraception and SRH work which can be applied elsewhere. One is the *Love9* show multi-media strategy, involving the TV airing combined with a telephone hotline, social media communication and school-based comprehensive sexuality education, which led to enthusiastic participation. Another example is the support to the MoH regarding sharing of evidence on the economic benefits of investing in FP, which enabled the ministry to present and win its case with the Ministry of Economy and Finance. Furthermore, the *SMARTgirl* programme experience shows the effectiveness of using peers as group leaders and outreach workers to reach younger entertainment workers.[151]

There is no evidence of UNFPA having brought best practice experiences from elsewhere to adapt and apply in Cambodia.

4.8 Supply-side activities

Q8) To what extent has UNFPA support for supply-side activities promoted rights-based and sustainable approaches and contributed to improved access to quality voluntary family planning?
Summary of the relation between the findings and the assumptions of the evaluation matrix: • UNFPA support on the supply-side of FP has contributed to promoting rights and choice, through provider training, expansion of the method mix and strengthening contraceptive security. • UNFPA has contributed to the expansion of the method mix available. Long-term and permanent method availability is limited in practice. • UNFPA has assisted in strengthening procurement systems. UNFPA advocacy and strategizing was also key to increased financial sustainability.

Progress and activities

Well-conceived supply-side interventions in family planning lead to better opportunities for rights holders to exercise their right to choice and access. To ensure access to quality family planning services, qualified human resources are essential.

Training of public health service providers on FP is an ongoing activity and focuses on the full range of methods (with emphasis on long-term methods, such as insertion of IUCDs and implants), quality of counselling, informed choice and side-effects. UNFPA supports the MoH technically and financially with traditional offsite training of, among others, midwives who are responsible for birth spacing.

[149] Section 4.5
[150] Assumption 5.2, Annex 3
[151] Assumption 5.2, Annex 3

The NGO University Research Co. (URC) Quality Health Services, with funding from United States Agency for International Development (USAID), complements UNFPA support with on-site (on the job) training, with strong attention for quality assurance.[152] Furthermore UNFPA reported in 2013 that staff of nearly 80 percent of all health centres had been trained on adolescent SRH services.[153]

Some informants indicated that training is not sufficiently provided and that many midwives did not receive (refresher) training on IUCD insertion and "*therefore do not offer the service to clients*". Also, there is a considerable shortage of secondary midwives, who are the only ones who can provide long-term methods (IUCDs and implants) at health centre level.[154]

While no data on the impact of trainings are available, several interview respondents felt that the technical competencies of providers and thus the quality of FP counselling and services continue to be major issues of concern.[155] This is also reflected in the issues around staff attitudes towards unmarried young people and other vulnerable and marginalised groups, as already discussed.[156]

The method mix has expanded during the period under evaluation.[157] Despite policies and training being in place, many referral hospitals do not provide FP services, including sterilisation for which they are the only source facility.[158] Non-scalpel vasectomy has been given little attention overall.[159]

In 2014, UNFPA reported that all of nearly 1,100 health centres provided at least three short-term contraceptive methods; in addition over 900 of these provided IUCD services and over 500 provided implants. Information collected from UNFPA staff and stakeholders on the availability of emergency contraceptives is inconsistent. However, all agree that their promotion is limited *"for fear of creating undue demand",* thus the demand for the EC remains low.[160] Although IUCDs are available at a subsidised price in public health facilities (or free of charge if clients qualify for health equity fund coverage), uptake is relatively limited due to perceived side-effects and actual costs. Implants are relatively expensive and have faced some stock out issues at some facilities, which is partly due to introduction of the voucher scheme and un-coordinated training by some NGOs.[161]

The MoH leads the contraceptive security working group (of which UNFPA is also member), tasked with monitoring the levels of contraceptive supply for the country. It has managed to avoid stock outs, except sometimes for implants. Commodity procurement by the Central Medical Stores was funded by German KFW until 2012 and since then, until the end of 2015, by the Australian government.[162] The government has agreed to absorb the full cost of annual contraceptive procurement in its 2016 budget (US$ 2.3 million) and beyond, which represents a substantial investment considering that its 2015 budget allocation is US$ 200,000 only. This is a very encouraging development that will strongly contribute to strengthening contraceptive commodity security.[163]

[152] Assumption 8.1, Annex 3
[153] Assumption 8.1, Annex 3
[154] Assumption 8.1, Annex 3
[155] Assumption 8.1, Annex 3
[156] Assumption 5.2, Annex 3
[157] Section 3
[158] Section 4.1
[159] Assumption 8.2
[160] Assumption 8.2, Annex 3
[161] Assumptions 8.2 and 8.3, Annex 3
[162] Assumption 8.3, Annex 3
[163] Section 4.3 and assumptions 2.2, 3.3 and 8.3, Annex 3

UNFPA contribution to supply-side strengthening

UNFPA was a driving force behind the expansion of the family planning method mix and its roll-out in health facilities. It also supported the MoH towards the extensive training of public health workers on FP.[164] UNFPA supported the Cambodian Midwifery Association to develop its core competency framework, which was launched in 2014 together with the MoH. UNFPA continues to support the regional training centres of the association, undertaking training monitoring.[165] This led to increased availability of FP information and counselling services. Yet, quality of services is under scrutiny and needs more attention, as also identified by UNFPA.[166] Adolescents, for example, do not yet find in public facilities the expected youth-friendly services.[167]

A second major supply-side type of support was an expanded choice of FP methods, driven by UNFPA. The UNFPA current country programme includes "*continued to support improvement and expansion of family planning services and choices*" (Noij, Kasumi et al. 2015: 22). Apart from a one-off procurement in 2009 (US$ 372,000 to introduce emergency contraception and Implanon), Cambodia has not received support from the global programme for reproductive health commodity security (GPRHCS) during the period under evaluation. The UNFPA CO, meanwhile, has been successful in working and advocating with development partners and the government to ensure commodity security through the establishment of a national budget for contraceptive procurement since 2014 onwards, with government fully absorbing related costs as of 2016.[168]

UNFPA intervention case example

Box 4 – Promoting long-term contraceptives in rural communities

People living in poverty are more likely to live in remote areas where they are underserved and disproportionately affected by costs associated with seeking health services;[169] unmet need in rural areas is somewhat higher than in urban settings (12.8 versus 10.8 (Sovannarith 2014, Ministry of Planning, Ministry of Health et al. 2015). UNFPA in 2013 decided to financially and technically support NGO RHAC in Takeo province to focus on community-based distribution of contraceptives (condoms, pills) and generate demand for long-term methods (IUCD, implant).

As part of the programme, information and education community gatherings are held, in particular targeting women to make informed choices about their reproductive health and contraceptive use. These events are reinforced through a mobile campaign using *remork-motos*, motorised rickshaws, a local mode of transport mostly used in urban centres in Cambodia. These tour rural communities with messages sounding from the loudspeaker and information posters hanging from three sides of the vehicle. Programme monitoring data show a considerable increase in IUCD users.

Also, the programme generated evidence that financial barriers in rural settings limit access to long-term contraceptives, which was subsequently used to successfully argue in favour of inclusion of long-term methods in the free-of-charge health equity fund benefit package that exempts those identified as living in poverty.[170]

At the same time, issues around implants, IUCDs, emergency contraceptives, the female condom and availability of permanent methods, imply that the method mix is not optimal. This in part

[164] Assumption 8.2, Annex 3
[165] Assumption 8.1, Annex 3
[166] Assumption 8.2, Annex 3
[167] Section 4.5
[168] Assumption 2.2, Annex 3
[169] Section 5.2
[170] Assumption 4.2 and 5.2, Annex 3

explains the initiative to strongly promote IUCDs through voucher schemes, including incentives for providers and clients, which was discussed earlier in terms of the apparent contradiction between UNFPA international policy and in-country practice.[171] The UNFPA support towards making FP services available in referral hospitals to a large extent was not followed through to generate results. The recent external evaluation of the current UNFPA country programme described this situation as a lost opportunity (Noij, Kasumi et al. 2015: 22).[172]

UNFPA also played a key role in contraceptive commodity security via its active participation in the contraceptive security working group and the capacity strengthening of the MoH Central Medical Stores.[173] So far it has not used its leverage to address the current challenges related to the contraceptives logistics management information system.[174]

4.9 Support from UNFPA headquarters and the Asia-Pacific Regional Office

We have included this as a separate section because a number of the findings of the case study apply to all the evaluation questions which include an assumption on HQ and RO roles (questions on service integration, enabling environment, rights-based approach, modes of engagement, and supply-side activities).

Technical guidance from HQ has been predominantly received through sharing of technical documents. The UNFPA CO feels that the Procurement Services Branch (Copenhagen) has been very helpful and swift with contraceptive procurement.

There has been little other direct contact with UNFPA HQ, while some "missed opportunities" were identified, such as the failure to invite the government to the London Summit on Family Planning (FP2020) which made the Royal Government of Cambodia (RGoC) feel excluded. Overall, the CO would welcome more engagement from the Technical Division.

Most technical support is provided by the nearby Asia-Pacific Regional Office (APRO, Bangkok). The CO feels it receives some quality technical support from APRO, mostly through trainings and workshops, though this is not frequent. Needs for support are identified on an annual basis by the CO and discussed with APRO for planning purposes, with additional on-going dialogue on needs and input required from the regional office.

The CO is of the opinion that APRO has an adequate level of technical capacity in FP and SRH, but that regional office staff time is rather limited.

Technical support regarding family planning has included sharing of technical and advocacy materials, support for country programme formulation, suggestions for consultants, training for country staff on commodity security, information exchange between offices in the region, and information on best practices.

5 CONCLUSIONS

[171] Section 4.6
[172] Assumption 8.2, Annex 3
[173] Assumptions 8.1, 8.2 and 8.3, Annex 3
[174] Assumption 8.3, Annex 3

5.1 Family planning is integrated into reproductive and maternal health policies, but with limited operational scope

UNFPA has played an important role, together with partners, in advocating and providing technical support for integration of family planning (FP) with other public sexual and reproductive health (SRH) services, including maternal health, post-abortion care, adolescent SRH, HIV, gender-based violence (GBV) and emergency responses. UNFPA paired this policy and strategy-level engagement with strong investments towards their implementation and making FP actually available through such integrated services.

At the same time, public health services in Cambodia to date have predominantly framed contraception in a maternal health context; so FP was always "integrated" in that way. UNFPA has used this context to advance the availability of FP for (usually married) women seeking maternal health services. While no robust data are available, interview and document findings make it likely this was an effective approach. Such an approach however does not cater for the needs of other important groups, such as adolescents, who could benefit from integration with a wider scope.

There is little evidence that UNFPA integration efforts led to enhanced quality of FP services.

- Origin: Evaluation question 1 (section 4.1)

5.2 UNFPA efforts have contributed to Cambodian ownership

UNFPA is the most trusted partner of the Cambodian government in matters of maternal health and FP. It is credited by all stakeholders for its "friendly influencing" approach and professionalism, which it uses to ultimately encourage national ownership of FP policies and programmes. The associated government political commitment is visible in key strategic documents, public statements and dedicated budget lines, and these form the building blocks for sustainable policies and programming.

- Origin: Evaluation question 2 (section 4.2)

5.3 Family planning sustainability: progress

UNFPA has made important contributions to the institutional sustainability of FP programmes, through its support towards national political commitment, key policies and strategies and incorporation of FP into mechanisms like the health equity funds. UNFPA in partnership with the Ministry of Health (MoH) has also strongly contributed to greater financial sustainability, by putting government budget commitment high on the agenda. The government has committed to take on the full responsibility for contraceptive procurement from 2016 onwards.

UNFPA has contributed to creating some degree of social sustainability of FP programmes through its support for community-based programmes and work in support of the needs and rights of a number of important vulnerable and marginalised groups (VMGs). While this has been effective for married women, other important groups, including adolescents, still have limited access due to a discouraging socio-cultural environment at community level and among providers. This shows that the assessment of social sustainability may lead to different conclusions, depending on the perspective assumed – what some might see as sustainable, others might qualify as insufficient and far from sustainable.

- Origin: Evaluation question 3 (section 4.3)

5.4 UNFPA: Broker of trust with critical reflection

UNFPA makes good use of its comparative advantage as a broker, at national and also sub-national level. The country office uses its relatively small financial weight strategically by building on its focused expertise and its close working relationship with the government.
It brokers partnerships among development partners, non-government organisations (NGOs) and government stakeholders, sometimes at programme level but most importantly as a key player in a vast number of coordination forums and working groups. As part of the (independent) UN system, it balances its role of supportive but also critical partner to the government in a way that allows for building credibility with civil society – such as around the "NGO law" – and building (modest) bridges with the for-profit sector.

UNFPA has strong visibility at country level, despite being seen as not seeking this.

- Origin: Evaluation questions 3 and 4 (sections 4.3, 4.4)

5.5 Enabling the environment: More policy than practice

UNFPA has identified key enabling factors for repositioning FP and has used its advocacy, technical and knowledge management roles to strengthen the enabling environment.
Its interventions however, were more focused on policy than implementation level. The environment for operationalisation of important policy aspects therefore is insufficiently favourable. In particular, increasing availability of quality SRH/FP services for adolescents and unmarried women and men still requires changes in the attitudes of health workers, and in socio-cultural issues at community level.

- Origin: Evaluation questions 4 and 5 (sections 4.4 and 4.5)

5.6 Demand creation: rights *versus* targets

The rate of uptake of modern FP has increased, as evidenced by the growth of the modern contraceptive prevalence rate (mCPR); increased demand satisfied and unmet needs reduction in the past decade. UNFPA contributed to this, notably through the provision of technical, financial, capacity-building and knowledge support to a number of state and non-state actors for facility, community and workplace-based interventions targeting garment factory workers, young people, health service clients and community-based clients. This was complemented by advocacy for pro-poor health equity fund arrangements.

UNFPA staff and key partners show a shared understanding of the meaning and importance of a rights-based approach to FP. The draft updated FP policy, to which UNFPA actively contributes, mentions as key principles: universal human rights (free choice and a range of methods), non-discrimination (make decisions free of coercion), gender equality and equity, evidence-based national relevance and accountability, among others. This approach is well-reflected in other key public policies, towards which UNFPA has also contributed.

Emphasis on long-term methods by various UNFPA-supported programmes can sometimes be justified in terms of balancing the contraceptive method-mix. However, it appears to be in contradiction with UNFPA policy on the elimination of any use of incentives or fee structures to favour the provision or use of one specific method. It is unclear whether UNFPA and other concerned stakeholders are monitoring the potential undue influence on clients' choice and possible providers' bias.

- Origin: Evaluation questions 4 and 6 (sections 4.4, 4.6)

5.7 Vulnerable and marginalized groups: progress and challenges

UNFPA has made substantial contributions to promoting sexual and reproductive rights and supported empowerment and capacity building, of adolescents, migrant garment factory workers and entertainment workers. Although overall contribution to outcomes cannot be measured, it is likely that UNFPA has contributed to increased respect for the rights of VMGs and improved access to services.

Interventions towards improving access for young people through capacity building of public health facility staff on youth-friendly services seem to have had limited impact, except for married young women. Strategies to strengthen unmarried young women's access to FP services therefore are insufficiently developed, including coordination with partners.

- Origin: Evaluation question 5 (section 4.5)

5.8 Knowledge generation: a good start

UNFPA has invested in knowledge generation for better understanding local contexts, including quantitative as well as qualitative research. It has generated substantial knowledge to identify the specific needs of VMGs to support the promotion of sexual and reproductive rights of several vulnerable and marginalised groups.

Efforts in support of knowledge generation through research and collection of best practices on demand-generation from within Cambodia and other relevant contexts, have been limited. This will be addressed in the new 2016-2018 Country Programme since it can help identify enablers for generating demand in contexts where it is clearly warranted from both a rights and public health point of view.

The contribution of UNFPA to knowledge regarding rights-based approaches towards FP is largely indirect but growing, through studies on client needs and satisfaction. Systematic generation, sharing and translation (for use in policy and programming) of evidence on the effectiveness of the various major interventions that UNFPA supports is yet to start.

- Origin: Evaluation questions 4, 5, 6 and 7 (sections 4.4, 4.5, 4.6, 4.7)

5.9 UNFPA adjusts its modes of engagement

UNFPA has monitored the changing national context and needs in Cambodia, and has taken into account the government's aspirations towards a middle-income country status. Consequently, the country office has gradually shifted its emphasis towards more upstream modes of engagement. UNFPA current strategic plan and business model enable the Cambodia CO to continue to employ a full package of interventions, including support for service delivery, capacity building, policy and advocacy, and knowledge management. However, the CO has already started to move away from direct service delivery support, to more upstream modes involving policy and advocacy, capacity development and knowledge management perceived as more strategic and sustainable as well as more attuned with the current country context.

- Origin: Evaluation question 7 (section 4.7)

5.10 Supply-side management: the method-mix potential is not fully realised

UNFPA support on the supply-side of FP has contributed to promoting rights and choice, through provider training, expansion of the method mix and strengthening contraceptive security. It has also contributed to the expansion of the available method mix. However, long-term and permanent methods uptake remains limited in practice.

Institutional sustainability is under scrutiny due to stakeholder doubts about the quality of the MoH logistics management information system and related procurement processes. It is unclear if and how these issues will be addressed.

- Origin: Evaluation question 8 (section 4.8)

ANNEX 1 – BIBLIOGRAPHY

anon (2014). *Joint Commitment from Participants in the National Family Planning Conference Phnom Penh "Choices not Chance" 27-28 November 2014*. Phnom Penh.

APN+ (2012). *Positive and Pregnant: How Dare You. A study on access to reproductive and maternal health care for women living with HIV in Asia. Findings from six countries: Bangladesh, Cambodia, India, Indonesia, Nepal, Viet Nam*. Bangkok, Asia Pacific Network of People Living with HIV/AIDS. Available from http://www.aidsdatahub.org/sites/default/files/documents/positive_and_pregnant_2012.pdf

Bruni, Laia, and others (2015). *Human Papillomavirus and Related Diseases in Cambodia. Summary Report 2015-03-20*. Barcelona, ICO Information Centre on HPV and Cancer (HPV Information Centre). Available from http://www.hpvcentre.net/statistics/reports/KHM.pdf

CIA (2015). The World Factbook: Zimbabwe, 11 August. Washington DC, Central Intelligence Agency. Available from https://www.cia.gov/library/publications/the-world-factbook/geos/zi.html

Clarke, David J (2014). *Youth and Comprehensive Sexuality Education, Thematic Evaluation Report*. Phnom Penh, United Nations Population Fund Cambodia.

Cockcroft, Melissa (2014). *Literature review on sexual and reproductive health and rights of migrant garment factory workers in Cambodia*. Phnom Penh, United Nations Population Fund Cambodia. Available from http://countryoffice.unfpa.org/cambodia/?publications=11321

CPN+ (2010). *People Living with HIV Stigma Index: Cambodia 2010*. Phnom Penh, Cambodian People Living with HIV Network. Available from http://www.stigmaindex.org/sites/default/files/reports/Cambodia People Living with HIV Stigma Index Report 2010.pdf

Health Unlimited (2007). *Final report. Consultative meeting on indigenous people's reproductive health, gender and population*.

HRW (2015). RE: Call on Cambodia government to drop draft NGO Law, 1 June. New York, Human Rights Watch. Available from http://www.hrw.org/news/2015/06/01/re-call-cambodia-government-drop-draft-ngo-law

Kates, Jen, and others (2014). *Mapping the Donor Landscape in Global Health: Family Planning and Reproductive Health*. Menlo Park, California, The Henry J. Kaiser Family Foundation. Available from https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8541-mapping-the-donor-landscape-in-global-health-family-planning-and-reproductive-health.pdf

Keller, Sheryl (2010). *Review of community-based distribution of contraceptives in Cambodia. Conducted for the Ministry of Health, National Reproductive Health Program*. Phnom Penh, National Reproductive Health Program.

Lee, Wan-Hea, and others (2015). The importance of trust, 12 May. The Phnom Penh Post, Reader's Letters. Available from http://www.phnompenhpost.com/analysis-and-op-ed/importance-trust

Loun, Mondol, Chinda Phan and Sotheavy Mao (2013). *Levels and Trends of Contraceptive Prevalence and Unmet Need for Family Planning in Cambodia: Further Analysis of the Cambodia Demographic and Health Survey*. Phnom Penh, National Institute of Statistics, Ministry of Planning

and Directorate General for Health, Ministry of Health. Available from http://countryoffice.unfpa.org/cambodia/drive/In-depthanalysisofLevelsandTrendsofContraceptivePrevalenceandUnmetNeedforFamilyPlanninginCambodia1May13.pdf

Meng, Kimhor, Mao Po and Chanthan Thiep (2013). *Teenage Fertility and its Socio-Demographic Characteristics and Risk Factors: Further Analysis of the Cambodia Demographic and Health Survey*. Phnom Penh, National Institute of Statistics, Ministry of Planning and Directorate. Available from http://countryoffice.unfpa.org/cambodia/drive/In-depthanalysisofTeenage_fertilityinCamboida1May13.pdf

Ministry of Health (1995). *Birth Spacing Policy for Cambodia*. Phnom Penh, Royal Government of Cambodia.

Ministry of Health (2008a). *Community Participation Policy for Health*. Phnom Penh, Royal Government of Cambodia. Available from http://thoinfocam.blogspot.nl/2012/02/cambodia-community-participation-policy.html

Ministry of Health (2008b). *Health Strategic Plan 2008-2015*. Phnom Penh, Royal Government of Cambodia. Available from http://www.wpro.who.int/health_services/cambodia_nationalhealthplan.pdf

Ministry of Health (2010). *Fast Track Initiative Road Map for Reducing Maternal & Newborn Mortality 2010 to 2015*. Phnom Penh, Royal Government of Cambodia. Available from http://www.cmidwivesc.org/documents/publications/pfs_39.pdf

Ministry of Health (2012). *National Strategy on Reproductive and Sexual Health 2012-2016*. Phnom Penh, Ministry of Health, National Reproductive Health Programme, Maternal and Child Health Centre, Royal Government of Cambodia.

Ministry of Health (2013). *Prakas on core competency framework for midwives in the Kingdom of Cambodia, December*. Phnom Penh, Royal Government of Cambodia. Available from http://www.cmidwivesc.org/documents/publications/pfs_36.pdf

Ministry of Health (2015a). *Report on National Family Planning Conference "Choices not Chance", 27-28 November 2014, Phnom Penh*. Phnom Penh, Royal Government of Cambodia.

Ministry of Health (2015b). *Updated Family Planning Policy and Manual (draft), Khmer version*. Phnom Penh, Royal Government of Cambodia.

Ministry of Planning, Ministry of Health and ICF International (2015). *Cambodia Demographic and Health Survey 2014. Key Indicators Report*. Phnom Penh/Rockville, Royal Government of Cambodia and ICF International. Available from http://countryoffice.unfpa.org/cambodia/drive/2014CDHSKIR_2-20-2015.pdf

MoEYS (2012). *Examining life experiences and HIV risks of young entertainment workers in four Cambodian cities*. Phnom Penh, Ministry of Education Youth and Sport, Royal Government of Cambodia. Available from http://www.unicef.org/cambodia/Young_entertainment_workers_report_Eng_Final.pdf

MOPAN (2014). *Technical report Volume I. UNFPA. Results by micro-indicators and by country. Section 4.3 Cambodia. Draft, November*. Phnom Penh, Multilateral Organisation Performance Assessment Network. Available from

http://www.mopanonline.org/publications/MOPAN_2014_UNFPA_Final_Technical_Report_Volume_I_Issued_December_11.pdf

Nakaie, N., and others (2014). Family planning practice and predictors of risk of inconsistent condom use among HIV-positive women on anti-retroviral therapy in Cambodia. *BMC Public Health* 14: 170. Available from http://www.ncbi.nlm.nih.gov/pubmed/24528885

National AIDS Authority (2014). *Cambodia Country Progress Report: Monitoring Progress towards the Targets of the 2011 UN Political Declaration on HIV and AIDS. Reporting Period: January 2012–December 2013*. Phnom Penh, National AIDS Authority. Available from http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/KHM_narrative_report_2014.pdf

NIDI (2015). *Annex Clearance Report Cambodia 2013*. The Hague, United Nations Population Fund and the Netherlands Interdisciplinary Demographic Institute Resource Flows Project.

NIPH, NIS and ORC Macro (2006). *Cambodia Demographic and Health Survey 2005*. Phnom Penh/Calverton, National Institute of Public Health, National Institute of Statistics and ORC Macro, December. Available from http://dhsprogram.com/pubs/pdf/FR185/FR185%5BApril-27-2011%5D.pdf

NIS, DGH and ICF Macro (2011). *Cambodia Demographic and Health Survey 2010*. Phnom Penh/Calverton, National Institute of Statistics, Directorate General for Health, ICF Macro. Available from http://dhsprogram.com/pubs/pdf/FR249/FR249.pdf

Noij, Frank, Nakagawa Kasumi and Em Sovannarith (2015). *UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015. Evaluation report, April*. Phnom Penh, United Nations Poluation Fund Cambodia. Available from https://data.unfpa.org/docDownload.unfpa?docId=159

Phnom Penh Capital (2013). *Strategy concept note on reducing poverty and vulnerability in Phnom Penh urban poor communities. Based on the rapid assessment and stakeholder consultation 2013, the Urban Poor Assessment 2012 and the Urban Poor Reduction Strategy for Phnom Penh 1999*. Phnom Penh.

RACHA (2015). *Consultation on the Global Strategy for Women's, Children's and Adolescents' Health, 20 March 2015, Cambodia*. Phnom Penh, RACHA.

RGoC (2003). *National Population Policy*. Phnom Penh, Royal Government of Cambodia. Available from http://countryoffice.unfpa.org/cambodia/drive/Cambodia_NPP(2003version).pdf

RGoC (2008). *National Strategic Development Plan Update 2009-2013. For Growth, Employment, Equity and Efficiency to reach Cambodia Millennium Development Goals*. Phnom Penh, Royal Government of Cambodia. Available from http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/documents/publication/wcms_145085.pdf

RGoC (2010). *Health Sector Support Project 1 (HSSP1) End of Project Assessment*. Phnom Penh, Royal Government of Cambodia.

RGoC (2013a). *Integration of demographic perspectives in development, Cambodia*. Phnom Penh, Ministry of Planning, Royal Government of Cambodia. Available from http://countryoffice.unfpa.org/cambodia/drive/FinalDemographicPerspective1May13.pdf

RGoC (2013b). *"Rectangular Strategy" for Growth, Employment, Equity and Efficiency, Phase III*. Phnom Penh, Royal Government of Cambodia. Available from http://cnv.org.kh/wp-content/uploads/2013/10/26sep13_rectangular-strategy_phaseIII.pdf

RGoC (2014). *National Strategic Development Plan 2014-2018. For Growth, Employment, Equity and Efficiency to reach the status of an upper-middle income country*. Phnom Penh, Ministry of Planning, Royal Government of Cambodia. Available from http://countryoffice.unfpa.org/cambodia/drive/NSDP2014-2018.pdf

RGoC (2015). *National Population Policy of Cambodia, 2015. Draft May 2015*. Phnom Penh, Royal Government of Cambodia.

Samandari, Ghazaleh, Ilene S. Speizer and Kathryn O'Connell (2010). The Role of Social Support and Parity On Contraceptive Use in Cambodia. *International Perspectives on Sexual and Reproductive Health* 36(3): 122-131. Available from http://www.guttmacher.org/pubs/journals/3612210.html

SBK Research and Development (2013). *Study on barriers to the use of modern contraceptive methods and on the impact of a media campaign on women's awareness and knowledge of modern contraceptives. Reproductive Health Project, Final report*. Phnom Penh, Ministry of Health, Essential Drugs Bureau, Department for Drugs and Food. Available from http://www.cgdev.org/doc/Cambodia-Case-Study.pdf

Shah, Jui A (2010). *UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia. Country case study prepared for the Center for Global Development Working Group on UNFPA's Leadership Transition*. Phnom Penh, Center for Global Development. Available from http://www.cgdev.org/doc/Cambodia-Case-Study.pdf

Sopheab, Heng (2014). *Reproductive, Maternal and Neonatal Health Knowledge, Attitudes and Practices among Female Garment Factory Workers in Phnom Penh and Kandal Provinces*. Phnom Penh, National Institute of Public Health. Available from https://cambodia.savethechildren.net/sites/cambodia.savethechildren.net/files/library/PSL Baseline Survey Report_Garment Factory_Final_SMALL.pdf

Sovannarith, Em (2014). *Family Planning Thematic Evaluation Report*. Phnom Penh, United Nations Population Fund Cambodia.

The RESPOND Project (2013). *Views on Family Planning and Long-Acting and Permanent Methods: Insights from Cambodia. RESPOND Project Brief No. 12. February*. New York, EngenderHealth (The RESPOND Project). Available from http://www.respond-project.org/archive/files/4/4.1/4.1.1/Brief12-2013-Views-on-Family.pdf

Tobin, Richard, and others (2011). *Evaluation of UNFPA/Cambodia's 3rd Country Programme, 2006-2010*. Phnom Penh, United Nations Population Fund Cambodia. Available from https://data.unfpa.org/docDownload.unfpa?docId=106

UNDP (2014). Table 1: Human Development Index and its components, 2012-2013. New York, United Nations Development Programme. Available from http://hdr.undp.org/en/content/table-1-human-development-index-and-its-components

UNFPA (2010). *A Human Rights–Based Approach to Programming. Practical Implementation Manual and Training Materials. New York: UNFPA and Harvard School of Public Health*. New York, United Nations Population Fund. Available from http://www.unfpa.org/resources/human-rights-based-approach-programming

UNFPA (2011). *Country Programme Action Plan (CPAP) 2011-2015 for the Programme of Cooperation between The Royal Government of Cambodia and The United Nations Population Fund*. New York, United Nations Population Fund. Available from http://www.unfpa.org/sites/default/files/portal-document/Cambodia_CPAP 2011-2015.pdf

UNFPA (2012a). *By Choice Not By Chance. Family Planning, Human Rights and Development. State of the World Population 2012*. New York, United Nations Population Fund. Available from https://www.unfpa.org/sites/default/files/pub-pdf/EN_SWOP2012_Report.pdf

UNFPA (2012b). *Cambodia Country Report. Evaluation of the UNFPA Support to Maternal Health. Mid-Term Evaluation of the Maternal Health Thematic Fund*. New York, United Nations Population Fund, Evaluation Branch, Division for Oversight Services. Available from http://ww.w.endfistula.org/webdav/site/global/shared/documents/Evaluation_branch/Maternal Health reports - Sept 2013/Country Reports - Sept 2013/UNFPA_layout3_Cambodia_En _20130724.pdf

UNFPA (2013). *United Nations Populations Fund. The UNFPA Strategic Plan, 2014-2017. Annex 3. Business model*. New York, United Nations Population Fund. Available from http://www.unfpa.org/sites/default/files/admin-resource/PD_Annex 3. Business model.pdf

UNFPA (2014a). Does UNFPA promote abortion?, November 2014. New York, United Nations Population Fund. Available from http://www.unfpa.org/frequently-asked-questions - abortion

UNFPA (2014b). *Evaluation of the UNFPA Support to Family Planning 2008-2013. Inception report*. New York, UNFPA Evaluation Office. Available from http://www.unfpa.org/sites/default/files/admin-resource/Final inception report UNFPA support to FP.pdf

UNFPA (2014c). *Financial Resource Flows for Population Activities in 2012*. New York, United Nations Population Fund (with cooperation of Netherlands Interdisciplinary Demographic Institute (NIDI)). Available from http://www.unfpa.org/publications/financial-resource-flows-population-activities-2012

UNFPA (nd). The Human Rights-Based Approach, nd. New York, United Nations Population Fund. Available from http://www.unfpa.org/human-rights-based-approach

UNFPA APRO (2011). *Socio-cultural influences on the reproductive health of migrant women. A review of literature in Cambodia, Lao PDR, Thailand and Viet Nam*. Bangkok, United Nations Population Fund Asia and the Pacific Regional Office. Available from http://www.unfpa.org/publications/socio-cultural-influences-reproductive-health-migrant-women-review-literature-cambodia

UNFPA Cambodia (2006). *Country Programme Action Plan (CPAP) 2006-2010 for the Programme of Cooperation Between The Royal Government of Cambodia and the United Nations Population Fund*. Phnom Penh, United Nations Population Fund Cambodia. Available from http://temporaryview.com/unfpa/download.php?file=6EA79D22d01.pdf

UNFPA Cambodia (2008). *Mid Term Review Report for the Programme of Cooperation between The Royal Government of Cambodia and The United Nations Population Fund 2006-2010*. Phnom Penh, United Nations Population Fund Cambodia.

UNFPA Cambodia (2011). *2011 Annual Report. Cambodia*, United Nations Population Fund Cambodia.

UNFPA Cambodia (2012). *2012 Country Office Annual Report. Cambodia*, United Nations Population Fund Cambodia.

UNFPA Cambodia (2013a). *2013 Country Office Annual Report. Cambodia*, United Nations Population Fund Cambodia.

UNFPA Cambodia (2013b). *Adolescents and youth. Country Programme Brief*. Phnom Penh, United Nations Population Fund Cambodia. Available from http://countryoffice.unfpa.org/cambodia/drive/FactsheetAdolescent.pdf

UNFPA Cambodia (2014a). *2014 Annual Report – Cambodia, 16 December. Finalized official report*. Phnom Penh, United Nations Population Fund Cambodia.

UNFPA Cambodia (2014b). *Entertainment workers are becoming smart girls. Country Programme Brief*. Phnom Penh, United Nations Population Fund Cambodia. Available from http://countryoffice.unfpa.org/cambodia/drive/FlyerA4smartgirlOL.pdf

UNFPA Cambodia (2014c). *Family Planning. Country Programme Brief*. Phnom Penh, United Nations Population Fund Cambodia. Available from http://countryoffice.unfpa.org/cambodia/drive/FactsheetFP.pdf

UNFPA Cambodia (2014d). *Investing for better health: what are the costs and benefits of strengthening contraceptive services for Cambodia?* Phnom Penh, United Nations Population Fund Cambodia. Available from http://countryoffice.unfpa.org/cambodia/drive/Investingforbetterhealth-costsandbenefitscontraceptiveservices.pdf

UNFPA Cambodia (2014e). *Situational Evidence Review Report. Sexual and Reproductive Health and Rights, Gender Equality and Women's Empowerment, Population and Development*. Phnom Penh, United Nations Population Fund Cambodia.

UNFPA Cambodia (2014f). *Strategic Plan (2014-2017): Implementation Action Plan for the UNFPA Country Office*. Phnom Penh, United Nations Population Fund Cambodia.

UNFPA Cambodia (2014g). *UNFPA supports remork-motos to deliver mobile family planning messages and services: promoting long-term contraceptive use in rural communities. Country Programme Brief*. Phnom Penh, United Nations Population Fund Cambodia. Available from http://countryoffice.unfpa.org/cambodia/drive/FlyerA4mototodelivery02.pdf

UNFPA Cambodia (2015). *SMART Girl Program Assessment (I) Result FY15*. Phnom Penh, United Nation Population Fund Cambodia.

UNFPA Cambodia (nd-a). *Key Priorities for the UNFPA Cambodia*. Phnom Penh, United Nations Population Fund Cambodia.

UNFPA Cambodia (nd-b). *National standard guideline on AFRSH khmer version final*. Phnom Penh, United Nations Population Fund Cambodia.

United Nations (2005). *Country programme document for Cambodia 2006-2010. DP/FPA/CPD/KHM/3*. New York, Executive Board of the United Nations Development Programme and of the United Nations Population Fund. Available from http://countryoffice.unfpa.org/cambodia/drive/UNFPACambodiaCPD2006-2010.pdf

United Nations (2009). *Situation Analysis of Youth in Cambodia*. New York, United Nations.

United Nations (2010). *Final country programme document for Cambodia 2011-2015. DP/FPA/CPD/KHM/4*. New York, Executive Board of the United Nations Development Programme and of the United Nations Population Fund. Available from http://countryoffice.unfpa.org/cambodia/drive/CPD2011-2015approvedbyExBoard.doc

United Nations (2014). *Cambodia Common Country Assessment-CCA. UNDAF 2016-2018*. New York, United Nations. Available from http://www.ilo.org/asia/info/WCMS_364553/lang--en/index.htm

United Nations (2015). *Country programme document for Cambodia 2016-2018. DP/FPA/CPD/KHM/5. Draft*. Phnom Penh, Executive Board of the United Nations Development Programme, the United Nations Population Fund and the United Nations Office for Project Services. Available from http://www.unfpa.org/sites/default/files/portal-document/Cambodia CPD - Draft FINAL - 28May15.pdf

Vathiny, Ouk Vong and Kruy Kim Hourn (2009). *Barriers to Contraceptive Use in Cambodia*. Kuala Lumpur, The Asian-Pacific Resource & Research Centre for Women (ARROW). Available from http://www.arrow.org.my/publications/ICPD+15NarrativeReport/ICPD15CAMBODIACASESTUDY.pdf

Westoff, Charles F, Kristin Bietsch and Rathavuth Hong (2013). *Reproductive Preferences in Cambodia. DHS Further Analysis Reports No. 87*. Calverton, Maryland, ICF International. Available from https://www.dhsprogram.com/pubs/pdf/FA87/FA87.pdf

WHO (2013). *Official Development Assistance (ODA) for Health to Cambodia 2001-2011*. Geneva, World Health Organization. Available from http://www.nationalplanningcycles.org/sites/default/files/oda_sheets/Cambodia/cambodia_-_khm.pdf

WHO (2014). Global Health Expenditure Database. Health System Financing Profile by country. Health System Financing country profile, Cambodia 2013, 2013. Geneva, World Health Organization. Available from http://apps.who.int/nha/database/Country_Profile/Index/en

WHO and Ministry of Health (2012). *Health Service Delivery Profile Cambodia 2012*. Manila, World Health Organization Regional Office for the Western Pacific. Available from http://www.wpro.who.int/health_services/service_delivery_profile_cambodia.pdf

World Bank (2015a). Cambodia Overview, April 2015. Washington DC, World Bank. Available from http://www.worldbank.org/en/country/cambodia/overview

World Bank (2015b). Cambodia Second Health Sector Support Program, 2015. Washington DC, World Bank. Available from http://www.worldbank.org/projects/P102284/cambodia-second-health-sector-support-program?lang=en

World Bank (2015c). Global Economic Prospects. Economy and region specific forecasts and data. Real GDP growth (%) by economy, region, and income level, 2015. Washington DC, World Bank. Available from http://www.worldbank.org/en/publication/global-economic-prospects/data?region=EAP

ANNEX 2 – LIST OF PEOPLE INTERVIEWED

NAME	TITLE
UNFPA	
Dr Vandara Chong	National Programme Officer Youth, SRH, Life Skills and HIV Prevention
Dr Marc Derveeuw	Representative
Mr Saky Lim	Local Government and M&E Programme Officer
Mr Solim Ly	Operations Manager
Mr Tum May	Assistant Representative
Mr Pon Rieng	Finance/Programme Associate
Dr Sokun Sok	SRH Programme Specialist
Ms Kangabelle Thou	Maternal Health Programme Officer
Mr Soktha Yi	Population and Development Analyst
MINISTRY OF HEALTH (PHNOM PENH, KAMPOT, TAKEO)	
Dr Tann Chheng	Deputy Director, Provincial health department Kampot
Dr Ork Kunthy	MCH staff, Provincial health department Kampot
Dr Lam Phirun	Manager, National RH Programme
Prof Tung Rathavy	Director, National MCH Centre
Dr Nuth Sinath	Deputy Director, Provincial health department Takeo
Mr Va Sokea	Deputy Director, Central Medical Stores
Dr Prak Sonnarith	MCH Chief, Provincial health department Takeo
Ms Soul Sotheary	MCH staff, responsible for birth spacing, Provincial health department Kampot
Dr Seng Thavy	MCH Chief, Provincial health department Kampot
Kraing Ampil health centre, Kampot	
Ms Em Sara	Staff responsible for birth spacing
Ms Chap Somona	Head, Kraing Ampil health centre
Prey Lovea health centre, Takeo	
Ms Huy Chanthy	Midwife, responsible for birth spacing
Ms Hok Son Hang	Midwife, ante-natal care
Mr Ny Sam Oeun	MCH staff
Mr Khi Sitha	Head, Prey Lovea health centre
Ms Nau Sovanntha	Midwife

Puth Sor health centre, Takeo	
Ms Leng Chantha	MCH staff, OD Bati
Ms Mam Malin	Midwife
Mr Nhem Meng	Head, Puth Sor health centre
Ms Vong Sotheary	Midwife
MINISTRY OF EDUCATION, YOUTH AND SPORTS	
Dr Yung Kunthearith	Deputy Director, School Health Department
Mr. Kim Sanh	Deputy Director, School Health Department
DEVELOPMENT PARTNERS AND NGOS	
Ms Theary Chan	Executive Director, Reproductive and Child Health Alliance (RACHA)
Mr Thou Chum	Director, Public & Private Partnerships, Marie Stopes International (MSI) Cambodia
Dr Cheang Kannitha	National Professional Officer for Making Pregnancy Safer, World Health Organization (WHO)
Dr Suos Premprey	Senior Program Manager – Health, Development Cooperation, Australian Embassy
Dr Susanne Pritze-Aliassime	Project Manager, Rights-Based FP and Maternal Health Project, GIZ
Ms Laura L. Rose	Senior Health Economist, World Bank
Ms Chi Socheat	Executive Director, Population Services Khmer (PSK)
Cambodian Women for Peace and Development (CWPD)	
Mr Chhan An	Program Manager
Mr Ban Chi	Project Coordinator
Ms Sos Finy	Field staff
Ms Meach Sotheary	Executive Director
Mr Heng Tola	M&E Manager
E-Cheng (footwear factory), Takeo	
Ms Ken Chantho	Factory nurse
Mr Thach Noun	OD Field staff, RHAC OD Bati
Ms Kreal Srey Poeu	Factory nurse
Reproductive Health Association of Cambodia (RHAC)	
Mr Po Daven	OD Field staff, RHAC OD Prey Kabas, Prey Lovea health centre, Takeo
Mr Ching Muth	Team Leader, RHAC Takeo
Mr Kol Pheng	Community-based distributor, Chum Rov
Ms Yung Sa-Em	Community-based distributor, Tnol Bot

Dr Veth Sreng	Community Health Specialist
Mr Mon Vantha	OD Field staff, RHAC OD Bati
Mr Seng Vichethr	Accountant
Dr Va Chi Vorn	Executive Director
USAID	
Mr Robin Mardeusz	Maternal & Child Health Team Leader
Dr Sam Sochea	Project Management Specialist, Office of Public Health and Education
USAID Quality Health Services – URC Cambodia	
Ms Katherine Krasovec	Chief of Party
Ms Sun Nara	Obstetric Care Technical Coordinator
Ms Chhoeur Socheat	FP Technical Coordinator
SERVICE USERS ((FOCUS) GROUP DISCUSSION PARTICIPANTS)	
(names known but kept confidential)	9 Female entertainment workers, focus group discussion; Cambodian Women for Peace and Development (CWPD) – SMARTgirl drop-in centre
(names not registered)	40+ Female community members, group discussion; Tnol Bot village, Prey Kabas district, Takeo province
(names not registered)	40+ Female community members, group discussion; Chum Rov village, Prey Kabas district, Takeo province
(names not registered)	6 Male community members; group discussion, Chum Rov village, Prey Kabas district, Takeo province

Abbreviations:

FP	Family Planning
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German International Development Cooperation)
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
OD	Operational District
RH	Reproductive Health

ANNEX 3 – DATA COLLECTION RESULT MATRIX

The data and information produced through the document review, and collected through interviews, focus groups and group discussion during the field visit in Cambodia are presented in the evaluation matrix below. Data and information are categorized along the evaluation questions and related assumptions for verifications and support the findings analysis presented in Section 4 of the present country note.
Note: text in bold at the beginning of some entries [in brackets] refers to the title of the quoted document.

Area of Investigation 1: Integration

To what extent has UNFPA supported integration of family planning with maternal health, HIV/STI and GBV services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?

Data collection methods:
Document review
Key informant interviews (KII)

Assumption 1.1 **UNFPA headquarters (HQ), regional office (RO) and country office (CO) staff and in-country partners are working towards a common understanding of the meaning and importance of service integration.**	**Information sources:**
Indicators: • Knowledge generated and shared regarding nature of and lessons learned from integration interventions • UNFPA staff, partners' and users' (women's and men's) perception of meaning and importance of service integration.	
Integration means that all health services are made available at one point (one-stop-shop), per level (community, health centre, hospital). This includes family planning (FP) services; with all necessary staff and materials to deliver such package. This is not the case right now, as there are no FP services available in maternal wards. It is in the guidelines already but not in practice. Integration should ensure there is no "*missed opportunity*".	NGO staff
Ideally all services, including FP, should be available as one package in a one-stop location. In Cambodia, this has been a debate – the government prefers the term "linkage" as it feels "integration" implies losing focus, e.g. for the HIV programme. UNFPA has pushed for better integration and as a result certain facilities are no longer separated (e.g. HIV and maternal and child health (MCH)). Through the "linked response" approach UNFPA still managed to help create a better HIV-FP connection. Now that funding decreases, the HIV programme also calls for more integration.	UNFPA staff

Birth spacing policy for Cambodia "*Birth Spacing services are provided to promote maternal and child health and prevent unwanted pregnancies. Birth Spacing services should be integrated with MCH Services.*"	(Ministry of Health 1995:2, Ministry of Health 2015a)

Assumption 1.2: **Country offices receive and put into practice technical guidance from HQ and ROs to support partners in delivering quality, integrated services.**	**Information sources:**
Indicators: • Number, frequency and type of technical assistance (TA) provided • RO plans address COs' needs for support in promoting service integration where appropriate • CO plans and programs reflect current technical guidance and best practices for integrated services • Evidence-based guidance developed to support the integration of FP or more in the following SRH services (in policies, plans, actual service delivery): maternal health, HIV/STIs, gender-based violence (GBV), level of emergency preparedness to address FP needs in emergency situations, adolescent sexual and reproductive health (SRH) (girls and boys).	*Note: Additional information on this and other assumptions referring to HQ and RO will be gathered during regional/global KIIs and the internet surveys to inform the synthesis (final) evaluation report.*
The notes below apply to all the questions on HQ and RO input (4.3, 6.4, 7.1, 8.5).	
There has been little support or funding from HQ, apart from regular sharing of technical papers. And there have been missed opportunities, such as the HQ failure to invite Cambodia for the London FP2020 Summit and the lack of response to the press-coverage on side-effects of Depo-Provera.	UNFPA staff
RO is supportive, by offering workshops, technical assistance (TA) and sharing guidelines and best practices; however "*they are very busy*".	UNFPA staff
Output indicator: Country office has received effective support from Regional Office during the year. "*The support provided by the Asia Pacific Regional Office both on a regular and ad-hoc basis was of a great value for the Cambodia Country Office. Such responsive support ranging from technical expertise to security issues received from the APRO did actually allow the CO to deliver its mandate in an effective manner."* This support included two MoH officials attending a quality reproductive health (RH) assessment to improve national capacity.	(UNFPA Cambodia 2014a: 29)

Assumption 1.3: **UNFPA support has been effective in stimulating service integration by in-country partners; government, civil society organisations (CSOs), private in policies, plans and actual services.**	**Information sources:**
Indicators: • Number and type of FP/service providers trained on service integration	

• Number and percentage of service delivery points that offer FP integrated with other services (and acknowledge UNFPA guidance for this) • Integrated service provision included in provider training programmes (with acknowledgement of UNFPA guidance for this) • Inclusion of integrated service provision in government policies and health plans.	
[Situational Evidence Review Report] "*The integration of reproductive and sexual health services, including family planning, within the overall health sector is a key component of the MoH Health Strategic Plan 2008-2015."*	(UNFPA Cambodia 2013a, UNFPA Cambodia 2014e: 29)
UNFPA has advocated for and supported integration of FP in government policies (National SRH policy), MCH services (ante natal care (ANC), post-partum care (PPC), post-abortion care (PAC)) and HIV services (voluntary counselling and testing (VCT), prevention of mother-to-child transmission (PMTCT)). FP is part of the minimum package of SRH in health centres and hospitals.	UNFPA staff
[Health Strategic Plan 2008-2015] The plan includes FP as part of essential services	(Ministry of Health 2008b: 27, 57)
FP and maternal health: Integration is really important, e.g. regarding PPC and PAC. FP is integrated in post-natal care (PNC) – part of all three (proposed) PNC visit protocols. Regional hospitals do not offer FP yet, e.g. they could integrate FP with PPC.	NGO and government staff
[Evaluation of the UNFPA Support to Maternal Health – Cambodia Country Report] "*Although UNFPA has supported the provision of family planning services, including diversification of methods on a long-term basis, some opportunities were missed, such as stronger integration in maternal health services and in adolescent sexual and reproductive health programme."*	(UNFPA 2012b: 26)
FP and GBV: Emergency contraception services are explicitly included in the 2014-2018 National Action Plan on VAW as part of Health services.	(RGoC 2014: 23)
FP is part of the violence against women (VAW) programme (i.e. emergency contraception (EC)) since 2006. EC is available in few health centres only. EC as such is not much promoted for fear of creating undue demand.	UNFPA staff
FP and HIV: Services for people living with HIV *(*PLHIV) and FP are integrated.	NGO staff
[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] UNFPA had a "*specific focus on entertainment workers (EWs) in HIV prevention, integrated with a family planning approach.*"	(UNFPA Cambodia 2013a, Noij, Kasumi et al. 2015: 26) NGO staff
[National Strategy on Reproductive and Sexual Health 2012-2016] "*HIV FP integration: Integration of HIV, reproductive health, tuberculosis (TB) and ANC through the 'Linked Response' initiative to prevent mother-to-child transmission of HIV (PMTCT) has expanded."* (p.15) The document also describes FP as part of the essential SRH service package.	(Ministry of Health 2012: 15, 34)
[FP practice and predictors of risk of inconsistent condom use among HIV-positive women on ART in Cambodia]	(Nakaie, Tuon et al. 2014: 1)

"*Conclusions: About one-quarter of women on ART are at risk to unintended pregnancy, although most do not plan to get pregnant. Furthermore, women on ART could be more empowered through improvement of communication and negotiation skills with partners to demand the use of condom during sexual intercourse. The use of other contraceptive methods that do not need partner involvement should be promoted."*	
*FP and emergency preparedness: [***Evaluation of the UNFPA Support to Maternal Health – Cambodia Report]** "*UNFPA has ensured that accessibility to critical EmONC and family planning services is included in emergency preparedness and response plans through providing support to the Joint Plan of the National Committee for Disaster Management, MoH, providing Minimum Initial Service Package training.*"	(UNFPA 2012b: 23-24, UNFPA Cambodia 2013a, MOPAN 2014) UNFPA staff

Assumption 1.4: **Service integration leads to improved user access and quality of services.**	**Information sources:**
Indicators: • Evidence of user consultations • Perception of different user groups (women and men, vulnerable and marginalised groups (VMGs), PLHIV) that access[175] and quality have improved by integration.	
[UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] "*To address youth health (…) UNFPA has also worked to increase availability and access to youth-friendly clinical and counselling services and overseen the finalization of key national strategies."*	(Shah 2010: 6)
Young people's access to services is difficult to facilitate from public services; NGOs are needed for this.	DP staff
[UN Cambodia Common Country Assessment-CCA. UNDAF 2016-2018] "*Young people, particularly unmarried young people, still have limited access to sexual and reproductive health services.*"	(United Nations 2014: 37)

[175] We define access as: availability, accessibility (distance, transport, time), affordability (willingness and ability to pay incl. opportunity cost) and socio-cultural acceptability

Area of Investigation 2: Coordination and National Ownership

To what extent has UNFPA successfully contributed on its own and in coordination with others to strengthening national leadership of family planning and improving sustainability?

Data collection methods:
Document review
Key Informant Interviews (KII)

Assumption 2.1: **UNFPA has developed and/or actively supported mechanisms to raise the profile of family planning in coordination with other FP/SRH stakeholders at Global, Regional and National levels.**	**Information sources:**
Indicators: Type of existing and emerging coordination mechanisms at each level with evidence of UNFPA support and FP-relevant contents of meetings and initiatives.	
[Evaluation of the UNFPA Support to Maternal Health – Cambodia Country Report] "*UNFPA has pioneered family planning services in a number of ways, including support to various policies and strategies. (…) ensuring that capacity-building activities for family planning services are planned and implemented and modern contraceptive methods are promoted and provided.*"	(UNFPA 2012b: 26)
"*UNFPA has leveraged its membership of the joint partnership arrangement/development partner interface group (JPIG) grouping of partners in the HSSP II to ensure that the issue of family planning (…) has been highlighted in high level fora such as the annual National Health Congress.*" UNFPA worked with USAID and other partners to advocate for increased attention to FP in Cambodia.	(UNFPA Cambodia 2012: 10)
"*UNFPA was able to successfully advocate for integration of Cambodian population dynamics, reproductive health and rights and gender in the Rectangular Strategy Phase 3 (SR3) and draft National Strategic Economic Development Plan 2014-2018.*"	(UNFPA Cambodia 2013a: 5)

Assumption 2.2: **UNFPA and other donors (including those influenced by UNFPA advocacy) have effectively supported national governments to assume ownership of FP-related policies and programmes.**	**Information sources:**
Indicators: • Existence of national FP policy and programme (separate or integrated with other SRH areas) • National budget allocations to FP • Number of other major donors actively supporting national ownership of FP, (on their own account or as a result of UNFPA advocacy).	

["Rectangular Strategy" for Growth, Employment, Equity and Efficiency, Phase III] "*The Royal Government will focus accordingly on the following priorities: (…) 7. Further improving reproductive, maternal and infant/ children health (…) through enhancing quality and effectiveness of reproductive, maternal, infant and children healthcare services by focusing on: expanded coverage of (…) consultation services on birth spacing options; (…) and provision of reproductive education and healthcare services to the youth.*"	(RGoC 2013b: 73, RGoC 2014)
"*2.268. (…) the goal is to reach 10% [unmet need] by 2016. Despite having no legal age restrictions on access to reproductive health services, including for contraceptives and access to abortion, there is a lack of understanding on how easily young people could make use of such services. The big need is to ensure the continued supply of contraceptive devices."* There is a need to focus on SRH/FP and on reproductive rights that promote choice.	(RGoC 2014: 77)
Sexual and reproductive health and rights (SRHR) key interventions include: "*Increase demand for and access to sexual reproductive health services, information, counselling and services including contraception, safe abortion and comprehensive abortion care, adolescent-friendly services (…) and ensure reproductive health commodity security system."*	(RGoC 2014: 182)
[National Strategy on Reproductive and Sexual Health 2012-2016] *"Family planning is considered a best investment for development and has been shown to contribute to reducing maternal, neonatal and child mortality."*	(Ministry of Health 2012: 14)
[Population policy (draft)] There is a need to address FP unmet need and improve FP services; in view of differentials across rural/urban areas, regions, wealth quintiles and the youth bulge. Objective 7 is to realize reproductive needs and fertility intentions, with a focus on unmet need, encouraging men to take responsibility for FP. FP programme directions include attention for unmet need, fertility decline and promotion of spacing.	(RGoC 2015)
The Fast Track Initiative to reduce maternal mortality has seven components, including FP. It is a priority for the government. UNFPA supports this via the HSSP II.	Government staff (Ministry of Health 2010)
[Report on National Family Planning Conference "Choices not Chance" - 2014] Opening speech by the MoH Secretary of State, closing remarks by the MoH Minister, showing high-level political commitment to FP. The report reports that Prof. Eng Huot, Secretary of State, MoH, in his speech mentioned that FP achievements (e.g. increased modern contraceptive prevalence rate (mCPR), reduced unmet need) "*were the result of determined efforts from the government to improve capacity and expand family planning service delivery, along with full support from DPs*" and that this has helped reducing maternal mortality. He also referred to remaining challenges: *"More attention needs to be placed on expanding and offering family planning services to vulnerable groups including adolescents and youth, migrants, factory workers, entertainment workers, ethnic minorities, disabled persons, and people living with HIV/AIDS."*	(Ministry of Health 2015a: 8)
UNFPA provided significant support to the national FP Programme: "*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*	(Noij, Kasumi et al. 2015: 42)

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."	
[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] "*UNFPA has supported four outcome areas and five outputs in line with the government's current Priorities*" as expressed in key policy documents, including the SRH Strategy 2012-2014.	(Noij, Kasumi et al. 2015: 24)
[Evaluation of the UNFPA Support to Maternal Health – Cambodia Country Report] "*UNFPA was able to advance the reproductive and maternal health agenda due to its long experience in Cambodia, which has given the agency a unique position vis-à-vis the government. This position was further consolidated after 2006 through UNFPA contribution to the Health Sector Support Programme II (HSSP II) and the technical leadership role it provided. (…) UNFPA advocacy efforts with high-level officials and parliamentarians have greatly contributed to increased government commitment."*	(UNFPA 2012b: 60)
[UNFPA Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] "*UNFPA began its collaboration with the national reproductive health programme (NRHP) working on commodity supply, particularly for contraceptives. Since then, its scope of work has expanded to include birth spacing and safe motherhood while continuing to support the RGC in its role as the steward of the health system. UNFPA has trained NRHP staff and continues to support supplementary training as needed."*	(Shah 2010: 6)
"*UNFPA was praised for its management and systems, its support of RGC-prompted priority issues, and its promotion of cross-ministry collaboration. Government representatives are particularly enthusiastic about UNFPA contributions, explaining that UNFPA's mandate supports national programs in a way that fosters their independence and development. Rather than pushing an agenda on ministries, UNFPA listens and responds, identifying feasible solutions and explaining what can and cannot be supported. For this role as advisor and collaborator, UNFPA is much appreciated."*	(Shah 2010: 7)
"*The current government commitment to RH/FP is UNFPA's doing*."	DP staff
"*UNFPA was able to successfully advocate for integration of (…) reproductive health and rights and gender in the Rectangular Strategy Phase 3 (SR3) and draft National Strategic Economic Development Plan 2014-2018."*	(UNFPA Cambodia 2013a: 5)
UNFPA provided technical and financial support to the development of the 2013 national SRH strategy. "*The strategy includes comprehensive SRH services including youth-friendly services, family planning, VAW* [violence against women]*, skilled birth attendance, EmONC, HIV and STIs, safe abortion, gynaecological services, SRH in emergency management, etc."*	(UNFPA Cambodia 2013a: 4, UNFPA Cambodia nd-b)
UNFPA played a major role in the new draft of FP policy and manual. UNFPA supports the development of key policy documents through technical assistance, funding of meetings and related logistics – e.g. the SRH Strategy, FP updated policy and manual, and the Youth SRH guidelines.	UNFPA staff
Securing government commitment to allocate budget for contraceptives: "*Support to building the capacity of the Ministry of Health in policy dialogue was critical in assisting them in positioning reproductive health and rights as national key priorities in order to mobilize the much needed resources from the national budget."*	(UNFPA Cambodia 2014a: 12)

[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] "*UNFPA, together with* Department of Foreign Affairs and Trade, Australia (*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 contributions. (…) 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.*"	(MOPAN 2014, Sovannarith 2014, UNFPA Cambodia 2014e, UNFPA Cambodia 2014d, Noij, Kasumi et al. 2015: 65)
"*In August 2015, senior MoH officials and Ministry of Economy and Finance (MEF) met and reviewed the proposed national budget plan for 2016, which included US$ 2.3 million for procurement of contraceptives in 2016 from the MoH. The MEF approved the request of the MoH with the requested amount as the MEF were fully informed about the needs and the cessation of donor support to the supply of contraceptives from 2016 onwards. This means, contraceptive procurement will be taken care of by the national budget from 2016 onwards.*"	UNFPA staff
Establishment of the pro-poor health equity fund: The health equity fund system started with MCH services. UNFPA was among those doing advocacy to expand it to primary health care services, including FP, which happened from 2006. The government contributes 40 percent of the cost of the health equity fund. To avoid a bias against more expensive FP services (implants, intra-uterine contraceptive device (IUCD)), UNFPA successfully advocated for adjustments in the reimbursement system. (Previously, providers would get the same small amount for any method).	UNFPA staff
[UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] "*UNFPA was also credited for highlighting critically needed reproductive health services, such as abortion and long-term family planning tools, for incorporation into expanded health equity funds.*"	(Shah 2010: 10)

Assumption 2.3: **Programmes are culturally/socially, institutionally and economically sustainable in different national contexts**	**Information sources:**
Indicators: • Trends in modern contraceptive prevalence rate (mCPR) • Percent of FP provided by the public, NGO and private sector • Government spending as percent of total expenditure on FP • Evidence of participation by CSOs (including end user groups, vulnerable and marginalised groups (VMGs)) and private sector in FP policy, planning and accountability mechanisms at national level.	
[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] "*In the SRH Component of the Country Programme (CP) considerable results have been achieved in terms of increased access and use of quality reproductive, maternal, new-born health services as evidenced by (...) the use of modern family planning methods, decrease*	(Noij, Kasumi et al. 2015: 72)

in fertility rate, increased contraceptive prevalence rate." The CPE concludes that UNFPA contributed to improvement in indicators, including the contraceptive prevalence rate (CPR).	
[Family planning thematic evaluation report (UNFPA Cambodia)] Increased CPR is attributed to UNFPA and other development partners (DPs).	(Sovannarith 2014: 57)
[Cambodia Demographic and Health Survey 2014. Key Indicators Report] "*Use of modern contraceptive methods has increased over the past ten years, from 27 percent of currently married women in 2005, to 35 percent in 2010, and to 39 percent in 2014. The most commonly used modern methods are the daily pill and injectables*" (p11). *"Thirteen percent of currently married women have an unmet need for family planning."* (p.14)	(Ministry of Planning, Ministry of Health et al. 2015)
[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] "*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."*	(Noij, Kasumi et al. 2015: 65)
"*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."*	(Noij, Kasumi et al. 2015: 66)
"*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."*	(Noij, Kasumi et al. 2015: 66)
[National Population Policy] "*High fertility (…) has been identified as a major obstacle to poverty reduction in Cambodia in the National Poverty Reduction Strategy. The priority action in this regard is to improve birth spacing and reduce fertility among the poor through providing and promoting improved family planning and reproductive health services. (…) Fertility decline will also reduce population growth and lessen the young dependency ratios. (…) The government (…) has adopted the birth spacing programme as a major policy to protect the health of mothers and newborn children, and help reduce rapid population growth."*	(RGoC 2003: 13)
The Cambodia MDG target of 60 percent mCPR is *"impossible to achieve*".	Government staff
The government MDG target of 60 percent mCPR is too ambitious. It implies an increase of over three percent per year, which is unusual. The increase in Cambodia is around 1 to 1.5 percent per year. However with the current 39 percent mCPR, 18 percent traditional methods and 12 percent unmet need, 69 percent FP total CPR is possible.	UNFPA staff
People feel FP is good for them, they prefer smaller household size, e.g. 4-5 instead of 7-10 children; they want to take care of their family.	UNFPA staff
UNFPA supported Commune Councils for Women and Children structures at local level in seven provinces with only a small budget support, to pursue more attention for need to reserve larger budget for social sector investment; and to "change the mind-set", influencing decentralised planning guidelines. This activity will be phased out at the end of 2015 under the new UNFPA global strategy (as there will be less attention for service delivery).	UNFPA staff

*Social sustainability: [***National Population Policy]** "*There is no organised opposition in Cambodia to birth spacing programmes or to introducing more comprehensive reproductive health and family planning services. Nor are there legal barriers to the provision of contraceptives to the unmarried or youth."*	(RGoC 2003: 13)
[Socio-cultural influences on the RH of migrant women in Cambodia, Lao PDR, Thailand and Viet Nam] "*Cultural notions of a "good" woman have also hindered migrant women from using contraception. In Cambodia, the purchase of condoms among women is linked to personal embarrassment and fear of gossip.*" There is a double standard for boys versus girls regarding premarital sex.	(UNFPA APRO 2011: 35-36)
[Views on Family Planning and Long-Acting and Permanent Methods/Cambodia] "*For most participants, contraceptive use was synonymous with birth spacing. Few participants talked about contraceptive use as a strategy to stop having any more children. (…) While respondents thought that having too many children or not enough time between births was socially unacceptable, they also frowned on having no or too few children."*	(The RESPOND Project 2013: 2-3)
[Barriers to Contraceptive Use in Cambodia] "*One factor that may be contributing to this outcome was that midwives at Health Centres (HC) currently providing family planning suggested that early use of birth spacing for young couples will lead to infertility after a couple of years."*	(Vathiny and Hourn 2009: 23-24)
"*From discussions with young pregnant women, we found that their mothers-in-law or older sisters often warned them against the use of modern contraceptive methods, due to fear of side effects. (…) The interviewed women stated that fertility after marriage is a vital attribute of their femininity. (…) women in both the young and old age groups generally suggested that the use of modern contraceptive methods is appropriate for those who already have one or two children."*	(Vathiny and Hourn 2009: 26-28)
Sensitivities around FP: Birth spacing once was not well understood and there were issues about side effects. Now it is explained, there is information and counselling. "*We prefer not to use the term FP, we use birth spacing."*	Government staff
After the civil war there was a felt need to have a bigger population. But population growth and economic growth need to go together (…) In the end the need to reduce the high maternal mortality and save women's and children's lives was the main argument for MoH to promote "birth spacing" – not "family planning", as it had a negative connotation of "limiting the family size", like the one-child policy in China. But still, people do not see the need to switch from short-term to long-term methods.	Government staff
The MoH is committed to FP (plans, funding). But higher up in government "birth spacing" is still sensitive: *"some people want more people and are against "birth control."* UNFPA could do more advocacy with the government (the levels above the MoH) regarding their support for FP. There is still a large pro-natalist sentiment in the government; they feel that the country has a small population compared to neighbouring countries.	DP staff
The MoH wants to improve FP services for young people but there are conservative influences. But still, the feeling of some that "the country needs more people" is less strong today. E.g. there was one province that did not allow FP long-term methods until a few years back – that ban is now lifted. UNFPA could work with parliamentarians on this.	NGO staff

[UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] "*Some stakeholders suggested that the RGC takes a pro-natalist stance, equating a growing population with a developing economy and political security. An increasing contraceptive prevalence rate may seem like a threat to security needs to officials who are not accustomed to viewing family planning as a health issue. While this may not serve as an outright barrier to UNFPA's work, senior-level officials may impede or delay progress on population and reproductive health goals."*	(Shah 2010: 11)
Some people ask why FP should be promoted. Of course it is not about restricting family size, but about ensuring freedom of choice and improving maternal health.	UNFPA staff

Area of Investigation 3: Brokerage and Partnership

To what extent has UNFPA acted as a broker at global, regional and country levels to promote family planning, acting in partnership with the public, private and non-state sector service providers?

Data collection methods:
Document review
Key Informant Interviews (KII)

Assumption 3.2: **At the country level, UNFPA COs brokered partnerships between public agencies, CSOs and private sector entities to promote FP and its integration with other SRH programmes.**	**Information sources:**
Indicators: • Other stakeholders and partners recognise the comparative advantages of UNFPA, its positioning and its potential contribution at global, regional and country levels, and respond to UNFPA initiatives in bringing them together • UNFPA participation and role in policy forums, networks, and other partnership mechanisms at global, regional and country levels.	
Key Cambodia coordination forums relevant for FP, in which UNFPA Country Office plays a substantial role *With government and development partners:* • Technical Working Group (TWG) for Health (Secretariat, Sub-TWG group on MCH) • Reproductive, maternal, newborn and child health (RMNCH) and Nutrition Task Force • Contraceptive Security Working Group • Technical Working Group on Gender (Steering Committee on Joint Communication Campaign GBV) • Technical Working Group Planning and Poverty Reduction	UNFPA, government, NGO and DP staff

• Technical Working Group Urbanization • Health Sector Support Program II – Joint Partnership Arrangement Development Partner Interface Group (HSSP II-JPIG) (HSSP II donors, MoH) • Joint Review Mission • Maternal Health Fast Track Initiative • National Commission for Subnational Demographic Development *With development partners:* • GBV Coordination Group • Development Partner Group – Sub-National Democratic Development • Health Partners Group meeting • Humanitarian Response Forum • Joint United Nations Team on HIV/AIDS • International Health Partnership+ • UN Youth Task Force • UN Youth Advisory Panel	(Shah 2010, Tobin, Toptosseda et al. 2011, UNFPA 2012b, Sovannarith 2014, Noij, Kasumi et al. 2015)
[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] 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."*	(Noij, Kasumi et al. 2015: 66)
[Family planning thematic evaluation report (UNFPA Cambodia)] Important partnership were established with government, pharmaceutical industry, non-government organisations (NGOs) and other development partners to increase FP results. *"The close alignment between the CP4's FP program and the National FP priorities means that CP4 have been highly relevant to the needs of Cambodians, especially those in rural and vulnerable groups."* (p. 26) *"The UNFPA country office has inventively supported for the national family program to put more focus on family planning intervention financially and technically as one key element priority into the national health strategic plan and its implementation plan. Based on the review of 2014 Annual Operation Plan 2014 in which UNFPA supported to MoH under the National FP, around US$ 542,070.00 was allocated to support for the scaling-up, capacity building and strengthening of family planning services and to promote reproductive health and rights related activities"* (p. 27), while UNFPA also supported NGO partners Cambodian women for peace and development (CWPD), Reproductive Health Association of Cambodia (RHAC) and Reproductive and Child Health Alliance (RACHA), and advocated with Department of Foreign Affairs and Trade (Australia) (DFAT) to fill procurement gaps. *"The current country program on FP has played an important role with the government, pharmaceutical producers (MSD) and other donors in order to increase results (…) as many stakeholders remarked."* (p. 58)	(Sovannarith 2014)

[UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] "*UNFPA is credited for having comprehensive approaches to problems, highlighting larger contextual factors, and bridging divides among ministries and partners. The success of UNFPA is attributed to a combination of trust, long-term credibility, and close government relationships.*"	(Shah 2010: 7)
"*The CO took the lead in advocating with the MoH and development partners to organise the first National Family Planning Conference which took place in late November 2014. The CO successfully advocated with DPs, NGOs and private sector to jointly support and finance the meeting.* [Beyond] *traditional DP and NGO partners, Bayer and Merck contributed financially and technically to the event."*	(UNFPA Cambodia 2014a: 11) UNFPA staff
"*The CO managed to secure a commitment from Merck Company to financing an operational research on consumer perceptions toward Implanon as a long term contraceptive method, with the estimated budget of around US$ 28,000. This was a successful effort in building partnership with the private sector."*	(UNFPA Cambodia 2014a: 11)
[Situational Evidence Review Report] UNFPA has the potential to foster strategic private sector partnerships for SRH and to ensure SRHR for all, especially marginalised populations.	(UNFPA Cambodia 2014e: 13)
UNFPA engages private sector companies to commit to SRH service provision to their employees (such as the garment sector) and to co-fund capacity development and research activities (e.g. MSD). It also involved private companies in the 2014 FP national conference. But there are limitations at programmatic level – e.g. there are only few pharmacies outside the capital in other cities. Maybe these can help address the issue of urban, higher-income women using natural methods over modern FP methods?	UNFPA staff
Our NGO is happy with the partnership with UNFPA. UNFPA says it is an equal partnership and our NGO still owns and drives the project.	NGO staff
[Health Sector Support Project I (HSSP I) End of Project Assessment] "*Although RH was not included in the original project design, it gained momentum with UNFPA becoming a partner in HSSP1."*	(RGoC 2010: 25)
[Country Programme Action Plan (CPAP) 2006-2010] Partnership strategy: "*In order to ensure the best use of UNFPA's resources, UNFPA will work in close collaboration with key government and donor partners in each of its programmatic areas. This will build on existing coordination efforts at both the inter-ministerial and the sectoral level, including participation in the on-going Consultative Group process, and participation in five government-donor technical working groups: health, gender, HIV/AIDS, education, and planning and poverty monitoring."*	(UNFPA Cambodia 2006: 19)

Assumption 3.3: **The visibility of UNFPA is sufficiently high at global, regional and country levels to bring together potential partners to increase commitment to FP.**	**Information sources:**
Indicators:	

• Other stakeholders and partners recognise the comparative advantages of UNFPA, its positioning and its potential contribution at global, regional and country levels, and respond to UNFPA initiatives in bringing them together • UNFPA participation and role in policy forums, networks, and other partnership mechanisms at global, regional and country levels.	
UNFPA has an active role and leverage in JPIG forum; a strong role in health partners meeting; and in the Health technical working group (TWG) Secretariat, which plays a key role in setting the agenda for discussions at national and provincial levels.	DP staff
UNFPA is the most trusted partner of government regarding maternal health and FP. It is well-respected, has good relationship and coordination with the government and the MoH; a good way of "*friendly influencing*" the Cambodian way. UNFPA can easily influence government policy decision-making; the MoH/NMCHC usually listens to UNFPA. It intends to translate policies and strategies into actions. UNFPA is seen as active both in policy and at operational level.	NGO and DP staff, (Sovannarith 2014, Noij, Kasumi et al. 2015)
MoH/ National Maternal and Child Health Centre (NMCHC) has respect for the professionalism and added value of UNFPA; other stakeholders engaging with NMCHC are often referred to UNFPA for guidance.	NGO staff
The UNFPA financial contribution (to HSSP II and other) is relatively small compared to other donors, but this contribution is combined with key advocacy and TA and generates leverage and influence with the government.	Government, UNFPA and DP staff
UNFPA has a key UN mandate for SRH/FP and plays a strong role in the TWG. It is active on policy, training and services/equipment level and was key to expanding the FP method mix. *"UNFPA does not have much money but its TA and collaboration is what Cambodia needs. UNFPA work is team work."*	Government staff
"UNFPA has good visibility even though that is not their intention. They provide adequate TA."	DP staff
UNFPA knows that, to be useful, it has to map and involve all stakeholders and not assume a competitive position. It does this well and has a high profile, also with RH NGOs that get USAID funding. It is important that UNFPA is open to contributions by other agencies; and that it works with both government and civil society.	DP and NGO staff
Generally – UNFPA is active, does a good job. "*We like how they work, not claiming SRH/FP as 'their' topic but respecting the role of others as wel*l." *"They have good programme managers."*	DP staff
[UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] "*Government representatives are particularly enthusiastic about UNFPA's contributions, explaining that UNFPA's mandate supports national programs in a way that fosters their independence and development. Rather than pushing an agenda on ministries, UNFPA listens and responds, identifying feasible solutions and explaining what can and cannot be supported. For this role as advisor and collaborator, UNFPA is much appreciated."*	(Shah 2010: 7)
UNFPA has a critical role – e.g. re. FP commodity planning, clinical issues (getting implants into the national guidelines), support to Central Medical Stores (CMS) (forecasting, training). Progress is sometimes slow, but there are results.	NGO staff

[Evaluation of UNFPA/Cambodia's 3rd Country Programme, 2006-2010] "*UNFPA is seen as an important partner in the Cambodian development and is well and appropriately recognised for its technical capacity which creates respect among other donors and the government. In turn, this respect provides the country office with leverage and political capital."*	(Tobin, Toptosseda et al. 2011: 35)
[Evaluation of the UNFPA Support to Maternal Health – Cambodia Country Report] "*UNFPA was able to advance the reproductive and maternal health agenda due to its long experience in Cambodia, which has given the agency a unique position vis-à-vis the government."*	(UNFPA 2012b: 60)
[Technical report Volume I. UNFPA. Results by micro-indicators and by country. Cambodia] "*At the sectoral level, UNFPA has gained credibility by producing evidence for reproductive health/maternal health policy debates and prioritization."* Ensuing discussions *"involve trusted partnerships with MoH and other key line ministries."*	(MOPAN 2014: 109)
[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] The active role of UNFPA in coordination forums *"(…) 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."*	(Noij, Kasumi et al. 2015: 24)
Lead role in securing government commitment to allocate budget for contraceptives: UNFPA played a key role in ensuring government commitment to budget for full contraceptive procurement costs as from 2016 onwards.	(UNFPA Cambodia 2014a)
[Technical report Volume I. UNFPA. Results by micro-indicators and by country Cambodia] "*The UNFPA COAR reports note the repeated advocacy that the agency has engaged in for allocation of national budget for contraceptives (…). UNFPA secured MOH support for the initiative and assisted the MOH to further target the Ministry of Economics and Finance. As of early 2014, the Royal Government of Cambodia now has established an individual budget line for the supply of contraceptives in the 2014 budget allocations."*	(MOPAN 2014: 109)
The government will take over FP commodity funding 100 percent as from 2016 – which is good and a key legacy of UNFPA CO efforts.	DP staff
Lead role in 2014 national family planning conference: "*The CO successfully advocated with DPs, NGOs and private sector to jointly support and finance the meeting. [Beyond] traditional DP and NGO partners, Bayer and Merck contributed financially and technically to the event, which gathered around 250 government officials, heads and representatives of development partners, civil society, NGOs, youth organisations, and community representatives. The conference at the end produced a joint commitment which reaffirms the government and stakeholders' commitment to rights–based family planning programme in Cambodia under the theme – Choices not Chance."*	(UNFPA Cambodia 2014a: 11)
Expectations of stakeholders on UNFPA role: Stakeholders mentioned a number of areas where they expected a continued or stronger UNFPA role, including: studies on user perspectives and needs, ensuring technical competency of providers, contraceptive security. Specific target groups mentioned were: young people, factory workers and minority ethnic groups.	DP and NGO staff
The role of UNFPA is not at community level; instead it is a role of advocacy, TA, knowledge management, monitoring implementation and policy development.	DP staff

[UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] *"(…) the specific area of family planning (…) suffers from a lack of leadership. Efforts are fragmented. (…) Family planning was noted to be the traditional advocacy sphere for UNFPA, so stakeholders have been surprised by the absence of UNFPA in this work in Cambodia."*	(Shah 2010: 13)
UNFPA should focus on their relationship and influence with the government, policy aspects, contraceptive security and TA, also via their regional office (RO).	DP staff
[UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] "*Reproductive health stakeholders would like to see UNFPA take on a stronger advocacy role specifically with the RGC on critical issues such as the limited available options for contraceptives and the lack of family planning services in hospitals. UNFPA's soft power with the RGC makes it well suited for this role although the suggestion goes against the status quo of interaction between the agency and NRHP."*	(Shah 2010: 9)
Expectations of stakeholders on UNFPA role – young people: The big challenge is how to reach (more) young and unmarried people with SRH/FP. UNFPA should support such strategy, it has not given enough attention to this.	Government, NGO and DP staff
The reported Cambodia demographic and health survey (CDHS) increase in teenage pregnancy was a wake-up call. But youth access to services is difficult to facilitate from public services; NGOs are needed for this.	DP staff
[UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] "*One NGO representative stressed the importance of continuing UNFPA work with youth, an area where UNFPA is a bit more engaged at the implementation level. Prior funding for addressing issues of youth (…) has effected little sustained change. UNFPA has the capacity to contribute sustained resources over time and have an impact."*	(Shah 2010: 9)
UNFPA could advocate with the government for an improved adolescent SRH policy. Unmarried teenagers, when they are pregnant, sometimes end up with untrained providers for unsafe abortion. There are sensitive (cultural) issues here, so it is good to bring lessons learned from elsewhere.	NGO staff
Expectations of stakeholders on UNFPA role – safe abortion: Few development partners address safe abortion – UNFPA should keep doing that; especially as not many clients and providers know it is actually legal and available.	NGO staff
[UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] Mentions that legal abortion often remains unsafe and inaccessible. NGOs have had difficulties to access funding for abortion-related work. "*According to NRHP, the barrier to increased work to make abortion safer in Cambodia lies with donors, not the government. One stakeholder specifically noted that 'UNFPA has been a leader in maternal health issues, although not on abortion'. (…) UNFPA is (…) well-positioned to effect change."*	(Shah 2010: 11-12)
[Evaluation of the UNFPA Support to Maternal Health – Cambodia Country Report] "*It was also reported that UNFPA had been hesitant to provide support for comprehensive abortion care, even when requested by the government. The evaluation team was informed that this was due to directives from UNFPA headquarters, as Cambodia abortion laws are some of the*	(UNFPA 2012b)

most liberal in the region." (p. 27) "*UNFPA has not taken the lead (…) and the difficult issues of quality of care, protocols and quality assurance surrounding family planning services and safe abortion have yet to be addressed.*" (p. 67)	
[National Strategy on Reproductive and Sexual Health 2012-2016] "*Abortion was legalised in Cambodia in 1997, and is available without justification in the first trimester of pregnancy. Abortion is still sensitive. Many are unaware that abortion is legally available and unsafe abortion was considered a key driver of Cambodia's high maternal mortality rate (MMR). (…) Despite its simplicity and acceptance as global practice, [medical abortion] is under-used and sometimes inaccessible."*	(Ministry of Health 2012: 16)
"*Despite having no legal age restrictions on access to reproductive health services, including for contraceptives and access to abortion, there is a lack of understanding on how easily young people could make use of such services." (p.77)* *"Key interventions (…) are (…): (…) Increase demand for and access to (…) [SRH] services and services including (…) safe abortion (…).*" (p.182)	(RGoC 2014)
[Barriers to Contraceptive Use in Cambodia] "*Abortion is legal at the woman's request before 12 weeks of pregnancy, but access in reality is limited, especially for poor women. All public facilities do not provide abortion services, and abortion is also carried out illegally in private practices, sometimes unsafely.*"	(Vathiny and Hourn 2009: 12, Sopheab 2014)
Indices of abortion among garment workers are high and imply an unmet need for FP.	(Sovannarith 2014, UNFPA Cambodia 2014e)
[Situational Evidence Review Report] "*Unsafe abortion has been considered a key driver behind Cambodia's high maternal mortality rates. In 2010, 32.8 percent of all abortions were self-induced or performed by unsafe providers, an increase from 21 percent in 2005.*"	(UNFPA Cambodia 2014e: 21)
[Reproductive Preferences in Cambodia. DHS Further Analysis Reports No. 87] The report concludes that abortion has increased over the last decade and explains the relatively low contraceptive prevalence in conjunction with the low level of fertility. "*The analysis found that in the absence of abortion, the total fertility rate (TFR) in 2010 might have been 3.7 births per woman instead of the reported 3.0."*	(Westoff, Bietsch et al. 2013: xi)
"*UNFPA does not promote abortion as a method of family planning. Rather, it accords the highest priority to voluntary family planning to prevent unintended pregnancies to eliminate recourse to abortion. (...) Where abortion is legal, national health systems should make it safe and accessible."*	(UNFPA 2014a)

Area of Investigation 4: Enabling Environment

To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information and exercise of rights?

Data collection methods:

Document review
Key Informant Interviews (KII)
Focus Group Discussion (FGD)
Group Discussions (GDs)
Site visits

Assumption 4.1: **UNFPA has identified key enabling factors in different country contexts and developed effective interventions to strengthen these.**	**Information sources**
Indicators: • Identification of enabling factors in CO annual reports • Interventions in CO plans at the national and community levels designed to strengthen the enabling environment • Evidence of enablers being strengthened at national and community levels (e.g. political commitment, community support) • Evidence of how enablers have facilitated strengthened FP information and services.	
[Joint Commitment from Participants in the National Family Planning Conference, 2014] The conference statement shows commitment to creating an enabling environment for FP as part of SRHR. "*We, the officials of the Ministry of Health, Development Partners, Representatives of Civil Society Organizations (…) hereby commit ourselves to ensuring a comprehensive family planning programme in Cambodia will be realized through: 1) Creation of an enabling environment for human rights based family planning as an integral part of sexual and reproductive health and rights*." The document further details that this commitment is to be realized through developing and revising national policies and guidelines, prioritizing VMGs for FP interventions, promoting a total market approach, and ensuring FP services are made available regardless of clients' marital or economic status, sexual orientation or gender identity.	(anon 2014: 1-2)
Lead role in 2014 national family planning conference: "*The CO successfully advocated with DPs, NGOs and private sector to jointly support and finance the meeting. (…) The conference at the end produced a joint commitment which reaffirms the government and stakeholders' commitment to rights–based family planning programme in Cambodia under the theme – Choices not Chance."*	(UNFPA Cambodia 2014a: 11)
WHO with UNFPA commissioned a 5-country study, including Cambodia, regarding lessons learned and necessary changes to current FP strategies, such as lowering unmet need and increasing long term methods.	DP staff
[Country Programme Action Plan (CPAP) 2006-2010] "*Key initiatives for Output 1 will include: Improve government-donor coordination and advance sector-wide approach (SWAp) approach within the Ministry of Health."*	(UNFPA Cambodia 2006: 17)
[Evaluation of the UNFPA Support to Maternal Health – Cambodia Country Report] "*UNFPA advocacy efforts with high-level officials and parliamentarians have greatly contributed to increased government commitment*."	(UNFPA 2012b: 60)

"The current government commitment to RH/FP is UNFPA's doing."	DP staff
UNFPA played a key role in ensuring government commitment to budget for full contraceptive procurement costs as from 2016 onwards.	(UNFPA Cambodia 2014a)

Assumption 4.2: **UNFPA has successfully supported partners at country and community levels to improve demand creation and access to services, thus enabling people to exercise their rights better.**	**Information sources:**
Indicators: • Improved service use and FP uptake (esp. where unmet need is high and by VMG) • Change in unmet need of different groups • Access barriers reduced, equity improved • Increased responsiveness to the needs of VMG.	
[Mid Term Review Report for CP 2006-2010] UNFPA support for RH – overall recommendations: "*family planning – introduce new methods, roll-out community based distribution nationwide, improve counselling and escalate mass media interventions to address misperceptions and drop-outs."*	(UNFPA Cambodia 2008: 10)
[Cambodia Demographic and Health Survey 2010] Intention to use FP by non-users was the same in 2010 (53 percent) as in 2005 (52 percent).	(NIS, DGH et al. 2011: 83)
[Integration of demographic perspectives in development, Cambodia] "*The total fertility rate has declined from past level yet the level of unmet need for family planning is high (…). If this potential demand is tapped and the unmet need addressed, the pace of fertility decline is likely to accelerate further."*	(RGoC 2013a: 14)
[Cambodia Demographic and Health Survey 2014. Key Indicators Report] Unmet need reduced from 17 percent in 2010 to 13 percent in 2014. "*Demand for family planning is the sum of unmet need and met need (with all methods). The total demand for family planning in 2014 in Cambodia is 69 percent, which is the same level as in the 2010 CDHS (68 percent."* Increased demand and access led to rise in CPR, reduced unmet need and increased demand satisfied.	(Ministry of Planning, Ministry of Health et al. 2015: 14) UNFPA staff
UNFPA is engaged in evidence generation regarding unmet need for FP and will continue to do so under the fifth country programme (CP5).	(Noij, Kasumi et al. 2015, United Nations 2015)
[Situational Evidence Review Report] "*In partnership with NGOs and the MoH, more intensive demand-generating interventions for family planning have been initiated in the past few years, including a specific focus on longer term methods particularly intra-uterine contraceptive devices (IUCDs). Promotional efforts include a media campaign using different TV and radio spots for national coverage and CBD programming targeted at more rural and remote areas, aimed at outreach for harder-to-reach women and poorer women.*"	(UNFPA Cambodia 2013a, UNFPA Cambodia 2014e: 20)

People want long-term methods when available, especially implants (which have a supply issue), before IUCD (because of rumours: IUCSs supposedly 'move around' in one's body, cause unexpected side-effects and cause a delayed return to fertility).	NGO staff
Community-based distribution (CBD) of contraceptives: The community-based distribution of FP method (pills, condoms) has led to increased use of services.	UNFPA staff
[Evaluation of the UNFPA Support to Maternal Health – Cambodia Country Report] UNFPA has introduced CBD, "*which aided the expansion of family planning provision in remote areas and for poor populations. However, coverage needs to be improved."*	(UNFPA 2012b: 27)
UNFPA supports demand creation at community level via the RHAC programme (in all nine operational districts in Takeo province): funding and TA, for services to women of reproductive age. This CBD programme uses Village Heath Support Group (VHSG) volunteers to sell pills and condoms (revenue is partly for health centre, partly an income for the volunteers) and do education, counselling and referral. They implement an IUCD voucher scheme (covering user fee, client transport cost, volunteer fee – US$ 5 incentive or each client referred for IUCD insertion), while maintaining informed choice by explaining all methods. Related components are the training of facility midwives to do IUCD insertion; and attention for SRH/FP of garment workers in 18 Takeo factories. However the CBD is not seen as overall effective.	UNFPA staff, (Sovannarith 2014)
[UNFPA supports remork-motos: promoting long-term contraceptive use in rural communities] The CBD programme contributed up to 30 percent to new FP clients in selected areas. [Remork-motos are motorised rickshaws, a local mode of transport mostly used in urban centres in Cambodia.]	(UNFPA Cambodia 2014g), NGO staff
Single-rod implants suddenly boosted, partly as providers got incentives: users paid US$ 5, the health equity fund (HEF) US$ 16, vouchers US$ 25. So now there may be a potential "provider bias" regarding implants.	UNFPA staff
"*The most important weakness in current CBD activities is spotty coverage in many ODs. While there is some extent of CBD in over 62% of ODs, only half of the villages far from a HC in them actually have a CBD Agent. Whole HC catchment areas and many villages are omitted, often ones that are unusually remote and/or poor."*	(Keller 2010: ii)
[Review of community-based distribution of contraceptives in Cambodia] "*CBD has a positive effect on modern contraceptive use in rural villages that are far from the health centres and shops, and accounts for a large share or modern method use in such areas. Its impact is much less when it is implemented in areas close to a health centre or markets."* (p. i) *"The potential profit from CBD sales under the present pricing structure and given the small population size of many villages is quite small, and in most cases amounts to just a dollar or so per month.*" (p. iii)	(Keller 2010)
CBD is labour-intensive, expensive and with small results (pills and condoms yield little / couple year protection). VHSGs are used for CBD but they are very busy already, e.g. they also have others tasks related to TB, malaria and health education. They could do a better job if they were properly incentivized; currently they only spend a few hours per month on	DP staff

volunteer work. VHSGs are now under MoH, but it has no funding to support this network. There is discussion to move them to Ministry of Interior (MoI), linked to the Community Investment Plan.	
CBD programme should be sustainable as it uses existing VHSGs, links with the health system, and health centres (HCs) can use user fees to support them (but only those do that show leadership).	NGO staff
Health centres sometimes see CBD as competition; CBD is still important in certain geographical areas but not all-over.	NGO staff
Among themselves, female service users can mention all available methods for FP. They know the CBD system and express to be happy with provider attitudes.	Female service users, observation
Young people's access: Adolescents do not come to a HC for FP, only for abortion, if needed. If they need FP, they seek private services -- e.g. a pharmacy, as in communities it is not culturally acceptable for unmarried girls to have sex (although boys are freer than girls). They feel exposed when coming to the HC and waiting in line.	Government staff
FP clients are mostly married women and over 20, while under-20 clients are rarely seen. Girls living here are busy as factory workers and most do not have a "sweetheart" (boyfriend) or are not sexually active. Those that do have partners do not use FP.	Government staff
For some years, unmarried girls have been accessing more FP services, due to changes such as social media, Facebook, TV and other mass media and internet. Before that they were shy.	Government staff
When a girl goes to the health centre to ask for FP the staff will sometimes laugh at her.	Male service users
Pro-poor features of programmes: the "ID poor" (identification of poor households) programme and HEF system has improved access to FP (and other services) for the poor. However *"not all who should benefit, are benefitting"*, due to administrative reasons or migration issues (e.g. leading to lack of required documentation).	NGO staff
"*UNFPA has been among donors supporting Health Equity Funds to enable poor people to access essential services, which has contributed to increased take-up of services at public health facilities.*"	(UNFPA Cambodia 2011: 13)
Factory workers' access: [Visit to footwear factory] UNFPA supports the factory workers' demand-side of FP through NGOs, via health education, training of factory service providers, CBD and referral.	NGO and UNFPA staff, observation
Gender issues and men's access: between them, the men know all methods and agree that spacing is good. However they feel FP is a women's responsibility, as it concerns their body, their health.	Male service users
Men are not targeted directly, but included in other programmes, via NGOs, communities and health centres.	UNFPA staff
[Consultation on the Global Strategy for Women's, Children's and Adolescents' Health 2015] "*Power dynamics within marital relationships were seen as particularly influential in terms of women's health. Concerns were raised that women don't have power to speak to their husbands about reproductive health. In particular, it was noted that a wife is often not able to talk to her husband about family planning."*	(RACHA 2015: 5)
[The Role of Social Support and Parity On Contraceptive Use in Cambodia] Results: "*Women who believed that their husband had a positive attitude toward contraception were more likely than those who did not to use a method (…), whereas*	(Samandari, Speizer et al. 2010: 122)

women who were nervous about talking with their husband about contraception were less likely than others to use a method (…) CONCLUSIONS: To promote contraceptive use, family planning programs should focus on increasing men's approval of contraception, improving partner communication around family planning and bolstering women's confidence in their reproductive decision making."	

Assumption 4.3: **HQ and ROs have supported COs in identifying needs, creating an enabling environment and promoting demand and access in different contexts**	**Information sources**
Indicators: • Frequency and nature of technical assistance (TA) visits and communications with focus on factors related to creation of enabling environment and promoting demand and access.	
This and other assumptions on RO and HQ support and guidance are consolidated in section 1.2 of the report.	

Area of Investigation 5: Vulnerable and Marginalised Groups

To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalized groups, including identification of needs, allocation of resources, and promotion of rights, equity and access?

Data collection methods:
Document review
Key Informant Interviews (KIIs)
Focus Group Discussion (FGD)
Group Discussions (GDs)
Sire visits

Assumption 5.1: **UNFPA globally and at country-level performs situation analyses to identify needs, challenges and rights violations forms, and identifies good practices on how to address these.**	**Information sources:**
Indicators • Evidence of gender-sensitive needs assessment of target groups for UNFPA supported interventions including identification of rights violations • Availability of accurate and sufficiently disaggregated data for targeting most vulnerable and marginalized groups	

• HQ/RO TA visits to support assessment, design, implementation, monitoring (including results-oriented monitoring) and evaluation of interventions to address the needs of VMGs • Evidence that good practices have been identified and disseminated.	
UNFPA has undertaken a series of 2010 Cambodia Demographic and Health Survey (CDHS) in-depth studies, regarding teenage fertility and unmet need for family planning, and also evidence reviews regarding family planning, adolescents, comprehensive sexuality education and others.	UNFPA staff, (United Nations 2009, Loun, Phan et al. 2013, Meng, Po et al. 2013, Clarke 2014, Sovannarith 2014, UNFPA Cambodia 2014e, Noij, Kasumi et al. 2015)
UNFPA has commissioned a secondary analysis of the SRH indicators of the CDHS 2000, 2005, 2010 and 2014, by wealth quintile for urban and rural people. This will also provide insights re young people's SRH. UNFPA also commissioned a study regarding urban poor; SRHR of migrant garment factory workers (addressing FP, abortion and STIs/HIV); and has addressed the situation of entertainment workers. More situation analysis regarding VMGs is needed.	UNFPA staff, (Cockcroft 2014)
[Situational Evidence Review Report] "*Vulnerable and at risk populations require targeted and specialised interventions (…) these include women with disabilities, female entertainment workers, PLHIV and especially women living with HIV, young people aged 10-24 including adolescent girls, female garment workers."*	(UNFPA Cambodia 2014e: 57-58)
UNFPA does not include research as part of the SMARTGirl programme; it uses routine data to show trends.	UNFPA staff
Regarding VMGs a field assessment is needed, to see what the evidence for interventions is. UNFPA should balance policy-level discussions with operational-level implementation better.	DP staff
Based on analysis of key indicators per across provinces, discussions are ongoing about the selection of high-priority provinces have been selected for CP5 and how to reach underserved population with SRHR services.	UNFPA staff
[Joint Commitment from Participants in the National Family Planning Conference, 2014] The conference statement shows commitment to addressing the FP needs of VMGs. "*We, the officials of the Ministry of Health, Development Partners, Representatives of Civil Society Organizations (…) hereby commit ourselves to ensuring a comprehensive family planning programme in Cambodia will be realized through: 1) Creation of an enabling environment for human rights based family planning as an integral part of sexual and reproductive health and rights*." (p. 1-2) The document further details that this commitment is to be realized through developing and revising national policies and guidelines, prioritizing FP interventions for "*marginalized groups, at risk populations, hard to reach populations and ethnic minorities*" (p. 2), and ensuring FP services are made available regardless of clients' marital or economic status, sexual orientation or gender identity.	(anon 2014)

Assumption 5.2:	**Information sources:**

UNFPA allocates resources to effective and targeted programming for the most vulnerable and marginalised groups.	
Indicators: • Number and type of program interventions targeted to VMGs • Percent of total budget allocations to partner activities which focus on VMGs.	
"*Insufficient focus has been placed on vulnerable groups – migrants, factory workers, ethnic minorities, entertainment workers, PLWHIV and disabilities."*	(UNFPA Cambodia 2014a: 12)
For government services to provide for VMGs will take time. While UNFPA works with the government system, it also supports NGO programmes for specific interventions with VMGs, to share the experience with government. UNFPA allocates support for VMGs, yet mostly via its support to MoH which, in turn, should also reach these special groups.	UNFPA staff
Serving VMGs is hard for government and MoH, they do not manage to serve their current client group (married women) well, let alone others like unmarried people. Public services are available, but clients do not use them. So others should take on VMGs; young people anyway go to the private clinics. UNFPA should support NGOs to work with young people; however the government and MoH are not ready. An enabling environment should be created.	NGO and DP staff
Young people, entertainment workers and sex workers experience problems of access, stigma and awareness. "*While all young women should have access to health care services, specific groups, including female garment workers, entertainment workers, women living with HIV, ethnic minority women, migrant women and adolescent girls, will require more focused attention on education about sexual and reproductive health and rights, including contraception and safe abortions.*"	(United Nations 2014: 32)
[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] "*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.*" (p. 15) The particular programme focus (…) reflected an emphasis on vulnerable groups" (p. 26).	(Noij, Kasumi et al. 2015: 15, 26)
Draft CP5: CP5 will focus on VMGs, including young people, people living in poverty, entertainment workers, garment factory workers and geographically remote populations.	(UNFPA Cambodia 2014e, United Nations 2015)
Young people -- The 2008 adolescent SRH guidelines refer to the essential service package, including: Provide information and counselling on birth spacing and provide contraception; pre- and post-abortion counselling including birth spacing service; and STI information including effective prevention of STI and AIDS.	(UNFPA Cambodia nd-b)

[UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] "*To address youth health (…) UNFPA has also worked to increase availability and access to youth-friendly clinical and counselling services and overseen the finalisation of key national strategies."*	(Shah 2010: 6)
Despite UNFPA efforts, there were "*FP insufficiencies*" in the adolescent SRH programme. Young people, particularly unmarried young people, still have limited access to SRH services.	(UNFPA 2012b, United Nations 2014)
[National Strategy on Reproductive and Sexual Health 2012-2016] "*Current low levels of reproductive and sexual health (RSH) knowledge among young people (…) is worrying. Young people in Cambodia tend not to use conventional services because of concerns about confidentiality and staff attitudes, preferring easy-to-use "One Stop Shops" in unthreatening, nongovernmental environments. (…) The unmet need for RSH information and services for young people in Cambodia is mainly met by NGOs."*	(Ministry of Health 2012: 17)
"*Despite having no legal age restrictions on access to reproductive health services, including for contraceptives and access to abortion, there is a lack of understanding on how easily young people could make use of such services.*"	(RGoC 2014: 77)
Young people and unmarried people are important groups, UNFPA has not given enough attention to these; the reported CDHS increase in teenage pregnancy was a wake-up call. There is stigma around adolescents and FP (self, community, provider).	Government, NGO and DP staff
UNFPA could advocate with the government for an improved adolescent SRH policy. Unmarried teenagers sometimes end up with untrained providers for unsafe abortion. There are sensitive (cultural) issues, so it is good to bring lessons learned and do more research.	NGO staff
UNFPA CP5 will have separate outcome for young people, via support to MoH (youth-friendly services), MoEYS (CSE) and BBC Media (TV soap *Love9*). Unmarried young women are targeted via radio, Love9, the RHAC community programme and the MoH youth-friendly services.	UNFPA staff
UNFPA with USAID co-funds the Cambodian BBC TV drama series *Love9*, which employs social media features. One evaluation notes it addresses FP and effectively manages to attract a wide young audience; and among others addresses FP. UNFPA itself maintains that "*reaching poor and vulnerable adolescents and youth through this Love9 intervention remains to be verified.*"	DP and UNFPA staff, (UNFPA Cambodia 2014a:10, United Nations 2014, Noij, Kasumi et al. 2015)
Young people/youth-friendly services – In total, 840 health centre staff were trained; in 79 percent of all health centres (1,058), staff was trained to provide SRH services to young people. End-2014, 684 HCs were trained in this kind of service, more than the original target of 400 HCs. Yet, given "*current system constraints, it is estimated that the actual service provision is limited*."	(UNFPA Cambodia 2013a, UNFPA Cambodia 2014e: 34, Noij, Kasumi et al. 2015)
The public youth-friendly services are not of high quality: young people do not go there due to staff attitude and confidentiality issues. They prefer to go to NGOs where they get better information and services. Issues persist around quality of counselling, paternalism and stigmatization of unmarried clients.	Government, NGO and UNFPA staff

"*Unmarried young people using FP is against our culture*." Also, when a girl goes to the health centre to ask for FP the staff will sometimes laugh at her.	Male service users
Adolescents do not come to health centre for FP but only for abortion, if needed. If they need FP they seek private services -- e.g. pharmacy, as in communities it is not culturally acceptable for unmarried girls to have sex (boys are more free) and they feel exposed when coming to the health centre and waiting in line.	Government staff
FP clients are mostly married women and over 20. Girls living here are busy as factory workers and most do are not sexually active. Those that have partners do not use FP.	Government staff
Since some years, unmarried girls are accessing FP services more; due to changes such as social media, Facebook, TV, mass media and internet. Before that they were shy.	Government staff
Communities are changing; there is more attention for adolescent decision making and more awareness that girls have boyfriends.	NGO staff
Public services are unable to provide adolescent SRH services; there are issues around privacy and confidentiality. NGOs are trusted by young people but their work is not sustainable; private clinics are sustainable.	NGO staff
Access to youth-friendly services is difficult to facilitate from pubic services. *"Public sector services will not work well unless there are also changes in the community, for which NGOs are needed."*	DP staff
Young people/CSE UNFPA supports MoEYS for CSE and life skills in seven provinces for grades 7-11, training teachers to reach students; as well as out-of-school youth. At least six NGOs also use these materials. The UNFPA role is advocacy, funding, TA at national and provincial levels and knowledge management. UNFPA advocacy is ongoing to integrate this extracurricular activity into the curriculum. Topics also include FP methods, the right to decide, and lesbian, gay, bisexual, transgender and intersex (LGBTI) issues, linked to an NGO-run hotline and OneWorld e-learning sessions. Teacher are usually comfortable teaching this and those who are not can rely more on the online sessions. Limited capacities of teachers can still pose challenges; while expansion to other provinces is limited due to budget availability. There are no impact indicators; the idea is that the CSE helps to change behaviour, reduce unintended pregnancy.	Government and UNFPA staff
As compared to 2010, the 2014 CDHS shows that youth knowledge on HIV has gone down from 98 percent to below 80 percent, this is due, in particular, to lack of funding to consistently address SRH issues in schools.	Government staff
Young people/factory workers UNFPA support a RHAC programme focusing on 17,000 (mostly young, female, migrant) garment workers in 18 factories, among others by advocating for setting standards for the services provided via the mandatory factory infirmaries (for factories over 50 workers).	UNFPA staff

Visit to footwear factory: All young women participating in the health education session (some married, others not) have personal reasons to prefer one FP method over another. Some do not like hormones, so prefer the IUCD. Some forget to take the pill, so prefer an injectable. Some have heard stories about IUCD side-effects, and thus prefer another method	Observation, NGO staff
[RMNH Knowledge, Attitudes and Practices among Female Garment Factory Workers] In a survey among 909 women (average age: 21), working in four garment factories served by a particular NGO, around 41 percent of ever sexually active women had used some form of contraception in the past 12 months. They obtained modern contraceptives mostly from pharmacies and private clinics (p.6). "*Correct contraceptive use may not be consistent as one fifth of women who became pregnant in the past 12 months reported that they were using modern FP methods at the time. (…) The risk of unplanned pregnancy is heightened by the low self-efficacy expressed by women in relation to refusing sex and using FP in challenging circumstances.*" (p. 32) Recommendations include empowering women and engaging men.	(Sopheab 2014)
Young people/HIV and entertainment work (EW) **[Examining life experiences and HIV risks of young entertainment workers in four Cambodian cities]** "*In 2008, Cambodia passed the Law on the Suppression of Human Trafficking. Since the 2008 law, there has been a significant shift of women working in brothels to those working in non-brothel based entertainment establishments.*" (p. 15) *"(…) the implementation of this law should also promote the right of all individuals to have access to sexual and reproductive health, and STI and HIV prevention, care, and treatment services.*" (p. 42) *It is important to implement the law "in accordance with the HIV law and the MoI Strategic Plan 2009-2013 for creating an enabling environment.*" (p. 13)	(MoEYS 2012)
Female EWs "*Further reported that violence, stigma and discrimination were commonplace, including self-stigma for being sex workers, which is poorly perceived in Cambodia." (p. 10)* *"Condom use with partners (sweethearts and clients) was inconsistent.*" (p. 13)	(MoEYS 2012)
A base line survey conducted in 2014 in nine provinces found that 35 percent of female EWs use FP services; a subsequent survey in 14 provinces found that only 10 percent used FP services.	NGO staff, (UNFPA Cambodia 2014b)
UNFPA supports the NGO-led SMARTGirl programme focusing on 16,000 (venue-, street-, casino-based) EWs in 14 provinces, with attention for HIV, STIs, maternal health and FP, via drop-in centres, peer education and outreach.	UNFPA staff, (UNFPA Cambodia 2013b)
"*Group leaders and outreach workers who have entertainment background reached younger EWs – the most hard-to-reach risk groups (street based and freelance sex workers).*"	(UNFPA Cambodia 2014a: 17)
All SMARTGirl programme FGD participants said they used FP/RH services at an NGO clinic in the "red-light" area and all were satisfied with services provided. They said the clinic targets poor and marginalised groups (PLHIVs, EWs and others); the staff working at the clinic were considered very friendly, without any judgment or discrimination.	Female service users

Regarding pregnancy prevention, five participants use short term and long term contraceptives, apart from condoms. The other four said they only used condoms due to side effects of other methods. All participants wanted to space but not limit the number of children. Six out of nine participants had experienced an abortion.	Female service users
Key priorities for the UNFPA Cambodia EW programme monitoring data show that on two out of three key indicators (consistent condom use with clients, abortion), program outcomes are worse than the 2013 behavioural surveillance survey average. The program scored better on the remaining key indicator (consistent condom use with sweetheart or husband).	(UNFPA Cambodia 2015, UNFPA Cambodia nd-a) UNFPA staff
[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] "*The field visit to three provinces confirmed that the capacity of the peer educators in the SMART Girl programme, which focuses on EWs, has been enhanced with support from UNFPA during the CP4 cycle, resulting in enhanced use of counselling, HIV rapid testing, access to FP and referral to public health services, where the majority of EWs had previously no access to such services*."	(Noij, Kasumi et al. 2015: 45-46)
PLHIV: **[Positive and Pregnant. A study on access to RMH care for women living with HIV in Asia]** "*Women in Cambodia, India, and Indonesia recorded the highest rate of being asked to undergo sterilisation (over 35 percent). (…) Cambodian women recorded the least choice to decline sterilisation (34 of 70 women).*"	(APN+ 2012: 28)
[National Strategy on Reproductive and Sexual Health 2012-2016] "*The PLHIV Stigma Index, conducted in 2011 by KHANA with UNAIDS support, found that 73 percent of Cambodian PLHIV had received counselling on their reproductive options, 79 percent were advised by a health professional not to have children, 19 percent reported being coerced into being sterilized, and 6 percent reported being coerced into termination of pregnancy*" (Ministry of Health 2012: 15). "*These findings are incredibly disturbing and will need to inform future action to ensure the reproductive rights of PLHIV are adequately ensured*" (CPN+ 2010: 5).	(CPN+ 2010, Ministry of Health 2012)
People living in poverty **[Review of community-based distribution of contraceptives in Cambodia]** "*CBD particularly benefits the poor, since these are both more likely to live in remote areas and are disproportionately affected by the cost of travel to obtain services. (…) The socioeconomic profile of CBD clients shows a higher percentage of poor than that of government health facilities and a much higher one than that of shops and other private sector sources."*	(Keller 2010: ii)
Urban poor: UNFPA and UNICEF work on new initiative to develop a minimum package of services to address needs of urban poor, including SRH/FP.	(Phnom Penh Capital 2013)
The poor have access to FP via the health equity fund or the (IUCD, long-term method) voucher schemes supported by donors. The UNFPA-supported RHAC voucher scheme for IUCDs covers US$ 5 user fee, offers transport money and pays for CBD client follow-up.	Government staff
People living in poverty/HEF The CO successfully advocated for including FP service fees into the HEF scheme. This is a third party financing mechanism covering user fees for poor people (those meeting the national "ID Poor" criteria). The package included IUCD and implant services. The ID poor/HEF system has increased access to FP (and other services for the poor),	(UNFPA Cambodia 2011, UNFPA Cambodia 2013a, CIA 2015), UNFPA and NGO staff

although research shows that only 40 percent of those eligible actually have access to services, e.g. due to administrative or migration reasons (such as missing documentation).	
To avoid a bias of the health equity fund against more expensive FP services (implants, IUCD), UNFPA successfully advocated for adjustments in the reimbursement system. (Previously, providers would get same small amount for any method while obviously costs for some were higher than for others.)	UNFPA staff
The government is committed to the HEF and contributes 40 percent of the cost; GoC has said it will continue even if donors do not.	UNFPA staff
[UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] "*UNFPA was also credited for highlighting critically needed reproductive health services, such as abortion and long-term family planning tools, for incorporation into expanded health equity funds.*"	(Shah 2010: 10)
Indigenous populations: UNFPA engaged an NGO to organise a consultative meeting on indigenous people's reproductive health, gender and population.	(Health Unlimited 2007)
[Socio-cultural influences on the RH of migrant women in Cambodia, Lao PDR, Thailand and Viet Nam] "*Indigenous people make up a majority of the population in the North-eastern provinces of Mondul Kiri and Rattanak Kiri where socioeconomic and health indicators compare unfavourably with the rest of the country. The particular needs and different cultural norms, beliefs and languages of indigenous peoples need to be addressed in reproductive health and other social sector interventions in order to address inequities in health outcomes."*	(UNFPA APRO 2011: 6)
UNFPA supports MoH services in remote provinces with ethnic minority populations, but it does not specifically design programmes for these.	UNFPA staff
There are minority ethnic groups in the northeast provinces and there is a big gap in access. Improving FP there takes time, due to issues around culture and leadership. This is a gap for UNFPA to work on.	NGO and DP staff
MSM: UNFPA identifies men who have sex with men (MSM) as a key affected population for HIV programming.	(United Nations 2010, UNFPA Cambodia 2014e)
LGBTI: The Cambodia speech in the 2014 UN Assembly mentioned LGBTI issues. Sensitive issues are OK with the government, whether these deal with FP, abortion, gay issues or gender identity.	UNFPA staff
[Joint Commitment from Participants in the National Family Planning Conference, 2014] The document shows attention for sexual orientation and gender identity.	(anon 2014: 2)

Assumption 5.3: **UNFPA promotes reproductive rights and supports capacity development to remove barriers and improve access, quality and integration of FP services with other services for the most vulnerable and marginalised groups.**	**Information sources:**
Indicators: • Rights of, and services for VMGs actively promoted in advocacy strategies with specific attention to gender issues	

• Type of capacity building interventions to address service barriers and improve access for, and enable exercise of rights by the most disadvantaged groups.	
Role UNFPA: capacity development around inclusion of CSE in school curriculum	Government staff
[UNFPA's Role in Population, Gender, and Reproductive Health. Country Case Study: Cambodia] "*One NGO representative stressed the importance of continuing the work of UNFPA with the youth (…). UNFPA has the capacity to contribute sustained resources over time and have an impact."*	(Shah 2010: 9)
UNFPA CP5 will have separate outcome for young people; 32 percent of the population are 10-24 years. UNFPA already supports MoH on youth-friendly services protocol/training curriculum and training; and works with MoEYS on CSE getting it from extracurricular into the curriculum.	UNFPA staff

Assumption 5.4: **UNFPA actively encourages VMG to participate in programme planning, implementation and monitoring and VMG receive capacity building to this end.**	**Information sources:**
Indicators: • Evidence for gender sensitive participation by VMG • Evidence for UNFPA support for training in participation.	
UNFPA does not have a direct relationship with target populations but via implementing partners. There the process can improve. (Umbrella) NGOs are involved in planning and monitoring, but not with VMGs directly. In the SMARTGirl programme, participants participate in programme design and monitoring.	UNFPA staff
The SMARTGirl program: "*Empowering EW/SWs through their active participation and dialogues in national and sub-national forums got their voices heard by the policy makers on issues of HIV, SRHR, and violence against women (VAW)."*	(UNFPA Cambodia 2014a: 17)
UNFPA coordinated the capacity development of the Youth Advisory Panel on the issue if the post-2015 sustainable development goals (SDGs).	(UNFPA Cambodia 2013a)
CP5 will strengthen capacity of both duty bearers and rights holders (p. 3), also regarding provision of quality FP to married and unmarried adolescents and youth.	(United Nations 2015: 3, 4)

Assumption 5.5: **Access to and utilization of services by VMG, according to their sexual and reproductive intentions, has improved.**	**Information sources:**
Indicators: • Documented evidence on improved VMG access and utilization of services • VMG user (women and men) satisfaction with service access and quality.	
VMGs lack access to FP.	(UNFPA Cambodia 2014a)

[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] "Hard-to-reach populations do not have sufficient access to FP services."	(Sovannarith 2014, Noij: 42, Kasumi et al. 2015)
In 1,000+ health centres and with 20,000+ health workers, things happen; not all staff always act in line with the policy. Some health workers have a "you have to do what I say" attitude, not a client-centred approach. VMG will have difficulties accessing the general services. Entertainment workers may not find what they need in the general health services, LGBTI people neither. This needs an NGO-approach, with special interventions such as the Smart Girl programme. The government can still serve garment factory workers and support community-based distribution of FP.	UNFPA staff
[Family planning thematic evaluation report (UNFPA Cambodia)] Poor people have increased access via the HEF.	(Sovannarith 2014: 56)
[Situational Evidence Review Report] Entertainment workers now have increased access to FP.	(UNFPA Cambodia 2014e)

Area of Investigation 6: Rights-Based Approach

To what extent has UNFPA implemented a human rights-based approach to family planning, in particular regarding access to and quality of care, and through support from HQ and RO for a rights-based approach in country?

Data collection methods:
Document review
Key Informant Interviews (KIIs)
Focus Group Discussion (FGD)
Group Discussions (GDs)
Site visit

Assumption 6.1: **UNFPA staff and key partners have a shared understanding of the meaning and importance of a rights-based approach to FP.**	**Information sources:**
Indicators: • Identification of definitions/descriptions of rights-based approaches • Perception of UNFPA and partners' staff of the meaning and importance of the rights-based approach.	
[Birth spacing policy for Cambodia] "*General Principles. Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. (…) 3. Individuals and couples should have unrestricted access to Birth Spacing services. 4. Birth Spacing methods are used on a voluntary basis without coercion or incentives. 5. Individuals and couples should be offered a choice of birth spacing methods. (…) 6. The choice of method should be made freely but the provider has a responsibility to exchange information with the client which makes this choice an informed choice."*	(Ministry of Health 1995: 2)
[National Strategy on Reproductive and Sexual Health 2012-2016] The document states as principle for "reproductive health rights": married and unmarried Cambodians "*have the right to reproductive and sexual health (RSH) information and to access safe, affordable, good quality RSH services that respect individual dignity.*" (p.8) In the same document, the indicator for family planning is however disaggregated in a way that focuses on maternal aspects, via "*Unmet need for birth spacing reduced*" and "*Unmet need for birth limiting reduced."*	(Ministry of Health 2012)
[Draft national population policy] The policy refers to Cambodia being signatory to the International Conference on Population and Development (ICPD), the Convention on Elimination of all forms of Discrimination against Women (CEDAW) and the Universal Declaration of Human Rights; and to the ICPD emphasis on dignity and human rights (p.16). It states that Cambodia "*will achieve population stabilization by addressing the individual's/couples reproductive needs by addressing unmet need for contraception and by encouraging men to take equal responsibility in use of contraceptive methods."*	(RGoC 2015: 18)

[2015 draft Birth Spacing Policy in Cambodia] (in Khmer) The document presents universal access to family planning as a human right, central to gender equality and women's and young people's empowerment, and a key factor in reducing poverty. It frames access to rights-based family planning as part of ensuring SRH and reproductive rights. Key principles mentioned are: • Universal human rights, such as the right to decide freely and responsibly on the number and spacing of children, and the right to choose from a broad mix of modern FP methods • Non-discrimination, with reference to VMGs and the right to make decisions free of coercion or discrimination • Gender equality and equity, not opposing or imposing contraception and free from GBV • Provision of evidence-based information and services to communities and individuals, especially VMGs • Access for adolescents and young people • Accountability and transparency, innovation, efficiency, quality, results and sustainability	(Ministry of Health 2015b)
The human rights-based approach (HRBA) is about the right to information, freedom of choice on when and how many children to have and whether to use FP, with a range of methods to choose from and the right to receive services. There is no feedback about any coercion. This is not a real problem in practice (although minors need to have their guardian's consent), there is no discrimination. Also service quality has improved, such as for entertainment workers. Sensitive issues can be addressed with the government, whether these deal with FP, abortion, gay issues or gender identity.	UNFPA staff
HRBA used to be about a choice of methods; now it seems to be more about access for certain vulnerable groups, e.g. people with disability. The government and UNFPA do care about HRBA; it is about respecting choice, no coercion. For UNFPA this translates to paying attention to young people and to community-based distribution.	DP, NGO and government staff

Assumption 6.2: **UNFPA programming incorporates human rights principles in the assessment, design, implementation and evaluation of FP program interventions.**	**Information sources:**
Indicators: • Evidence of a rights-focused needs assessment, quality assurance mechanisms, participatory processes, and accountability mechanisms within programs • Evidence of attention to barriers and protocols for addressing coercion • User satisfaction with FP access and quality (men, women, VMGs).	
The various UNFPA Cambodia programming documents and reports show attention for a range of HRBA issues, such as regarding the principles of reproductive choice and rights; accountability and responsiveness towards the needs and rights of all people; reproductive rights of sex workers; and human rights standards such as freedom from discrimination, coercion and violence.	(UNFPA 2011, UNFPA Cambodia 2011, UNFPA Cambodia 2013a, UNFPA Cambodia 2014a, UNFPA

	Cambodia 2014f, United Nations 2015, UNFPA Cambodia nd-a)
[Situational Evidence Review Report] "*A comprehensive human rights-based approach (…) has been recommended and to some extent introduced, including more integrated services, innovative approaches using media, peer networks, psychosocial counselling and legal support."*	(UNFPA Cambodia 2014e: 30-31)
"*The conference at the end produced a joint commitment which reaffirms the government and stakeholders' commitment to rights–based family planning program in Cambodia under the theme – Choices not Chance."*	(Ministry of Health 2015a: 11)
"*UNFPA was able to successfully advocate for integration of Cambodian population dynamics, reproductive health and rights and gender in the Rectangular Strategy Phase 3 (SR3) and draft National Strategic Economic Development Plan 2014-2018.*"	(UNFPA Cambodia 2013a: 5)
Securing government commitment to allocate budget for contraceptives: "*Support to building the capacity of the Ministry of Health in policy dialogue was critical in assisting them in positioning reproductive health and rights as national key priorities in order to mobilize the much needed resources from the national budget."*	(UNFPA Cambodia 2014a: 12)
[Family planning thematic evaluation report (UNFPA Cambodia)] "The UNFPA country office has inventively supported for the national family program to put more focus on family planning intervention financially and technically as one key element priority into the national health strategic plan and its implementation plan. Based on the review of 2014 Annual Operation Plan 2014 in which UNFPA supported to MoH under the National FP, around US$ 542,070.00 was allocated to support for the scaling-up, capacity building and strengthening of family planning services and to promote reproductive health and rights related activities."	(Sovannarith 2014: 27)
2014 National family planning conference: "*The CO successfully advocated with DPs, NGOs and private sector to jointly support and finance the meeting. (…) The conference at the end produced a joint commitment which reaffirms the government and stakeholders' commitment to rights–based family planning programme in Cambodia under the theme – Choices not Chance."*	(UNFPA Cambodia 2014a: 11)
Young people, entertainment workers and sex workers experience problems of access, stigma and awareness. "*While all young women should have access to health care services, specific groups, including female garment workers, entertainment workers, women living with HIV, ethnic minority women, migrant women and adolescent girls, will require more focused attention on education about sexual and reproductive health and rights, including contraception and safe abortions.*"	(United Nations 2014: 32)
[National Strategy on Reproductive and Sexual Health 2012-2016] "*The PLHIV Stigma Index, conducted in 2011 by KHANA with UNAIDS support, found that 73 percent of Cambodian PLHIV had received counselling on their reproductive options, 79*	(CPN+ 2010, Ministry of Health 2012)

percent were advised by a health professional not to have children, 19 percent reported being coerced into being sterilized, and 6 percent reported being coerced into termination of pregnancy" (Ministry of Health 2012: 15). "*These findings are incredibly disturbing and will need to inform future action to ensure the reproductive rights of PLHIV are adequately ensured*" (CPN+ 2010: 5).	
CP5 will strengthen capacity of both duty bearers and rights holders, also regarding provision of quality FP to married and unmarried adolescents and youth.	(United Nations 2015: 3, 4)
[Joint Commitment from Participants in the National Family Planning Conference, 2014] The conference statement shows commitment to a HRBA to FP. "*We, the officials of the Ministry of Health, Development Partners, Representatives of Civil Society Organizations (…) Hereby commit ourselves to ensuring a comprehensive family planning programme in Cambodia will be realized through: 1) Creation of an enabling environment for human rights based family planning as an integral part of sexual and reproductive health and rights (…) 2) Improved availability of good quality, human rights-based, family planning services (…) 3) Increased demand for family planning according to client's reproductive health intentions and preferences (…) 4) Improved availability and reliable supply of quality contraceptives (…).*"	(anon 2014: 1-3)

Assumption 6.3: **UNFPA is developing a body of evidence and lessons learned regarding human rights-based approaches for FP.**	**Information sources:**
Indicators: • Identification of evaluation and research and/or briefs on lessons learned related to human rights-based programming.	
UNFPA Cambodia has co-commissioned a number of studies that contribute to the evidence-base on client needs and satisfaction: • Cockcroft: Literature review on SRH and rights of migrant garment factory workers in Cambodia • Loun et al.: Levels and Trends of Contraceptive Prevalence and Unmet Need for Family Planning in Cambodia: Further Analysis of the Cambodia Demographic and Health Survey • Meng et al.: Teenage Fertility and its Socio-Demographic Characteristics and Risk Factors: Further Analysis of the Cambodia Demographic and Health Survey • Sovannarith: Family planning thematic evaluation report • UNFPA Cambodia: Situational Evidence Review Report. Sexual and Reproductive Health and Rights, Gender Equality and Women's Empowerment, Population and Development • Westoff et al.: Reproductive Preferences in Cambodia. DHS Further Analysis Reports No. 87.	(Loun, Phan et al. 2013, Meng, Po et al. 2013, Westoff, Bietsch et al. 2013, Cockcroft 2014, Sovannarith 2014)
UNFPA is engaged in evidence generation regarding unmet need for FP and will continue to do so under the fifth country programme (CP5).	(Noij, Kasumi et al. 2015, United Nations 2015)

[Situational Evidence Review Report] "*While improving, the low levels of quality counselling and service provision for family planning remains a challenge in the public health sector."*	(UNFPA Cambodia 2014e: 20)

Assumption 6.4: **COs receive and put into practice technical guidance from HQ and ROs to support rights-based FP.**	**Information sources:**
Indicators: • Number, frequency and type of TA provided • RO plans address capacity gaps and support needs of COs, and ROs provide timely support • CO strategies and programmes reflect current technical guidance and best practices for rights-based FP.	
This and other assumptions on RO and HQ support and guidance are consolidated in section 1.2 of the report.	

Assumption 6.5: **Rights holders consider that duty bearers understand their rights to FP and SRH.**	**Information sources:**
Indicators: User satisfaction with FP availability and quality (men, women, VMGs).	
Female service users are happy with provider attitudes and know the CBD system. They can mention all available methods for FP.	Female service users
Footwear factory visit: Some young women factory workers say HC staff are friendly and explain properly all methods; others say not all health workers are friendly and that explanations are not OK.	Observation, female service users
"*Young people, particularly unmarried young people, still have limited access to sexual and reproductive health services."*	(United Nations 2014: 37)
Regarding working with VMGs: accessibility is still an issue, as e.g. there is a big gap in access for ethnic groups.	DP staff
CP5 will strengthen capacity of both duty bearers and rights holders (p. 3), also regarding provision of quality FP to married and unmarried adolescents and youth (p. 4).	(United Nations 2015: 3, 4)

Area of Investigation 7: Modes of Engagement

To what extent has UNFPA adapted its mode of engagement[176] to evolving country needs in different settings, using evidence and best practice?

Data collection methods:
Document review
Key Informant Interviews (KIIs)

Assumption 7.1: **HQ and ROs provide support and TA to COs to identify and adapt to changing needs over time**	**Information sources**
Indicators: • Number of visits and TA input from ROs and HQ to collection and analysis of evidence on changing needs in FP engagement • Other activities (staff workshops, training, etc.) conducted by HQ and ROs) to support program innovation and/or incorporation of best practices into programs.	
This and other assumptions on RO and HQ support and technical are consolidated in section 1.2 of the report.	

Assumption 7.2: **UNFPA COs monitor changes in country context and needs over time and adapt their mode of engagement and programme development accordingly.**	**Information sources:**
Indicators: • Evidence of continued monitoring of country context and needs • Evidence collected and analysed on the appropriateness of the mix • Change of engagement modes used over time • Existence and frequency of coordination on engagement modes with national stakeholders and development partners.	
[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] UNFPA has done several evidence generation and analysis studies.	(Noij, Kasumi et al. 2015: 35)
[Strategic Plan (2014-2017): Implementation Action Plan for the UNFPA Country Office] "*In the Strategic plan for 2014 to 2018, Cambodia is classified as a country with high needs and low ability of the government to sustain and finance their development. (…) Cambodia will therefore implement a full package of interventions and have a larger number of programme*	(UNFPA Cambodia 2014f: 2-3)

[176] "Modes of engagement" refers to the four modes of engagement in the current UNFPA strategic plan (support for service delivery, capacity building, advocacy, knowledge management).

staff. (…) However the country office is committed to upstream the modes of engagement and work gradually towards less of direct service delivery and more of knowledge management, Policy and Advocacy and Capacity development." The CO has already engaged in upstream work and sees the new country programme cycle as an opportunity.	
Changing modes is a balancing act and depends on the country economic status (with an associated risk: becoming lower-middle income country means donors will withdraw) and the RGoC willingness to invest in social services. Changes also imply changing the skills in the CO regarding translation of policy, negotiation and quality focus. The role of UNFPA is innovation, generating new knowledge and responding to a changing environment.	UNFPA staff

Assumption 7.3: **UNFPA interventions and engagement modes support country moves towards increased sustainability of FP and SRH interventions.**	**Information sources**
Indicators: • Evidence of change in engagement modes supporting moves towards sustainability • Percent of overall FP financial needs covered by national budget • Allocation of funds to FP in medium and long-term health sector plans.	
UNFPA played a key role (alongside other DPs) in convincing the government, in 2013, to allocate a national budget for FP procurement, from 2014 (US$ 100,000), to 2015 (US$ 200,000) and then assuming the full budget in 2016 (more than US$ 2m).	UNFPA staff
[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] The UNFPA CO can make use of all modes of engagement, including: advocacy and policy dialogue, knowledge management, capacity development and service delivery. UNFPA has already started to move away from direct delivery. In future it should focus on the other modes of engagement and prepare a changed business model, for when the country reaches middle income status. Operational involvement is expected to be gradually replaced by more analytical and strategic activities.	(Noij, Kasumi et al. 2015: 28)
UNFPA failed to clarify how it was "*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."*	(Noij, Kasumi et al. 2015: 66)

Assumption 7.4: **UNFPA identifies and applies good practice at country, regional and global levels.**	**Information sources:**
Indicators: • Results-oriented monitoring and evaluation systems are in place and inform programming	

• Evidence of good practices identified with attention for rights and gender issues • Examples of application of good practice at country, regional, global level.	
UNFPA Cambodia COAR 2014 identifies a number of lessons learnt, such as lessons regarding: • The role of strong leadership and commitment in encouraging programme implementation • The benefits of linking the Love9 programme with hotline counselling and comprehensive sexuality education • The critical importance of building the capacity of the MoH in policy dialogue, in order for it to mobilize the much needed resources from the national budget • The need for coordination among DPs and NGOs that work in human resources for health related to SRH • The benefits of engaging group leaders and outreach workers with an entertainment background to reach younger entertainment workers.	(UNFPA Cambodia 2014a)

Area of Investigation 8: Supply-side Activities

To what extent has UNFPA support for supply-side activities promoted rights-based and sustainable approaches and contributed to improved access to quality voluntary family planning?

Data collection methods:
Document review
Key Informant Interviews (KIIs)
Focus Group Discussion (FGD)
Group Discussions (GDs)

Assumption 8.1: **Provider training supported by UNFPA is client-centred, quality-focused and promoting rights and freedom of choice in FP.**	**Information sources:**
Indicators: • Nature of training programmes offered by MoH and other partners • Behaviour change communication and client counselling included in training, including gender perspectives	
UNFPA support for provider training on methods (all methods and counselling in general) has helped to improve services and respond to increased demand for FP services. Training emphasizes informed choice.	NGO, government and UNFPA staff, (United Nations 2010)

	(Executive Board of UNDP and UNFPA 2010-3801:3)
"*The CO supported the Cambodian Midwifery Council (CMC) to develop Core Competency Framework for Midwives (…) this was then included in the midwifery training curriculum. (…) In addition, UNFPA continued to support Regional Training Centres to monitor and follow up midwifery students during practice at health facilities.*" (UNFPA Cambodia 2014a: 7)	(Ministry of Health 2013, UNFPA Cambodia 2014c, UNFPA Cambodia 2014a)
"*As per the national guideline on youth-friendly clinical health services, the curricula have been used in the training to health service providers. In total, 840 health centre staff were trained. 79 percent of the total health centres (1,058) have their human resources trained to provide sexual and reproductive health service to young people*." (UNFPA Cambodia 2013a: 22)	(UNFPA Cambodia 2011, UNFPA Cambodia 2013a)
[Health Sector Support Project I (HSSP I) End of Project Assessment] The evaluation identified further training needs: "*At health facility level, the health facility survey indicated that 84.4 percent of those who had attended training felt that they still needed additional training."*	(RGoC 2010: 29)
Staff have been trained on youth-friendly services and say that they are open to counsel/assist young people, take a non-judgmental approach and build trust. Many midwives were shy but now do better with sexuality education for unmarried adolescents. UNFPA is *"doing a good job"* regarding trainings on FP and strengthening the health system.	Government staff
MoH is committed to putting human resources in facilities (all health centres have primary midwives but only 50 percent have secondary midwives), but for capacity development it relies on donor support.	DP and government staff
Quality of care issues: Quality of services is still an issue. Hospitals do not give a good service to the poor. Counselling and long queues lead to time constraints. It is important to ensure technical competency of providers.	DP and NGO staff
[Evaluation of the UNFPA Support to Maternal Health – Cambodia Country Report] "*Some development partners and NGOs reported that (…) UNFPA had focused (…) not enough on trainings for family planning services and sexual health." (p.27)* *"UNFPA has not taken the lead (…) and the difficult issues of quality of care, protocols and quality assurance surrounding family planning services and safe abortion have yet to be addressed."*	(UNFPA 2012b: 67)
Many midwives did not receive the comprehensive (refresher) training on IUCD insertion; and when they do not have self-confidence, they do not offer the services to clients. Staff training on FP should be ongoing (due to retirements, new staff coming in) to build and maintain competencies.	Government and NGO staff
[Situational Evidence Review Report] "*While improving, the low levels of quality counselling and service provision for family planning remains a challenge in the public health sector."*	(UNFPA Cambodia 2014e: 20)
Footwear factory visit: Some young women factory workers say health centre staff are friendly and explain properly all methods; others say not all health workers are friendly and that explanations are not good enough.	Female service users

Assumption 8.2: **UNFPA support to procurement promotes availability of a wider method mix.**	**Information sources:**

Indicators: • Range of methods procured by UNFPA, development partners and national governments • Range of methods available at service delivery points for all user groups.	
[National Strategy on Reproductive and Sexual Health 2012-2016] In 2010, around 50 percent of couple-years protection was generated in the public sector, 48 percent through social marketing and the remainder in the private sector.	(Ministry of Health 2012)
[Evaluation of the UNFPA Support to Maternal Health – Cambodia Country Report] "*Since 2004, UNFPA has played a leading role in (…) the introduction of long-term family planning methods (such as Implanon procured in 2009 by the GPRHCS), and (…) the provision of intrauterine devices (IUCD) and voluntary surgical contraception (VSC) and the introduction of emergency contraception." (p. 26)* *"(…) UNFPA shifted support towards (…) procurement of specific methods (Implanon) in anticipation of commodity shortfalls*" (p. 27). Non-scalpel vasectomy has been given little attention overall.	(UNFPA 2012b) UNFPA staff
"*All 1,094 HCs are reportedly providing at least three FP methods, 962 HFs with IUCD services and 527 with implant services, 63 RHs having staff trained in FP, and 43 are providing FP services*." In 2013, less than half (40) of the 93 referral hospitals (RHs) were providing family services, even though health staff in 60 referral hospitals had been trained.	(UNFPA Cambodia 2013a, UNFPA Cambodia 2014e, UNFPA Cambodia 2014a: 8)
[Study on barriers to the use of modern contraceptive methods] Access to IUCDs and sterilization are still major issues in Cambodia; while there are subsidized or free services for some, a majority of users still have to pay.	(SBK Research and Development 2013: 9)
[UNFPA Country Programme Evaluation Cambodia: Fourth Programme Cycle, 2011-2015] "*UNFPA's current country programme has (…) continued to support improvement and expansion of family planning services and choices,*" (Noij, et al. 2015: 22) especially including implants and IUCDs. The ongoing limited access to FP services in hospitals however is described as a lost opportunity (ibid.: 42), even when they are the only source for permanent methods.	(Sovannarith 2014, Noij, Kasumi et al. 2015) NGO staff
UNFPA was key to expanding the FP method mix. FP started with emphasis on FP for "spacing" but the DHS shows that need and demand for FP for "limiting" is increasing; hence the need to expand the method mix with more emphasis on long-term methods.	Government staff
Short term methods (pill, injectable, condom) are widely available; long-term methods (implants, IUCD) only in the half of the health centres that have secondary midwives. EC is available in some facilities.	Government and NGO staff, female service users
[Views on Family Planning and Long-Acting and Permanent Methods: Insights from Cambodia] *"(…) the contraceptive method mix remains limited. The pill (15 percent) and the injectable (10 percent) continue to be the most widely used modern methods. Use of long-acting permanent methods (LA/PMs) (e.g., the intrauterine device [IUCD], the hormonal implant, and*	(The RESPOND Project 2013: 1)

male and female sterilization) is quite low. (…). At the same time, traditional method use has increased more rapidly than expected."	
UNFPA sources offer inconsistent views on the status and target group of EC. One source: EC is also part of the VAW programme. EC was introduced in 2006 but is available in a few health centres only, as well as for entertainment workers. EC is not much promoted for fear of creating "*undue demand".* Another source: EC is available in all health centres, to be used for post-intercourse emergencies (due to condom rupture or when no protection was used) and in case of rape. It is not supposed to be targeting special groups like entertainment workers, as they may use EC instead of regular protection.	UNFPA staff, (UNFPA Cambodia 2013a, UNFPA Cambodia 2014e)
The female condom 2 was registered in 2009; but there was no demand and it was no longer offered.	(UNFPA Cambodia 2011), UNFPA, NGO and DP staff
NGO services offer removal of implants as part of the insertion package (with fee-exemption). A number of clients ask for removal, e.g. when they want to switch methods because of perceived side effects; or when they want to become pregnant.	NGO staff
Shift to long-term methods: The method mix is important; but it is skewed towards short-term methods, while budget-wise IUCD is most cost-effective. It is important to take into account client preferences but also programme perspectives, hence the rationale for the IUCD voucher programme. Implants are more popular than IUCDs but have stock-out issues and are too expensive. The IUCD (as such the most cost-effective methods) carries many myths regarding its side-effects. Government, with its limited budget, should focus on IUCDs.	NGO staff
UNFPA support helps to make services affordable and makes long-term methods accessible. However people do not see the need to switch from short-term to long-term methods. And many women do not want to "*put something inside*" [i.e. an IUCD].	Government staff
Marie Stopes International (MSI) and Population Services Khmer (PSK) report very few client "rejecters" coming back to have the implant or IUCD removed. Maybe there is a private sector bias, as the quality of service may be higher, e.g. if potential side-effects are explained better than in the public sector. A rights-based approach for implants lies in good counselling and access to removal.	UNFPA and government staff

Assumption 8.3: **Strengthened procurement and logistics systems and related health system improvements are designed to be financially sustained by national governments.**	**Information sources:**
Indicators: • Trend in FP methods (as percentage of MoH budget) • Trends in contributions by other development partners • Value-for-money in method mix, which meets user needs (men and women, adolescents, VMGs).	

[National Strategy on Reproductive and Sexual Health 2012-2016] "*The MOH Contraceptive Security Working Group (CSWG) has been active for ten years, ensuring contraceptive security for Cambodia."*	(Ministry of Health 2012: 15)
[Evaluation of the UNFPA Support to Maternal Health – Cambodia Country Report] "*UNFPA technical support is generally considered to be of good quality and the procurement system is effective. UNFPA also plays an advocacy role in helping to address commodity shortfalls."*	(UNFPA 2012b: 28)
UNFPA supports the MoH and is responsible for all public sector contraceptive procurement. This results in consistent and sufficient stock of contraceptives in health facilities.	(UNFPA Cambodia 2013a, UNFPA Cambodia 2014a)
The current FP programme often subsidizes also those who can afford services – while they should target those who can't afford them (segmentation).	NGO staff
There are no stockout reports from HCs for any method; except sometimes for implants (when CMS gave less than 25 percent of requested amount).	Government and UNFPA staff
Procurement of contraceptives post-2015: From 2016 there will be no more donor funding for contraceptive commodity security; but handing over to government should not be that abrupt. Also, dependency on the national budget only would make contraceptive supply unreliable.	Government staff
[Evaluation of the UNFPA Support to Maternal Health – Cambodia Country Report] "*The procurement and management of the logistics management information system (LMIS) remains an outstanding issue. There is no exit strategy or sustainability for continued donor support in the area of contraceptive security.*"	(UNFPA 2012b: 61, Ministry of Health 2015a)
There will be a contraceptive commodity crisis, as government is not ready to take on the full US$ 2m budget needed in 2016. The influence of UNFPA is limited here and could be stronger.	NGO staff
DFAT provided FP commodity procurement funding during 2008-2015, co-financed by UNFPA. Now government will take over 100 percent of funding as from 2016, which is a success and a key legacy of UNFPA CO efforts.	DP staff
RGoC has agreed to make budget of US$ 2.4million available in 2016 to cover all contraceptive procurement.	UNFPA staff
LMIS: UNFPA provided "*technical and advisory support to the Ministry of Health's RHCS-WG to perform its function in better coordination, advocacy, monitoring and enhancing reproductive health commodity security."*	(UNFPA Cambodia 2013a: 13), government staff
Contraceptive security should be a priority area for UNFPA. The LMIS is not functioning at 100 percent, as there are issues with "value for money" and high-level Government influences. The World Bank published a report some years ago, indicating that government pays 8-15 times the current market prices for commodities such as drugs.	DP and UNFPA staff
[Evaluation of the UNFPA Support to Maternal Health – Cambodia Country Report] "*Gaps in technical support led to issues concerning the sustainability of the logistics system."*	(UNFPA 2012b: 27)

Assumption 8.5: **HQ provides appropriate support to CO level in capacity building and procurements.**	**Information sources:**

Indicators: • Effective monitoring of CO needs by HQ • Number and type of TA and other support inputs.	
This and other assumptions on RO and HQ support and technical are consolidated in section 1.2 of the report.	

ANNEX 4 – SRHR AND FAMILY PLANNING EXPENDITURE (2008-2013)*

PROJECT	IMPLEMENTING PARTNER	Spending per year SRHR INCL Family Planning						TOTAL SPENDING 2008-13 SRHR INCL FAMILY PLANNING	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
		2008	2009	2010	2011	2012	2013			
KHM4U301 (AUA58): Contraceptive procurement	**UNFPA**						**$320,103**	**$320,103**		
Non-Core							$320,103	$320,103	100%	$320,103
CMB3P11E: Population Dynamic	**GOVT**	**$119,343**	**$99,540**	**$130,233**				**$349,116**		
Core		$119,343	$99,540	$130,233				$349,116	10%	$34,912
CMB3P32E: Population data	**GOVT, UNFPA**	**$1,044,739**	**$485,687**	**$510,078**				**$2,040,504**		
Core		$1,044,739	$485,687	$510,078				$2,040,504	10%	$204,050
CMB3R11C: Strengthened national capacity to develop, implement, and evaluate gender sensitive reproductive, family planning policies, strategies and protocols	**GOVT, UNFPA**	**$101,193**	**$137,753**	**$262,898**				**$501,844**		
Core		$101,193	$137,753	$262,898				$501,844	100%	$501,844
CMB3R11F: Population Dynamic	**GOVT**	**$106,576**	**$102,908**	**$107,581**				**$317,065**		
Core		$106,576	$102,908	$107,581				$317,065	10%	$31,707
CMB3R22C: Increased access to high quality reproductive	**GOVT, UNFPA**	**$281,394**	**$517,293**	**$844,218**	**$195,507**	**$67,625**	**$88,591**	**$1,994,628**		

* Values in '000 US$

PROJECT	IMPLEMENTING PARTNER	Spending per year SRHR INCL Family Planning						TOTAL SPENDING 2008-13 SRHR INCL FAMILY PLANNING	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
		2008	2009	2010	2011	2012	2013			
health and family planning information and services										
Core		$153,495	$267,013	$144,748	$195,507	$67,625	$88,591	$916,979	100%	$916,979
Non-Core		$127,899	$250,280	$699,470				$1,077,649	20%	$215,530
CMB3R33C: Strengthened capacity of relevant government institutions and NGOs to provide high quality reproductive health services and family planning	**GOVT, UNFPA**	**$696,416**	**$1,075,813**	**$974,586**				**$2,746,815**		
Core		$291,604	$364,085	$512,853				$1,168,542	100%	$1,168,542
Non-Core		$404,812	$711,728	$461,733				$1,578,273	20%	$315,655
CMB3R54C: Increased awareness of women, men, and youth about reproductive health, reproductive rights, and available services	**NGO**	**$305,849**	**$511,388**	**$214,787**				**$1,032,024**		
Core		$141,766	$141,817	$131,058				$414,641		
Non-Core		$164,083	$369,571	$83,729				$617,383		

PROJECT	IMPLEMENTING PARTNER	Spending per year SRHR INCL Family Planning						TOTAL SPENDING 2008-13 SRHR INCL FAMILY PLANNING	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
		2008	2009	2010	2011	2012	2013			
CMB3R54F[177] (Project Title 1): Increased awareness of women, men, and youth about reproductive health, reproductive rights, and available services (Comprehensive Sexual Education) AND CMB3R54F (Project Title 2): Increased awareness of women, men, and youth about reproductive health, reproductive rights, and available services (local/community participation)	**GOVT, UNFPA**	**$416,418**	**$539,881**	**$551,396**				**$1,507,695**		
Core (Project Title 1)		$265,996	$285,692	$318,252				$869,940	10%	$86,994
Core (Project Title 2)		$150,422	$254,189	$233,144				$637,755	15%	$95,663
GRP6R13A (ZZT05): Contraceptive procurement	**UNFPA**		**$372,267**					**$372,267**		
Non-Core			$372,267					$372,267	100%	$372,267
KHM4P11E: Population Dynamic	**GOVT**				**$400,091**			**$400,091**		
Core					$400,091			$400,091	15%	$60,014
KHM4P31F: Population Dynamic	**GOVT**				**$297,881**			**$297,881**		

[177] This project has two project titles, each of which refer to a different implementing partner.

PROJECT	IMPLEMENTING PARTNER	Spending per year SRHR INCL Family Planning						TOTAL SPENDING 2008-13 SRHR INCL FAMILY PLANNING	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
		2008	2009	2010	2011	2012	2013			
Core					$297,881			**$297,881**	15%	$44,682
KHM4P32E: Population Data	**GOVT**				**$350,647**			**$350,647**		
Core					$350,647			**$350,647**	10%	$35,065
KHM4P41G: Population Dynamic	**GOVT**				**$104,675**			**$104,675**		
Core					$104,675			**$104,675**	15%	$15,701
KHM4R33C: Strengthened capacity of relevant government institutions and NGOs to provide high quality reproductive health services and family planning	**GOVT**				**$272,262**			**$272,262**		
Core					$272,262			**$272,262**	100%	$272,262
KHM4R52D: Comprehensive Sexual Education	**GOVT**				**$251,516**			**$251,516**		
Core					$251,516			**$251,516**	10%	$25,152
KHM4U101: Population Dynamic	**GOVT**					**$288,591**	**$319,123**	**$607,714**		
Core						$288,591	$319,123	**$607,714**	15%	$91,157
KHM4U103: Population Dynamic	**GOVT**					**$250,426**	**$147,983**	**$398,409**		
Core						$250,426	$147,983	**$398,409**	15%	$59,761
KHM4U301 (Project Title 1): Increased national capacity to availability, accessibility, acceptability, affordability,	**NGO, GOVT**					**$652,202**	**$1,166,355**	**$1,818,557**		

PROJECT	IMPLEMENTING PARTNER	Spending per year SRHR INCL Family Planning						TOTAL SPENDING 2008-13 SRHR INCL FAMILY PLANNING	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
		2008	2009	2010	2011	2012	2013			
and utilization of quality reproductive, maternal, newborn services **KHM4U301 (Project Title 2): Strengthened capacity of relevant government institutions and NGOs to provide high quality reproductive health services and family planning**										
Core (Project Title 1)							$242,316	**$242,316**	40%	$96,926
Core (Project Title 2)						$652,202	$924,039	**$1,576,241**	100%	$1,576,241
KHM4U404: HIV and STI Prevention	**NGO**					**$252,550**		**$252,550**		
Core						$252,550		**$252,550**	10%	$25,255
KHM4U405: HIV and STI Prevention	**NGO**						**$246,588**	**$246,588**		
Core							$246,588	**$246,588**	10%	$24,659
KHM4U603: Comprehensive Sexual Education	**GOVT**					**$349,461**	**$248,626**	**$598,087**		
Core						$349,461	$248,626	**$598,087**	10%	$59,809
KHM4U702: Population Data	**GOVT**					**$365,574**	**$524,872**	**$890,446**		
Core						$365,574	$524,872	**$890,446**	10%	$89,045
RAS6R43A: HIV and STI prevention and HIV and FP linkage	**UNFPA**				**$73,825**			**$73,825**		

PROJECT	IMPLEMENTING PARTNER	Spending per year SRHR INCL Family Planning						TOTAL SPENDING 2008-13 SRHR INCL FAMILY PLANNING	% FAMILY PLANNING OF TOTAL SPENDING	TOTAL FAMILY PLANNING SPENDING
		2008	2009	2010	2011	2012	2013			
Non-Core					$73,825			**$73,825**	10%	$7,383
RAS6U410: HIV and STI prevention and HIV and FP linkage	**NGO, UNFPA**					**$38,520**	**$79,670**	**$118,190**		
Non-Core						$38,520	$79,670	**$118,190**	10%	$11,819
TOTAL CORE SPENDING ON SRHR INCLUDING FP		$2,375,134	$2,138,684	$2,350,845	$1,872,579	$2,226,429	$2,742,138	$13,705,809		$5,682,276
TOTAL NON-CORE SPENDING ON SRHR INCLUDING FP		$696,794	$1,703,846	$1,244,932	$73,825	$38,520	$399,773	$4,157,690		$1,366,233
TOTAL SPENDING ON FAMILY PLANNING COMMODITIES (NON-CORE)										
TOTAL SPENDING SRHR AND FAMILY PLANNING		**$3,071,928**	**$3,842,530**	**$3,595,777**	**$1,946,404**	**$2,264,949**	**$3,141,911**	**$17,863,499**		**$7,048,508**

The information presented in the above table was shared by the UNFPA country office in Cambodia. Under the guidance of the UNFPA Evaluation Office, the country office in Cambodia identified projects in support of FP – those fully dedicated to FP as well as those in which FP activities were mainstreamed – and reported the amount spent (annually) under each project. Project expenditure was disaggregated into core and non-core funding. The country office was then asked to estimate the percentage (%) of the project in support of FP – 100 percent in cases where projects were fully dedicated to FP and an estimated percentage for projects in which FP activities were an aspect of the project (mainstreamed). The type of implementing partner (NGO, government and/or UNFPA) – information also provided by the country office - is captured in the table, as well.

The above approach was chosen due, primarily, to challenges in obtaining FP expenditure through the use of the UNFPA financial management platform (Atlas). For the period under evaluation, the UNFPA financial management platform did not explicitly track FP expenditure and, when it did so, did not capture all/the full range of FP expenditure. Prior to 2011, there was no dedicated FP project outcome code within Atlas. Instead, activities advancing FP were embedded in other projects, posing significant challenges to capturing FP expenditure. In 2012 this changed: reflecting a shift in UNFPA outcomes, a dedicated FP project outcome code was introduced in Atlas (the U3 code). While this contributed to an improved ability to track FP expenditure, the code does not capture expenses corresponding to FP activities that are mainstreamed/ included within other interventions, with the attendant challenges remaining.

As mainstreaming poses particular challenges to accurately identifying the entirety of projects and activities in support of FP in Atlas, and subsequently, in determining the amount spent in support of FP, country offices – deeply familiar with the specifics of a project - were requested to report on FP expenditure. A degree of subjectivity exists in, inter alia, selecting FP projects and estimating/ assigning the percentage of a project dedicated to FP (in cases where the activities have been embedded). However, the country office is best positioned to address this, offering a sound determination based on intimate knowledge of a project and its implementation.

The country office was provided with two guidance notes: one focusing on which activities should be considered FP and the other on estimating percentages. On the former, guidance listed the expenses that should be considered expenditure in support of FP, including projects with a U3 code, projects funded through the Thematic Fund for Reproductive Health Commodity Security, expenses incurred to strengthen information systems pertaining to FP or expenses incurred to create enabled environments for human-rights FP.

A typology/ percentage guidance note was also provided. This note listed activities - under different Strategic Plan (2014-2017) outputs - that can be considered to have a FP component, with the corresponding suggested percentage included. While this was offered as a tool to support the country office, the country office was encouraged to offer the percentages that best reflected the actual expenses related to FP in Cambodia.

ANNEX 5 – LIST OF IMPLEMENTING PARTNERS

GOVERNMENT:	
Ministry of Health (MoH)	
CMB3R33C:	Strengthened capacity of relevant government institutions and NGOs to provide high quality reproductive health services and family planning
KHM4R33C:	Strengthened capacity of relevant government institutions and NGOs to provide high quality reproductive health services and family planning
KHM4U301:	Strengthened capacity of relevant government institutions and NGOs to provide high quality reproductive health services and family planning
Ministry of Education, Youth and Sport (MoEYS)	
CMB3R54F	Increased awareness of women, men, and youth about reproductive health, reproductive rights, and available services (Comprehensive Sexual Education)
KHM4R52D	Comprehensive Sexual Education
KHM4U603	Comprehensive Sexual Education
Ministry of Interior (MoI)	
CMB3R54F	Increased awareness of women, men, and youth about reproductive health, reproductive rights, and available services (local/ community participation)
CMB3R11F	Population Dynamic
KHM4P31F	Population Dynamic
KHM4U101	Population Dynamic
Ministry of Planning (MoP)	
CMB3P32E	Population data
CMB3P11E	Population Dynamic
KHM4P11E	Population Dynamic
KHM4U103	Population Dynamic
KHM4P32E	Population Data
KHM4U702	Population Data
National Committee for Population and Development (NCPD)	
KHM4P41G	Population Dynamic
NGOs:	
BBC Media Action (BBCMA)	
KHM4U301	Increased national capacity to availability, accessibility, acceptability, affordability, and utilization of quality reproductive, maternal, newborn services

Cambodia Health Education Media Service (CHEMS)	
CMB3R54C	Increased awareness of women, men, and youth about reproductive health, reproductive rights, and available services
Cambodian Women for Peace and Development (CWPD)	
KHM4U405	HIV and STI Prevention
RAS6U410	HIV and STI prevention and HIV and FP linkage
Khmer Youth Association (KYA)	
CMB3R54C	Increased awareness of women, men, and youth about reproductive health, reproductive rights, and available services
Reproductive and Child Health Alliance (RACHA)	
KHM4U301	Strengthened capacity of relevant government institutions and NGOs to provide high quality reproductive health services and family planning
Reproductive Health Association of Cambodia (RHAC)	
KHM4U301	Strengthened capacity of relevant government institutions and NGOs to provide high quality reproductive health services and family planning
UNFPA	
CMB3R11C	Strengthened national capacity to develop, implement, and evaluate gender sensitive reproductive, family planning policies, strategies and protocols
CMB3R22C	Increased access to high quality reproductive health and family planning information and services
CMB3R33C	Strengthened capacity of relevant government institutions and NGOs to provide high quality reproductive health services and family planning
CMB3R54F	Increased awareness of women, men, and youth about reproductive health, reproductive rights, and available services (local/community participation)
CMB3P32E	Population Data
GRP6R13A (ZZT05)	Contraceptive procurement
KHM4U301 (AUA58)	Contraceptive procurement
RAS6R43A	HIV and STI prevention and HIV and FP linkage
RAS6U410	HIV and STI prevention and HIV and FP linkage

ANNEX 6 – DETAILED KEY FACTS

Indicator	2012	2014	Source of Data
Population and Development			
Population, total	14,832,255	15,328,136	World Bank[1]
Population, aged 0-14 (% of total)	32	32	World Bank[1]
Population, aged 15-64 (% of total)	64	64	World Bank[1]
Population, ages 65+ (% of total)	4	4	World Bank[1]
Population growth (annual %)	1.6	1.6	World Bank[1]
Urban Population (% of total)	20	21	World Bank[1]
Population Density (per sq. km of land area)	84	87	World Bank[1]
Life Expectancy at birth, total (years)	67	68.4	World Bank[1]
Literacy rate, population 15+ years, both sexes (%)	-	73.9	Human Development Report[2]
Youth Literacy rate, population 15-24, both sexes (%)	-	-	World Bank[1]
Human Development Index (HDI)	0.543 (Rank 138 out of 187)	0.555 (Rank 143 out of 188)	Human Development Report[3]
Human Development Classification (very high, high, medium, low, upper middle, high)	Medium	Medium	Human Development Report[178]
Total GDP at market price (current US$)	14,038,383,450	16,777,820,333	World Bank[1]
Economic growth rate (GDP growth annual %)	7.3	7.1	World Bank[1]
GINI Index	30.8	-	World Bank[1]
Multidimensional Poverty Index (MPI), HDRO specifications	0.212	0.211	Human Development Report[3]
Government Effectiveness			
World Bank CPIA Quality of Public Administration rating (1=low to 6 = high)	2.5	2.5	World Bank[1]
UNFPA: Need and Ability to Finance			
UNFPA country quadrant	-	Red	UNFPA Strategic Plan[179]
Gender Equality and Empowerment			
Gender Inequality Index	0.473 (Rank 96 out of 148)	0.477 (Rank 104 out of 155)	Human Development Report[3]
Women representation in parliament, total (%)	18.1	19	World Bank[1]
Violence against women ever experienced (%)	-	22.3	Human Development Report[3]

[178] United Nations Development Programme. (2016). Country Classification. Retrieved from https://pharmacoepi.org/pub/1c08ab60-2354-d714-5192-9cc81d38354f

[179] United Nations Population Fund. (2015). UNFPA Strategic Plan. Retrieved from https://webcache.googleusercontent.com/search?q=cache:PBcjL1DHDYJ:https://www.unfpa.org/sites/default/files/about-

Employment to population ratio, 15+, female (%) (modeled ILO estimate)	79	78	Human Development Report[5]
Ratio of girls to boys in primary and secondary education (%)[4]	-	-	World Bank[1]
Reproductive Rights and Reproductive Health			
Fertility rate, total (births per woman)	2.7	2.7 (2013 data)	World Bank[1]
Adolescent fertility rate (births per 1,000 women ages 15-19)	49	51	World Bank[1]
Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant)	-	12.0	World Bank[1]
Prevalence of HIV, female (% ages 15-49)	0.2	0.2	World Bank[1]
Prevalence of HIV, male (% ages 15-49)	0.1	0.1	World Bank[1]
Maternal mortality rate (per 100,000 live births)	178	167	World Bank[1]
Under 5 mortality rate (per 1,000 live births)	36	31	World Bank[1]
Contraceptive use, modern methods (%)	-	51.3	UN DESA Population Division Estimates and Projections of Family Planning Indicators[5]
Unmet need for family planning (number of married or in-union women aged 15 to 49 who want to stop or delay childbearing but are not using a method of contraception, %)	-	9.9	UN DESA Population Division Estimates and Projections of Family Planning Indicators [5]
Demand for family planning satisfied (% of total demand for family planning among married or in-union women aged 15 to 49 that is satisfied)	-	87.2	UN DESA Population Division Estimates and Projections of Family Planning Indicators[5]
Births attended by skilled health staff (% of total)	74	-	World Bank[1]
Antenatal care (any skilled provider)	89.1% (2010 data)	-	Demographic Health Survey[180]; World Bank[1]

[180] Demographic and Health Surveys. (2010). Cambodia. Retrieved from http://dhsprogram.com/pubs/pdf/FR312/FR312.pdf